



Expert Opinion in Medico Legal Cases –

Is it **IMPORTANT?**

What is
PACT ?

Imaging in
Uterine
Anomalies

Surgery
on Endometriosis :
A Double-edged Sword

INSIDE
INBOX

Contents

01

Congenital Uterine Anomalies
Dr Wang Pei Yoke

02

Changes in Private Obstetrics and Gynaecology Practice
Datuk Dr Puraviappan Arunasalam Pillay

03

MRKH : The Malaysian Chapter – Exploring the Needs and Bridging the Gap
Dr Anizah Ali

05

Use of Mesh in Treating Urinary Stress Incontinence
Assoc Prof Dr Sivakumar S Balakrishnan

06

Surgery on Endometriosis : A Double-edged Sword
Assoc Prof Dr Mukhri Hamdan

08

Imaging in Uterine Anomalies
Dr Erica Yee Hing @ Wong

09

Recurrent Primary Spontaneous Pneumothorax – An Unusual Complication of Pregnancy
*Dr Phon Su Ee
Dr Ng Beng Kwang*

11

Expert Opinion in Medico Legal Cases – Is it Important?
Mr Harikannan Ragavan

13

OGSM Activities

19

AOFOG–OGSM Gynaecological Oncology Meeting
Dr Suresh Kumarasamy

21

What have we been up to?
Dr Eeson Sinthamoney
SEASON'S GREETINGS & HAPPY NEW YEAR 2019
Nom de Guerre

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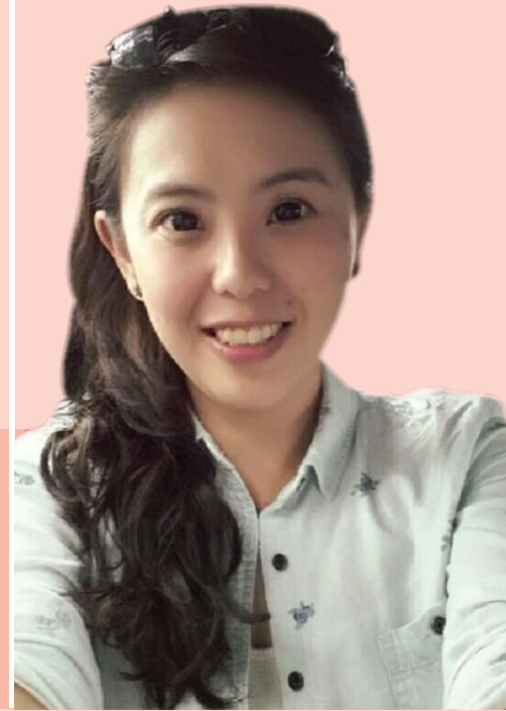
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Congenital Uterine Anomalies (CUAs)

Dr Wang Pei Yoke



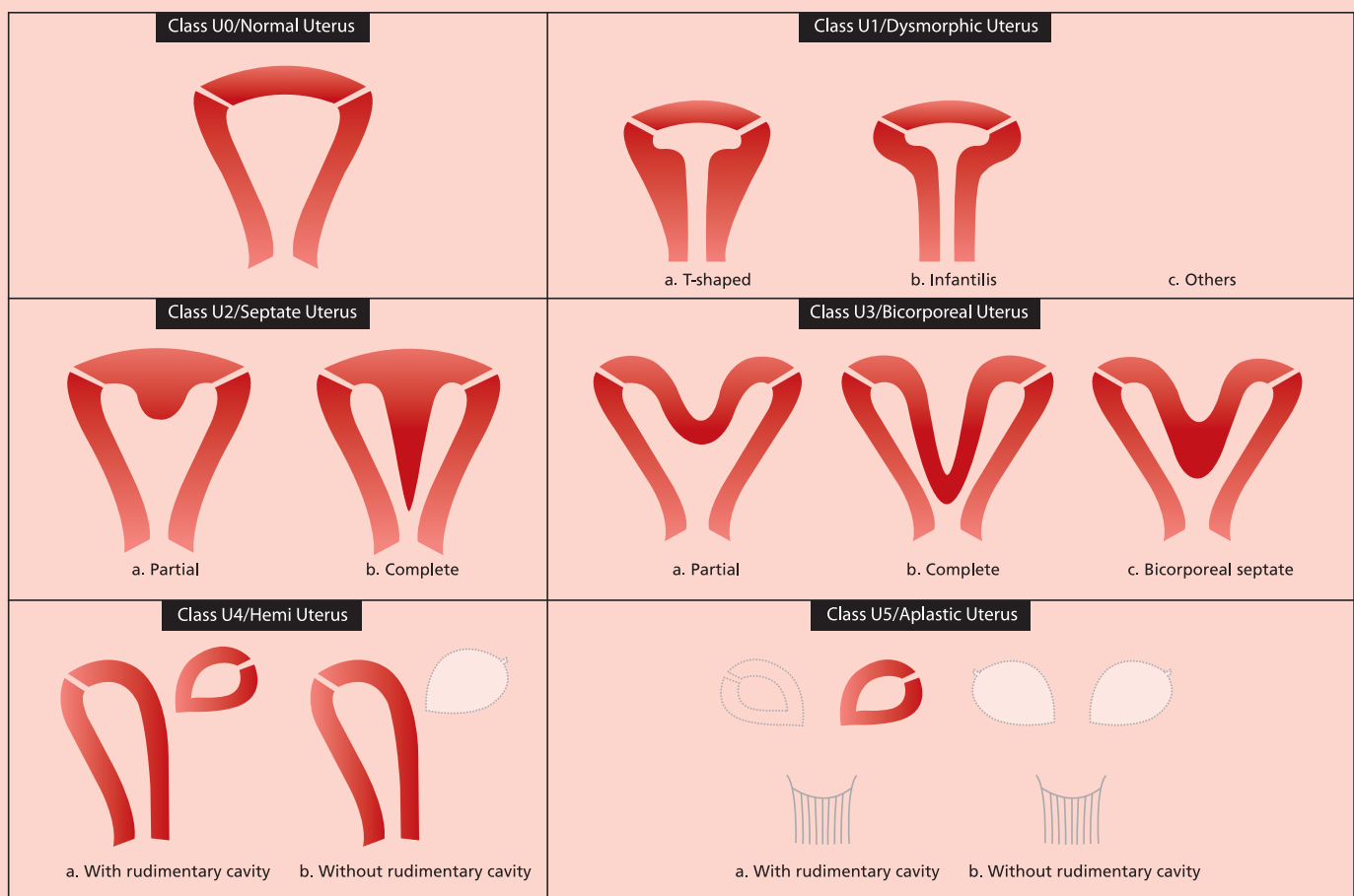
1. Prevalence

- Unselected population: 5.5%
- Infertile women: 8.0%
- History with miscarriage: 13.3%
- History of miscarriage and infertility: 24.5%

3. Potential consequences

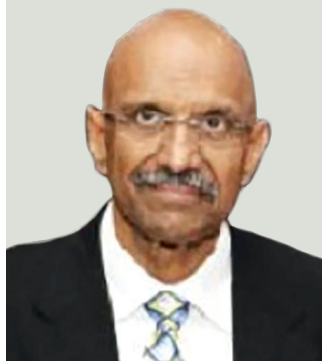
- Pregnancy rate (RR 0.85)
- Miscarriage rate (RR 1.68)
- Preterm deliveries (RR2.21)
- Malpresentation at delivery (4.75)
- Low birth weight (RR1.93)
- Perinatal mortality rate (RR2.43)

2. Classification of CUAs



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Changes in Private Obstetrics & Gynaecology Practice

Datuk Dr Puraviappan Arunasalam Pillay



It has been 43 years since I left as a lecturer in O&G from UMMC for private practice. The practice of O&G has changed immensely in all aspects during this period. It was a norm during the 1960's, 70's and 80's to have individual maternity homes run by O&G specialists all over the country. We had to work long hours and be on call 24 hours a day. We, at that time, replaced the maternity homes run by midwives. We had to be prepared to act promptly in all emergencies. We acted as anaesthetists, able to intubate patients while waiting for the anaesthetist to arrive, as well as resuscitate new-borns who were delivered with very low APGAR scores before the paediatrician arrives.

FETOMATERNAL MEDICINE

Care of patients was similar to hospital practice with routine blood tests, regular follow-ups and delivery of the parturient at term. Vacuum and forceps deliveries were conducted without any problems. The incidence of LSCS in the 70's and 80's was only 5% going up to 30% in 2000-2010 for fear of medical litigation.

2D linear ultrasound was first introduced in the early 1980's in private practice and is still the standard practice.

Dual and triple tests along with Pregnancy Associated Plasma Protein a (PAPPa), Nuchal translucency and HCG tests were available since 1990 and patients were screened using these tests whenever needed. Patients were referred to detailed ultrasound scans centres which specialised in them. In turn, we began using 3D scans in 1990.

Now, over the past few years, prenatal non-invasive maternal serum screening test (NIPT) is offered to all patients to detect early aneuploidy and other chromosomal defects. Due to the costs, a number of patients will opt for the dual or triple test and detailed ultrasound

scan. During the early 90's, amniocentesis for genetic screening was performed in highly suspicious cases and was offered to patients above the age of 35.

It was a routine in my practice to monitor all our deliveries using CTG and sometimes foetal scalp blood pH assessments. Ultrasound foetal growth monitoring throughout the pregnancy was accomplished, and suspicious cases were referred for colour doppler assessment of foetal wellbeing and timing of delivery.

The nightmare in Obstetrics was postpartum haemorrhage which had to be dealt with urgently by:

- Massage
- Compression of the aorta
- Syntocinon and ergometrine
- Blood transfusion and, if necessary, hysterectomy where the incidence in my practice was 1:600

INFERTILITY

Apart from taking a good history followed by physical examination, the ensuing investigations were done, namely: seminal analysis, laparoscopy, hormonal profile and occasional HSGs before treatment. Depending on the results, stimulation of ovulation using Clomiphene with a maximum of 150 mg for 5 days along with the administration of HCG, when there were sufficient mature follicles, followed by Intrauterine insemination (IUI) for three attempts were conducted.

Since 1986, IVF was available, and patients were referred to centres where it was offered. GIFT, IVF, ICSI, assessment of ovarian reserve by antral follicle count and AMH were left to the experts.

ONCOLOGY CASES

All care pertaining to this field were referred to oncologists. Patients were requested to come for regular, yearly

follow-ups for Pap smears and blood tests including tumour markers. Vulval, cervical and endometrial Ca discovered after proper investigations were referred to oncologists, including all suspicious ovarian tumours.

OFFICE GYNAECOLOGY

All cases of vaginal infections were investigated and treated accordingly, namely: Gardnerella vaginalis, Trichomonas and monilial infections. PID cases were treated as inpatients. Since 2007, HPV vaccine was available to all patients between the age of 12-30 years. Since 2017, Gardasil 9 vaccine is available.

Colposcopy was offered to patients with suspicious cervical Pap smears. Atrophic vaginitis and evaluation of urinary symptoms were assessed and managed.

CONTRACEPTION

Counselling was routine to all patients in the reproductive age group. Advice was given on the various methods. The following contraceptive methods were offered:

- Hormonal – Oral contraceptives, Depo Provera, Implanon
- IUCD – Began with Lippies loop, Copper T, Copperfix, Multiload 375 and Mirena
- Surgery – Postpartum & elective tubal ligation were accomplished using Pomeroy technique, Filshie clips and Yoon rings. Vasectomies were done for males. All benign cases of ovary and uterine prolapse were managed by the usual conventional methods.

Conclusion

In future, I believe all Maternity houses will be closed and O&G practice will be hospital-based except centres for ultrasound, infertility and office-based gynaecological procedures. CME is a must for all practitioners to keep abreast of changes in the field. The clinician must be aware of all recent advances and be adept accordingly.

MRKH: The Malaysian Chapter – Exploring the Needs and Bridging the Gaps

Dr Anizah Ali



Mayer–Rokitansky–Kuster–Hauser (MRKH) syndrome is characterised by congenital aplasia of the uterus and upper 2/3 of the vagina in females with otherwise normal karyotype (46XX) and phenotype. Estimated incidence is one in 4,500 female births¹⁻². Anomalies are postulated due to fusion failure of Müllerian duct derivatives; however, exact aetiology remains unknown. While most cases were sporadic, currently, increasing numbers of familial cases suggest the possibility of a genetic cause³.

The diagnosis is often elusive among young children; usually clinched upon reaching adolescents as the typical presentation is primary amenorrhoea. In Malaysia, cases may still be misdiagnosed. A few were presented for subfertility investigation and sexual dysfunction. Examinations would reveal normal secondary sexual characteristics and normal external genital; devoid of vagina or uterus. Shallow vaginal dimple might be evident but ovaries function normally. MRKH is divided into 2 types: Type I, purely genital malformation; and Type II, MRKH encompasses Müllerian anomaly with varying degrees of other associated anomalies (i.e., renal/urinary tract malformations, skeletal, auditory defects and rarely heart and central nervous system anomalies⁴. MURCS association: Müllerian renal, cervicothoracic somite abnormalities⁵ are included in MRKH Type II.

Hormonal assays and karyotyping are both expected to be normal. Transabdominal ultrasonography is an important diagnostic tool enabling delineation of normal ovaries with absent/hypoplastic uterus. Magnetic resonance imaging (MRI) is reserved when ultrasonographic findings are inconclusive. It is superior for assessing renal and skeletal malformations. Albeit being the gold standard, laparoscopy remains an invasive procedure; thus, reserved for those with uncertain diagnosis⁶.

Impact of diagnosis may be overwhelming for patients, families and spouses. Hence, disclosure of diagnosis should be conducted by trained clinicians in a tactful manner. Upon disclosing the diagnosis, pertinent issues must be thoroughly discussed. Is marriage possible? How about sex? Could they ever be a mother? These are among the common questions encountered by our Paediatric Adolescent and Gynaecology (PAG) clinic, UKMMC.

Marriage is possible with the assistance to enable penetrative sexual intercourse via the creation of a neo-vagina, either surgically or non-surgically. In most cases, this is amenable via non-surgical method; gradual vaginal dilatation with vaginal dilators. This is reserved for patients ready to commence sexual activity. Owing to the high success rate, this approach is advocated as a first-line treatment for neo-vagina creation⁷. Surgical options include McIndoe operation, Vecchiotti procedure, Sigmoidal vaginoplasty, William's method, Davydov technique



MRKH Malaysia –
A Malaysian Founded
Support Group For MRKH Women

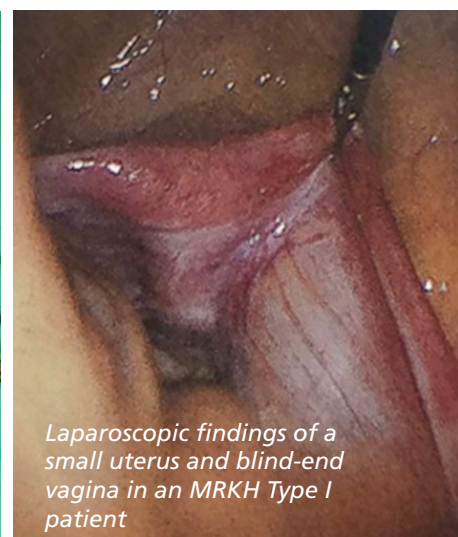
and Creatsas's method. We had a case where sigmoid vaginoplasty was performed successfully.

Ultimately, sterility issues are the most challenging aspect to manage. Options are surrogacy and adoption. However, Islam does not permit surrogacy. Recent focus had shifted to uterine transplantation⁸ following a Swedish team's success stories of 8 livebirths from uterine transplantations. Though promising, in Malaysia, there is yet a consensus on the matter, and efforts towards this should be made to determine whether it is a feasible option; being a multi-ethnic country with differing beliefs.

MRKH patients often face psychological distress, thus psychological support is crucial. An on-going local study is exploring the impact of MRKH diagnosis on the lives of patients. Locally, Malaysian MRKH is a support group providing a platform dispersing needed support for peer MRKH sisters. Since its conception 4 years ago, it has 30 members. UKMMC PAG team works closely with them and conduct meet-ups, educational talks and discussions; identifying needs and dealing with concerns. Not only did these efforts help the patients, but also their families as well.

Conclusion

The Malaysian scenario has a fair share of MRKH cases, however, efforts are required to increase both the public and clinicians' awareness on the syndrome for early referral and diagnosis by trained clinicians, followed by a multi-disciplinary team management. Pressing needs for both therapeutic care (neo-vagina creation and addressing sterility) should go hand-in-hand with psychological support; thus, reassuring that they are never alone through this journey. Only by actively exploring their concerns and needs will we be able to bridge the gap towards a holistic management for MRKH women.



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Use of Mesh in Treating Urinary Stress Incontinence

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Urinary stress incontinence (USI) is a common problem among women. It was reported that the incidence of urinary incontinence in women is 25-45%¹. It was thought that almost 30% of women after the age of 40 would develop urinary stress incontinence. It is a bothersome symptom that affects their quality of life. There have been several ways to treat this condition beginning with the Kegel exercise which strengthens the pelvic floor; this is the initial treatment advocated to these women. There are vaginal pessaries designed for USI but there was no major improvement on these. Surgical treatment has been the mainstay option for those who did not improve with conservative treatments.

Several methods of surgical treatments were tried such as Kelly's fascial plication and pubo-vaginal needle suspension. However, among the more popular and successful surgeries was the Burch Colpo-suspension². However, this is a major surgery and has higher risk of intraoperative bleeding as well as post-operative voiding dysfunction.

Prof Petros and Prof Ulf Ulmstein proposed in their integral theory that the anatomical site of the pathology is the defect at the mid-urethra at the pubo-urethral ligament³. This ligament is particularly



weakened or damaged during childbirth, causing the urine leak during raised intra-abdominal pressure. This led them to relook at the pubo-vaginal slings. After extensive research, the world saw the introduction of the "Tensionless Vaginal Tape" (TVT)⁴⁻⁶. It is a short procedure, safe and presented a great success rate. It was also easy to learn. It took the world by storm. It was easily embraced and further modifications were attempted to improve the surgery. The trans-obturator approach and the mini-slings were among these variants^{7,8}. However, the placement at the mid-urethra was the key to the success of the slings.

The common intraoperative complication was bladder perforation, which was easily managed. Rare incidences of other organ perforations have been described. Post-operative problems of voiding dysfunction are seen but rarely a major problem. The trans-obturator approach has the possibility of thigh pain but again, rarely requires surgical intervention. There is a 5% risk of mesh exposure through the vagina which could be easily dealt with^{7,8}. There were a variety of meshes initially used, but the general agreement is to employ monofilament Type 1 polypropylene mesh. Some women have problems with chronic pelvic pain and this can be difficult to manage. This, unfortunately, tends to present itself later, even after several years.

The overall success rate of the mid-urethral slings is about 90% and it was a great boon to women suffering from urinary stress incontinence^{4,5}. It is a minimally invasive surgery, has minimal complications and good long-term effectiveness. The success of the TVT was extrapolated to be used in vaginal prolapse repairs. The larger meshes are implanted in the vagina. Even though the long-term effectiveness of vaginal meshes as opposed to native tissue repairs have been shown, unfortunately, complications of vaginal meshes began to present itself. The problems of mesh infection, exposure and chronic pain was debilitating to some women where the mesh had to be excised. As more women were presented with these problems, The FDA took notice and issued alerts and warnings. This was followed by multiple legal cases in the USA.

It made the physicians take notice and be cautious in the mesh used. Even though this mainly involved vaginal meshes, the mid-urethral sling was also tainted in this issue. The legal cases tend to include the slings as well in the mesh group, even though sling use has

Con't Page 5

been in practice for more than 20 years. Recently in July 2018, the UK and the NHS have temporarily halted the use of mid-urethral slings pending further review. This is very unfortunate as it deprives women from receiving appropriate treatment for USI.

So where are we heading⁹? We hope that good sense prevails, and the use of mid-urethral slings will be reinstated in the UK. A relook at Burch Colposuspension is possible but many surgeons are not trained in this and will require retraining. The fascial sling can be used as an alternative to polypropylene tapes. There are intra-urethral injections of bulking agents as an option¹⁰. Hopefully, new research will provide better implant material that may avert potential complications associated with the mesh.

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Endometriosis has posed a significant management challenge, particularly in patients with infertility. It has caused a remarkable health care burden similar to other chronic diseases such as diabetes and hypertension. This is partly contributed by many controversies surrounding the management of endometriosis. It begins with the question of whether endometriosis should be diagnosed surgically or not, as the availability of higher resolution transvaginal ultrasound scan can now replace the role of laparoscopic diagnosis. But on the other hand, there is evidence to prove that surgical diagnosis and treatment of endometriosis does increase spontaneous pregnancy rates; whether this evidence is strong enough to recommend surgery for all infertile women to exclude endometriosis is still debatable.

ENDOMETRIOMA AND FERTILITY

Endometrioma represents a more severe stage of endometriosis. Endometrioma occurs within the ovarian tissue and will thus have a direct effect on the quality of the oocytes and the ovarian reserve. For instance, we found that using follicular fluid from patients with endometriosis on mouse oocytes clearly indicates that endometriosis causes the release of reactive oxygen species, which leads to poor follicular growth and final maturation of mouse oocytes^{1,2}.

SURGERY ON ENDOMETRIOMA

Surgery for endometrioma is often difficult as endometriomas are more adherent and the challenge is to preserve as much normal ovarian tissue as possible while removing all unwanted diseased ovarian tissue. Two large published meta-analysis have concluded that surgery for endometrioma reduces the ovarian reserve, with a reduction in the Anti-Müllerian Hormone levels and the antral follicles count after surgery compared to before surgery^{3,4}. For large endometriomas, certainly a laparoscopic cystectomy is more beneficial than aspiration as the risk of recurrence is higher with the latter. Therefore, the primary surgery is important and should be done by skilled surgeons to prevent recurrent and repeated surgeries, resulting in better fertility outcome.

ENDOMETRIOMA PRIOR TO IVF: TAKE IT OUT OR LEAVE IT

Patient with endometriosis have poorer IVF outcomes⁵. A reproductive medicine specialist must weigh the benefit and

Surgery on Endometriosis: A Double-edged Sword

Risks of surgical treatment of endometrioma prior to ART

Risks of intact/untreated endometrioma during ART

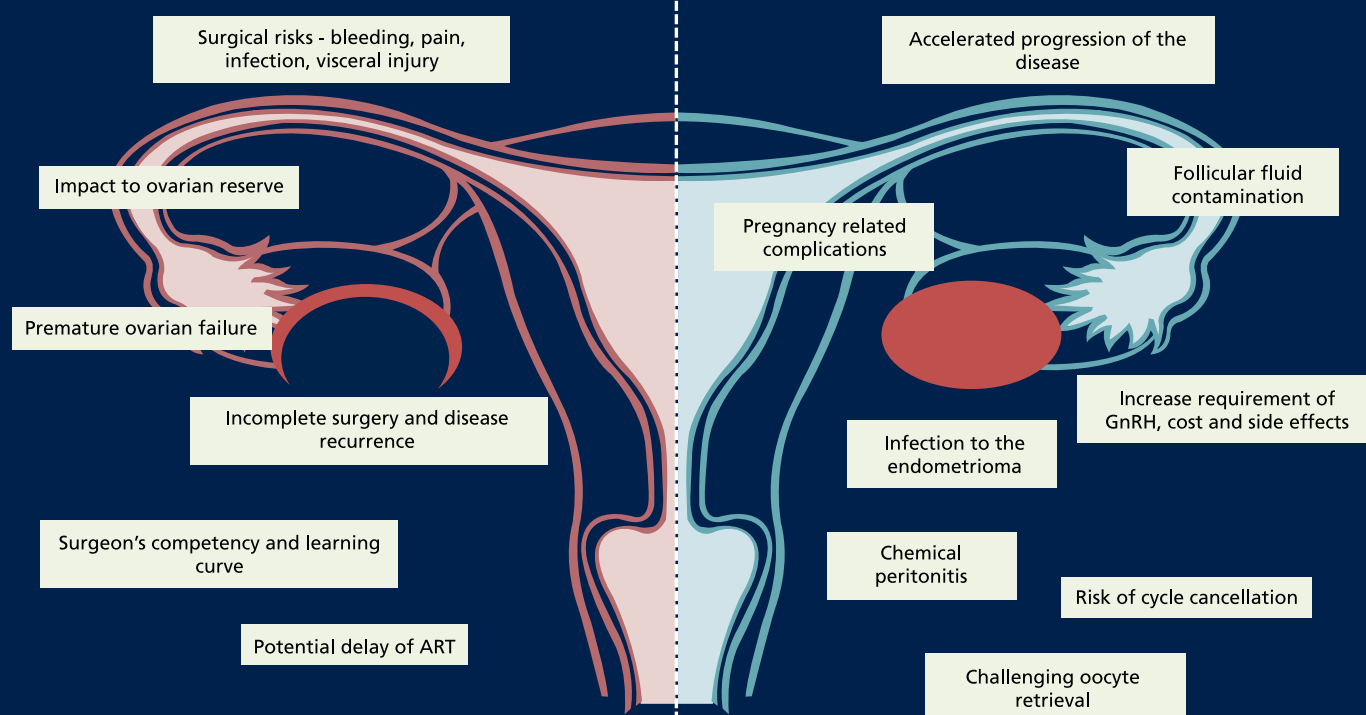


Figure 1: Graphic to show risks between surgery and untreated endometrioma during IVF/ICSI cycle. Hamdan, M. et al. (2015). The impact of endometrioma on IVF/ICSI outcomes: A systematic review and meta-analysis; HRU

risk of surgery in cases of endometrioma (Figure 1). Each case must be individualised and discussed with the patient prior to decision. It was found that there is no added benefit for cystectomy compared to an intact endometrioma for patients planned for IVF⁶. There are guidelines suggesting surgical treatment for cases with endometrioma with size ≥ 4 cm, however, this must be considered with caution since with each surgery, there is a reduction in the ovarian reserve. The patient's subsequent plan for fertility treatment and her ovarian reserve should be assessed prior to the decision for surgery or not⁷.

In conclusion, there are no fixed treatment recommendations for a patient with endometrioma regarding whether she will benefit from surgical intervention prior to IVF or not; requiring further assessment. Thus, each case must be individualised, and the plan must be discussed with the patient before any interventions.

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Imaging in Uterine Anomalies

Dr Erica Yee Hing @ Wong

Congenital uterine anomalies encompass unicornuate uterus, uterus didelphys, bicornuate uterus, septate uterus, arcuate uterus, müllerian hypoplasia/agenesis, and diethylstilbestrol-related anomaly (DES uterus). Ultrasound and magnetic resonance imaging play the most important roles in evaluation of suspected uterine anomalies. These modalities provide information on the external uterine contour which distinguish different types of uterine anomalies, are radiation-free, and are able to assess for concomitant renal anomalies.

ULTRASOUND (US)

US is typically the first investigation ordered in suspected uterine anomaly due to its availability and low cost. It is usually done transabdominal. Transvaginal imaging is superior but is not always possible, e.g. in vaginal obstruction. Studies have found transvaginal US to have 75-100% sensitivity and up to 95% specificity. A negative US however does not exclude uterine anomalies, because significant limitation remains in identification of unicornuate uterus and rudimentary uterine horn.¹ Newer 3-dimensional US offers higher sensitivity

(almost 100%) by enabling reconstructed coronal view of the uterus which is invaluable in evaluation of uterine fundus and endometrial cavity.^{2,3}

MAGNETIC RESONANCE IMAGING (MRI)

MRI is the gold standard for imaging uterine anomalies.³ It provides high-resolution images of the uterus internally and externally. Most uterine anomalies can be diagnosed confidently on MRI, with 100% accuracy reported, and very low false negative and false positive rates.^{3,4} It also allows diagnosis of associated renal anomalies, reported to occur in 40% of cases, e.g. renal agenesis, duplex or pelvic kidney.¹ MRI is however time consuming and expensive, hence is usually done when US and/or HSG are deemed inadequate for diagnosis. Figures 1 & 2 from a single patient allows the diagnosis of OHVIRA syndrome (obstructed hemivagina and ipsilateral renal anomaly).

HYSTEROSALPINGOGRAPHY (HSG)

Usually done as an investigation in infertility to evaluate tubal patency and uterine cavity. It used to be the primary imaging modality before the advent of MRI and ultrasound. HSG provides high-resolution images of uterine cavity and fallopian tubes, and is still the key imaging test for assessing tubal abnormalities. Presence of divided rather than triangular uterine cavity is suggestive of uterine anomaly, but it is not possible to distinguish the subtypes because HSG does not provide information on external uterine contour.¹ HSG requires injection of contrast into uterine cavity and radiation exposure, so pregnancy has to be excluded prior to examination. Due to its limitation in diagnosing uterine anomalies, it has largely been replaced by US and MRI. The only exception is a subtype called DES uterus, where HSG depicts the T-shaped uterine cavity that is not seen on US or MRI.³

CONCLUSION

US should be the initial investigation in suspected uterine anomalies, but a negative US does not exclude uterine anomaly. MRI provides diagnostic information in most cases. HSG should only be requested in the case when tubal patency assessment is required, and when DES uterus is suspected, as it has lower accuracy in diagnosing uterine anomalies and involves ionising radiation.

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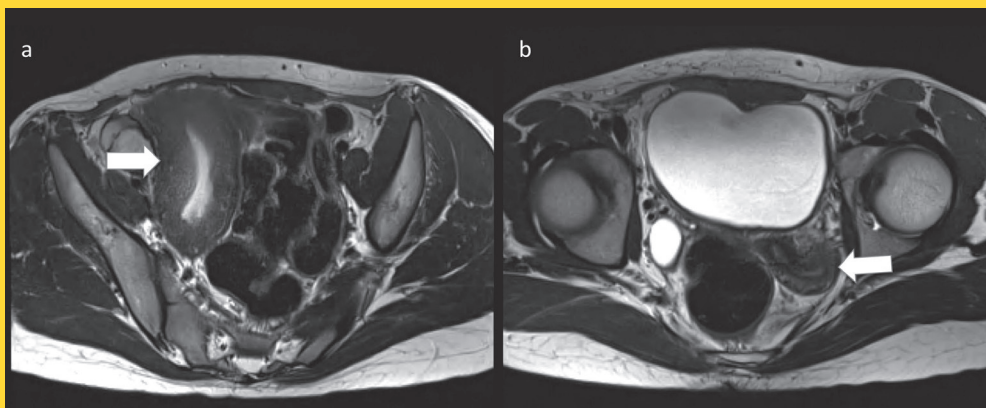


Figure 1: T2 MRI pelvis axial view. a) Uterus didelphys showing the larger right uterine horn with mild haematometra (arrow); b) the smaller left uterine horn (arrow)

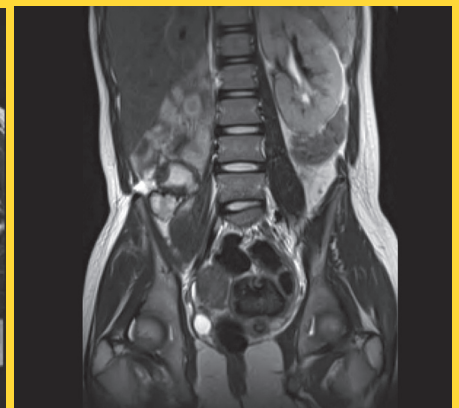


Figure 2: T2 MRI abdomen coronal view showing right renal agenesis.

Recurrent Primary Spontaneous Pneumothorax: An Unusual Complication of Pregnancy

Dr Ng Beng Kwang



Dr Phon Su Ee

Acute respiratory failure in pregnancy is a major cause of maternal and perinatal morbidity and mortality. The causes include acute respiratory distress syndrome, venous air embolism, asthma, thromboembolic disease, pneumothorax and pneumomediastinum¹. Among the various causes, primary spontaneous pneumothorax (PSP) during pregnancy is rare and to date, there are only approximately 60 cases globally reported in the literature²⁻¹².

A 35-year-old gravida 4 para 2+1 was presented with a sudden onset of shortness of breath at 21 weeks gestation and rushed to the emergency department. She had no fever, chest pain, palpitation or history of trauma. Upon arrival, she appeared tachypnoeic with a respiratory rate of 30 breaths per minute. Respiratory examination revealed hyper-resonant percussion note and significant reduced air entry over the right lung. Thus, chest radiography (CXR) was performed with abdominal shield confirming a right-sided pneumothorax [Figure 1]. Intercostal chest tube was inserted and connected to an underwater seal system. She was discharged with Pneumostat™ (Atrium Medical Corp) chest drain valve after nine days of hospitalisation.

She remained asymptomatic until 25 weeks gestation in which she developed a second episode of breathlessness and pleuritic chest pain. On examination, her chest tube was dislodged, hence, a new chest tube drainage was reinserted. Her symptoms resolved completely after eight days of admission. Subsequently, the chest tube was removed at 27 weeks gestation after lung inflation was confirmed by a repeat CXR.

Unfortunately, she had another two episodes of right-sided pneumothorax at 31 weeks and 37 weeks gestation. She was nursed in HDU and co-managed with cardiothoracic team during every episode of pneumothorax. She went into labour when she was admitted for her 4th episode of pneumothorax. The couple was counselled regarding mode of delivery and she opted for trial of vaginal delivery. Epidural analgesia was used to relieve her labour pain. She had an uncomplicated vaginal delivery.

High resolution CT scan was performed on day-4 postpartum. There were bilateral pneumothoraxes predominantly on the right side with scattered pulmonary cysts and sub-pleural bulla [Figure 2]. She was discharged home with a Pneumostat™ (Atrium Medical Corp) chest drain valve on day 8 postpartum. Her chest tube drainage was removed on Day 14 postpartum. Up to one year postpartum until now, there is no further recurrent episode of pneumothorax.

PSP is a pathological condition in which there is extra pulmonary air within the chest accompanied by lung collapse without trauma to the lung or chest wall¹⁰. Ruptured sub-pleural apical bulla or bleb is the commonest cause of PSP⁹, while secondary spontaneous pneumothorax develops in pre-existing lung disease such as chronic obstructive pulmonary disease, bronchial asthma, pulmonary tuberculosis and lymphangioleiomyomatosis; or in the case of cocaine use and hyperemesis gravidarum².

Patients commonly presented are in their second to fourth decade of life (18-39 years old) with the mean age of 27 years old, and half of them are presented during the third trimester⁷. The typical symptoms of spontaneous pneumothorax include chest pain, shortness of breath and paraesthesia, regardless of the cause^{3,8}. Physical examinations showed tachypnoea, cyanosis and reduced breath sounds similar to those in non-pregnant patients. The risk of recurrent pneumothorax is up to 44% in pregnant women¹¹.

Chest radiography (CXR) is required for confirmation of diagnosis. However, this should be balanced against the ionising radiation risk to the foetus, particularly during the period of organogenesis. Thus, abdominal shield should be used together with standard CXR. Other radiological imaging (i.e., computed tomography scan) might be useful in selected cases; especially prior to surgical intervention^{5,7}.

Treatment of PSP during pregnancy is based on its severity. Small pneumothorax could be treated conservatively⁴; whereas larger, persistent or recurrent pneumothorax may require interventions such as needle aspiration, chest tube drainage, thoracotomy/thoracoscopy and pleurodesis^{2,3,5}. Generally, treatment for spontaneous pneumothorax during pregnancy is similar to any patients with pneumothorax.

A review of 45 cases of spontaneous pneumothorax during pregnancy by Nwaejike et al. showed that 9% of cases were managed conservatively by observation only, 7% needed aspiration, 29% required chest tube drainage and 55% were managed surgically⁷. A similar pattern of management was observed by Wong et al. where 11% of patients were observed conservatively, 31% were managed by intercostal drainage only; 47% of patients were managed by thoracotomy and 11% by VATS². This patient was treated with chest tube drainage despite having four episodes of recurrent pneumothorax. Surgical option in the form of video-assisted thoracoscopy surgery (VATS) was offered but the patient was not too keen.

Wong et al. and Nwaejike et al. shared a similar outcome in terms of mode of delivery. Both reviews reported 57-61% of patients had successful vaginal delivery, 20-22% required instrumental delivery and only 14-18% underwent caesarean delivery^{2,7}. Allowing spontaneous vaginal delivery seems to be a safe option for women with PSP during pregnancy. The decision for caesarean section would be based solely on obstetrics indication. For patients who opt for vaginal delivery, perhaps the use of epidural analgesia and forceps delivery are recommended to prevent increased intra-thoracic pressure that might worsen or increase the existing risk of recurrent pneumothorax^{2,7}. Besides that, healthcare providers should be aware that the use of nitrous oxide as labour analgesia could exacerbate a tension pneumothorax¹². In the present case, epidural was used as labour analgesia and there were no maternal or neonatal complications. In the event where a caesarean section is needed, avoiding general anaesthesia is recommended as barotrauma from positive pressure ventilation can lead to spontaneous pneumothorax⁶.

This patient had a CT scan performed on day-4 postpartum. Bilateral pneumothoraces predominantly on the right side and scattered pulmonary cysts with sub-pleural bulla were noted. Her chest tube was removed on day-14 postpartum. She remained asymptomatic without recurrence for the past one year though no surgical intervention was undertaken.

In conclusion, pneumothorax should be considered as one of the differential diagnosis in any pregnant women with shortness of breath and chest pain, though it is uncommon. The optimal management of recurrent PSP in pregnancy remains controversial but should be the same as non-pregnant women.

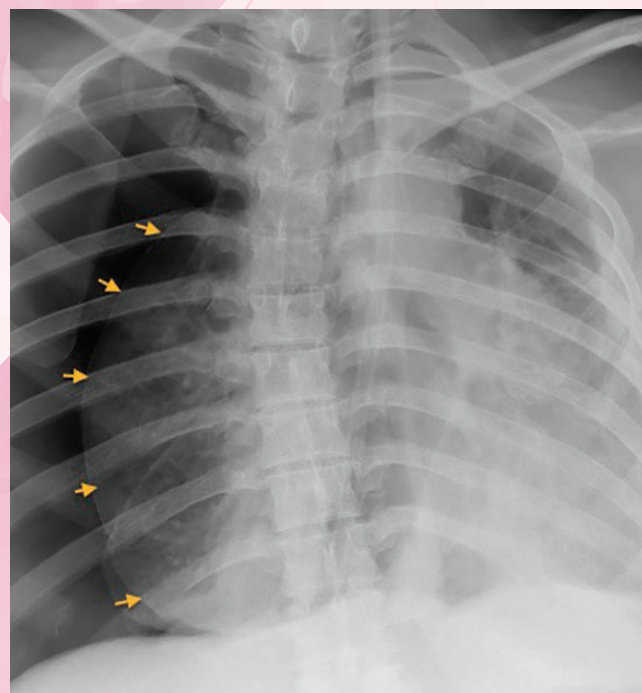


Figure 1: Chest radiography displayed a right-sided pneumothorax (arrow heads).

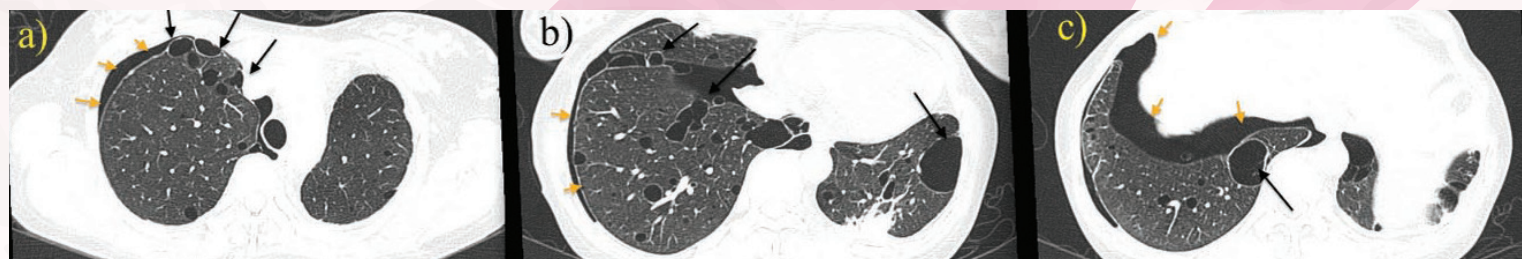


Figure 2: Computed tomography thorax presented right pneumothorax (short arrow heads) with multiple bulla (long arrow heads) of varying sizes in both lung fields, predominantly in the right hemi thorax (a: upper lung; b: middle lung; c: lower lung).

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Expert Opinion in Medico Legal Cases – Is It Important?



The idea for this article was borne out of my personal view that this is an extremely important issue when it comes to defending doctors in medico legal cases.

The question I am always asked is – do we need an expert opinion in matters involving medico legal cases? My answer has always been YES, we do.



I will attempt to state why in this article.

But before embarking on reasons why an expert is important, the first task would be to define who is an Expert.

Who is an Expert?

S 45 of the Evidence Act 1950 state that an expert is "...a person especially skilled inscience..... and whose judgment the court relies on to form an opinion or decision" [paraphrased by author]

In the case of U-Television Sdn. Bhd. & Anor v Comintel Sdn. Bhd. [2017 5 MLJ 292], the Federal Court held that for a witness to be an expert:

- a. He must be truly independent; and
- b. skilled in the area in which he is giving evidence.

Many times in Medico Legal cases, the question is asked of whether a doctor who happens to be one of the treating doctors for the Claimant/Patient can come as an expert witness. The answer would be no because the said doctor would not have satisfied the criteria of an expert as envisaged by S 45 of the Evidence Act 1950.

In fact, this particular point was raised in the U-Television case cited above.

In U-Television [which was a case which required technical evidence], the Plaintiff relied on the evidence of their Senior Manager and their CEO and Director. The Federal Court rejected their evidence as expert testimony on the basis that they were not deemed "independent".

The Federal Court held that the 2 witnesses were members of the Plaintiff's senior management team and as such, should be treated as having an interest in this case. Furthermore, they were witnesses of fact [i.e., of what happened] as opposed to witnesses who came to give an opinion.

The primary role of an expert is to assist the court in coming to a decision which involves and requires technical evidence. Although an Expert may be engaged by either the Plaintiff or the Defendant in a case, their primary obligation is to give independent opinion to assist the court in coming to a decision in a matter.

Their obligation is not and is never to the party that engages them to be an expert.

Now that we know who an Expert is, we must now look into when does a court require expert evidence.

When does a Court require Expert Evidence?

It is often wondered when a party should bring an expert to provide evidence.

Thankfully, the Federal Court in the U-Television case decided that when a Court has determined that there was a need for technical evidence for parties to prove their respective case, expert evidence is required to assist the court.

Therefore, in a medico legal case where the Patient/Plaintiff would normally allege that the Doctor/Defendant was negligent either in his/her diagnosis, advise or treatment protocol, both the Patient and the Doctor would require an expert to provide his/her views on the matter in question.

You may ask 'why'? You may even suggest that you as the doctor in question are equipped to explain the technicalities of the matter in question. However, what the court needs is an independent assessment of the matter.

It cannot be denied that medicine is scientific and technical in nature. It also cannot be denied, especially in light of the decision in U-Television, that the courts will require expert evidence/testimony to assist them in coming to a decision on the matter.

Therefore, it is clear that in a medico legal case, the courts will require expert evidence/testimony to assist them in making a decision.

How does a Court decide a Medico Legal case?

In medico legal cases, as we have highlighted above, the court will require expert evidence to assist them in making a finding. But what would be the process that the Court undertakes in evaluating expert evidence?

Generally, the courts have faced conflicting expert evidence on matters which have reached the courts. The Court of Appeal in *Batu Kemas Industri Sdn. Bhd. v Kerajaan Malaysia & Tenaga Nasional Bhd.* [2015 5 MLJ 52] held as follows:

1. When expert opinions are in conflict with one another, the court is obliged to assess the evidence and accept, if necessary, the most reliable parts in forming its decision.
2. In that process, the court may put relevant questions to the expert for the purposes of clarification and/or eliciting further information.

This would mean that because the primary duty of the expert is towards the court, the Court can ask questions to the expert to seek clarification with a view of better understanding the technical evidence.

In medico legal cases, before the Courts can determine the negligence of the doctor being sued, they too will evaluate the expert evidence adduced.

In the Federal Court decision of *ZULHASNIMAR HASAN & ANOR v DR KUPPU VELUMANI & ANOR* [2017] 1 LNS 1057, essentially, the Court held:

- a. Although as a discipline, medicine involves specific knowledge, however its practice does not often admit to scientific precision.
- b. It requires the Courts to accept the views of responsible body of men skilled in that particular discipline.
- c. The court will analyse the logic and reasonableness of conflicting medical opinion.
- d. If the expert opinion of the Doctor stands the test of logic and reasonableness, then the Court would find it in favour of the Doctor.

It is clear that in medico legal cases, the requirement to have an expert come and testify is paramount. In fact, we cannot emphasise this enough simply for the reason that, as shown above, without expert evidence, we as lawyers for doctors cannot mount a credible defence in Court.

CONCLUSION

The Courts have acknowledged that disputes in medicine is not a matter that the Courts can or are equipped to resolve. They will require the help of experts.

The challenge remains in convincing medical practitioners of the importance of giving evidence as experts. It is hoped that this article does in some way go towards convincing the sceptics.

Written by

Harikannan Ragavan

Managing Partner

Jayadeep Hari & Jamil

[Medico Legal lawyer since 2000]



The objectives included pattern recognition, understanding foetal heart rate adaptations and advances in intrapartum foetal resuscitation. Apart from the experienced Malaysian team, it was a holistic course incorporating experts from Singapore, Prof Devendra Kanagalingam, judicial commissioner, Mr Darryl Goon, and consultant neonatologist, Dr Irene Cheah. The course consisted of short lectures intercepted with plenty of quizzes and interactive case discussions. The grand-rounds involving experts from various fields were well-received and the participants felt engaged, enabling them to stump experts and interact with faculty apart from discussing their complicated experiences.

We had a total of 70 participants from various cadre, including senior consultants. Despite CTG being an integral part of obstetrics, 73% of participants never attended a CTG course before nor had any formal training in intrapartum foetal surveillance. 94% of participants felt that their objectives were achieved, and 87% felt more competent in interpreting CTGs at the end of the course. The course received an impressive score of 4.5/5 and 100% of them voted that they would recommend it to their colleagues, including senior obstetricians.

Advanced Course in Intrapartum Foetal Surveillance

28th October 2018,
Taylor's University

The Obstetrical & Gynaecological Society of Malaysia (OGSM), together with the team behind the successful Intensive Course in Obstetric Emergencies (ICOE), inaugurated the very first Advanced Course in Intrapartum Foetal Surveillance. Appreciating the challenges related to intrapartum foetal monitoring, including the ever-increasing medico-legal circumstances, this was an advanced interactive course conceptualised for the experienced clinician.



A similar course dedicated to midwives was held a day before and the response was equally overwhelming where we trained almost 65 midwives. The midwives were very engaging and able to manage even complicated CTG traces by the end of the course. The importance of a systematic approach and communication were highlighted to the midwives.

Our objectives were fulfilled and since this very first endeavour was a huge success, we are already planning to make it a regular event in Malaysia as well as throughout the region for the benefit of everyone. We already have interest from neighbouring countries such as Bangladesh and Cambodia and hopefully this will be another feather in the illustrious OGSM's cap.





Intensive Course in Obstetric Emergencies (ICOE) in Vietnam

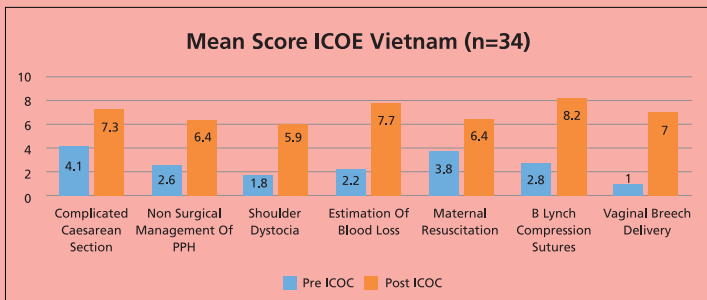
15-17th August 2018

After having successful stints in Myanmar, Mongolia, Bangladesh, Cambodia, Laos, Japan, India, Pakistan and Sri Lanka, Vietnam became the 10th country where OGSM, via ICOE, had recently spread its wings as well. It remains a remarkable feat knowing that ICOE is only 4 years young.

As a collaboration between Ho Chi Minh Obstetrics and Gynecology Association and OGSM, a total of 8 passionate trainers went to Ho Chi Minh City with the single objective of training and disseminating skills in obstetric emergencies.

A total of 34 participants were trained over two days, which was an overwhelming success.

We did create an impact as there were significant differences before and after the course, and this was consistent across all ICOE courses in Malaysia and in the region. We also had a one-day train the trainers course, and plans are in place to visit Vietnam again in 2019. Hopefully, they will be able to independently adopt our popular course one day. We definitely made an impression in Vietnam and with luck, this will reflect on improvements in the management of obstetric emergencies within the region.



PACT Fills the Gap!

PACT (Preparatory Assistance Courses for Trainees) is the acronym chosen for the newly revamped series of courses by OGSM for our trainees. In keeping with the philosophy of “filling the gaps”, we have divided these courses to Trainee Updates, Simulated Exams and Part 3 Circuit Courses. Our aim is to move away from didactic teaching and to hopefully change the method of how our trainees approach the exams. We have recruited a team of highly enthusiastic young specialists; all of whom have recently passed their specialist exams. They would be able to provide a unique insight into the ever-evolving exams. We have had two courses since the inception of this committee. Both had positive feedbacks from the trainees and trainers who attended. The courses are held in the OGSM office for the time being but there are plans to go nationwide. Thank you for the continual support.

Dr Hoo Mei Lin

Trainee Committee Chair 2018-2020



“OGSM recently revamped the Trainee’s Masterclass for those of us taking our MRCOG/Masters in O&G. It is now called Preparatory Assistance Courses for Trainees (PACT). I was fortunate enough to be able to attend the first session held on the 10th of November 2018, dedicated to early pregnancy. To say the least, it was well organised and planned. The program came with a detailed reading list!

The day began early and we were met with the infectious enthusiasm of our speakers whose knowledge was not only extensive, but also exam-orientated. We were not focused on lectures and information; instead, we were given questions and concepts. Every session, we were made to answer numerous interactive questions on the topics discussed. By the end of each session, we were made to understand the concept of each topic instead of absorbing blind information. We tackled difficult topics such as termination of pregnancy and the law. We even attempted multiple EMQs on it.

We were also given a first-hand opportunity to experience OSCE stations in preparation for Part 3. Some of the cases involved a difficult teenager and also a concerned mother with multiple miscarriages. They proved to be challenging OSCE stations. However, our trainers were very patient and willing to share their tricks and experiences to handle similar situations in the exam.

By the end of the day, our brains were tired from answering questions on early pregnancy and our phone batteries were dying from using “Mentimeter” (Our interactive platform to answer questions) but our confidence to face the exam grew stronger. It was really encouraging to see so much support and concern from the trainers who had spent so much of their time and effort on all the materials and questions. I am really excited to look out for more PACT sessions in the future. Keep up the good work, OGSM.”

Dr Jagdeesh Kaur





Medico-legal Meetings

The medico-legal subcommittee under the governance of Dato' Professor Dr. Tharmaseelan has organized three meetings, two were with our medical indemnity insurance providers while the last was in collaboration with the Medico-legal Society of Malaysia (MLSM). All three were reasonably well attended. Judging by the zeal of the attendees and level of interaction with the speakers, medico-legal issues are set to remain in the fore-front of the Society's unresolved issues for the foreseeable future. The last meeting with MLSM was of particular interest, as it stimulated OGSM to take the lead in seeking to get the leaders of our fraternity to draw up a consensus statement on the prevailing situation with Cerebral Palsy in Malaysia.

Medico-legal Forum: 'Cerebral Palsy, Court Decisions and the Future - Protecting Yourself'

Date: Saturday, 15th December 2018 | Time: 7.00 pm

Venue:

Obstetrical & Gynaecological Society of Malaysia,
Suite A-05-10, Plaza Mont Kiara,
No. 2, Jalan Kiara, Mont Kiara, 50480 Kuala Lumpur

Chairperson : Prof Dato' Dr NKS Tharmaseelan

A programme organised in collaboration with the Medico-Legal Society of Malaysia :



Kindly RSVP to administrator@ogsm.org.my to facilitate catering

OGSM Contraceptive Course



The OGSM Contraceptive Course was held on the 10th of November 2018 in Lahad Datu. It was well attended with 57 participants comprising of Medical officers, General Practitioners, Pharmacists and Nurses. Most of are working in Primary Care or O&G Departments dealing with Women Health care as part of their daily routines. The course enabled them to acquire practical contraceptive management concepts and principles. They were also able to share and learn many practical solutions to their daily challenges pertaining to counseling and provision of Contraceptives for women. Most of the feedbacks requested for the course to be conducted annually at the very least and many will recommend their colleagues to join the course in the future as they found the course delivered was very practical and relevant to their daily work.

As the organiser, i feel that these void in Contraceptive training need to be extended as far and wide as we can to reach many others so that we can continue to provide the critical SRH care and meet the needs of all women and girls.

John Teo
OGSM Family Planning Subcommittee

OGSM Held Its First CSR Activity For The Year 2018/2019 on Saturday the 8th of December



This was in the form of an afternoon at the Women's Aid Organisation shelter at an unmarked location in Selangor, during which we spoke to its residents about women's health and contraception, and then conducted a free clinic for them, with consultations, breast examinations and pap smears.

The residents of the shelter comprise women who have fled from their homes or were forced to leave, usually because of some form of abuse by their partners and/or their families, often with young children hastily in tow. Others are victims of human trafficking who have been abandoned or have escaped from their captors. All are women with few resources who are vulnerable to unplanned pregnancies, and have poor access to healthcare.

In light of this, it is our intention to focus our attention this year on providing assistance to these women and WAO, by conducting regular sessions such as this, raising funds and donating resources needed for the running of their shelter.

Sincere thanks to Dr Hoo Mei Lin and Ms Prema for their invaluable time and effort which made this first session possible.

Dr Goh Huay-yee
CSR Chair 2018/2019

Note : If you are interested in contributing in any way to our CSR activities, please contact Ms Prema at administrator@ogsm.org.my





AOFOG-OGSM Gynaecological Oncology Meeting, Kuala Lumpur, Malaysia 26th July 2018



Dr Suresh Kumarasamy

*FRCOG, FRCPI Convener,
AOFOG-OGSM Gynaecological
Oncology Workshop 2018,
Chairman, Sub-Committee on
Gynaecological Oncology, OGSM*

The Asia Oceanic Federation of Obstetrics & Gynaecology (AOFOG) and the Obstetrical & Gynaecological Society of Malaysia (OGSM) held a one-day Gynaecological Oncology educational meeting in Kuala Lumpur, Malaysia on Thursday 26th July 2018. This meeting was held as a pre-congress event prior to the Malaysian International Scientific Congress of Obstetrics and Gynaecology held from 27th July 2018 to 29th July 2018. This educational meeting was also supported by the International Gynaecological Cancer Society.

A wide range of topics covering the entire spectrum of gynaecological oncology practice were investigated during the workshop. Topics included Quality of Life in Gynaecological Oncology, Hereditary Gynaecological Cancers – Genetic Tests, Screening and Risk Reduction, Surgery for Cancer of the Cervix, Cervix Cancer – when to use Adjuvant treatment and Managing Advanced Disease, Borderline Tumours of the Ovary, Epithelial Ovarian Cancer – Surgery in Primary and Recurrent Diseases, Chemotherapy and Targeted Therapy in Ovarian Cancer, Germ Cell Tumours of the Ovary, Endometrial Cancer – Controversies in Management and Trophoblastic Disease – Current Management and Uterine Sarcomas. The program was comprehensive yet succinct and provided an up to date review of current knowledge in the field of gynaecological oncology for the busy practitioner in a day. Lectures were supplemented by videos of gynaecological oncology surgical procedures and techniques. There were lively discussions during the question and answer sessions that followed the lectures.

A distinguished international faculty from the Asia-Oceania region delivered the lectures. The faculty included: Prof Michael Quinn (Australia), Prof Hextan Ngan (Hong Kong), Prof Aikou Okamoto (Japan), Dr Suresh Kumarasamy (Malaysia), Prof Woo Yin Ling (Malaysia), Assoc Prof Timothy Lim Yong Kuie (Singapore), Prof Young Tak Kim (Korea) and Prof Suk-Joon Chang (Korea).

About 60 participants attended the workshop. The President of AOFOG, Dr Ravi Chandran, graced the opening and welcomed the delegates in his introductory speech.

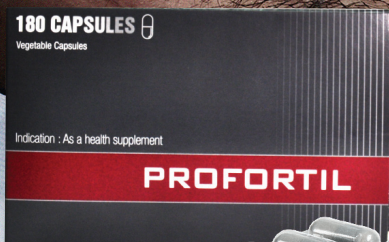
I would like to place on record my thanks to Dr Ravi Chandran and AOFOG for supporting the meeting. I am also grateful for the support of the International Gynaecological Cancer Society and its President Prof Michael Quinn for paying for the flights of two of the international faculty.

Many of the participants said that they had benefitted from attending the event and requested that similar educational events be held in future.

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What have we been up to ?

The new council and sub-specialty chairpersons have certainly hit the ground running. The last four months have been extremely demanding for all. The medico-legal subcommittee under the governance of Dato' Professor Dr. Tharmaseelan has organized three meetings, two were with our medical indemnity insurance providers while the last was in collaboration with the Medico-legal Society of Malaysia (MLSM). All three were reasonably well attended. Judging by the zeal of the attendees and level of interaction with the speakers, medico-legal issues are set to remain in the fore-front of the Society's unresolved issues for the foreseeable future. The last meeting with MLSM was of particular interest, as it stimulated OGSM to take the lead in seeking to get the leaders of our fraternity to draw up a consensus statement on the prevailing situation with Cerebral Palsy in Malaysia.

The Trainee subcommittee under Dr. Hoo Mei Lin has also been extremely dynamic, having already organized three training sessions thus far, with a further six sessions planned for the next few months. The take-up rate and reaction from the trainees is a clear indication that the Society is indeed 'filling-the-gap' as intended and we are undoubtedly on the right track.

Dr. Wong Choon Meng, our newly appointed chair of the 'Everyday Practical Obstetrics and Gynaecology' (EPOG) subcommittee, has taken on his new role with astounding fervor. He choose to rename the subcommittee as he felt that 'Out-patient Gynaecology' as it was previously known, did not truly reflect the bona fide scope of this particular area of interest. He has made all arrangements for the first 'Update in Obstetrics and Gynaecology' meeting, with the second to follow later. Also on the cards is the possibility of an exciting 'Aesthetic Gynaecology' workshop, likely in the third quarter of our term.

The iCOE team, under the leadership of Dr. Gunasegaran and FIGO awardee Dr. Tang Boon Nee have held several of their signature workshops both locally and abroad and have been bestowed the honor and privilege of being invited to new regions including China, Japan and Korea to showcase their special module. The iCOE program is exemplary in that it shows exactly how much OGSM can do to make a true difference in Obstetric care. This has only been possible because it has such an enthusiastic team with clear vision, commitment, dedication and leadership.

As expected, the Menopause subcommittee ably led by Dr. Premitha Damodaran have taken it upon themselves to 'set standards' by initiating a working committee to draw up a Clinical Practice Guidelines on Menopause Management in Malaysia. OGSM has traditionally shunned this type of endeavor due to the extreme hard work that's required but Dr. Premitha isn't the sort easily deterred.

The OGSM Contraceptive Course continues to play an unparalleled role in plugging an enormous inequality in the provision of this much needed training to medical professionals, allied healthcare providers and the lay public. Dr. John Teo, as we all know too well, is extremely passionate about this. Thus far, his robust program has reached out to three hundred people over three courses held since July last year with a further seven courses planned national wide for the next few months.

The CSR team has also set itself in motion. Dr. Goh Huay-ye, previously our very able Hon. Secretary has already started teaching sessions with the Women's Aid Organization where they provide important health related education to women housed in their shelter.

It is undeniable that OGSM is THE lead provider of specialty related activities in Malaysia. Of late, our advocacy role is also slowly but surely intensifying. The commitment, passion and dedication shown by many of our members, especially those appointment as the subcommittee chairpersons has been a true inspiration. We hope others will see this as a cue to move their respective agenda forward too.

Best wishes from all of us and a Happy New Year!

Dr Eeson Sinthamoney

SEASON'S GREETINGS &
HAPPY NEW YEAR

2019

"Sitting regally upon waking on the household throne,
Meditating on my navel amid a buzzy drone.
Reading multitudes of wishes on social media,
Contemplating superficial electronic cheer.
Repetitively same or similar in one form or other,
Should I contribute more inane expressions in ilk and manner?
Perpetuating propagating e-drivel by lazy forwarding,
Invariably necessitating multiple jabs at deleting,
Or engage mind in gear, put thumb to keypad for some meaning.
Maybe of simpler utility to share wishes on basic function,
Oft forgotten, disregarded, afforded scant attention.
Of Asclepius and Epione's daughter,
In 2019 beyond and further.
In homage to Hygieia, she of all things clean and sanitary,
My 2019 wishes to all and sundry.
An appetite undiminished a stomach at peace,
A good night's rest, aches and worries to cease.
A gut and its bugs in symbiotic harmony,
Sphincters opening and closing on demand dutifully.
Valves functioning with lubricated efficiency,
Unclogged passages flowing smooth and easy.
Tubes and ducts with no stones blocking,
Taps and outlets with no more dripping.
All these wishes heartfelt and ordinary,
All I wish for in aging perpetuity

~ ~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!

CERVICAL CANCER PREVENTION

WHAT EVERY WOMAN NEEDS TO KNOW



The Roche Cervical Cancer Portfolio

Provide the focus you need to make decision with confidence, certainty and conclusiveness

TESTING FOR CERVICAL CANCER

2 key ways to detect cervical cancer risk¹



PAP test

- Screen for changes in cervical cells, but do not detect all cervical abnormalities²
- PAP cytology alone is **not enough**³



High-risk HPV test

- Can **detect all** cancer-causing **types of HPV**, particularly **type 16 and 18**⁴
- cobas® HPV test** is a superior predictor of cervical cancer risk compared head-to-head with Pap cytology^{5,6,7}

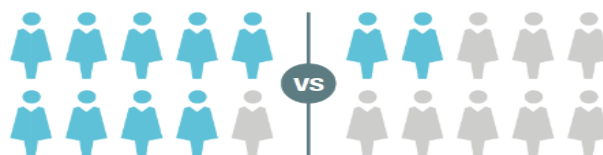
Did you know cervical cancer is:

- Caused by** persistent infection of the Human Papilloma Virus (HPV)⁸



- 70%** of all cervical cancers are caused by **HPV types 16 and 18** which are **35X more likely** to have pre-cervical cancer than others⁹

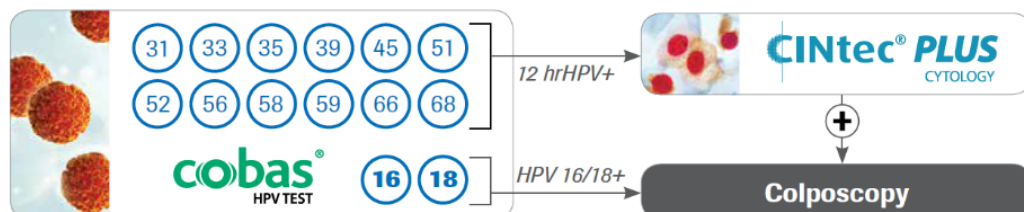
- Highly preventable** if detected early¹



If cervical cancer is found early ~9 in 10 women will survive 5+ years vs ~2 women if found late¹⁰

More effective referral of HPV+

Reduced missed disease



35% increase in sensitivity $\geq \text{CIN3}^{11}$
vs hrHPV pooled positive result with PAP Triage of all HPV+

Send those with the most oncogenic genotypes or transforming HPV infections to colposcopy, **reducing risk of loss to follow-up**

The three tests in the Roche Cervical Cancer Portfolio answer key question with certainty¹²

Screen	Manage	Diagnose
For the cause of cervical cancer and identify those at highest risk	Women who will benefit from immediate intervention when transforming HPV infections are present. Minimize the risk of losing women to follow-up	With p16 advanced biomarker technology to provide clear visual confirmation of the presence or absence of precancerous cervical lesion

HPV16and18.com



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