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Obstetrical and Gynaecological Society of Malaysia

2018/2019 Council Issue 4

EMBRACING, ENGAGING & INFORMING

The Duty of an **Obstetrician** and the case for a **'Firewall'** in Malaysia

Ongoing Challenges and Dilemmas in In-Vitro Fertilisation (IVF)

Vascular Injuries during Gynaecologic Surgeries

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A publication by the Obstetrical and Gynaecological Society of Malaysia

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Dr Chakr Sri Na Nagara

The Death of Obstetrics (and the Resurrection of Midwifery)

I was recently requested to pen a few words on the development of Obstetrics over the past half a century, having practiced in this field for more than 50 years. It dawned upon me as I contemplated the subject that both positives and negatives are present.

As practicing obstetricians, we are all too familiar with, and celebrate, the advances in our field of practice, leading to improved outcomes to both mothers and their babies. We are in the unique field of medicine where we have two patients simultaneously. We must manage and care for both, sometimes facing situations when their differing conditions are at odds with each other. Nonetheless, the past 50 years has seen a better understanding with improved protocols resulting in vast improvements to outcome the indices.

For example, recent advances in ultra-sonology have allowed obstetricians the benefit of a "third eye" to peep into the womb and actually see the baby in 2D, 3D and even 4D, as well as in colour.

Prematurity, if not eradicated, has become more manageable; providing better results to even severely premature babies.

The scourge of maternal haemorrhage and puerperal sepsis is better controlled and much less prevalent, except in less accessible regions of the country.

But today's presentation is not intended to "praise Caesar". Instead it is a wake-up call, as not all is well in the practice of obstetrics. Too often, many of us are in denial.

More and more obstetricians are giving up the practice and just do gynaecology. We face challenges from several sources. From our patients, we are facing increasing demands that are often unrealistic. Pressures from patients, their relatives and friends often translate into unrealistic expectations for perfect deliveries and perfect babies. No doubt this is fuelled by increasing access to litigation and possibility of big awards. Any deviation from perfection is increasingly faced with blame (first), followed by litigation and potential awards in the millions.

Patients, on the one hand, expect us to be altruistic, providing near perfect services at unrealistically low fees. The Obstetrics and Gynaecology Society should take part of the blame for accepting a ceiling fee of RM1890/= for LSCS. If that is the case, what should be the fee for a normal vaginal delivery? We are NOT realistic, especially in the face of spiralling cost of Professional Indemnity Insurance (PII) premiums.

The cost of PII fifty years ago was less than RM 1K. Today, it is 100 times more. The vital question is, "has the fee for the obstetrician increased in tandem with the PII?" Not so. Fifty years ago, the fee for a normal vaginal delivery was about RM 250/- and that of LSCS was about RM 500/-. Today, it is not anywhere near 100 times that [see relative increase in PII]! Only less than 4 [four] times, at RM 1890/-.

Another punitive issue to the practicing Obstetrician in Malaysia is the rationale behind the sky rocketing escalation.

Are we (in Malaysia) subsidising litigation cost of other countries? Are the premiums of Malaysian Obstetricians based on local risks? If we consider the premiums charged by international PIIs and compare them to premiums of local PIIs (which are based on local conditions) we can see a vast difference.

The type of PII coverage also requires clarification. There is a great difference between "event based" insurance and "case based" insurance. We must demand for "event based" policy. No one can afford "case based" insurance where we must WORK for 25 years after we stop PRACTISING simply to pay for PII premiums which are escalating year by year since the statute of limitation extends to 25 years after the event.

To add insult to injury, the MOF has this strange ruling where (according to our Tax Consultants) any awards from a successful litigation against the obstetricians will result in the Obstetricians being taxed on the amount awarded as "untaxed income". This happens if we annually claim the premiums we pay for PII as "tax deductible".

Thus, we can see that the present-day obstetrician is facing the "perfect storm". This will result in less and less doctors taking up the speciality, while practicing obstetricians are currently exiting the practice to only do gynaecology which attracts a lower premium.

Those in the private practice will be tempted to refer Obstetric patients to public facilities. Public facilities will be overloaded, and this will get progressively worse as there will be fewer young doctors taking up the speciality. The job of delivery will eventually fall on midwifes and "Bidans".

Midwifery training will need to be expanded and the "Bidan" programme reintroduced.

How this future scenario translates into Maternal & Foetal Healthcare outcomes can only be left to the imagination. My bet is that it will not improve and most likely get worse.

That being so, the public will need to feel the pain before any possible positive change can take place. Changes will need to come from the MOH [Fee Schedule], MOF [Insurance/Taxation] and the Judiciary [Quantum of Awards]. But this change must be initiated by the OGSM. No one else will do this onerous job for us. This is the most urgent task for society.

So, fellow colleagues, we are facing the (slow) death of obstetrics, and the resurrection of midwifery if we live with our heads buried in the sand.

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Prof Emeritus Arulkumaran Sabaratnam

YB Puan Hannah Yeoh Tseow Suan

Prof Jon Hyett

Prof Shin Ushiro

Prof Sonia Grover

YBhg Tuan Tommy Thomas

Prof William Ledger

The Duty of an Obstetrician and the Case for a 'Firewall' in Malaysia

Prof Nazimah Idris
Consultant and Professor of O&G
International Medical University Malaysia

The Scenario:

A woman who claims to be a refugee but without valid identification documents had an operative delivery in a government hospital. She and her baby are well enough to be discharged after two days of observation.

Problem 1:

Her hospital bill has come up to RM4500.00. She has difficulty paying such a huge sum.

Problem 2:

Hospital authority has informed the Immigration Department of her undocumented status and she is to be detained and deported.

Problem 3:

Immigration will take her in only if doctors can certify she is 'fit to travel by air'.

Problem 4:

For every additional day of hospital stay, the bill will continue to escalate.

Problem 5:

We need the bed!

As of the end of November 2018, there are about 163,600 refugees and asylum-seekers registered with UNHCR in Malaysia. A huge majority are from Myanmar (141,700). Of these, 81,760 are Rohingyas, followed by Chins (27,130), Myanmar Muslims (9,800), Rakhine's and Arakanese (4,010) and other ethnicities from Myanmar.

They mostly reside in Selangor, Kuala Lumpur and Pulau Pinang, comprising of 65.4% of the total refugees and asylum seekers. Around 67% of refugees and asylum-seekers are men, while 33% are women . For every person documented, it is estimated that there may be 2 or 3 who are not, so we are easily looking at a figure of at least half a million in number.

1951 Refugee Convention and the 1967 Protocol

A refugee is defined as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion,

nationality, membership of particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution".

The 1951 Refugee Convention and its 1967 Protocol entitled refugees to several rights; i.e., the right to not be returned to a country where he or she faces serious threats to his or her life or freedom, the right not to be expelled except under certain strictly defined conditions, the right to education, the right to access the courts, the right to work and the right to freedom of movement within the territory.

Malaysia is not a signatory to the above Convention, hence people with the refugee status in Malaysia are not entitled to the above rights. Malaysia is, however, a signatory to the universal Declaration of Human Rights which recognises the right to seek asylum and has extended much help on humanitarian grounds.

For refugees registered with the United Nations High Commissioner for Refugees (UNHCR), the documents accord them access to healthcare and protection from arrest and prosecution. They are also entitled to a 50% discount on health service fees as charged to non-citizens if they seek treatment at public hospitals. Unfortunately, many refugees and asylum seekers remain undocumented, exposing them to threats of detention and deportation which consequently affect their health seeking behaviour. Unlike other unregistered migrants, such as economic migrants, deportation of refugees back to their home countries is not an option for them due to fear of persecution.

As healthcare professionals, many of us come into almost daily contact with undocumented migrants, including refugees and asylum seekers. At the heart of it, we should be able to serve them as any other members of the community and accomplish our goals of service. However, at present and for quite some time now, immigration enforcement authorities have enlisted our services as auxiliaries in search of undocumented migrants . We are routinely required to check the immigration status of our patients and pass on the information to the Immigration Office for possible detention and deportation.

For obstetricians, this would mean sending a mother who's still recovering from childbirth and her new-born to an immigration depot, where living conditions are far from ideal, to say the least, until they are ready to be deported. If the undocumented migrant is a refugee, she would be in prolonged detention because of the unlikelihood of deportation, and a prolonged separation from her family with all the imaginable bureaucratic difficulties in getting her refugee status documented before she can be released.

This brings us to a probable solution – erect a firewall!

The Firewall

The concept of a firewall refers to the separation of immigration enforcement activities and provision of essential services . In our case, it is healthcare; specifically, women's health.

The idea of firewalls is to ensure protection of the rights of refugees and other undocumented migrants. Firewalls are designed to particularly ensure that immigration enforcement authorities are not able to access information concerning the immigration status of individuals who seek assistance or services at medical facilities and other public service institutions . Firewalls ensure that we healthcare service providers do not have an obligation to be their 'agents' to inquire or share information about our patients' immigration status.

In 2016, the European Commission against Racism and Intolerance (ECRI) has published a General Policy Recommendation (GPR) on safeguarding undocumented migrants from discrimination. This GPR calls for: 'the creation of effective measures (hereafter "firewalls") to prevent state and private sector actors from effectively denying human rights to irregularly present migrants by clearly prohibiting the sharing of the personal data of, or other information about, persons suspected of irregular presence or work, with the immigration authorities for purposes of immigration control and enforcement' .

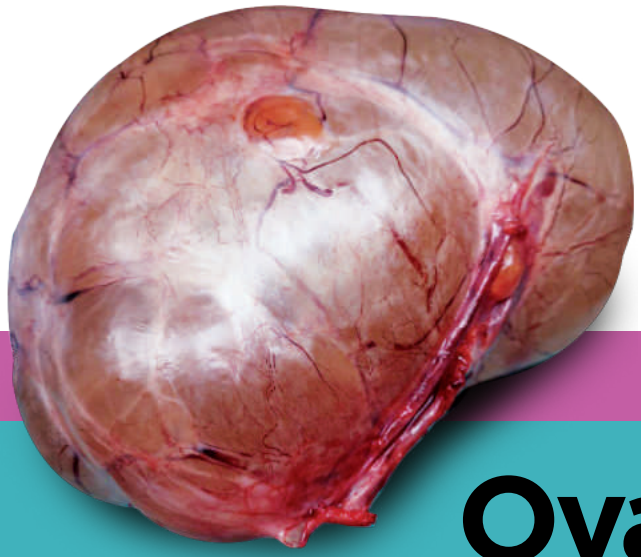
Some examples of firewalls are already existing and are practiced in Europe. The Swedish government has implemented confidentiality rules for both citizens and non-citizens, including undocumented migrants, for access to health care and education, creating a robust firewall in the sphere of health. Healthcare workers are not allowed to disclose undocumented patient information to anyone, with the exception of when a court, prosecutor, police officer or tax authority demands to know if a certain person is being treated at a health care institution.

For us in obstetric services, a firewall means we are not obligated to be an 'agent' for the Immigration Department. Our refugee mums and their new-borns are protected from detention, they will not need to stay too long in the ward waiting for the immigration officers to come get them into the Immigration Depot. They can be discharged to recover in the relative comfort of their own home, nurturing their new-born and we get our much-needed beds.

Moreover, our humanity may not then feel so bruised.

A Malaysian at FIGO

The new FIGO President has requested Datuk Dr Abd. Aziz Yahya, OGSM Past President, to assist with the preparations for FIGO 2021 in Sydney, Australia. He has been appointed to the congress committee and this is certainly testament that OGSM did well in organizing FIGO 2006 in Kuala Lumpur! The FIGO President also felt Datuk Dr. Aziz's experience as the Chairman for the 2015 Vancouver Congress would be of benefit to the committee organizing the Sydney event. Congratulations!



Dr Lee Chui Ling

Ovarian Cancer Statistics in Malaysia

4th common women cancer

Approximately 700 new cases per year in Malaysia

Incidence peak between 45-69 year olds

Lifetime risk: 1 in 158 of all females

Risk factors:

- Nulliparous
- Non-breastfeeding
- Ovulation induction agent
- History of breast cancer
- Early Menarche and late menopause
- Obesity

Among women with BRCA1 or BRCA2 mutations, the risk of developing ovarian cancer by age 80 years is 44% and 17%, respectively

56% presented at late stage (Stages 3, 4)

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Fetal Surgery

Dr Patrick Chia
FRCOG, FAFPM (Hon)

The Ethical Debate. It was Michael Harrison who first performed foetal surgery to correct an anatomical defect 30 years ago. During that time, the concept of the foetus as a patient was the subject of much philosophical and ethical debate. The ability to treat the foetus sparked off some difficult bio-ethical discussions which question the responsibilities of society, physicians, policy makers and the pregnant woman towards the foetus. McCullough and Chervenak (2008) had argued that the pervasive term "unborn child" should not be used to describe the foetus. At that time, the concept of the foetus as a patient and pre-requisites or indications for prenatal surgical treatment were still evolving. However, over the past thirty years, this has become commonly accepted and the ethical framework for maternal-foetal intervention is now well established.

The imaging revolution. Improvements in imaging technologies such as in high resolution 2D, 3D, 4D ultrasounds and the MRI are able to confirm the diagnosis and also exclude any associated abnormalities. Coupled with the knowledge and insight into the natural history of specific anomalies, it has improved our ability to prognosticate the outcome of an individual foetus and permit a more accurate selection of foetuses that will benefit from prenatal surgery; allowing clinicians to accurately identify complex anomalies prenatally and stratify their severity. In a recent editorial for the International Society for Ultrasound Obstetrics and Gynaecology (ISUOG) journal, Tutschek (2018) commented that 3-D printing provides yet another level of interaction: the so-called physical "haptic" experience. This will further enhance the understanding of normal and abnormal foetal anatomy for teaching and learning health professionals and prospective parents (Tutschek, 2018).

All foetal treatments are maternal-foetal interventions and the most important consideration is the safety of the mother and her future reproductive potential.

With evidence-based practice in mind, it is extremely difficult to conduct a meaningful study on the subject. The paucity in the numbers and the rarity of conditions often hamper research. The heterogeneity of cases makes comparison of long-term outcomes difficult. Nonetheless, we have a consensus in the management of some anomalies to be able to offer some patients a choice in making an informed decision about their pregnancy.

The scope of foetal surgical intervention

a) Ultrasonography-guided vesico-amniotic and, less commonly, thoraco-amniotic shunt insertion;
b) Fetoscopic techniques for ligation of umbilical cords in acardiac twins, selective laser photocoagulation of communicating vessels in twin-to-twin transfusions and ablation of the posterior urethral valves;
c) Open foetal surgery allows for surgery on the foetus while placental perfusion is maintained, with the goal of continuing intrauterine gestation as long as possible post-operatively.

CONDITIONS	INTERVENTION	RESULTS
MENINGOMYELOCELE	ANTENATAL OPEN REPAIR (OR) vs	OR had less hindbrain herniation
vs Fetoscopic repair	Better neonatal outcome and	
vs Postnatal repair	Improved motor function	
Lower urinary tract obstruction	Fetoscopic therapy vs	NO difference in outcome
Vesico-amniotic shunt		
Pleural effusion	Shunting	
a) Lung lesion b) Hydrops resolved c) Overall survival		Smaller by 21% 83% 70%
Twin-to-twin transfusion syndrome	Laser photooagulation	65-70% (survival rate)
TRAP and selective reduction of MC twins	Cord occlusion	50% Mortality (nothing done)
Congenital diaphragmatic Hernia (CDH)	Fetoscopic survival	24 - 49%

Table 1. This table presents some of the therapeutic techniques used to treat the foetus.

OPEN maternal-foetal surgery has remained limited to only a few anomalies (see Table 1). It is important to appreciate that the development of this field has accelerated in technological progress for prenatal diagnosis and intervention, leading to an improved understanding of the pathophysiology and natural history of disorders. This allows a comprehensive counselling of prospective parents in centres with focused expertise in the management of foetal anomalies. This has driven the evolution of a less invasive and much SAFER therapeutic approach such as FETO (Fetoscopic Endo-luminal Tracheal Occlusion).

The Malaysian scenario. As in other developed countries, Malaysia enjoys the technological advances which have been responsible for the rapid development of foetal medicine. However, there is no national program for the screening of foetal abnormalities. The Ministry of Health (MOH 2006) appointed an expert committee and the following are their recommendations:

"Due to the ethical and religious issues… prenatal screening, invasive diagnostic procedures and termination of pregnancies, a national programme of routine antenatal maternal serum screening for Downs Syndrome, neural tube defects and Thalassaemia, are not recommended. However, screening should be made available to women who request the test."

Malaysian mothers today have the option of foetal treatment. Although limited in availability and costly, foetal therapy is now a realistic option for a variety of conditions that previously entailed certain dangers. Foetal monitoring and newer surgical endoscopic procedures have made this process of treating the mother with an anomalous baby a much safer one. In this context, the closest we have come to foetal intervention is the ex utero intrapartum (EXIT) procedure. Maternal risks also weigh in heavily on the ethical debate. The pregnant woman undergoes a general anaesthesia. With this follows the risk of peri- and post-operative bleeding and the high risk of preterm birth which usually results in a repeat hysterotomy.

The care is multi-disciplinary and involves a maternal-foetal-medicine (MFM) specialist or perinatologist, neonatologist, anaesthetist and neuro-surgeon (or paediatric surgeon); whichever specialist is appropriate. These sub-specialists are only just available in the country as more Malaysian doctors develop interests and gain more experience in looking after the mother and her baby in this often difficult circumstance.
All needling and shunting procedures are available in a few key centres in the private sector where most of the expertise are available. The endoscopic procedures are limited to the availability of experts performing the surgical procedure. As far as I am aware, no open surgical procedures have been performed in this country.

Conclusions: *The development of foetal medicine and therapy has been slow in this country. This is not due to the legislative indifference to change abortion laws. The vast majority of these decisions are not governed by legislation in most countries.*

In contrast, many of the world's religions do offer direct or indirect guidance about what a woman should or should not do during pregnancy. Religious beliefs and perspectives are therefore likely to have a considerable impact on the decision-making processes of some pregnant women.

The advances in foetal imaging have improved our diagnostic accuracy. It has allowed the development of in-utero interventions. Improving ultrasound resolution offers remarkable precision for ultrasound-guided foetal intervention procedures. As less invasive techniques and equipment evolve, the indications for foetal therapy are likely to expand.

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Neoadjuvant Chemotherapy In Epithelial Ovarian Cancer: An Update

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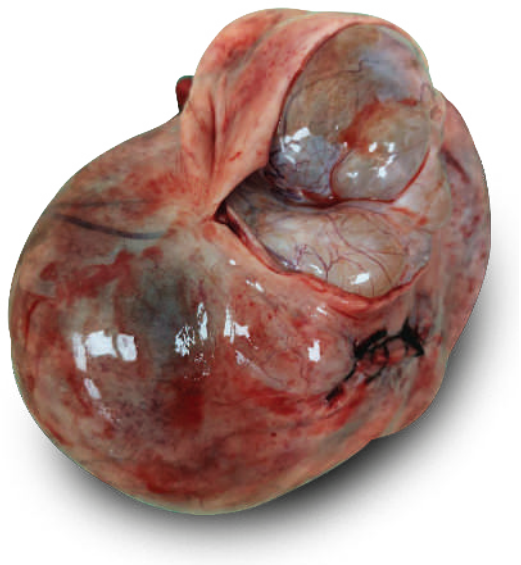
INTRODUCTION

Primary debulking surgery followed by chemotherapy has been considered a standard treatment for patients with advanced ovarian cancer. Nearly all retrospective and prospective studies have confirmed that the extent of cytoreductive surgery and the amount of residual disease are among the most important factors to determine the survival of women with advanced ovarian cancer. An optimal surgery which is defined as leaving residual tumour of less than 1 cm is not always possible, especially in old patients, patients with poor co-morbidity and extensive tumour bulks[1].



NEOADJUVANT CHEMOTHERAPY

Neoadjuvant chemotherapy (NACT) is an approach to medically cytoreduce the tumour in order to increase the proportion of patients with advanced ovarian cancer to achieve optimal cytoreduction after subsequent surgical treatment.

Cytoreduction performed after neoadjuvant chemotherapy is also called interval cytoreductive surgery or interval debulking surgery (IDS). Interval debulking surgery is usually performed after 2-4 cycles of chemotherapy. After IDS, chemotherapy will be continued.

Potential benefits of neoadjuvant chemotherapy are[2]:

a. Reduced risk of perioperative morbidity (e.g., lesser blood loss, a lower requirement of intensive care unit admission, shorter duration of hospital stay, etc.
b. Higher rate of optimal cytoreduction (ranging from 77-94%)
c. Facilitate the response of any residual tumour to subsequent chemotherapy
d. Better quality of life

Despite the above benefits, there is still no solid evidence that neoadjuvant chemotherapy and IDS improve survival. The first line of chemotherapy regimens for epithelial ovarian cancer is the Paclitaxel and Carboplatin combination.

SELECTION CRITERIA FOR NACT

Selection criteria for neoadjuvant chemotherapy reported in many studies are:

a. "Unresectable" disease on CT scans; e.g., massive ascites, pleural effusion, etc.
b. Dense adhesion between bowel, mesentery and omentum
c. Omental disease extending to spleen
d. Large diaphragm disease
e. Multiple bowel involvements
f. Peritoneal carcinomatosis
g. Porta hepatis disease
h. Extensive disease in liver surface

When the selection is done by a Gynaecologic Oncologist, 10-20% of patients with advanced ovarian cancer will fulfil the above criteria. A study had shown that CT scan is not reliable in predicting suboptimal cytoreduction. Laparoscopy is probably reliable and more accurate in assessing operability than a CT scan, but it requires anaesthesia and is an invasive procedure. Furthermore, magnification of the tumour through laparoscopy can mislead the surgeon that the tumour is unresectable[3]. Therefore, the role of laparoscopic assessment prior to NACT is still debatable.

Diagnosis of ovarian cancer prior to neoadjuvant chemotherapy is important. The accuracy of cytologic diagnosis (from peritoneal fluid, pleural fluid or FNAC) was found to be as good as histologic diagnosis in the diagnosis of epithelial ovarian cancer prior to neoadjuvant chemotherapy (92%-98% accuracy). Clinical prediction using imaging and tumour markers were less accurate[4].

CURRENT STUDIES ON NACT FOR OVARIAN CANCER

Phase III randomised controlled trial by Rose et al. (GOG trial) involved 550 patients with stages 3 and 4 epithelial ovarian cancer that had a residual disease > 1 cm after an initial attempt of surgical cytoreduction. All patients were subjected to 3 cycles of chemotherapy (Paclitaxel/Carboplatin). Those with no disease progression will be further assigned either secondary cytoreduction or continue with the same chemotherapy. The study had shown that there was no difference in terms of progression-free survival and risk of death in both groups[5].

Earlier, the meta-analyses reported inferior survival rate among patients treated with neoadjuvant chemotherapy as compared to primary surgery. Bristow et al., in his meta-analysis, had found that survival outcome was inversely proportional to an increasing number of preoperative chemotherapy cycles, with each additional cycle associated with a 4.1 month reduction in median survival. This may be due to the increasing number of cycles which will promote the development of chemo-resistant cell clones[3].

A Cochrane Systematic Review by Tangjitgamol et al. assessing the effectiveness of interval debulking surgery reported that they could not conclude whether interval debulking surgery following adjuvant chemotherapy would improve the survival of women with advanced epithelial ovarian cancer. IDS appeared to yield a benefit only in patients whose primary surgery was not performed by expert surgeons[6].

The results of EORTC 55971 trial was released in September 2010. In this trial, 670 patients with biopsy proven stage 3C or 4 ovarian carcinoma, primary peritoneal carcinoma or fallopian tube carcinoma were randomly assigned to receive either primary debulking surgery followed by platinum-based chemotherapy, or to receive neoadjuvant platinum-based chemotherapy followed by interval debulking surgery and then platinum-based chemotherapy. There was no difference in a survival rate between both study arms. However, neoadjuvant chemotherapy followed by interval debulking surgery was associated with a lower postoperative mortality, shorter operation time, as well as less grade 3 haemorrhage, venous complications and infections. The authors note that whenever debulking surgery is performed, either as primary treatment or following NACT, complete resection of all macroscopic tumours was the strongest independent variable predicting overall survival[7,8].

CHORUS (Chemotherapy or Upfront Surgery) is phase III randomised controlled trial to investigate timing of initial surgery in ovarian cancer presented at stage III-IV. The study arm was treated with 3 cycles of neoadjuvant chemotherapy followed by surgery and a continuation of another 3 cycles of chemotherapy after surgery. The authors concluded that neoadjuvant chemotherapy was associated with increased optimal debulking, less early mortality and similar survival (progression free survival and 3 years overall survival)[9]. This result was consistent with EORTC 55971.

Two earlier studies (EORTC 55971 and CHORUS) demonstrated non-inferior survival of patients treated with NACT. However, they could not evaluate true treatment invasiveness because of adding diagnostic laparotomy or laparoscopy before treatment in over 30% of both arms of EORTC 55971 and in 16% of NACT arm of CHORUS. Later, there was a more recent phase III randomized trial known as JCOG 0602 to compare treatment invasiveness. In JCOG 0602, a total of 8 cycles of chemotherapy were given. In the neoadjuvant chemotherapy arm, 4 cycles were given prior to interval

surgery. In the standard arm, interval debulking surgery was optional for patients who had undergone suboptimal or incomplete primary debulking surgery. Treatment invasiveness was compared between arms. The NACT arm required fewer surgeries (mean 0.86 versus 1.32, $p < 0.001$) and shorter total operation time (median 273 min versus 341 min, $p<0.001$) than the standard arm and required a lower frequency of abdominal organ resection or distant metastases resection. In the NACT arm during interval debulking surgery, blood or ascites loss was smaller and the albumin transfusion and grade 3-4 adverse events after surgery, in total, were less frequent[10].

A SCORPION trial (randomised phase III trial) investigated whether NACT was superior to primary debulking surgery in terms of Progression Free Survival (PFS) and postoperative morbidity in advanced epithelial ovarian cancer (AEOC) patients, endowed with high tumour load. Tumour load was assessed by laparoscopy predictive index (PI) and high tumour load is defined as PI of 8-12. Paclitaxel and Carboplatin was the chemotherapy regimen used in both groups. The study concluded that NACT was not superior to primary debulking surgery in terms of PFS for advanced epithelial ovarian cancer patients endowed with high tumour load receiving maximal surgical effort[11].

A systemic review and meta-analysis by Xiao, Xie & Zhang et al. on platinum-based neoadjuvant chemotherapy versus primary surgery in ovarian carcinoma for stages IIIc and IV ovarian carcinoma had identified 12 comparative studies involving 1372 patients who underwent NACT followed by interval debulking and 2,680 patients who underwent primary debulking surgery followed by chemotherapy. They reported that there was no difference found in the median progression-free survival. A significantly higher incidence of major infections, vascular events and wound complications were found in patients in the primary debulking group. The authors concluded that NACT could improve the optimal debulking rate and decrease the postoperative adverse reactions, but whether it could improve overall survival still requires verification by conducting more randomised controlled trials[12].

CONCLUSIONS

Although survival data have not yet indicated superiority for neoadjuvant chemotherapy in patients with ovarian cancer, it remains a reasonable approach as it decreases the morbidity of surgery. NACT is now an acceptable treatment for selected patients with advanced epithelial ovarian cancer. There are still unanswered questions with regards to neoadjuvant chemotherapy (NACT) such as (1) Criteria for best candidate for NACT, (2) Duration and number of cycles of chemotherapy prior to surgery, (3) Duration and number of cycles of chemotherapy after surgery, (4) Role of targeted therapy in patient undergoing NACT and (5) Whether the failure to achieve optimal cytoreductive surgery is due to the result of the surgeon's skill or cancer biology. Despite of that, at present, based on the recent phase III trials, primary chemotherapy before surgery is an acceptable standard of care in selected women with stages III and IV epithelial ovarian cancer. Patients with ovarian cancer are best treated by trained Gynaecological Oncologists.

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Obstetrics and Gynaecology – **A Perspective from Three Countries**

Dr Maryam Raya

From early on, as a young medical student, I decided to venture into a surgical specialty and paid special attention to my surgical rotations. I did my MBBS in Malaysia, internship in Bangladesh and finally, I'm working as a surgical medical officer in my country, the Maldives. Due to a particular interest I had in certain specialties, including Obstetrics and Gynaecology, I spent a fair amount of time in O&G postings during my journey in these three countries.

My first proper exposure to obstetrics and gynaecology was as a medical student in my clinical years. I can say with utmost pride that I was trained under possibly the best, who managed to spark an interest in me for the field. Obstetrics & gynaecology is a field which requires patience, persistence, excellent knowledge, fine surgical skills and an ability to remain calm even in the most nerve-racking situations. These qualities were perfectly depicted by my professors and their ability to not only help patients medically, but also in every aspect of their lives; this really influenced my decision to further venture into the field.

Therefore, when I left Malaysia as a fresh, young graduate and embarked on the very first steps of my journey to become an independent clinician as an intern in Bangladesh, I paid special attention to my postings in surgical fields, including obstetrics and gynaecology.

I worked as an intern in Chittagong Medical College, which is one of the largest in the area with 1000 inpatient beds and about 5000 outpatients in a single day. The doctors in the hospital see an astoundingly large number of patients with bare minimum facilities.

I will always fondly remember the 3 months I spent in the O&G posting as one of the best times of my life. Initially, it was tough to get used to the overwhelmingly large number of patients; the pressure of dealing with not only one life, but two at any given time was always present, and of course the infamous attitude and hostility of the specialists. The financing of the health system in Bangladesh is characterised by increasingly high out-of-pocket payments and most patients who sought treatment in a government facility such as CMCH were extremely poor. Therefore, everything

had to be managed with bare minimum facilities which was an extremely difficult aspect for me to get accustomed to as a Malaysian graduate. I remember having patients who would not be able to afford sufficient suture materials and us doctors hunting through boxes in our resting rooms and medical supplies provided by the government and labelled as the 'poor fund' – aptly named as sometimes, the poor fund was so poor, it did not have any supplies. Gradually, as we adapted to the situation, some of us would carry essential supplies such as a few suture materials, bottles of local anaesthesia and spare gloves in a small sling bag worn over our shoulders. There would be so many patients at times, that we would have to lay down mattresses, mats and rugs on the floor, in-between beds, on the corridors and every possible corner.

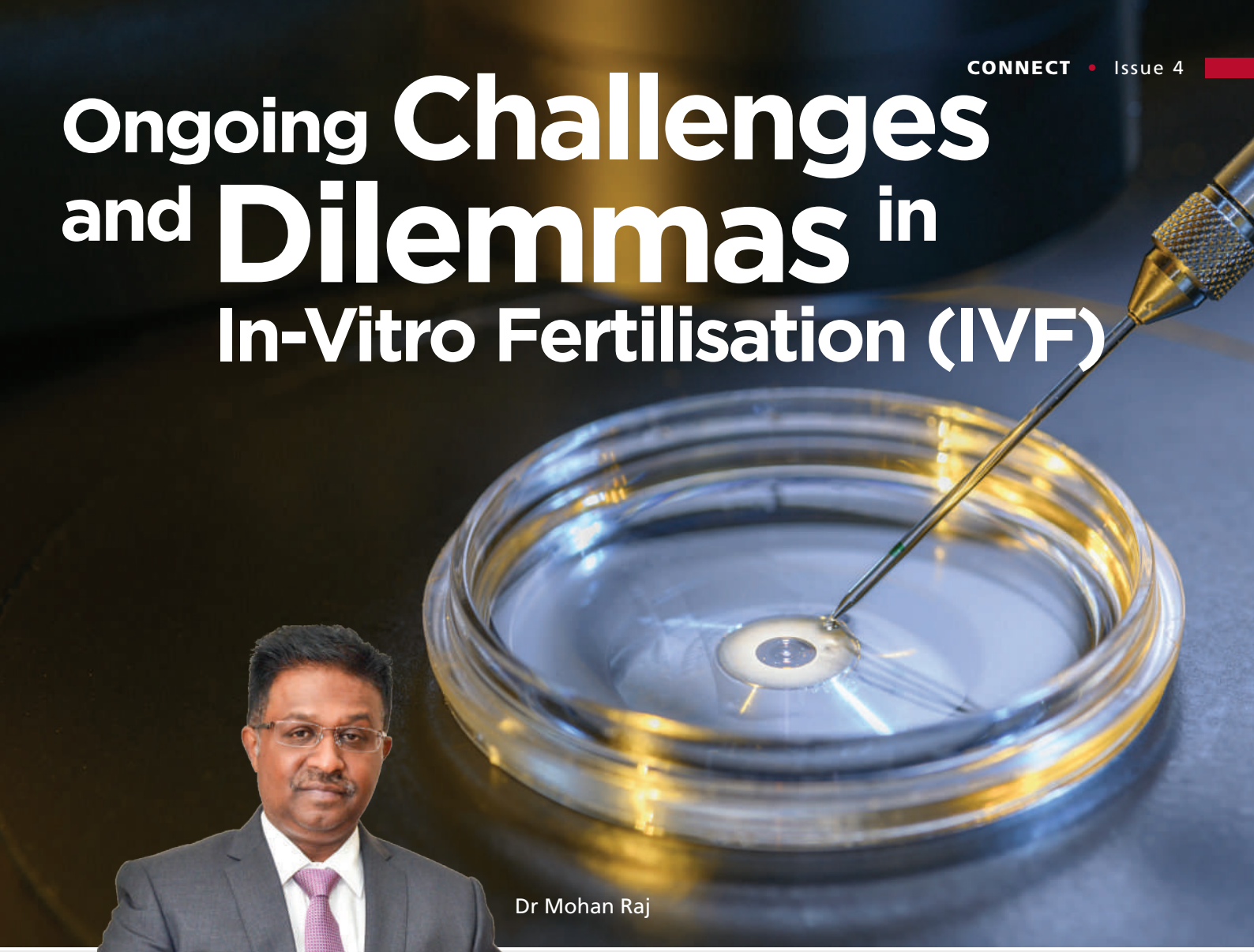
Some of my most memorable duties were in the labour room – there are no accurate words to describe the atmosphere in this room on an admission day for our unit, but the closest term would be organised chaos. To an outsider, it would seem like there was not a single thing in place but if you were a person working in the room, you would know exactly how things were functioning, where the patients were, who's cervix was dilated and how many centimetres. During my first night shift in the labour room, I was fortunate enough to deliver 10 little babies into the world – it was the first time I experienced the sheer joy of being able to independently deliver them. The feeling of helping a mother deliver a baby, handing them over to her at the end and watching the pure happiness on her face surpasses the many struggles of working in such a highly stressful environment. The registrars, consultants and professors I worked under were excellent teachers who made us competent enough to independently function in any situation; they taught us to manage almost anything until the consultant arrived. There were nights we delivered twins, babies in breech presentations or patients with eclampsia and in labour by ourselves until the consultants who were attending other emergencies were able to come to our rescue. One more aspect of the job that I thoroughly enjoyed was the variation – we could begin the day with something as calm as attending to a patient with dysmenorrhea and then end it in a frenzy dealing with a patient with post-partum haemorrhage or one with shoulder dystocia before any cerebral ischemia occurs.

When I started work as a medical officer, the first job I applied for was in the department of obstetrics and gynaecology in a tertiary centre in the Maldives. The number of patients were much less as compared to Bangladesh; and in Maldives, patients have an insurance scheme. Therefore, all facilities are available for patients and the cost was covered by the government. However, as patients were more demanding and litigation rates were rising, consultants were extremely paranoid; everything had to be cross checked with them. We, as medical officers, lacked the opportunity to make any independent decisions and our clinical exposure was limited.

One more infamous aspect of working in O&G is the overwhelming pressure from seniors – registrars, consultants and specialists. Obstetricians and gynaecologists are known for their short temper and zero tolerance to any mistakes. I did experience a similar environment in both Bangladesh and Maldives. However, in Bangladesh, as I integrated more into the team, I began to understand why the environment was such. The overwhelming pressure to deal with such a large number of patients who come with life-threatening conditions place the seniors under immense stress and sometimes, it manifests as what we juniors perceive as anger. As the seniors got more used to my presence and they began to develop a sense of trust in me, I found it easier to communicate with them. However, I had trouble blending in while I worked in Maldives and I was unable to integrate myself into the team. I found it emotionally exhausting to be extremely stressed at work and it hampered with my personal growth as an aspiring clinician. Our clinical exposure was limited, therefore the joy of being part of the patient's journey was limited and not enough to neutralise the stress of busy schedules and difficult patients, as in Bangladesh. Working in obstetrics and gynaecology can be extremely taxing due to many factors but the bond we develop with patients, especially while being a part of their lives at poignant milestones such as conception, birth and major surgeries, makes it worthwhile.

An author wrote in a BMJ article describing obstetrics and gynaecology as the Red Savina Habanero of medicine if variety was the spice of life – I do not think there could be a better metaphor. There is always spice, excitement and rush in the life of an obstetrician. The months I spent in O&G made me a better doctor and as I embark on an attempt to become a surgeon, the skills and qualities I learnt in O&G postings did not just make me a better doctor, but also a better human being as well.

Ongoing Challenges and Dilemmas in In-Vitro Fertilisation (IVF)



Dr Mohan Raj

When IVF was introduced into fertility care, pregnancy rates were only in low single digits. Therefore, in order to improve their patients' pregnancy chances, practitioners transferred what appears today like unreasonably high numbers of embryos. As IVF improved and pregnancy chances per embryo (called implantation rates) increased, high rates of multiple pregnancies increased the risk of miscarriage, preterm delivery, small baby (intrauterine growth restriction), high blood pressure, gestational diabetes, foetal loss and high risk of operative delivery.

However, with multiple improvements over time, such as optimised embryo culture and stimulation protocols, pregnancy rates have improved and the practice of transferring multiple embryos was revised. The rationale was that single embryo transfer is really the only effective way to minimise multiple pregnancy rates.

Therefore, it is now clear that allowing embryos to develop in culture to day 5 in the development or blastocyst stage, pregnancy rates are much higher. In the past, embryos were transferred on day 2 or day 3 of development, and it was much harder to know which one had a good chance of implantation. Thus, it was routine to transfer multiple embryos at this stage. Today, most IVF centres allow embryos to develop to the blastocyst stage from day 3 until day 5.

The rationale of day 5 blastocyst transfer is based on increasing the probability of obtaining advanced embryos with the highest chance of survival; i.e., implantation. The prolongation of embryo culture to day 5 requires a relatively high number of top-quality blastocysts. Good quality cleavage-stage embryos increase the likelihood of good quality blastocyst embryos. Therefore, it would be prudent to expect no advantage if only a few good quality blastocysts exist in the culture.

Unfortunately, IVF does not always result in pregnancy even when a perfect day 5 blastocyst is transferred because there are other factors that determine its viability. Blastocysts may look very similar under the microscope but genetic factors that cause poor development after transfer or miscarriages are not readily seen with the naked eye. Up to 1/3 of pregnancies that result end in biochemical losses or spontaneous miscarriages.

While there are many underlying reasons, a significant proportion of these losses are due to genetic imbalances that can now be detected through embryo biopsy and genetic testing. More importantly, the time for having a baby is a special consideration for patients struggling with infertility. Technology is now available to choose the best embryos that will help lessen the time to a successful live birth. Selection of the best embryos by genetic testing should be offered to all couples undergoing IVF, and this will soon be the practise in the future because it increases the pregnancy rate and lowers the chances of miscarriage.

The introduction of intracytoplasmic sperm injection (ICSI) by Palermo et al. in 1992 has changed the revolutionary way of assisted reproduction technology by allowing us to efficiently treat patients with low sperm count, low motility, low morphology, testicular spermatozoa and previous failure of conventional IVF. In these situations, suboptimal spermatozoa could by-pass the physiological check-points of natural fertilisation and generate embryos; and subsequently, babies. Conventional ICSI has the hypothetical risk of injecting immature, DNA damaged, aneuploid, low motile, morphologically abnormal spermatozoa.

Although ICSI has been successfully applied worldwide for several years, we have no real knowledge regarding the hypothetical long-term side effects on ICSI adults. The recent refinements of the ICSI procedure such as selecting spermatozoa prior to ICSI by their maturation markers and non-invasive imaging sperm selection techniques such as IMSI (Intracytoplasmic morphologically selected sperm injection) can be of help in the selection of the ideal spermatozoa. These new advances in ICSI may allow the selection of the spermatozoa contributing to improved fertilisation, embryo quality, blastocyst formation, reduction in miscarriage and successful pregnancy.

Louise's own birth was the landmark that changed the face of reproductive medicine. Despite the risks involved, the popularity of IVF continues to grow, and there is no denying the happiness that the procedure has brought to hundreds of thousands of couples who would never have had children without it. "Let's make pregnancy possible".

Vascular Injuries during Gynaecologic Surgeries

Miss Lim Li Yi,
Mr Mohamad Azim Md Idris

Vascular injuries during gynaecologic surgeries are infrequent but associated with catastrophic complications and high mortality. Complex pelvic anatomy and intimate relationship of the pelvic structures increase the risk of vascular complications. The risk is even greater with gynaecologic oncology surgeries when tumours invade adjacent organs or distort normal anatomy.

The frequency of vascular complications is not known. A previous survey performed in Sweden showed that vascular injuries complicated 0.93 per 10000 laparoscopic procedures, 0.73 laparotomies and 0.33 major vaginal surgeries. All laparoscopic injuries reported were localised to the iliac arteries, and injuries during laparotomy were frequently venous.

Vascular injuries commonly occurred during dissection by direct injuries or thermal injuries from electrocautery and energy devices. Rarely, vessels were ligated as they were mistaken as other structures. In the case of laparoscopic surgeries, injuries can occur during the placement of the Veress needle or trocar.

Careful pre-operative planning is the key to prevent vascular injuries. Close collaboration with vascular teams is essential, especially for complex cases. In oncological cases where vessels are involved, multidisciplinary meeting should be arranged to discuss operability and the need for vascular bypass.

During surgery, sharp dissection is preferred over electrocautery or energy devices when dissection is near the vessels. Immediate recognition and prompt repair of any iatrogenic vascular injuries are key to prevent serious complications. Initial control of bleeding vessels should be accomplished by digital or sponge pressure. The use of non-vascular instruments to gain vascular control should be avoided as it results in further vascular trauma. The choice of reparative technique should be based on the type of injuries, the underlying diseases and extensions, general condition of patients, surgeons' experience and the availability of vascular surgeons or general surgeons with vascular experiences in a practising centre or nearby centres.

The most common arterial injuries are to iliac vessels. Reconstruction is obligatory for any injury to the common iliac artery and external iliac artery as ligation of these arteries lead to limb loss in 53.8% and 46.7% of cases, respectively . The keys to reconstruction are proximal and distal control, mobilisation of the injured vessel, followed by the removal of unhealthy segments. Primary repair or tension free primary anastomosis will be preferred. If, however, these options are not feasible due to the risk of stenosis or insufficient length, venous patch repair, saphenous vein interposition graft or bypass will be performed. Iliac veins including common, external and internal iliac veins are the most common site for venous injuries . These injuries can be repaired with lateral venorrhaphy, primary anastomosis, interposition graft or ligation.

Close observation for post-operative complications are crucial. These include re-bleeding, thrombosis of the injured vessels or bypass grafts and distal embolism. There is no clear guideline on post-operative anticoagulant or antiplatelet and their duration. In a small-scale study on patients with traumatic arterial injuries, there was no significant difference in the outcome between those who did and did not receive anticoagulant and antiplatelet after surgical reconstruction. However, we believe that this should be determined on individual basis. In cases with intima injuries and high risk of thrombosis, post-operative anticoagulants and antiplatelets may be beneficial.

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MENOPAUSE

The Menopause Committee has been working in collaboration with the Malaysian Menopause Society to establish evidence-based Clinical Practice Guidelines in Menopause Management in Malaysia. All meetings are held at the OGSM offices.

The members of the working committee are:

- Dr Premitha Damodaran (Chair)
  (Pantai Hospital Kuala Lumpur)
- Dr Raman Subramaniam (Foetal Medicine and Gynaecology Centre)
- Dr Ho Choon Moy (Pantai Hospital Cheras)
- Dr Ng Beng Kwang (UKM)
- Prof Em Dato' Dr Nik Mohd Nasri (USIM)
- Prof Dr Jamiyah Hassan (UMMC)
- Prof Dr Nik Haslina Nik Hussain (USM)
- Dr Chan Siew Peng (SJMC)

The committee has had 5 meetings to date and is presently halfway through the initial write up with the aim of completing the CPG by the 3rd quarter of the year. The next meeting would be with the representative from the Ministry of Health with a briefing of the format and style expected. The aim is to finish this CPG in the next 6 months with the hope of Launching it during the World Menopause Day 2019.

Asian Society of Gynaecological Oncology 5th International Workshop on Gynaecological Oncology, Korea

Dr Suresh Kumarasamy
Council Member, Asian Society of Gynaecological Oncology
Chairman, Gynaecological Oncology Sub-committee, OGSM

The Asian Society of Gynaecological Oncology (ASGO) was formed in 2008 with the aim of scientific exchange and collaboration, provision of educational opportunities, deepening friendship between members and ultimately improving the care of women with gynaecological cancer in Asia. The role of ASGO is particularly important as almost half of all gynaecological cancer deaths occur in Asia[2]. ASGO alternates between organising international workshops and Biennial meetings every year.

ASGO held its 5th International Workshop on Gynaecology Oncology together with the 12th Korean Society of Gynaecological Oncology Workshop for Young Gynaecologic Oncologists at Ajou University Hospital, Suwon, Korea from August 23 to August 25, 2018. It was a well-organised and well-attended workshop with about 317 participants from 15 countries. The faculty consisted of 54 invited speakers from 11 countries who gave a total of 54 presentations covering a wide range of topics in Gynaecological Oncology.

As in previous years, ASGO provided support for young gynaecological oncologists or trainees in gynaecological oncology from Malaysia to attend the workshop. The support involved USD 500 towards air fare, as well as free accommodation and registration. The criteria for applicants were that they had to be Malaysians and under 40 years old before the 26th of July 2018. The applicants were also required to submit an abstract for oral or poster presentation at the workshop. There were a number of applicants for support to attend the workshop. The successful applicants were Drs Khoo Boom Ping, Sharifah Adibah, Chew Kah Teik and Mohd Faizal Bin Ahmad. All four of them attended the workshop and benefited from the exposure.

In the next meeting, ASGO will be organising the 6th Biennial Meeting. This meeting will be held between October 10-12, 2019 in Songdo Convensia, Incheon, Korea.

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Trainees Report on the 5th Asian Society of Gynaecological Oncology Workshop, Korea

Dr Mohd Faizal Bin Ahmad
Clinical Specialist & Lecturer
Reproductive Endocrinologist & Oncofertility Trainee
UKM Medical Centre
Participant
5th Asian Society of Gynaecologic Oncology (ASGO) Workshop, Suwon, Korea

I am fortunate to be given the opportunity to attend the 5th Asian Society of Gynaecologic Oncology (ASGO) Workshop held in Conjunction with the 12th Korean Society of Gynaecological Oncology Workshop for Young Gynaecologic Oncologists held from the 24th to the 25th August 2018 at Ajou University Hospital, Suwon, Korea.

This was a two-day workshop consisting of lectures on various gynaecology malignancies as well as chemotherapy and targeted therapy. There was also a session on recent clinical trials in Asia.

Part of the workshop's aims was to help young doctors in the field of gynaecological oncology to showcase their research activities and update their knowledge.

The highlight of the second day was the Oral Presentation session for Junior doctors. Doctors from Korea, Malaysia, China, Indonesia, Bangladesh and Thailand were given the chance to make oral presentations. I was given the opportunity to do a presentation on my five-year review of metabolic syndrome and endometrial cancer at the University Kebangsaan Malaysia Medical Centre.

Apart from the excellent lectures and wonderful junior doctor's session, we trainees were also served with a great Korean cruise. There was a memorable welcome dinner during the first day of the course. There was also a great opportunity for social networking among faculty and trainees. We had the chance to exchange ideas and also establish relationships with colleagues from other countries with a view of future collaboration and research in gynaecological oncology.

At the end of the workshop, all trainees were given a certificate of attendance and reimbursement for the flight ticket. We obtained an incredible amount of new knowledge in the field of gynaecological oncology. This beautiful and transformational workshop is one that should not be missed. It was one of the best workshops I have ever attended!

OGSM Contraception Course 12th of January Report

Dr John Teo

The 1st OGSM Contraception course for 2019 was conducted on the 12th of January at Subang Jaya in collaboration with the Federation of Reproductive Health Associations of Malaysia.

It was well attended with 97 participants from KL, Klang, Shah Alam, Pahang and Johor. More than 50% of attendees were doctors from government health clinics, university hospitals and general practitioners. Others were nurses, pharmacists and even just graduated medical students waiting for postings.

General feedback to the course was very positive.

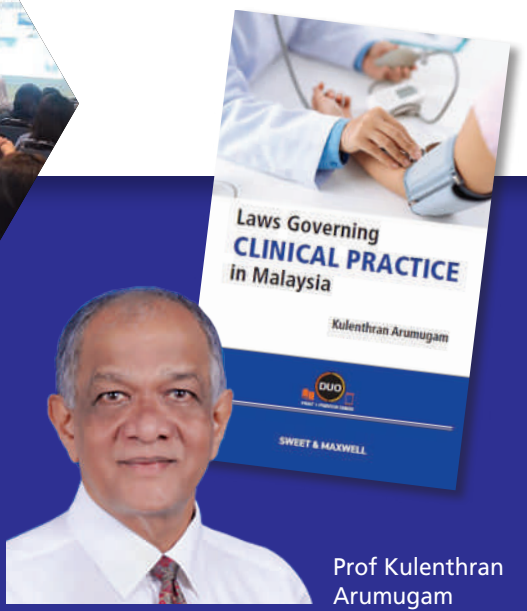
Everyday Practices in Obstetrics and Gynaecology (EPOC) Subcommittee report

Dr Wong Choon Meng

Season's greetings to all. Since assuming the chairmanship of EPOC, I have taken up the mandate to bring the 3R's to our members i.e. Renewal of our knowledge, Revalidation of our skills, and Reconnect with our fellow colleagues. It has been a hectic few months as I, with the help of Council, fellow subcomittee's heads and staff of OGSM, arrange many relevent talks and meetings to meet this aspiration.

I am happy to report the successful conclusion of our first OBGYN Update Series of the year on 13/1/2019 at Pullman KLCC. This full-day meeting with 12 interesting and practical topics attracted very good turnout, both juniours and seniors. There were many out-station participants as far away as East Malaysia joining this meeting. A big applause for all the Speakers for giving the latest updates and practical clinical tips. The networking of colleagues from various states and private/public sectors was an added value. Through your feedback, I will try to keep the topics relevent and practical.

So, do keep an eye out for out notices for future events.



Prof Kulenthran Arumugam

This book has been authored primarily for medical practitioners in Malaysia. It is written in a manner that can be easily understood by readers with no legal background. Regular references are made to various legislation such as the Medical Act 1971. The Medical Regulations 2017 and the Traditional and Complementary Medicine Act 2016 which will help readers appreciate the statutory scheme regulating clinical practice in Malaysia. Reference are also made to guidelines like the Code of Professional Conduct by the Malaysian Medical Council.

Each chapter starts with learning objective to ensure that the reader obtains a clear understanding of the subject matter covered. This book begins with a brief introduction to the Malaysia Legal System in general. It then goes on to discuss the laws governing the medical profession and the application of the law of negligence in the area of medical treatment. This book also deals with the elements of clinical practice that may give rise to criminal liability on medical practitioners, especially gross negligence, abortion, assisted suicide and euthanasia. The topical issues of consent, refusal of consent, advance directive, organ donation and organ transplant are usefully covered. Rounding up the multi-faceted coverage of this book, the related topics of medical reports, expect opinion and the certification of death are considered.

This book is written by an author with a unique background as he is a practitioner, a medical professor and also a law graduate. Drawing on this special set of skills and knowledge, the author provides and extremely illuminating account of the laws that govern clinical practice in Malaysia. It is fully up-to date, taking into account amendments made by the Medical (Amendment) Act 2012 which came into force in July 2017. This book is suitable for medical practitioners who have already spent several years in the medical profession and those who are just beginning their journey in the profession. It is a book which should be readily available for easy reference.

The book will be available at Kamal Bookstore, MPH and Kinokuniya Bookshops and is priced at :
RM 80 for hard copy + ProView (e-copy)
RM 64 for the ProView (e-copy) only
For personal delivery contact
Naleena Catherine of Thomson Reuters
Tel: **603 5115 3025** or **012 615 9680**

The Regional Recognition for OGSM

Dr Gunasegaran PT Rajan
Director, ICOE

Since its launch in September 2014, ICOE has conducted 50 courses in 52 months and has trained more than a 1000 doctors, both locally and overseas. ICOE has been conducted in 11 regional countries: Myanmar, Cambodia, Laos, Vietnam, Pakistan, India, Bangladesh, Sri Lanka, Nepal, China and Mongolia.

OGSM, via the ICOE, is now recognised as a professional organisation that delivers quality medical teaching to the region. More importantly, OGSM is respected for offering these medical education without any levies on copyright or franchise fees.

The OGSM produced the 'Handbook of Obstetric Emergencies' which has regionally sold over 500 copies and is used as a resource material in hospitals and universities. There is a strong interest to translate the book into Mandarin and Japanese.

The consistent high quality of the OGSM course has not only earned the endorsement from AOFOG, but AOFOG also collaborates with OGSM in several Asia Oceania countries. Other regional recognitions include:

- China and Japan both conduct their own simulation in obstetric emergency courses and OGSM has been invited to participate in these conferences.
- Laerdal, who produce medical simulation and training equipment, has engaged with OGSM to provide consultancy for curriculum and faculty development in Nepal for the Bachelor of Midwifery programme.
- These regional courses have attracted the attention of global health care organisations and they have reached out to OGSM to seek collaboration in global maternal health. They include the Harvard Centre for Global Maternal Health and the Boston based Ariadne Labs who are renowned for developing the WHO Checklist.

It is complex to measure the impact of ICOE in these countries. Most of these countries have low resources with a multitude of issues and whose maternal health indices are poorer than us. If the course can, in a small way, train a professional to reduce a bad maternal or neonatal outcome, then OGSM and its members should feel proud that their efforts have not been unfruitful. We must continue to support and advocate obstetricians around the region.

OGSM, through the ICOE, has created a network within these countries by engaging with regional national societies, the ministry of health as well as universities. This network should now form a conduit for OGSM to further conduct other educational initiatives and enhance its regional imprint.

Trainees' 'Study-Circle' on Reproductive Medicine

Dr Mohamed Hatta Tarmizi
Sub-committee Chairman for Reproductive Medicine

The Trainees' 'Study-Circle' on Reproductive Medicine and Infertility was held at the Sabah Women and Children's Hospital, Kota Kinabalu on the 15th of February 2019. This program, also supported by OGSM, was initially meant for a dozen of our MRCOG trainees in preparation for their upcoming MRCOG Part 2 and 3 examinations. However, the response was too overwhelming, therefore, we had to open up the registration to other doctors within the state. In the end, we had nearly 60 registered participants and had to reluctantly and politely decline a few other interested doctors. Participants came from all over Sabah as well as Sarawak.

Speakers included Dr Murizah M. Zain from Hospital Sultanah Bahiyah, Alor Setar who spoke of PCOS and its fertility implications, Dr Arivendren on fertility sparing surgery in gyne-oncology, Dr Nathira A. Majeed on investigating and managing the infertile couple, Dr Connie Liew on sexual dysfunction and Dr Fathi Laila on endometriosis and infertility.

Meanwhile, Dr Ana Vetriana spoke about counselling teenagers with congenital abnormalities of the genital tract followed by 3 mock clinical counselling sessions on the subject; brilliantly conducted by Dr Connie Liew, Dr Melanie Kuan and Dr Fathi Laila. Afterwards, the organising Chairman, Dr Mohamed Hatta, shared 2 topics on male infertility and assessment criteria for IVF in the UK. After lunch, the participants were tested with more than 50 SBA and EMQ MRCOG styled questions, moderated by Dr Melanie Kuan.

Lastly, the sessions ended at approximately 5 p.m. where the organising chairman thanked the Trainees, Dr Rathi, Dr Thawa and Dr SK Thong (and team), for conducting a successful course which had positive feedbacks from numerous participants.

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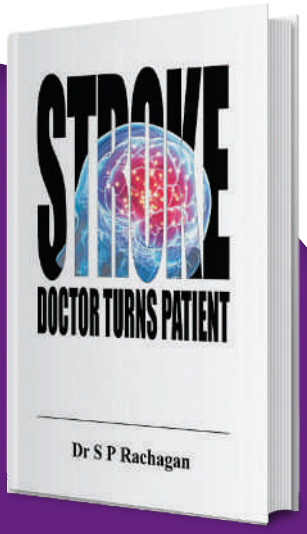
OGSM's Book on Display in Taiwan

"These photos were sent to Dr. Ravi Chandran, Past President of OGSM and current AOFOG President by the Taiwan OG Society (TAOG) showing our OGSM book proudly on display in their museum in Taipei. He had presented them our book in 2017. Below that is a memento he had presented to them in 2013 on behalf of OGSM."



Dr SP Rachagan,
President of OGSM 1999/2000, details in Stroke: Doctor Turns Patient illustrates his determined and arduous journey back to O&G practice. This included a proctorship even more demanding than that recommended in the RCOG guidelines.
The book is available at MPH, Borders, Kinokuniya and Amazon. For more information visit https://sprachagan.com/

Could this be the Solution?

Dr Eeson Sinthamoney

Historically, there have been many occasions when the fraternity has felt under siege. Sometimes, the perceived problem dissipates, while on other occasions we become numb, grow tolerant and somehow develop coping mechanisms that allow us to move forward. Certainly, raising litigation and its associated medico-legal indemnity coverage costs have been haunting us for some years now, with little respite. In fact, some argue that the situation may well have worsened over the last twelve months when several Obstetricians were told that their coverage would not be renewed as they were seen to be an 'insurance risk'. So, what then? Three strikes and we're out?

Recently we were reliably informed that if Cerebral Palsy payouts were to be taken out of the equation, our indemnity premiums would reduce, and probably equate those of other specialities. Therefore, a logical solution would be to somehow curtail such payouts, especially since scientific evidence suggest that only in approximately 10% of these cases is there actually clinical negligence.

So how exactly are these judgements reached? Again, we have been reliably informed that in reality, the situation is such that two experts (the definition of an 'expert' is unfortunately contentious apparently), from opposing divides, provide contrasting opinions and fortify these opinions with scientific evidence from differing sources (again, the definition of 'evidence' is also contentious), both trying to convince the judge on the truth of the matter. Suffice to say, the winner is often the one who sounds more convincing, rather than on a true interpretation or representation of the facts.

It was therefore suggested, that a sensible and reasonable way forward would be to devise, as a fraternity, a consensus opinion on the aetiology of Cerebral Palsy and to look at compensation mechanisms from a more local perspective. Certainly, other issues related to Cerebral Palsy can also be alluded to, but the former two being of the utmost importance.

If this consensus stand were to be scrutinized by our peers, and then further developed and improved upon with input from Neonatalogists, Paediatric Neurologists, Rehabilitation Medicine Specialists and other related experts (possibly from abroad too), it was envisioned that such a robust and cohesive voice could then provide a firm background understanding of Cerebral Palsy (in a Malaysian context) which may then hopefully form the basis upon which we can be judged for any perceived misdoing.

We are happy to inform you that the Society, in collaboration with the College of Obstetricians and Gynaecologists has actually embarked on such an endeavour, ably led by Dato' Dr. Alex Mathews, a stalwart of OGSM. With the host of eminent luminaries of our fraternity on board, I am without doubt that this endeavour will reach fruition.

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