Final Program

The First International Conference of the Kurdistan-Iraq Society of Obstetricians and Gynecologists

3rd – 5th of April 2014
Rotana Hotel
Erbil - Kurdistan

www.kisog.org

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Welcome Note:

On behalf of the Organizing Committee of Kurdistan-Iraq Society of Obstetricians and Gynecologists (KISOG), it gives me a great pleasure to welcome your participation in this important meeting at Rotana Hotel in Erbil, 3rd– 5th April 2014. We are pleased to host such an event and we promise it will be a groundbreaking gathering in every aspect.

This gathering will provide an opportunity to share new experiences, and exchange information and to updated knowledge on the latest Obstetricians and Gynecologists issues.
The conference has invited several eminent international experts from around the world, and great efforts have been made to structure a program of topics to meet the needs of Obstetricians and Gynecologists in their routine daily practices.

We anticipate stimulating and interactive discussions throughout the program with lectures, slide seminars, workshops and special sessions.

We feel certain that the convening of this gathering in Erbil will also provide the participant with an interesting cultural exposure with a most dynamic mixture of old and new. Erbil offers both a modern infrastructure and a highly educated populace together with a culture that is steeped in history, and a rare opportunity to visit a diversity of archaeological wanders including The Citadel, Waterfalls and Landscapes.

We look forward to your active participation and involvement in the scientific and social events of this gathering, assuring you that every effort will be made to make your journey and stay amongst us in Erbil both fruitful and enjoyable.

President of the Conference
Ariana Khalis Jawad

Executive Committee :

Dr. Ariana Khalis Jawad (President)
Dr. Ali Abdulrazaq Al Dabbagh (Erbil)
Dr. Fareed Hanna (Erbil)
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Dr. Shleer Faeq Ghareeb (Sulaymani)
Dr. Chnar Mustafa Ahmed(Dhok)

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Dr. Maeda Shamdeen (Dhuok)
Dr. Muhsan AlSabak (Basrsa)
Dr. Ali Alhussaeni (Dyala)
Dr. Rezan Abdulqadr (Uk)
Dr. Maream Baker (Sulaymani)
Dr. Mayson AlHaydari (Erbil)
Dr. Abubakir Majeed Saleh (Erbil)
Dr. Mahabad Saber Ali (Erbil)

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Dr. Ronak Ibrahem (Sulaymani)
Dr. Khalida Mohamad Amen (Kirkuk)
Dr. Parez Raza (Erbil)
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Dr. Shanaz Hamed (Erbil)
Dr. Jwan Omer (Erbil)
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Vian Rawandozi (Erbi)

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Vian Rawandozi (Erbil)
Shoula Galani (USA)

Speakers:

Dr. Abdel Latif Abu Khadra	Jordan
Dr. Abeer Inab	Jordan
Dr. Adeola Olaitan	UK
Dr. Ali Hellani	UAE
Dr. Assem Al Hajj	Lebanon
Dr. Ezedeen Bahaaldeen	Iraq
Dr. Fadi Mirza	Lebanon
Dr. Faysal El Kak	Lebanon
Dr. Fawaz Khazaaleh	Jordan
Dr. Handrean Soran	UK
Dr. Isam Latayfeh	Jordan
Dr. Jamil Shaaban	Jordan
Prof. Joseph Nasif	Lebanon
Dr. Maeda Shamdeen	Iraq
Dr.Mahabad Ali	Iraq
Dr. Maryam Salmani	Iran
Dr. Martin Olsen	USA
Dr. Mazen El Zebdeh	Jordan
Dr. Michel Abou Abdallah	Lebanon
Prof. Mutasem Taha	Jordan
Dr. Mohamed Mostafa	Egypt
Dr. Randall Williams	USA
Dr. Rezan Abdul-Kadir	UK
Dr. Sabat Barawi	Iraq
Dr. Sharif Omar	USA
Dr. Shahla Alalaf	Iraq
Dr. Suleiman Dabit	Jordan
Dr. Suresh Kumarasamy	Malaysia
Dr. Susan P. Raine	USA
Dr. Syed Hussain	Pakistan
Dr. Pat O'Brien	UK
Dr. Tang Boon Nee	Malaysia
Dr. Theresa Wang	UK
Dr. Zaid Kilani	Jordan

Workshop Presenter:

Dr. Adil Al-Qaysi	UAE
Ghada El Khaldi	UAE
Jaime Wong	Malaysia
Dr. Osama Shawki	Egypt
Rosa Touat	UK
Teresa Flavin	UK

Speakers bio

Abdel Latif Abu Khadra, Jordan

Dr Abu Khadra is a qualified MD, and a Consultant Urologist, working in the private sector, in Amman, Jordan. He is qualified for his M.B.B.ch received in 1983, and received his Master Degree in urology in 1989 from Jordan University, has a Jordanian Board in Urology and a fellowship at Thomas Jefferson University (USA) in 1992, and started his private urology center in Amman with a main interest in male infertility management. He is a founding member and the president of the Jordanian Society for Fertility and Genetics (2010-2013), He is the author and co-author of more than 30 publications and two book chapters, currently serves on the editorial Boards of several local and regional Journals in the fields of urology and andrology. The fields of scientific interest are stem cell research and microsurgery in male infertility.

Abeer Inab, Jordan

Dr Annab is a member of the Jordanian Association of Obstetrics and Gynecology, a member of Middle East Fertility Society (MEFS), and a member of American Society of Fertility. She received her Medicine Degree and general surgery from Baghdad University/ medical college.

Adeola Olaitan, UK

Is a Consultant Gynecological Oncologist, at the University College London Hospital; Was Deputy Chair consultant in 2012, Lead in Gynecological Oncologist 2011, teaching post graduate in ESGO and RCOG sub specialty trainer in Gynecological Oncology RCOG appraiser of training programs in Clinical exp.

Ali Hellani, UAE

PhD from Claude Bernard University in France, world-renowned Reproductive Geneticist with over 15 years of experience, particularly in Pre-Implantation Genetic Diagnosis PGD. In his early years, Dr. Hellani established the first Pre-Implantation Genetic Diagnosis laboratory in the Gulf Region at King Faisal Specialist Hospital in Saudi Arabia with a grant from HRH Prince Al Waleed Bin Talal Al Saud. He went on to establish the state of the art Genetic Diagnosis Lab of Saad Specialist Hospital-Al Khobar. Dr. Hellani was the first scientist worldwide to diagnose multiple diseases on a single cell as well as the first to diagnose the whole set of chromosomes on a single cell. He is currently the first and only scientist to perform PGD on single gene disorders with direct HLA matching. Dr. Hellani has written 46 publications and is a reference lab for the screening of genetic diseases and PGD for many IVF centers.

Assem Al Hajj, Lebanon

- MD, FACS, GENERAL SURGERY
- President-elect of the American College of Surgery – Lebanon Chapter
- Fellow of the American College of Surgeon
- Lebanese Order of Physicians
- Member of the International Hepato Pancreatico Biliary Association
- Member of the Lebanese General Surgical Society

Ezedeen Bahaaldeen, Iraq

Consulant Gynecologist
Assistant Professor

Speakers bio

Fadi Mirza, Lebanon

Dr Mirza, MD, FACOG, Obstetrics & Gynecology and Maternal Fetal Medicine, currently Assistant Professor and Director of Medical Staff Affairs, AUB Medical Center, Beirut, Lebanon, worked as Adjunct Assistant Professor, Columbia University College of Physicians and Surgeons , in New York USA

Faysal El Kak, Lebanon

Dr El Kak is a Clinical Associate at the Women's Health Center, Dept of ObGyn, at the American University of Beirut- Medical Center, & a Senior Lecturer of Health Behavior and Sexual health, Faculty of Health Sciences, AUB. President of Osteos, past president of LSOG.

Fawaz Khazaaleh, Jordan

Dr Fawaz is Chairman of the OBGYN Department, and a Consultant Maternal-Fetal Medicine and Interventional Fetal Medicinw. And an Associate Prof. of OBGYN at the Department of OBGYN, Faculty of Medicine at the University of Jordan

Handrean Soran, UK

MBCHB, MRCP, MSc, CCST Endo & Diab, MD, FRCP
Consultant physician and endocrinologist with a specialist interest in lipidology, calcium and bone metabolism. He received his MD in medicine from Manchester University in 2010. He was elected as fellow of Royal College of Physicians Edinburgh in 2009. He provides a tertiary centre lipoprotein disorder and calcium and metabolic bone disease services. He is the lead of Cardiovascular Trials Unit at Central Manchester University Hospitals NHS Foundation Trust. His research work is mainly based on cardiovascular risk, lipoprotein metabolism, LDL quality, HDL functionality and Obesity. He successfully supervised MD and PhD students and currently a supervising PhD and MD students. Dr Handrean Soran is the endocrinology and diabetes associate training programme director and education lead North West Deanery.

Isam Latayfeh, Jordan

Got the Higher Specialization in Medicine in Obstetrics and Gynecology from Jordan University and the Jordanian Board in Obstetrics and Gynecology in 1997. He got the Certificate/ Diploma of Gynecological Oncology from the Royal Australian and NewZealand College of Obstetrics and Gynecology in Melbourne in 2005. At present he is the Vice Dean, associate Professor, Chairman of Obstetrics and Gynecology Department, faculty of medicine at Jordan University of Science and Technology and at King Abdullah University Hospital. He is the Chief of the Gynecologic Oncology Section (part-time) at King Hussein Cancer Center in Amman, Jordan. Dr LATAIFEH is specialized in advanced minimally invasive surgery in OBGYN. Member of the IGCS and ESGO

Jamil Shaaban, Jordan

Is an Obstetrician and Gynecologist, member of the Jordan Society of Obstetricians and Gynecology. Dr. Jamil holds a Bachelor Degree in MD- medical school from University of Heidelberg in Germany. Since 1996 he has been a member of the Obstetrician and Gynecologist Department of Jordan Hospital.

Speakers bio

Joseph Nasif, Lebanon

Minimally Invasive Gynecological Surgeon, Secretary General of the Middle East Society for Gynecological Endoscopy (ESGE), Member of the American Association of Gynecological Laparoscopists (AAGL) and of the European Society for Gynecological Endoscopy (ESGE). Has many multimedia publications, book chapters, reviews and original articles in well-known websites and journals. Reviewer in many scientific journals.

Maeda Shamdeen, Iraq

Assisted proof, Consultant OBG, MRCOG/FRCOG
Graduated from: Mosul medical college, 1973, Degree good from the first quarter.
Postgraduate –MRCOG August 1983, Royal college of obstetric and gynecology –London
Member and fellow of –Royal College of Obstetrics& Gynecology
Member of –kurdestani society of obstetrician and gynecologist
Jobs headed:
Director of kurdestani board OBG oct 2010-up to now

Mahabad Ali, Iraq

Is an Obstetrician and Gynecologist, Member of –Kurdistan Society of obstetrician and gynecologist
Jobs headed; Hospital manager assistant for scientific purposes in Maternity teaching hospital-Erbil.

Maryam Salmani, Iran

- 2003 - 2005 Post-doct., Kyorin Medical Uni., Tokyo, Japan
- 1996-2003 Ph.D., Histology and Embryology, Tarbiat Modares Uni..
- 1992 - 1995 M.Sc., Anatomical Sciences, Tarbiat Modares Uni..
- 1989 - 1992, B.Sc., Physiotherapy, Medical Uni. of Tehran.
- Assistant Professor, Department of Tissue Engineering, National Institute of Genetic Engineering and Biotechnology, Pajoohesh Blvd. Tehran-Karaj Highway, 17th Km., 14155-6343, Tehran, Iran.

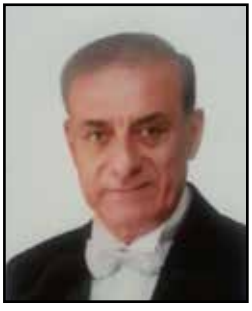
Martin Olsen, USA

graduated from Muskingum College, New Concord, Ohio - B.S. in May 1981. His Postgraduate studies were at Chattanooga Unit- University of Tennessee and College of Medicine, Erlanger Medical Center, in April 1989- June 1991-Obstetrics/Gynecology, and Akron General Medical Center, 2009. Dr Martin is currently Professor and Program Director, Department of Obstetrics & Gynecology James H. Quillen College of Medicine East Tennessee State University, Fellow of the American College of Obstetrics and Gynecology and the North American Society of Pediatric and Adolescent Gynecology and the Southern Medical Association and the Association of Professors of Gynecology and Obstetrics and the Society for Simulation in Healthcare.

Mazen El Zebdeh, Jordan

Medical Degree, Cairo 1972, a Diploma, Royal College of Physicians Ireland 1979, MRCOG (Member of the Royal College of Obstetricians And Gynecologists) London 1980, FRCOG (Fellow of the Royal College of Obstetricians And Gynecologists) London 1994, obtained certificate on Educational Planning and Evaluation, a certificate of Research Methodology from King Faisal University and Harvard University. Currently working part time senior consultant in OBGYN at the Islamic Hospital and in private practice.

Speakers bio



Michel Abou Abdallah, Lebanon

Is a fertility specialist, fellow in reproductive Endocrinology and Andrology from McGill University, Montreal, Canada. As reproductive medicine specialist, He is an executive and faculty member of the Canadian Foundation for Reproductive Medicine, Montreal and Toronto, Canada. Currently, serving as Executive Director of the Middle East Fertility Society; Founder and past president.

Mutasem Taha, Jordan

- Ph.D in Synthetic Organic Chemistry. Loughborough University., Leics., UK
- Professor of Drug Design and Medicinal Chemistry at the Department of Pharmaceutical Sciences.
- Head of the Drug design and Discovery unit at the Faculty of Pharmacy/ University of Jordan
- Associate Professor at the Department of Pharmaceutical Sciences
- Dean Assistant at the Faculty of Pharmacy/University of Jordan
- Assistant Professor at the Department of Pharmaceutical Sciences.
- Ph.D in Synthetic Organic Chemistry
- M.Sc in Medicinal Chemistry and Drug Metabolism

Mohamed Mostafa, Egypt

Prof. Obstetrics and Gynaecology, Faculty of medicine, Over 16 years of experience in IVF, in Egypt at Al Azhar University and Nile Badrawi Hospital and the Gulf Region at Dr. Erfan Hospital in Saudi Arabia, Dr. Mohammed Hold the following:

- The Infertility Diploma from Geneva Switzerland 1999.
- M.D Obstetrics and Gynaecology: Faculty of Medicine, Al Azhar University , November 1998
- MSC. Obstetrics and Gynaecology: Faculty of Medicine, Al Azhar University signed up Excellent with honor, November 1993.
- M.B.B.Ch Faculty of Medicine , Al Azhar University signed up Excellent with honor December 1989.

Randall Williams, USA

Is an Obstetrician/Gynecologist, in Raleigh, North Carolina. Member of the American College of Obstetrics and Gynecology and works with the American Bar Association in their Global Rule of Law Initiative. Received his medical degree at the University of North Carolina at Chapel Hill.

Rezan Abdul-Kadir, UK

A Consultant Obstetrician and Gynaecologist, graduated from the Royal College of Surgeons Edinburgh 1995, the Royal College of Obstetrician and Gynaecologists, London 1993, received the Arab Board Certificate (O&G) Jordan 1990. Currently Consultant Obstetrician and Gynaecologist at Haemophilia Centre. Awarded Ulla Hedner Haemostaisis Award 2011, Novo Nordisk Haemophilia Foundation Award 2010.

Sabat Barawi, Iraq

- Head of Ob&Gyn dept College of Medicne/ Salahadin Uni. 1986-1994
- Consultant Gynecologist Fredericia Hospital/ Denmark 1996-2009
- Danish Board in OB&Gyn 2000
- Norwigian Board in OB&Gyn 2001
- Back to College of Medicine Hawler Medical University 2009
- Head of Ob&Gyn dept & assistant Professor College of Medicine/ Hawler medical University 2010
- Different publcations in Obst & Gyn.

Speakers bio

Sharif Omar, USA

Vice President, Africa & Middle East Region
LIPTIS Pharmaceuticals, USA

Shahla Alalaf, Iraq

Assistant Prof. in Obstetrics & gynecology, Medical College, Hawler Medical University; Erbil; Iraq.
Supervisor for postgraduate thesis (High diploma in Obstet and Gynecol.), Master degree of nursing college students.
•Trainer for postgraduate students of Arabic Board students.
•Co-Supervisor for 3 PhD in IVF students
Member and head of scientific committee in Kurdistan-Iraq society of Obstetricians and Gynecologists

Suleiman Dabit, Jordan

Dr. Suleiman Dabit, head of fertility and genetic department at Al Khalidi Medical Center was graduated from Vienna University, Faculty of Medicine in 1986.
Dr. Dabit is practicing IVF since 1994 as a senior consultant in the Reproductive Medicine Unit of AL-AMAL Maternity Hospital in Amman, He is also member of board of the Middle East Fertility Society.
Dr. Dabit is having many awards, such as the Organon Middle East Fertility Society Research Award, and the award of the Jordanian Society of Obstetricians and Gynaecologists Research Award.

Suresh Kumarasamy, Malaysia

Has MBBS, MObGyn (Malaya), FRCOG (London), FRCP (Ireland), AM Fellowship in Gynecological oncology (UK). Consultant Obstetrician and Gynecologist. Gynecological Oncologist Gleneagles Penang adjunct Associate Professor. Penang Medical College Council Member.

Susan Raine, USA

She received her MD from Baylor College of Medicine in Houston, Texas., completed a Juris Doctor degree at the University Of Texas School Of Law in Austin, Texas. Currently an Associate Professor at Baylor College of Medicine in the Departments of Obstetrics and Gynecology and the Center for Medical Ethics and Health Policy.

Syed Hussain, Pakistan

Representative and Head of Mission, World Health Organization, Iraq

- Doctorate in Public Health (DrPH)
- Master Public Health (MPH)
- One Year Diploma in Computer Packages
- Bachelor of Medicine; Bachelor of Surgery (MBBS).

Speakers bio

Pat O'Brien, UK

Consultant & Honorary Senior Lecturer in Obstetrics and Gynaecology at University College London Hospitals since 1999. He is currently the Divisional Clinical Director for Women's Health. Specialises in Maternal Medicine and High-Risk Obstetrics.
Chair of the International Division of the Institute for Women's Health in London and a media spokesperson for the Royal College of Obstetricians & Gynaecologists. He sits on the Editorial Boards of the Journal of Obstetrics & Gynaecology and the BJM. Examines for the DRCOG examination. Member of The Obstetric Guideline Development Group of the National Institute for Clinical Excellence in the UK. Works regularly with BBC Television as an advisor.

Tang Boon Nee, Malaysia

Consultant Obstetrician & Gynaecologist, Works privately in Sime Darby Subang Jaya Medical Centre, Malaysia.
Her Qualifications are MBBS (University of Adelaide 1992) and FRCOG (RCOG UK 2011).
Working in the Ministry of Health, Malaysian until 2002, Working in private since. Takes great pride with her voluntary work in the Obstetrical and Gynaecological Society of Malaysia (OGSM) and is the current OGSM president. Through OGSM, Dr Tang is an accreditated trainer of the Life Saving Skills Workshop and had been involved in teaching Obstetrics Emergencies throughout Malaysia. Although out of government service, Dr Tang is still actively involved with work propagating safe delivery and motherhood in the Ministry of Health, often sitting in various committee meetings regarding safe delivery via her work with OGSM.

Theresa Wang, UK

British Medical Association
British Society of Colposcopy and Cervical Pathology
Royal Society of Medicine, Fellow of the Royal Society of Art (FRSA), American Society of Colposcopy and Cervical Pathology, National Vulvodynia Association, London Obstetric Medical Group, Foundation for Integrated Health.

Zaid Kilani, Jordan

A Medical Doctor graduated from Goettingen University, Germany 1964, received his Medical training and teaching of Obstetrics and Gynecology, Cambridge and London Universities, UK. Fellow of Royal College of Obstetricians and Gynecologists, London. Appointed by His Majesty king Abdullah the second as a senator in the upper house in 2013

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Workshops

Workshops

Thursday 3rd of April

Out Patients Gynaecology Nursing work shop

Location : Rotana Hotel - Hareer Hall
Time : 9:00 am –11:20 am
Fees: 50$

Time	Topic
09:00 - 09:20	Role of a Nurse in Gynaecology outpatient clinics, Teresa Flavin
09:20 - 09:40	Role of a Nurse in Emergency Gynaecology Unit, Rosa Touat
09:40 - 10:00	The Extended Role of a Nurse Specialist, Teresa Flavin
10:00 - 10:20	Coffe Break
10:20 - 10:40	Pre- Assessment Clinic, Rosa Touat
10:40 - 11:00	Infection Control, Teresa Flavin and Rosa Touat
11:00 - 11:20	Interactive Session and Case Scenarios, Teresa Flavin and Rosa Touat

Rosa Touat, UK

Specialist Nurse in Early Pregnancy Unit and Emergency Unit.
Line Manager for the Early Pregnancy unit.
17 years of extended experience in Gynaecology (Paris & London).
Involved in setting up new service.
Involved in Gynaecology Audits.
Responsible for Staff Appraisals and Professional Development.

Teresa Flavin, UK

Vulval Nurse Specialist & Nurse Colposcopist,Colposcopy Dept.
Vulval Nurse Specialist at the Royal Free hospital since March 2008. Currently works alongside Professor Alan MacLean, Professor Wendy Reid and Miss Deborah Boyle in assisting them with there clinical work.
Leads 3 Nurse led Vulval clinic' a week, Reviews Patients Management of Treatment with Topical Corticosteroids, gives advise and teaching on the use of vaginal dilators as well as providing direct support and education to patients.
Fully qualified Nurse Colposcopist and has own clinic once a week.

Workshops

Thursday 3rd of April

Basic Obstetric Ultrasound

Location : Rotana Hotel - Ashtar Hall
Time: 09:00 am - 16:00 pm
Fees: 50$

Time	Topic
08:00 - 09:00	Introduction to Obstetric U/S
09:00 - 10:00	Fetal Biometry
10:00 - 10:30	Coffee Break
10:30 - 11:30	U/S of Placenta
11:30 - 12:30	U/S of Cord and Amniotic Fluid
12:30 - 14:00	Lunch Break
14:00 - 15:00	Doppler U/S in Obstetric
15:00 - 16:00	Practical Session

Adil Al-Qaysi, UAE

- Fellowship in Materno-fetal Medicine & Fetal Cardiology. Thomas Jefferson University. Philadelphia. USA.
- Fellowship of the Royal College of Radiologists, UK (FRCR, UK)
- Board Certified in Radiology. Jordanian Board of radiology.
- PhD College of Medicine. Al-Nahrain University. (Radiopathology) Baghdad- IRAQ. Thesis entitled (Local staging of Bladder Carcinoma: Endorectal MRI, Histopathology &Immunohistochemistry: Correlative study)
- DMRD College of Medicine University of Baghdad. IRAQ.
- MB; Ch.B.College of Medicine University of Mosul. IRAQ
- M.O.H license: License No & Date: R-47189: 30 May 2004
- HAAD license: License No & Date: GD 5739: 18 May 2006
- From 27.05.2011 till now: CEO. Consultants Medical Centre. Abu Dhabi. UAE.

Workshops

Thursday 3rd of April

Hands-on workshop Office Hysteroscopy: The Magic Stick in Modern Gynecology

Location : Divan Hotel
Time : 09:00 am - 16:00 pm
Fees: 50$

Time	Topic
09:00 - 09:30	Making the Habit of Success
09:30 - 10:30	Application of GnRha in Modern Gynaecology: Safety, Precision and Perfection
10:30 - 11:00	Coffee Break
11:00 - 11:30	Office Hysteroscopy: The Magic Stick in Modern Gynaecology
11:30 - 12:00	Hysteroscopy & Infertility: Improve your Results from Zero to Perfection
12:00 - 12:30	Modern Approaches for Management of Uterine Bleeding: No More Wombless Life
12:30 - 13:00	LunchBreak
13:00 - 16:00	Hands-on Workshop

Osama Shawki, Egypt

- MD, MSOb, MBBcH
- Professor in Department of Obstetrics and Gynecology, Cairo University, Kasr El Einy Hospital
- Faculty professor Giessen school for endoscopic surgery
- Director of Al Ebtesama Centre for Infertility.
- Director of Hysteroscopy Academy for Research & Training (HART)
- Editor European journal for GYN surgery
- Elect Active Member American Society For Reproductive Medicine (ASRM), American Society for Reproductive Surgeons (SRS) & European Society For Gynecologic Endoscopy (ESGE)
- Referee Coordinator and Representative to European Society For Endoscopy.

Workshops

Friday 4th of April

Utilizing Telemetry, The Value and Benefits

Location: Rotana Hotel - Hareer 3 Hall
Time: 10:30 pm - 12:30 pm
Fees: Free of charge (Maximum 15 attendees)

Ghada El Khaldi, UAE

- Masters in Healthcare Management from The Royal College of Surgeons, Irland.
- BS in Nursing from Makassed University, Beirut.
- Clinical Applications Specialist (Maternal- Infant Care), GE Healthcare from August 2012, till now.
- Registered Nurse and Duty Charge nurse in NICU, at Welcare Hospital, Dubai, from November 2009 until July 2012.

Saturday 5th of April

3D/4D Ultrasound in Obstetrics and Gynecology

Location: Rotana Hotel - Hareer 3 Hall
Time: 10:30 pm - 12:30 pm
Fees: Free of charge (Maximum 15 attendees)

Jaime Wong, Malaysia

Advanced application specialist in GE Healthcare specializing in Women Health Ultrasound and 3D/4D ultrasound. She has over 5 years of experience in clinical application training for the Middle East, Africa, Central Asia and Turkey region.
She has conducted various courses including Voluson User's day in the region. Prior to this, Jaime was a clinical sonographer in the fetal medicine unit in Thomson Medical Center, Singapore.

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1. Queisser Luft A. Dydrogesterone use during pregnancy: Overview of birth defects reported since 1977. Early Human Development. 2009;85:375-7.

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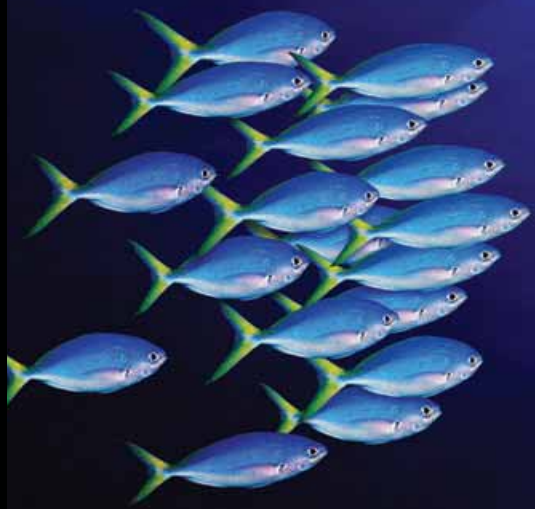

Thursday Rotana Hotel
3 April 2014

Opening Ceremony (18:00 - 20:00)

National Anthem

President of the Conference
"Dr. Ariana khalis Jawad"

Memorial Lecture: Remarkable people in remarkable events
"Dr. Zaid Kilani"

Video About Kurdistan

Awards

Opening the exhibition followed by reception

Scientific Program

Friday Hall A
4 April 2014

Session 1 - (08:50 -10:30)
Moderators: *Dr. Zaid Kilani, Dr. Ariana Jawad, Dr. Sarmad khunda*

Time	Keynote Lectures
08:50 - 09:10	Comparison Between the Scientific and Quranic Explanation for Human Creation (English L.) *Dr. Jamil Shaaban, Jordan*
09:10 - 09:30	Ovarian Hyper Stimulation Syndrome: Should be a History *Dr. Zaid Kilani, Jordan*
09:30 - 09:50	In Vitro Maturation Of Human Oocytes *Dr. Suleiman Dabit, Jordan*
09:50 - 10:20 **Hikma Sym**	Thrombophilia and Adverse Pregnancy Effects *Dr. Fawaz Khaza'aleh, Jordan*
10:20 - 10:30	Q & A
10:30 - 11:00	Coffee Break

Session 2 - (11:00 - 12:20)
Moderators: *Dr. Jamel Shaaban, Dr. Shahla Alalaf, Dr. Tang Boon Nee*

Time	Keynote Lectures
11:00 - 11:20	Engaging the Judiciary in O&G Medical-Legal Disputes: The Malaysian Experience *Dr. Tang Boon Nee, Malaysia*
11:20 - 11:40	Maternal Mortality in Iraq: The Trends, Gaps and Actions *Dr. Hussain Jaffar, Pakistan*
11:40 - 12:10 **Abbott Sym**	Contemporary Management of Threatened Miscarriage *Dr. Fadi Mirza, Lebanon*
12:10 - 12:20	Q & A
12:20 - 14:30	Prayer & Lunch Break

Session 3 - (14:30 - 16:10)
Moderators: *Dr. Mazen El Zebdeh, Dr. Sabat Barawi, Dr. Ezedeen Bahaaldeen*

Time	Keynote Lectures
14:30 - 14:50	Myomectomy: Laparoscopic VS. Laparotomy-Farah Hospital Experience *Dr. Zaid Kilani, Jordan*
14:50 - 15:10	Recurrent Miscarriage Update *Dr. Mazen El-Zebdeh, Jordan*
15:10 - 15:30	Premature Ovarian Insufficiency *Dr. Mazen El Zebdeh, Jordan*
15:30 - 16:00 **AMS Sym**	The Role of Nutrients in Improving Fertility *Dr. Ezedeen Bahaaldeen*
16:00 - 16:10	Q & A
16:10 - 16:50	Coffee Break

Session 4 - (16:50 - 18:20)
Moderators: *Dr. Fareed Hanna, Dr. Lass Hawezi, Dr. Maeda Shamdeen*

Time	Keynote Lectures
16:50 - 17:10	Use Of Simulation In Medical Education *Dr. Martin Olsen, USA*
17:10 - 17:30	Milestone of Residence Training Program *Dr. Susan Raine, USA*
17:30 - 17:50	Quality Assurance in Health Care *Dr. Sabat Barawi, Iraq*
17:50 - 18:10	Teaching Obstetrics Emergencies Skills: Making it a Nation Wide Experience *Dr. Tang Boon Nee, Malaysia*
18:10 - 18:20	Q & A

Friday Hall B
4 April 2014

Session 1 - (08:50 -10:20)
Moderators: *Dr. Abeer Annab, Dr. Ali Alhussaeni, Dr. Fawaz Khazaaleh*

Time	Keynote Lectures
08:50 - 09:10	*UK* Fetal Anemia Update *Dr. Fawaz Khazaaleh, Jordan*
09:10 - 09:30	Fetal Surgery Update *Dr. Fawaz Khazaaleh, Jordan*
09:30 - 09:50	Estrogen Effect On Skin Thickness In Menopausal Women *Dr. Michel Abu Abdullah, Lebanon*
09:50 - 10:10	Update in Menopausal Replacement Therapy (MRT) *Dr. Abeer Annab, Jordan*
10:10 - 10:20	Q & A
10:20 - 11:00	Coffee Break

Session 2 - (11:00 - 12:10)
Moderators: *Dr. Abdel Latif Abu Khadra, Dr. Muhsan Al Sabak*

Time	Keynote Lectures
11:00 - 11:20	The Role of Infertile Male Evaluation in the Era of ICSI: is it Necessary? *Dr. Abdul Latif Abu khadra, Jordan*
11:20 - 11:40	Letrozole for Ovulation Induction, A Farwell to CLOMIPHENE Citrate *Dr. Michel abu Abdullah, Lebanon*
11:40 - 12:00	Managment of High Risk Multiple Pregnancy *Dr. Fawaz Khazaaleh, Jordan*
12:00 - 12:10	*Q & A*
12:10 - 14:30	Prayer & Lunch Break

Session 3 - (14:30 - 16:00)
Moderators: *Dr. Martin Olsen, Susan Raine, Dr. Ali Hussani*

Time	Keynote Lectures
14:30 - 14:50	Modern Management of Pelvic Mass *Dr. Isam Latayfeh, Jordan*
14:50 - 15:10	New Method of Vaginoplasty in Vaginal Ageneses, Shamdeen's Vaginoplasty *Dr. Maeda Shamdeen, Iraq*
15:10 - 15:30	Management of Sexual Assault *Dr. Martin Olsen, USA*
15:30 - 15:50	Gender Based Violence *Dr. Susan P. Raine, USA*
15:50 - 16:00	Q & A
16:00 - 16:50	Coffee Break

Session 4 - (16:50 - 19:00)
Moderators: *Dr. Ali Al Dabbagh, Dr. Khalida Amen, Dr. Suleiman Dabit*

Time	Keynote Lectures
16:50 - 17:10	Episiotomy: To do or not to do *Dr. Jamel Shaaban, Jordan*
17:10 - 17:30	Thyroid Disease in Pregnancy *Handrean Soran, UK*
17:30 - 17:50	*Fertility Preservation in Patients Suffering From Cancer* *Dr. Suleiman Dabit, Jordan*
17:50 - 18:10	Breast Cancer *Dr. Assem Al Hajj, Lebanon*
18:10 - 18:30	Role of Surgery in Epithelial Ovarian Cancer *Dr. Isam Latayfeh, Jordan*
18:30 - 18:50	Molecular Aspects of Endometrial Receptivity *Maryam Kabir-Salmani, Iran*
18:50 - 19:00	*Q & A*

Saturday Hall A
5 April 2014

Session 1 - (08:30 - 11:10)
Moderators: *Dr. Michel Abu Abdallah, Dr. Tang Boon Nee, Dr. Faysal El Kak*

Time	Keynote Lectures
08:30 - 08:50	PCOS in Adolesnt Challenge in Clinical Practice *Dr. Faysal El Kak, Lebanon*
08:50 - 09:10	PCO, A Vicious Cycle of Endocrine Disorders *Dr. Michel abu abdallah, Lebanon*
09:10 - 09:40 Bayer Sym	Visanne, the Novel Drug for Endometriosis *Prof. Joseph Nasif, Lebanon*
09:40 - 10:20 Liptis Sym	- Liptomama® Plus - Proper Maternal Nutrition from before Conception and Beyond - Aphrofem® - Advancing Expectations in Female Sexual Dysfunction Management *Dr. Sharif Omar, USA*
10:20 - 10:40	Hyerprolactenemia and AUB *Dr. Faysal El Kak, Lebanon*
10:40 - 11:00	Abnormal Uterine Bleeding: The New Classifications and Management Implications *Dr. Faysal El Kak, Lebanon*
11:00 - 11:10	Q & A
11:10 - 11:40	Coffee Break

Session 2 - (11:40 - 13:10)
Moderators: *Dr. Randall Williams, Dr. Maream Baker, Dr. Susan Raine*

Time	Keynote Lectures
11:40 - 12:00	Minimally Invasive Gynecology (Including Robotics) or Office-Based Surgery *Dr. Susan P. Raine, USA*
12:00 - 12:20	Prevention and Management of GYN Surgical Complications *Dr. Randall Williams, USA*
12:20 - 12:40	New Techniques in Operative Hysteroscopy *Dr. Randall Williams, USA*
12:40 - 13:00	Female Urinary Steress Incontenence: Update in Diagnosis Options and Sling Operation Complications *Dr. Shahla Alalaf, Iraq*
13:00 - 13:10	Q & A
13:10 - 14:30	Lunch Break

Session 3 - (14:30 - 16:00)
Moderators: *Dr. Ghada Al Sakkal, Dr. Chro Fattah, Dr. Hanaa Al Anie*

Time	Keynote Lectures
14:30 - 15:10 Baghdad Pharma Sym	The Role of Nutraceuticals in Infertility Management *Prof. Mutesem Taha, Jordan*
15:10 - 15:30	Different Protocol of Ovulation Induction *Dr. Mohamed Mostafa, Egypt*
15:30 - 15:50	What Modern Genetic Testing Could Add to the Field of Medicine *Dr. Ali Al Hilani, UAE*
15:50 - 16:00	Q & A
16:00 - 16:30	Coffee Break

Session 4 - (16:30 - 17:40)
Moderators: *Dr. Suresh Kumarasamy, Dr. Mahabad Ali, Dr. Rozan Yassen*

Time	Keynote Lectures
16:30 - 16:50	Prevention of OHSS *Dr. Mohamed Mostafa, Egypt*
16:50 - 17:10	Medico-Legal Aspects of Gynecological Practice *Dr. Suresh Kumarasamy, Malaysia*
17:10 - 17:30	HPV Vaccination *Dr. Suresh Kumarasamy, Malaysia*
17:30 - 17:40	Q & A

Saturday Hall B
5 April 2014

Session 1 - (08:30 - 11:10)
PPH Symposium
Moderators: *Dr. Pat O'Brien, Dr. Rezan Abdul-Kadir*

Time	Keynote Lectures
08:30 - 09:00	Maternal Mortality in Maternity Teaching Hospital -Erbil Over 3 Years Period *Dr.Mahabad Ali, Iraq*
09:00 - 10:00	RCOG Guideline *Dr. Pat O'Brien, UK*
10:00 - 10:30	Obstetric Aspects *Dr. Pat O'Brien, UK*
10:30 - 11:00	Haemostatic Aspects *Dr. Rezan Abdul-Kadir, UK*
11:00 - 11:10	Q & A
11:10 - 11:40	Coffee Break

Session 2 - (11:40 - 13:25)
Vulval disorder Symposium
Moderators: *Dr. Theresa freeman Wang, Dr. Rezan Abdul-Kadir*

Time	Keynote Lectures
11:40 - 12:25	Overview of Vulval Disorders (Vulvodynia, Dermatosis and VIN) *Dr. Theresa freeman Wang, UK*
12:25 - 13:15	Interactive Session and Case Presentations *Dr. Theresa freeman Wang, UK, Teresa Flavin, UK*
13:15 - 13:25	Q & A
13:25 - 14:30	Lunch Break

Session 3 - (14:30 - 16:00)
Moderators: *Dr. Adeola Olaitan, Dr. Assem Al Hajj, Dr. Isam Latayfeh*

Time	Keynote Lectures
14:30 - 15:00	Ovarian Cancer - Medical Management *Dr. Suresh Kumarasamy, Malaysia*
15:00 - 15:30	Cervical Cancer *Dr. Adeola Olaitan, UK*
15:30 - 15:50	Diagnosis and Management of Endometrial Cancer *Dr. Adeola Olaitan, UK*
15:50 - 16:00	Q & A
16:00 - 16:30	Coffee Break

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Abstracts

Abstract

A comparison between the scientific and Koranic explanation for Human creation

Dr Med Jamil Sha'ban

People have always been interested in knowing how they originated, and how they were born.
Ancient people, filled with curiosity, developed many answers to these questions.
All of what we know now about the development of the embryo within the uterus is based on the accumulated scientific knowledge achieved over the centuries and particularly due to advanced researches in resent years after the development of the modern technology.
Scattered through out the Koran are many statements about embryology.
The progress of embryology through the ages from the earliest records to the present and Enlightenment in this field in the holy
Koran and Hadith are discussed.
Read in the name of your Lord who created. Created man from a clot.
(Al alaq 2-1)
This is the first Aya in the Holy Koran and this is the first stage in human Creation.
In the Holy Koran God gave, 14 centering ago a detailed description of human creation from clay, ending with death, then
resurrection in many verses (Aya).
Conclusion
The holy Koran was the first to exactly describe human development 14 centuries ago, long before the discipline of
Embryology was even established.
Only in the last century, modern science was able to prove in detail and with evidence what was reveled, in TRUTH, in the Holy Koran.

Ovarian Hyperstimulation Syndrome: Should Be a History

Z. Kilani, L. Haj Hassan, T. Shaban

Superovulation to treat infertile women remains in spite the vast experience over the past 40 years a medical method not without devastating and serious consequences in otherwise healthy young women seeking pregnancy. Ovarian hyperstimuation syndrome (OHSS) is considered the gravest complication of superovulation which can be life threatening. It is characterized by formation of multiple cysts in both ovaries and fluid displacement from intravascular to the third space. It can vary from mild to severe forms. While in mild cases the syndrome includes ovarian enlargement, abdominal distention and weight gain. In severe cases a critical condition can emerge with ascites, pleural effusion ,liver and kidney dysfunction and thromboembolic sequalae requiring admission to the intensive care unit. The condition might end with residual physical complications, psychological manifestations and even death.

The incidence of OHSS has been reported to be as high as 33% with the severe form occurring in 0.5%-4% of patients. Prevention of this serious syndrome relies principally on identifying patients at risk and individualization of stimulation protocols.

Although the condition of OHSS is poorly understood, and its pathogenesis remains a controversial subject, several measures have been adopted to limit the occurrence of this complication and improve the management of patients at risk without cycle cancellation, including: a. withholding or reducing hCG dose, b. withholding gonadotropins and delaying hCG administration till Estradiol level decreases (coasting), c. inducing final oocyte maturation using GnRH agonist or d. recombinant human LH (rhLH), e. In vitro maturation (IVM), f. cryopreservation of embryos. Other strategies include follicular aspiration and intravenous albumin administration.

It will be emphasized that the main factor behind the shift of fluid in the third space is the vascular endothelial growth factor (VEGF). Its intense existence is demonstrated in highly vascularized CL and acts directly on endothelial cell to induce proliferation and angiogenesis. mRNA to VEGF is enhanced by hCG in a time and dose dependent way.

In OHSS tyrosine hydroxylase gene, which is essential for Dopamine synthesis is down regulated. High VEGF expression is associated with decrease in dopamine production. DA administration interferes with VEGF effect observed in OHSS.

The pathophysiology and management of spontaneous OHSS with and without pregnancy will be discussed.

Abstract

In Vitro Maturation Of Human Oocytes

Suleiman Dabit

In vitro maturation of oocytes is a safe and effective treatment offered in some fertility centers for assisted reproduction, where immature oocytes are retrieved from unstimulated ovaries. Therefore, the procedure avoids ovarian stimulation with expensive gonadotropins, side effects of the medications, and risks such as ovarian hyperstimulation syndrome. Added advantages are reduced frequency of monitoring scans and shorter treatment regimen compared with in vitro fertilization.

The culture media used widely is complex, with tissue culture medium, supplemented with various sera, gonadotropins (FSH and LH), and estradiol.

The side effects of medications, although mild, are a nuisance. Most importantly, the risk of OHSS is avoided. With more experience gained, thinner retrieval needles (19 or 20 G), and intravenous sedation with local infiltration, women do not have any more discomfort than they experience during an IVF retrieval. All women are discharged 2 to 3 hours after the procedure.

Treatment success depends on patient selection. Pregnancy rates with IVM are correlated with the number of immature oocytes retrieved.

Women undergo a baseline scan between days 2 and 5 of scan, ovarian volume, ovarian stromal blood flow velocity, number of antral follicles, sizes of the follicles, endometrial thickness, subendometrial blood flow, and presence of cysts are recorded.

In various published series, no increased rates of congenital malformations with IVM

Engaging the Judiciary in O&G Medical Legal Disputes

The Malaysian experience

Dr Tang Boon Nee

A teaching program was initiated by the O&G Society of Malaysia for teaching the Judiciary regarding the medical aspects of common despited cases for O&G. We demonstrated possible scenarios involved in medical legal disputes and various surgical procedures in handling Obstetrics emergencies.
This talk aims to describe the teaching program and to assess the judiciary's response towards it. It showed that the judiciary had much to learnabout the medical procedures and had appreciated the opportunity to do so.

Abstract

Myomectomy: Laparoscopic vs. Laparotomy- Farah Hospital Experience

Z. Kilani, L. Haj Hassan, S. Kilani,T. Shaban

Uterine leiomyomas are clinically appeared in 25-50% of women. Leiomyomas called also fibroids, are benign neoplasms usually require treatment only when they cause symptoms. The most common symptoms for which women seek treatment are abnormal uterine bleeding and pelvic pressure or pain.

The current practical methods for treatment of fibroids are:

Surgical:
• Laparotomy, myomectomy
• Laparoscopic myomectomy
• Robotic- Assisted laparoscopic myomectomy
• Embolization to the uterine artery

Non Surgical:
• High intensity focused ultrasound (HIFU)
• Gonadotropin-releasing hormone (GnRH)
• Progesterone antagonist mifepristone (RU 486)

The main discussion will focus on laparoscopic surgery to be or not to be? Advantages and hazards. Farah surgical method will be elaborated to prevent bleeding, haematoma and adhesions. High intensity focused ultrasound will be discussed which might replace in some cases all previous available methods.

Recurrent Miscarriage update

Dr. Mazen EL-Zibdeh . MD, MRCOG, FRCOG. Amman .Jordan

Recurrent miscarriage (RM) defined as loss of three or more consecutive pregnancies before it reaches viability. It occurs in 1% of couples trying pregnancy. Risk of recurrence depends on the age of the couple, the number of previous miscarriages, and history of previous term delivery and the possible cause of previous pregnancy losses.
Causes of RM are numerous. Environmental factors, genetic factors, embryonic chromosomal abnormalities, anatomical factors such as uterine cavity defects and cervical insufficiency are recognized causes.
Recently, our knowledge of immunology of early pregnancy has increased and it has been recognized that miscarriage may occur when maternal immune response to fetal and placental antigens is abnormal. Therefore, immunological causes of RM have been recognized including activation of the inflammatory mediators and natural killer cells (NK. Cells) . Also antiphospholipid antibodies, and inherited thrombophelia are among the recognized causes of RM.

Assessment of couples with RM must be comprehensive, efficient and cost effective. Several treatment options will be discussed and it should be evidence based.

Abstract

Premature ovarian insufficiency

Dr. Mazen EL-Zibdeh . MD, MRCOG, FRCOG. Amman .Jordan

Ovarian aging is a process associated with the decline in number of ovarian follicles, menstrual irregularities, ovarian hormone deficiency, anovulation, decrease of fertility and finally complete irreversible cessation of menses, known as menopause which usually occurs at the mean age of 51 years. In premature ovarian insufficiency (POI) the ovaries stop functioning normally in women who are younger than 40 years of age.

POI, may be due to inappropriate gonadotropin stimulation of the ovaries as a result of hyno thalmic-pituitary disorder or due to spontaneous follicular depletion associated with accelerated atresia and follicular dysfunction. Genetic and chromosomal abnormalities are seen in 20-30 % of cases like Fragile X- Chromosome and Turners' syndrome. Also certain autoimmune diseases and enzyme deficiency states are found associated with POI.

In my presentation the etiology of POI, clinical syndromes and the work up of this condition will be discussed. Patients' management in regards to fertility prospect and HRT will be discussed.

Use Of Simulation In Medical Education

Dr Martin Olsen

Medical simulation has demonstrated an increasing role in the education of medical students and residents. Simulation functions include transfer of knowledge, practice of diagnostic skills, practice of surgical skills, emergency drills, and team training. Many types of simulation exist including use of animal tissue to practice surgical skills, low-fidelity manikins to practice delivery techniques, virtual reality simulation to practice laparoscopic surgical techniques, and high-fidelity simulation to practice open surgical skills and team training. Learners find simulation to be both educational and enjoyable. Medical simulation has been shown to improve learner performance in some specific areas. This session will describe some specific simulation activities at the presenter's home institution.

Disclosure
The presenter is a consultant for Gaumard Scientific and the holder of a patent on the surgical simulation device Surgical Chloe.

Abstract

The Obstetrics and Gynecology Milestone Project

Dr Susan Rain

The Obstetrics and Gynecology Milestone Project is a joint project of The Accreditation Council of Graduate Medical Education (ACGME), the American Board of Obstetrics and Gynecology (ABOG) and the American College of Obstetrics and Gynecology (ACOG). The Milestones are designed for use in evaluation of resident physicians in the context of their participation in an ACGME-accredited residency or fellowship program. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation.

Teaching Obstetrics Emergencies: Making It A Nation Wide Experience

Dr Tang Boon Nee

This talk aims to share the Malaysian experience with introducing an Obstetrics Emergency Course to the nation's doctors and midwives. By using a systematic approach, at the end of 5 years, we mana'[[ged to train 674 doctors and midwives in the Obstetrics Life Saving Skills course; spreading the knowledge to the whole country. A remarkable feature is that the trainers are voluntary and are not paid for their services. I aim to describe the essential features in such a program.

Abstract

UK Fetal Anemia Update

Dr. Fawaz Khaza`leh

It estimated that more the fifity different Red Blood Cell antigens associated with Hemolytic disease of the newborn, only three of them associated with severe fetal disease which is anti-D, anti-c, and anti-Kell.
The majority of fetus at risk for red cell allo-immunization are detected early via antibody screening in early pregnancy. Occasionally fetuses may be hydropic at their first presentation.
Serial amniocentesis for the determination of bilirubin concentration by deltaOD450 spectrophotometry use to be the standard method for diagnosis and management of pregnancies at risk of fetal anemia. A comprehensive ultrasound, including Doppler studies, may be able to establish the diagnosis of this disease. The use of Doppler studies in RhD sensitised pregnancies is based on the preimse that the fetus with anemia will increases his cardiac output to preserve oxygen supply in the face of progressive anemia. These changes may be observed in the intrahepatic umbilical vein or in the middle cerebral artery peak velocity using Doppler studies. These studies are non-invasive and real-time and considered today the new standered method for monitoring of pregnancies at risk of fetal anemia caused by the RhD disease or other causes for fetal anemia such as Kell and alpha-thalassemia and both of these conditions are are not amenable to deltaOD450 testing by amniocentesis.
Human Parvovirus (HPV) B19 may be responsible for up to 27% of the overall cases of no immune fetal hydrops . Myocarditis and bone marrow aplasia is thought to be the cause of fetal anemia and fetal hydrops.

Fetal Surgery Update

Dr. Fawaz Khaza`leh

In-utero fetal interventions can be divided into two main categories based on the aim of the procedure: Diagnostic Procedures which includes amniocentesis, Chorionic villous sampling. Fetal skin, liver, muscle, and fluids biopsy, and Fetal blood sampling Therapeutic procedures which includes fetal endoscopy and minimally invasive ultrasound guided procedures (Fetal blood transfusion, Fetal shunt insertion , and Radiofrequency ablation). Open surgery: performed for spina bifida, large chest masses that cause hydrops, and a vascular SCT that causes hydrops.

Conditions amenable to Fetal "Surgery" includes: Lung lesions (Pleural effusions and CCAML, Lower Urinary Tract Obstruction (LUTO), Twin Problem (TTTS, Acardiac twin, and Complicated monochorionic twins), Congenital Diaphragmatic Hernia (CDH), Neural Tube Defects , SCT, and Airway obstruction - EXIT procedure.

Prerequisites before any fetal intervention should include: Detailed fetal evaluation(Ultrasound, Fetal Echocardiography , Karyotype, Fetal Electrolytes), Ethical review of each case by special committee, Multidisciplinary counseling including different specialty (Perinatology, Paediatrics, Genetics, Surgery, Nursing, and Social Work), Parental informed consent where all options should be discussed, the risks and the benefits of the intervention and long term follow up studies.

Abstract

Estrogen effect on skin thickness in menopausal women

Michel Abou Abdallah, M.D.

Skin thickness is proportional to collagen content and is affected by sex, age, hormonal milieu, lifetime sun exposure and smoking.
Ultrasonographic measurement of skin thickness is preferred over skin biopsies because of the wide variations observed depending on the cut and site of the specimen.
“ Transparent skin” is related to a change in dermal collagen. A similar collagen change may occur in osteoporotic bone.
In 1970 Stevenson et al. demonstrated an association between the skin and osteoporosis. Since 1980 several studies of Brincat and various collaborators suggested that skin thickness and skin collagen content could be used to predict women at risk for osteoporotic bone fracture.
Over 90% of the body’s collagen is concentrated in the organic bone matrix and in skin. Osteoporosis may be the unseen consequence of the climacteric loss of collagen, but dry thin flaky skin is the visible one. In terms of health economics, the beneficial effects of estrogen on osteoporosis is far greater than its effects on the skin; however this may not be the case for a women in early menopause who still care for her look and appearances and better appreciate the overall beneficial effects of estrogen replacement therapy.
The purpose of this review is to assess the potential benefit of therapy with conjugated estrogens therapy on skin thickness in post menopausal women.

Update in Menopausal Replacement Therapy (MRT)

Dr.Abeer Annab

Menopause is a physiological event in women s` life, it is not a disease status. However, it causes symptom in significant number of women.
Medical and mental health status evaluation of ladies at menopause and post menopause is important to maintain a healthy life style especially women now are living longer.
MRT is most effective treatment for vasomotor symptom. Benefits Out weights the risks for symptomatic women before age of 60 or within 10 years of menopause. MRT dose and duration of therapy should be consistent with patient treatment goals and risks factor should be individualized.

Abstract

The role of infertile male evaluation in the era of ICSI : Is it necessary??

Abdel Latif Abu Khadra, M.D.

The most important advance in the last 20 years in the treatment of the otherwise untreatable infertile male has been the advent of intracytoplasmic sperm injection (ICSI). The ability to inject a single sperm into an egg and produce a pregnancy has now allowed men who before could never have had children of their own to produce their own biological offspring.

Three important points need to be addressed when assessing the role infertile male evaluation in the era of ICSI.

1. Infertility as a symptom, one dose not want to miss the diagnosis of serious or life-threatening condition presenting as male infertility.
2. Reversible causes of male infertility are numerous, and these should be identified and treated.
3.The role of the urologist has now changed and become pivotal in many assisted reproductive technique (ART) in male factor cases, since new techniques for sperm procurement must be mastered.

It is important consequently to address each one of these topics.

Aromatase inhibitor for ovulation induction

Michel Abou Abdallah, M.D.

Aromatase is a member of the cytochrome P450 hemoprotein containing enzyme complex super family. It catalyzes the rate-limiting final step in estrogen (E) production, the hydroxylation of androstenedione to estrone and of T to E2. Its activity can be demonstrated in the ovaries, adipose tissue, placenta, brain, muscle, fibroblasts, osteoblasts, liver, and breast.

For many years, aromatase inhibitors have been used as an adjunct treatment for breast cancer. They could be steroidal or nonsteroidal inhibitors. Steroidal inhibitors are derivatives of androstenedione that act as false substrates, binding irreversibly to the androgen-binding site.

The third-generation aromatase inhibitors include two nonsteroidal inhibitors, anastrozole and letrozole, and a steroidal agent, exemestane. Anastrozole and letrozole are selective aromatase inhibitors. They are reversible and highly potent.

Letrozole and anastrazole are completely absorbed after oral administration, with a mean half-life of approximately 45 hours (range, 30–60 hours).

Estrogen exerts a negative feedback on the hypothalamic–pituitary axis and decreases the release of FSH from the pituitary gland. Blocking E production by inhibiting aromatization, would release the hypothalamic–pituitary axis from estrogenic negative feedback. As a result, FSH secretion increases, stimulating the development of ovarian follicles. Because aromatase inhibitors block high levels of E from androgen conversion, the effects in women with polycystic ovary syndrome (PCOS) are more prominent. In addition, androgens that normally converted to estrogens accumulate in the ovary, and these androgens increase follicular sensitivity to FSH. Unlike CC, aromatase inhibitor does not deplete E receptors or produce a negative effect on the endometrium. Clomiphene citrate, on the other hand, has a longer half-life (2 weeks) that results in prolonged central E receptor depletion.

Aromatase inhibitors are a new group of drugs to join the arsenal of fertility treatments. They are orally administered, easy to use, and relatively inexpensive, with minor side effects. Anastrazole and letrozole are third-generation aromatase inhibitors that have been used for ovulatory disorders and for superovulation.

The data on letrozole suggest that it can be used to replace CC as the first-line treatment for women with ovulatory disorders. Compared with CC, its use is associated with thicker endometrium. For superovulation, there is a trend for higher pregnancy rates with letrozole than with CC. When letrozole is added to gonadotropin regimens, it leads to less gonadotropin requirement and a pregnancy rate that is comparable to that with gonadotropin-only treatment.

It seems that the dose of 5 mg daily for 5 days is the most effective.

Aromatase inhibitors are promising new drugs for the induction of ovulation and superovulation. After 4 decades of CC treatment, a new era of ovulation induction has finally arrived.

Abstract

Managment of High Risk Multiple Pregnancy

Dr. Fawaz Khaza`leh

Monochorionic twins occur in 0.3% of all pregnancies. 75% of monozygotic twin pregnancies are Monochorionic; the remaining 25% are dichorionic diamniotic. Monochorionic twin pregnancy should be diagnosed at an early stage of pregnancy because it is associated with many complications in comparison of dichorionic twin gestation.
TTTS: complicates about 8-10% of MCDA pregnancies, result from intertwin vascular connections within the placenta, which lead to volume depletion in the donor twin, with oligohydramnios, and to volume overload in the recipient twin, with polyhydramnios.
TAPS: form of chronic feto-fetal transfusion, characterized by large inter-twin hemoglobin differences, The pathogenesis of TAPS is based on the presence of few, minuscule arterio-venous (AV) placental anastomoses (diameter <1mm) allowing a slow transfusion of blood from the donor to the recipient and leading gradually to highly discordant Hb levels. It complicates approximately 3 to 5% of monochorionic twin pregnancies.
TRAP: Occurs in 1% of monochorionic twin pregnancies, involving an acardiac twin whose structural defects are incompatible with life, and an otherwise normal “pump” twin. IUFD of co-twin: the incidence of single IUFD in monochorionic twins ranges between 2.6-4.6, it carries a risk of co-twin demise.

Modern Management of Pelvic Mass

Dr. Isam Lataifeh

Adnexal masses are frequently found in both symptomatic and asymptomatic women. They may be benign or malignant. In premenopausal women, physiologic follicular cysts and corpus luteum cysts are the most common adnexal masses, Malignant neoplasms are uncommon in younger women but become more frequent with increasing age. The initial detection and evaluation of a pelvic mass requires a high index of suspicion, a thorough history and physical examination. Transvaginal ultrasonography remains the standard for evaluation of adnexal masses. Findings suggestive of malignancy in an adnexal mass include a solid component, thick septations (greater than 2 to 3 mm), bilaterality. Measurement of serum CA-125 is a useful test for ovarian malignancy in postmenopausal women with pelvic masses. Asymptomatic premenopausal patients with simple ovarian cysts less than 10 cm in diameter can be observed or placed on suppressive therapy with oral contraceptives. Postmenopausal women with simple cysts less than 3 cm in diameter may also be followed, provided the serum CA-125 level is not elevated and the patient has no signs or symptoms suggestive of malignancy. All women, regardless of menopausal status, should be referred if they have evidence of metastatic disease, ascites, a complex mass, an adnexal mass greater than 10 cm, or any mass that persists longer than 12 weeks.

Abstract

New Method of Vaginoplasty in Vaginal Agenesis, Shamdeen's Vaginoplasty

Dr. Maeda Shamdeen, Iraq

Aim: To present a new technique of vaginoplasty in Mayer-Rokitansky-Kuster-Hause (MRKH) syndrome

Methods and interventions: A case series study of 145 females presented with primary amenorrhea due to vaginal agenesis, on which the new procedure of Vaginoplasty was conducted on those suffering from MRKH syndrome. Evaluation of cases was conducted through clinical, laboratory, sonography and laparoscopy, to confirm the diagnosis of MRKH syndrome.

Shamdeen`s Vaginoplasty; creating a new vagina by two-skin flap from labia minora and majora. The first step was to excise two skin flaps, one from each side of labia, keeping the insertion of one flap anterior and the other posterior, separate the two layer of the skin flap. The second step was by creating a space between the bladder and rectum by blunt dissection, creating a pouch extended to the pouch of Douglas .The third step was to sutures the two flaps as a tube, three bites of the top stitches sutured with the highest point in the created pouch but left un tightened, inverting this tube, and then tighten the sutures on the top to keep it in place, betadiene socked pack left for 7 days. Regular dilatation weekly and sexual practice after 8 weeks. All were folled up for three years.

Results: one hundred forty five cases of primary amenorrhea, in which 29 cases (20%) found to have MRKH syndrome, 23 married women underwent Shamdeen`s vaginoplasty. Most of the patients were satisfied post operatively; functionally and psychologically, only one case had severe post operative infection and moderate vaginal stricture.

Conclusion: the created vagina got normal anatomical position, covered with normal skin, took shorter operative duration, convenient for patients, had good results, not that invasive, and relatively inexpensive.

Key words: Primary amenorrhea, MRKS syndrome, vaginal agenesis, vaginoplasty.

Management of Sexual Assault

Dr. Martin Olsen

Sexual assault is the most under reported crime and is unfortunately a common issue faced by female patients. Most sexual assault victims do not seek medical care and those who do sometimes face unpleasant interactions with the healthcare system.

The patient's recovery from a sexual assault can begin during her evaluation if the experience is sensitive and caring. Questions must be asked in a respectful and professional manner with comprehensive history taking that will be discussed in the presentation. The most important part of the physical examination is to insure that the patient does not have life-threatening injuries. A sexual assault evidence collection kit may also be completed if the patient permits this evaluation. Laboratory analysis includes testing for sexually transmitted diseases. A pregnancy test is indicated so that if positive the assault survivor will know that the rapist was not the father of her fetus. Specific testing for substances using in drug facilitated sexual assault may be indicated. Treatment includes post-coital contraception, sexually transmitted disease prevention and psychologic follow-up.

Abstract

Office-Based Surgery and the ACOG Scope Program

Dr. Susan P. Raine,

The appeal of office-based surgery has increased due to advances in surgical techniques, technology, and anesthetics. As a result, surgeons are not longer restricted to the operating room; however, surgery in the office setting presents its own set of challenges for health care providers. In response to this, the American College of Obstetrics and Gynecology (ACOG) developed The Safety Certification in Outpatient Practice Excellence (SCOPE) for Women's Health Program that defines quality and safety indicators for women's health care in the office setting. Review and certification by the SCOPE program is available to any medical practice offering office-based obstetrics and gynecology services, including international practices.

Episiotomy To Do or Not To Do

Dr Med Jamil Sha'ban

Episiotomy came into common practice In the world since women started to give Childbirth at hospitals. Until now a days Episiotomy is rarely performed when women are giving child-Birth at home.

Is it a must ? Is it luxury ? Does it decrease morbidity? Is it evidence based medicine? Is it because we believe it is good?

A review of the literature on episiotomy shows that too little is known.

Accumulating data suggest that the indications for episiotomy may be far fewer than traditionally thought and that the potential disadvantages may be far Greater than the advantages.

Abstract

Fertility Preservation in Patients Suffering From Cancer

Dr Suleiman Dabit

Cancer treatment can have a major impact on fertility. Certain cancer treatments can harm your fertility or cause sterility. The effects, which might be temporary or permanent, can occur immediately or at some point after treatment. The likelihood that cancer treatment will harm your fertility depends on several factors, including the type of cancer, cancer treatment and your age at the time of treatment.

Male fertility can be harmed by the surgical removal of the testicles or by chemotherapy or radiation that damages sperm quantity, quality or DNA.

Female fertility can be compromised by cancer treatments that involve the surgical removal of the uterus or ovaries.

The effects of chemotherapy and radiation therapy also depend on the drug or size and location of the radiation field.

Women who are about to undergo cancer treatment have various options when it comes to fertility preservation.

- Embryo cryopreservation.
- Egg freezing (oocyte cryopreservation).
- Gonadal shielding.
- Ovarian transposition (oophoropexy).

Other methods of fertility preservation for women still being researched include ovarian tissue cryopreservation — in which ovarian tissue is surgically removed, frozen and later reimplanted — and ovarian suppression before cancer therapy, in which hormonal therapies are used to suppress ovarian function and protect eggs during cancer treatment.

Men can also take steps to preserve their fertility before undergoing cancer treatment.

- Sperm cryopreservation.
- Gonadal shielding.

Other methods of fertility preservation for men still being researched include testicular tissue cryopreservation — in which testicular tissue is surgically removed, frozen and later reimplanted.

Role of Surgery in Epithelial Ovarian Cancer

Dr. Isam LATAIFEH

Epithelial ovarian cancer is the fifth most frequent cause of cancer death in women and remains the leading cause of gynecologic cancer-related deaths in the US and Europe. There is no proven screening test for this disease. Many women present with vague symptoms, including abdominal bloating, change in bowel or bladder habits, early satiety, or abdominal pain. For these reasons, many patients present with advanced metastatic disease at diagnosis. Surgery is the main treatment for most ovarian cancers and has 2 main goals: staging and debulking. The mainstay of treatment of advanced ovarian cancer is primary surgery aiming at complete resection followed by platinum and paclitaxel chemotherapy. It's important that this surgery is gynecologic oncologists who have training and experience in treating staging, and debulking ovarian cancer. Cancers that are debulked properly are called optimally debulked. Women with these cancers have a better outlook for survival than cancers that are sub-optimally debulked. Women with sub-optimally debulked ovarian cancer may need to have more surgery later. Cytotoxic chemotherapy has an important role in the treatment of this disease, in the neoadjuvant, adjuvant, and recurrent setting. For the medically fi t patient, surgery also has an important role in the management of ovarian cancer for diagnosis, primary therapy, and treatment of recurrent disease.

Abstract

Molecular Aspects of Endometrial Receptivity

Dr Maryam Kabir-Salmani

The success rate of several advanced basic and clinical techniques in the field of mammalian biotechnology, including cloning, pre-implantation genetic diagnosis, and assisted reproductive techniques (ART) depends mainly on the success rate of pregnancy following in vitro fertilization-embryo transfer (IVF-ET). The techniques used in ART have advanced considerably since the first in vitro fertilization birth in 1978. However, despite these advances, pregnancy rates are still relatively low and have not increased significantly in the last decade. Based on the facts that embryo implantation is considered as the last barrier in ART and that inadequate endometrial receptivity is responsible for approximately two-thirds of implantation failures, intensive research work has been performed to understand the physiology, regulation, and the clinical assessments of the endometrial receptivity to improve the success rate of IVF-ET. Considering the fact that up to 50% of embryos possess chromosomal errors such as aneuploidy, triploidy, translocations and other genetic disorders; receptive endometrial layers may provide a gating mechanism that help screen out impaired embryos. Receptivity, as originally conceived, is functionally defined: that state of uterine differentiation that is permissive for embryo attachment, a definition which has frustrated efforts to establish morphological and molecular correlates, particularly in the human, where ethical and moral constraints prohibit in vivo functional testing. The dominant features of the receptive phase endometrium can be categorized as: I) the plasma membrane transformation of luminal epithelium, II) glandular secretion, III) stromal decidualization and IV) the changes of the immune cell populations. Determining molecular mechanisms of human embryo implantation is an extremely challenging task due to the limitation of materials and significant differences underlying this process among mammalian species. This review primarily concerns with biochemical and molecular events in the endometrium coordinated within its receptivity period termed as the window of implantation.

PCOS in Adolesnt Challenge in Clinical Practice

Dr Faysal Al Kak

PCOS continues to be a debatable clinical topic in our practice in relation to diagnosis and management. Definitions of PCOS are changing, the most recent being the NIH workshop classification of 2012. In all these classifications, and based on growing research- based evidence, PCOS, preferable called, Androgen Excess syndrome, is becoming more critical in the adolescent population due to its metabolic disorders consequences. This presentation will try to present challenges in diagnostic workup in adolescents presenting to clinical services

Abstract

PCOS vicious cycle of endocrine disorders

Prof. Michel Abou Abdallah

The dilemma associated with the diagnosis of PCOS, arising from a variety of clinical and endocrine presentations, has resulted in disagreement concerning its pathogenesis, aetiology, and classifications.
Four board approaches can be distinguished in visualising the problem of PCOS.
The first, “The Top-down approach”, which emphasises the neuroendocrine approach such that GnRH pulse abnormalities predominate in the thinking of its disciples.
The second, “the bottom-up approach” in which the starting point is ultrasonographie identification of a polycystic ovary.
The third perspective would be that of the “Androgen approach”, whose proponents are currently focusing on the important interactions between the adrenal and ovarian sources of androgens in this syndrome.
The fourth perspective would be that of the “Insulin approach”, where impressive evidence for a primary defect of insulin action has been observed.
PCOS appears to be about to yield some of its mysteries and to have some of its discrete subsets defined.

Hyerprolactenemia and AUB

Dr Faysal Al Kak

This presentation will review updates on the assessment of hyperprolactinemia in cases of AUB, and it will stress the algorithms of diagnosis and protocols of management based on clinical

Abstract

Abnormal Uterine Bleeding: The New Classifications and Management Implications

Dr Faysal Al Kak

Implications
Benign abnormal uterine bleeding in the reproductive age women represents a critical load of clinical work. Several algorithms have been developed to aid gynecologists to manage these medical conditions, FIGO expert group developed the PALM-COIN classification to try to standardize clinical protocols in the management of abnormal uterine bleeding. This presentation will cover these aspects

Abstract

Gender-Based Violence

Susan P. Raine

Violence against women throughout the lifecycle is largely overlooked and underreported with significant consequesnces for the health and well-being of the individual woman and the family unit. Health care worker recognition of and response to the violence perpetrated against women is key to halting this distructive cycle and allowing women to reach their full potential.

Abstract

Prevention and Management of Gynecological Surgical Complications

Randall W. Williams, M.D., FACOG

Gynecological surgical procedures have benefits but also risks that are inherent to the procedures. Surgeons have a duty to discuss these with patients preoperatively and then work to prevent complications but be prepared to recognize them and treat them should they occur. As my former Chairman, William Droegemueller used to say, when surgeons say they never have complications with a procedure, it just means they have not done enough of the procedures to experience a complication.

The incidence of death from Total Abdominal Hysterectomy is 1/1000, Bowel injury 1/250, Ureteral injury 1.3/100, Significant bleeding 7/100, infection 4/100. For D and C, the risk of perforation is 1/100 in premenopausal women and 1/50 in postmenopausal women. For laparoscopy, minor complications are 2/100, complications requiring emergent surgery 2/1000 and death is 2/100000. Risk of dying during pregnancy as a point of reference is 1/10000. In the United States, between 44,000 and 98,000 patients die each in because of injuries that result from errors. 85% of all reported sentinel events that result in death and injury have a root cause of ineffective communication. Two fundamental tenets in the prevention of complications are “Hope for the best but prepare for the worst” and “When everybody is responsible, nobody is responsible.”

New Techniques in Operative Hysteroscopy

Randall Williams, M.D.,FACOG

With increasing lifespans for women worldwide, the incidence of bleeding from endometrial anatomic pathology and postmenopausal bleeding will rise. New technology has made the treatment of endometrial pathology such as polyps and fibroids easier and allowed the treatment of these in the office possible. The work up of postmenopausal bleeding using endometrial biopsy and ultrasound will be discussed. We will also discuss the use of the Smith and Nephew Truclear 2.9 mm Morcellator Blade in the office as an adjunct in the diagnosis and treatment of dysfunctional uterine bleeding, menorrhagia, and postmenopausal bleeding.

Abstract

Medico-legal aspects of Gynaecological practice

DR SURESH KUMARASAMY MBBS, MObGyn, FRCOG, FRCPI

The main areas of challenge in Gynaecological practice are contraceptive and sterilization failure, screening errors and when complications that occur following surgery. Contraceptive counseling must cover options, failure rates, contraindications as well as correct usage. Counseling for patients undergoing sterilization must include failure rates, irreversibility and risks of the procedure.

Risks of the menopause must be explained together with treatment risks. The woman concerned will need to balance these risks and make a decision regarding her care.

Breast and cervical cancer screening must include assessment of symptoms as well as review of previous reports. Arrangements must be made for a follow up after a suitable interval of time. Measures should be in place to avoid clerical and filing errors.

Informed consent before surgical procedures is mandatory. Alternatives to the procedure as well as risks must be discussed in detail. Risks of bleeding, infection, deep venous thrombosis, as well as damage to surrounding organs as well as their sequelae should be explained. Prophylactic antibiotics as well as heparin therapy should be administered as appropriate.

Complications of laparoscopic surgery are potentially more serious as there is often a delay in diagnosis. Factors that increase the risks of laparoscopic complications are complex surgery, older patients, extremes of weight, previous abdominal surgery and adhesions, poor surgical technique, lack of experience as well as faulty equipment. During surgery, structures should be visualized clearly and care must be excised during sharp dissection as well as during probing and retracting and when using thermal energy.

Good patient care, communication, good record keeping as well as obtaining appropriate training prior to carrying out procedures will decrease the risk of medico-legal challenge.

HPV VACCINATION

DR SURESH KUMARASAMY MBBS, MObGyn, FRCOG, FRCPI

HPV infection is the aetiological agent for cervical cancer. In addition, a number of other cancers are associated with HPV infection including anal cancer, vulval and vaginal cancer and some head and neck cancers. HPV infection with HPV 6 and 11 also results in genital warts and recurrent laryngeal papillamatosis

Although screening with the pap smear has decreased the incidence of cervical cancer in many countries, the impact of screening in developing countries has been unsatisfactory. HPV related disease in developing countries with limited screening account for 80% of the global cancer burden.

Primary prevention through HPV prophylactic vaccination offers a new tool to improve cervical cancer control. Large phase III randomized controlled trials involving several thousand women worldwide have convincingly shown that the HPV vaccines are efficacious and safe. Protection of previously unexposed women is greater than 90% against the target HPV types.

The primary target population for vaccination are adolescents before sexual debut and exposure to HPV. International committees on immunization practices have recommend routine vaccination of girls aged 11-12 using three doses of the vaccine. Vaccination is also recommended as catch up vaccination for unvaccinated girls and women aged 13 to 26 years.

In April 2007, Australia became the first country to introduce a national government-funded HPV vaccination program using the quadrivalent vaccine. Large declines in genital wart as well as high grade cervical abnormality incidences have been seen in the vaccinated age groups confirming the “real world” efficacy of HPV vaccination. Similar data has been reported from other countries

Malaysia was the first middle-income country in the world to implement a national HPV vaccination program in September 2010. It is a school based vaccination program targeting girls at Year 7 of school (13 years), with clinic based immunisation for out of school 13 year old girls. This program was very successful with 95.9 and 97.9% of parents giving consent for their daughters to be vaccinated and 97.9% and 95.9% of girls with parental consent completed all 3 doses in 2010 and 2011 respectively. .

The reasons for the success of this program included endorsement and recommendation by the medical profession, political will and leadership, involvement of stake holders early, predicting and managing potential risks as well as monitoring implementation closely . Other factors were a good existing school health program, “halal” certification of the vaccine (as over 60% of the population are Muslim), involvement of the Ministry of Education and giving sufficient information about the vaccine and its safety to parents.

In 2012 a catch up vaccination program was introduced targeted at girls aged 18yeras.

The Malaysian HPV vaccination program could be a model for the developing world, where organised and effective screening is unlikely to be successfully implemented in the short term

Abstract

Maternal mortality in Maternity Teaching -Erbil over 3 years period

Mahabad Ali, Iraq

Maternal mortality data reflect the health care status of any given country in general and the efficiency of health care to women in particular .
Maternal mortality is defined by the World Health Organization (WHO) as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes .
With the lack of a national register for maternal deaths in Kurdistan , hospital based statistics will remain the only source of information regarding maternal mortality as a reflection of maternal care in Erbil city, Death in the hospital is fair representative of the number of death in the community because
not all childbirths take place in the hospital.
Maternity teaching Hospital –Erbil Services serve more than 1million of the Kurdistan population, account for more than 60% of birth rate in Erbil (total birth 42-46000/year) city.

Postpartum Hemorrhage Symposium

Rezan A Kadir and Patrick O'Brein

Postpartum hemorrhage (PPH) remains one of the leading causes of maternal morbidity and mortality worldwide, though lack of a precise definition precludes accurate data of the absolute prevalence of PPH. Uterine atony is the most common cause and account for over 70% of cases. Other obstetric causes include retained placental product and genital tract trauma. Inherited bleeding disorders are also associated with an increased risk of PPH. Acquired coagulopathy can complicate PPH, if not recognised and treated early, it can lead to progression to an intractable haemorrhage, Early and aggressive treatment of PPH is a key factor in reducing the morbidity and mortality associated with this global health problem. The numerous risk factors for and causes of PPH necessitate a multidisciplinary approach to management and close collaboration between the obstetric, anasethatic and haematology teams with the support of the blood bank. The PPH symposium will cover obstetric and haemostatic aspects of PPH, including the RCOG guidelines for the management of PPH. The role of haemostatic monitoring and the use of haemostatic agents are also discussed.

Abstract

Maternal mortality in Maternity Teaching -Erbil over 3 years period

Rezan A Kadir

Vulval pain, classification, and management strategies Dermatoses- clinical symptom based classification of vulval skin disorders: a lesion, pruritus, pain awareness of the ISSVD terminology.
Lichen sclerosis, lichen planus, lichen simplex chronicus, dermatitis, psoriasis, vulval ulcers Premalignant and malignant disease- VIN-usual type and differentiated VIN diagnosis and management

Postpartum Hemorrhage Symposium

Rezan A Kadir

The incidence of endometrial cancer is increasing, particularly in the developed world and this is related to the obesity epidemic. Risk factors for endometrial cancer can be classified as those related to an increased oestrogen/progesterone ratio and those not directly related to this. Women typically present with post-menopausal bleeding and an ultrasound scan may be used to aid diagnosis, with recourse to an endometrial biopsy if the endometrial thickness is greater than 4mm. The majority of women present with early stage disease and treatment is traditionally by total hysterectomy and bilateral salpingo-oophorectomy. Published literature, from our centre and others have demonstrated that the minimal access approach is safer, particularly in morbidly obese women. Complete surgical staging should involve systematic pelvic and para-aortic node dissection but the role remains controversial, both from the therapeutic aspect as well as in guiding adjuvant therapy. High risk cases are given pelvic radiotherapy which reduces local recurrence but does not improve survival. It is also associated with toxicity. The role of chemotherapy is currently being investifgated. As this cancer is curable, quality of life aspects should be considered

Abstract

Ovarian Cancer – Medical Management

DR SURESH KUMARASAMY MBBS, MObGyn, FRCOG, FRCPI

The standard treatment for epithelial ovarian cancer starts with staging and cytoreductive surgery. Patients are classified as having limited disease (stage I and II) or advanced disease (stage III and IV). Patients with limited disease are classified as having low or high risk for recurrence. Low risk for recurrence includes: Grade 1 or 2 disease, no tumor on external surface of the ovary, negative peritoneal cytology, no ascites and tumor growth confined to the ovaries. High risk for recurrence includes: Grade 3 disease, preoperative rupture of the capsule, tumor on the external surface of the ovary, positive peritoneal cytology, ascites, tumor growth outside of the ovary, clear cell tumors and surgical stage II Chemotherapy is indicated in all patients with ovarian cancer except those patients with surgical-pathological stage I disease with low-risk characteristics.

Standard postoperative chemotherapy for advanced ovarian cancer is combination therapy with carboplatin and paclitaxel. Cytoreductive surgery followed by standard combination chemotherapy can achieve clinical complete remission in about 75% of patients with advanced disease.

Neoadjuvant chemotherapy has a role in patients with advanced ovarian cancer who are not candidates for initial surgical cytoreduction due to poor performance status or co-morbidities. Two or three 3 cycles of conventional chemotherapy are given and the patient is then re-evaluated for surgical cytoreduction. Although the GOG 172 trial showed that intraperitoneal chemotherapy resulted in improved overall survival and progression free survival in patients with minimal residual disease after primary surgery, the high rate of toxicity, discontinuation rates as well as port site problems has not made this form of treatment popular.

The majority of patients with advanced ovarian cancer will have a recurrence. Based on the disease-free interval after completing chemotherapy, patients can be classified in 2 categories: (1) platinum-sensitive (relapse >6 months after initial chemotherapy) and (2) platinum-resistant. Patients with platinum-sensitive disease may exhibit a good response if re-challenged with a platinum-based regiment. The probability of response increases with the duration of disease free interval. Combination chemotherapy has been shown to be superior to single-agent carboplatin in this situation. Patients with platinum resistant disease should be treated with non-platinum single agent chemotherapy.

Secondary cytoreduction in recurrent ovarian cancer should be considered in platinum sensitive patients who were optimally debulked at their primary surgery, have an isolated recurrence and no ascites. Following surgery, platinum-based chemotherapy is recommended.

Targeted therapy has been found to have activity in ovarian cancer. The most research has been carried out with the anti-angiogenic agent Bevacizumab which has been shown to be effective and well tolerated when added to conventional chemotherapy followed by maintenance therapy in the front line setting as well as in platinum sensitive and platinum resistant recurrent disease. Further research is needed to determine optimal duration & timing of treatment, cost effectiveness as well as potential tumour or host biologic factors that can predict efficacy & adverse events. Clinical trials are underway with other novel agents which may lead the way to better outcomes in the future.

Research Abstract (Posters)

Posters

Frequency of Ectopic Pregnancy in a Maternity teaching Hospital – Erbil
Ariana. K. Jawad ,Mahabad .S.Ali, Lava O .Muhammad

Prevalence and determinants of caesarean section in Sulaimani Maternity Hospital
Rawa J.Mohamad,Zhian.s.Ramzi

Vaginal delivery after caesarean section with less than two years interval
GhadaAlsakkal ,Raida Mala Fatah

Determinants of utilization of antenatal care services in Erbil city
Asmar Aziz , Jwan M. Zangana

Association between severty of anemia and maternal factors during pregnancy in Maternity teaching Hospital – Erbil.
Hamdia M. Ahmed , Awaz A. Saeed,Miss. Warda H. AboaAllah

Incidence and probable risk factors of still birth in Maternity teaching Hospital in Erbil city
Shahla K. Al alaf

Ginger and metaclopromide on the treatment of nuases and vomiting in pregnancy.
Maysoon Sharief

New method of vaginoplasty in vaginal ageneses
Maeda Shamdeen

400 mcg sublingual misoprostol versus 600 mcg in the treatment of first trimester incomplete miscarriage
Ishraq Mahmood Shakir ,.Mina jalil Mustafa.

Maternal mortality at Maternity teaching Hospital- Erbil,Kurdistan:Hospital - based data, 2011-2013
Mahabad .S.Ali , Ariana. K. Jawad, Rojan K.Jawad

Advanced Stage Of Squamous Cell Carcinoma of the Vulva : A case report
Mohamad Smadi

400 µg sublingual misoprostol versus 600 µg in the treatment of first trimester incomplete miscarriage

Mina J. Mustafa, Ishraq M. Shaki

Background: : Various methods has been described for management of first trimester incomplete miscarriage, the active methods are: surgical methods which are highly effective methods but are associated with anesthetics and surgical risks. Medical methods by Misoprostol had been shown to be effective, acceptable and widely used treatment for incomplete miscarriage.
Objectives: A case comparable study was conducted to compare the efficacy, patients' acceptability and the side effects sublingual administration of single dose of 400mcg with single dose of 600mcg of misoprostol in the treatment of first trimester incomplete miscarriage.
Patients and methods: This study was conducted from 1st April 2011 to 1st February 2012 in Maternity Teaching Hospital in Erbil city/ Kurdistan region / Iraq, and included 120 patients with incomplete miscarriage at a gestational age ≤ 12 weeks. They were randomly received either single dose of 400mcg or 600mcg of misoprostol sublingually. Patients returned for follow-up and re-evaluation of abortion status after 7 days. Patient with a continues incomplete miscarriage underwent surgical evacuation.
Results: The success rate in the first and second group was 90% and 91.7% respectively and patients' acceptability in the first and second group was 96.7% and 95% respectively with no statistical significant difference between both groups. Gastrointestinal side effects like nausea and diarrhea were more in the second group.
Conclusions: A single dose of 400 mcg sublingual misoprostol is better than single dose of 600 mcg sublingual misoprostol in the treatment of first trimester incomplete miscarriage, with fewer side effects and more acceptable by patients.

Advanced Stage Of Squamous Cell Carcinoma of the Vulva : A case report

Mohamad Smadi,Ghada S.AL-Sakal

Background: Squamous Cell Carcinoma is an uncommon tumor and presents 3-5% of all female genital tract malignancies
It is the most common carcinoma of the vulva
Case report: A- 47 Years old female presented to the gynaecological outpatient clinic in Maternity Teaching hospital,Complaining of Sever vulval itching and Bleeding since five years ago.
Local inspection revealed ulcerated mass covering all the vulva and vagina to the degree that
there was occlusion In the vulval introitus .
Biopsy was taken and the histopathological result revealed well differentiated Squamous Cell Carcinoma .
Finally the diagnosis was stage IVa Squamous Cell Carcinoma of vulva.
Key words: Squamous Cell Carcinoma-vulva -advanced

Incidence and probable risk factors of still birth in Maternity Teaching Hospital in Erbil city

Shahla K.Al-alaf, Shahla K. Al alaf

Background: Death of an infant in utero or at birth has always been a devastating experience for the mother and of concern in clinical practice.
Objectives: To determine the incidence, probable risk factors & association of Stillbirth with different maternal variables in Maternity Teaching Hospital.
Patients & methods: A case control study, was conducted in Maternity Teaching Hospital in Erbil city, Kurdistan region, Iraq, from first of April to thirty first of December 2011.Three hundred seventy nine women had stillbirth, and regarded as cases while 758 women delivered alive newborns and regarded as control group.
Results: The incidence of stillbirth during the period of the study was 20.4 per1000 total births. Macerated stillbirth was about four times higher than the fresh stillbirth. There were statistically significant differences between the cases and controls in relation to: maternal age (≥ 35 years), level of education, history of antenatal care visits, parity, medical diseases of the mother, congenital anomalies of the newborn, and history of previous stillbirth. The probable causes of stillbirth were unexplained in 65.4% of cases. Other probable causes were maternal medical diseases, fetal congenital anomalies, preterm labour, antepartum haemorrhag and fetal asphyxia. Less frequent causes were cord prolapse, malpresentation, & obstructed labour.
Conclusion: The incidence of stillbirth is high in Maternity Teaching Hospital. Advanced maternal ages, low educational level, poor antenatal care, increase parity, maternal medical diseases (hypertension and diabetes), fetal congenital anomalies, and history of previous stillbirth were risk factors for stillbirth.

Vaginal Birth after Caesarean section with less than 2 years inter delivery interval

GhadaAlsakkal , Raida Mala Fatah

Background: A dramatic rise in caesarean deliveries has been occurring over the past three decades. The old myth of “once a caesarean always a caesarean” is no longer acceptable as this increases maternal morbidity.
Objective: To evaluate the safety and success rate of vaginal birth after caesarean section (VBAC) performed before less than 2 years.
Patients and methods: A cross-sectional study was conducted from May 2012 to October 2012 in Maternity Teaching Hospital, Erbil city, Kurdistan region, Iraq.
92 patients with single lower segment cesarean section underwent trial of labour and were included in this study and followed up during their labour. Patients monitored for vaginal bleeding, scar tenderness, tachycardia.
Results: Fifty two (56.5%) women had successful VBAC and 40(43.5%) had a repeated cesarean section. Factors found to be significantly affecting VBAC were parity (p value 0.01), inter-delivery interval (p value 0.00), Indications of previous cesarean section (p value 0.015).
Conclusion: VBAC is a reasonable choice for women with single lower segment cesarean section with good monitoring of mother and baby during labour. Short inter-delivery period does not preclude vaginal delivery in a woman with single lower segment cesarean section providing that there is no contraindication for vaginal delivery.

Association between severity of anemia and maternal factors during pregnancy in Maternity Teaching Hospital/Erbil city

Hamdia M. Ahmed, Awaz A. Saeed, Miss. Warda H.

Objectives: This study aimed to find out the association between severity of anemia with following maternal factors: sociodemographic, medical and obstetrical history, diet and medication and clinical manifestation.
Material and Methods
A descriptive study was conducted on 64 anemic pregnant women in Maternity Teaching Hospital/Erbil city, during the period 1st Mar to 30th June 2013. A purposive (non-probability) sampling was used.
A questionnaire format was prepared by researchers which included following parts: sociodemographic data, medical and obstetrical history, diet pattern and medication, clinical manifestation and Hb level at admission.
Results: 57.8% of the study sample had moderate anemia during pregnancy. The majority of the study sample aged between 18-35 years, resident in urban area and were housewife. There was significant association between severity of anemia with residency and number of taking leafy green vegetable/week. There was no association between severity of anemia and following maternal factors: age, occupation, monthly salary income, educational level, previous medical and obstetrical history, current obstetrical history, diet pattern and mediation.
Conclusions: Severity of anemia are associated with residency and diet pattern. Further study with large sample size is needed to find out maternal factors as risk factors of anemia during pregnancy in Maternity Teaching Hospital.

Determinants of utilization of antenatal care services in Erbil city

Asmar A. Dhahir, Dr. Jwan M. Zangana

Background and objectives:. This study was done to determine the factors affecting utilization of antenatal care among reproductive age group women (15-49) years in Erbil city.
Method: A cross-sectional study was done between1st April 2012 till 1st April 2013 in Erbil city at two places (Birth & death certification register center & Maternity Teaching Hospital).A sample of 500 women among reproductive age group (15-49) years was collected by using questionnaire through direct interview. Statistical package for social sciences (SPSS) version 18 was used for data entry and analysis.
Result: This study revealed that antenatal care service utilization in the study area was 82.4%. However, from those who attended antenatal care service 45.8% started antenatal care visit during the first trimester of pregnancy and 41% had less than four visits. Women's education and occupation, socioeconomic state, number of children, Tetanas toxoid vaccine, distance to antenatal care service and knowledge about alarming sign &symptom of pregnancy were major predictors of antenatal care service utilization.
Conclusion: Nearly 41% of women did not receive adequate number of visits as recommended by the World Health Organization. Women's education and occupation, socioeconomic state, number of children, Tetanas toxoid vaccine, distance to ANC service and knowledge about alarming sign &symptom of pregnancy are significantly associated with rate of receiving antenatal care.
Keywords: ANC, pregnancy, education, occupation

Frequency of Ectopic Pregnancy in a Maternity teaching Hospital – Erbil

Ariana. K. Jawad, Mahabad .S.Ali, Lava O.Muhammad

Objective: To assess the frequency of ectopic pregnancy and to evaluate the prelevance of the risk factors and management outcomes of ectopic pregnancies at Maternity Teaching Hospital –Erbil.
Methods: This retrospective study was done in Maternity Teaching Hospital, Erbil City(MTH-Erbil), over a period of three years , where the medical records of patients with the diagnosis of ectopic pregnancy were reviewed. Data was collected on initial presentation, A total of 272 cases were included in the study.
Results: The frequency of ectopic pregnancy was 0.36% .Mean age was 22.95 ± 5.6 years. Multiparous women were found to be more prone to ectopic pregnancy (63.%). Most frequent maternal age were less than 30 years old (86.8%). Majority (25.7%) of the patients had previous medical induced, spontaneous or surgical abortion. 21.2% had previous pelvic surgery, 15% had previous ectopic pregnancy , 18.08% had used different treatments for infertility , Intrauterine 6% of patients had Intrautrine Contraceptive Device (IUCD) in situ. 4.5% of patients had uterine fibroids.
Conclusion:
1. If a woman of reproductive age comes with pain in the abdomen, there is a high suspicion of ectopic pregnancy and take seriously unless otherwise proved.
2. Further research into ectopic pregnancy should focus on risk factors common to these conditions.
Keywords: Risk Factors, Ectopic Pregnancy, MTH-Erbil.

Maternal Mortality at the Maternity teaching hospital-Erbil, Kurdistan: Hospital - based data 2011-2013

Mahabad .S.Ali, Ariana. K. Jawad, Rojan K.Jawad

Background & objective: The aim of this study is to highlight the main cause of avoidable death that leads to maternal mortality among those admitted to Maternity teaching Hospital-Erbil

Methodology: This survey was carried out in Maternity teaching Hospital-Erbil (MTH-Erbil). The data collected were from the obstetrics and gynecology medical records at this department in Maternity teaching Hospital-Erbil. Variables included in this study are those related to patients' age, number of parity, mode of delivery of the last baby. In addition, some clinical data were included related to causes leading to death and underlying condition of death.

Results: Of the total 75000 live birth recorded in the hospital during the study period (2011-2013), 33 maternal deaths were recorded which gives an overall Maternal Mortality Ratio (MMR) of 44 per 100,000 live births. Preeclampsia and eclampsia was among the top causes of maternal deaths in this study (42.4%) followed by rapture uterus and bleeding 30.3% .

Conclusion: Efforts must therefore be made on the health care providers, hospital managers and government to maintain the current downward trend in our maternal mortality ratio.

Key wards: Maternal mortality, MTH-Erbil, causes

Prevalence and determinants of Caesarean section in Sulaimani Maternity Hospital

Rawa J. Mohamad, Zhian S.Ramzi

BACKGROUND: The rate of cesarean sections (CS) around the world is steadily rising. knowledge about rate of CS in Sulaimani Maternity Hospital form basis to study trends of CS later on.
OBJECTIVES: To find out the prevalence, indications, and consequences of cesarean sections in Sulaimani Maternity Hospital.
METHODS: Women undergoing Cesarean section from 1st May to 31 September 2006 were included in this prospective study. All cases delivered by Cesarean section were directly interviewed by the researcher and information was collected using a questionnaire. The detailed questionnaire included socio-demographic data, previous obstetric history, indication of CS, maternal and neonate complications of CS.
RESULTS: Among the 4433 deliveries that occurred in Sulaimani Maternity Hospital throughout the study period, 1342 were delivered by CS with an overall rate of 30.27%. It was found that 70% of CS was urgent while the elective CS represented 30%. Failure of labor progress was the most frequent indication of CS (29.1%). It was followed by previous CS (8.3%), then fetal distress (6.4%) and breach presentation (6%). Regarding maternal complications of CS, bleeding was reported in 2.4% and urinary tract infection was seen in 0.1%. respiratory distress and Prematurity was seen in 1.3% and 0.4%, respectively.
CONCLUSIONS: Nearly third of women attending maternity Hospital were delivered by CS, third of which was elective. Obstructed labor was most prevalent indication of CS. Prevalence of maternal and neonatal complications was very low.
Key words: Cesarean section. Sulaiman.

Ginger and metaclopromide on the treatment of nuases and vomiting in pregnancy

Maysoon Sharief, Susan A. Shaker

Objective: To determine the effectiveness of ginger in comparison to metoclopramide for the treatment of nausea and vomiting in pregnancy.
Patients & Methods: A comparative randomized prospective trial has been done at Basrah Maternity and Child Hospital .Sixty three pregnant women with a gestational age between 8-12 weeks who had nausea and vomiting required antiemetic. They had no medical complication and were not hospitalized. women were randomly allocated to receive either 500 mg of ginger plus 400 mcg of folic acid two times /day or 10 mg of metoclopramide three times/ day for 21 days. The degree of nausea and vomiting were assessed by visual analog scale and Likert scale recorded before treatment and after 1 week, 2 weeks, 3 weeks of treatment.
Results: All participants except three remained in the study. The visual analog score of post-therapy minus baseline nausea decreased significantly in both groups (2.57±1.7),(1.39±1.6) respectively with more statistically significant with metoclopramide group ($P<0.01$) .
The number of vomiting episodes in ginger group was 0.73±0.31 compared with (0.97 ± 0.2) in metoclopramide group although the difference was not significant.
Fifty percent of women using ginger reported that their symptoms had improved compared with (66%) in metoclopramide group using Likert scales($P>0.04$). No adverse effect of ginger on pregnancy outcome was detected.
Conclusion: Ginger is effective for relieving the severity of nausea and vomiting of pregnancy in comparison to metoclopramide.

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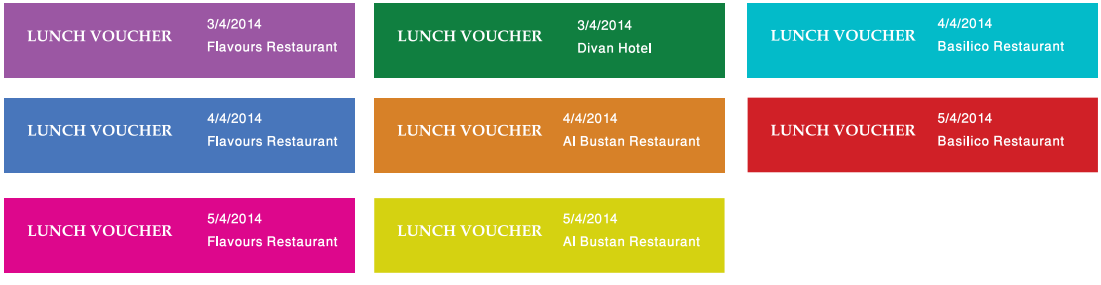

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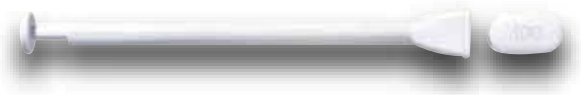

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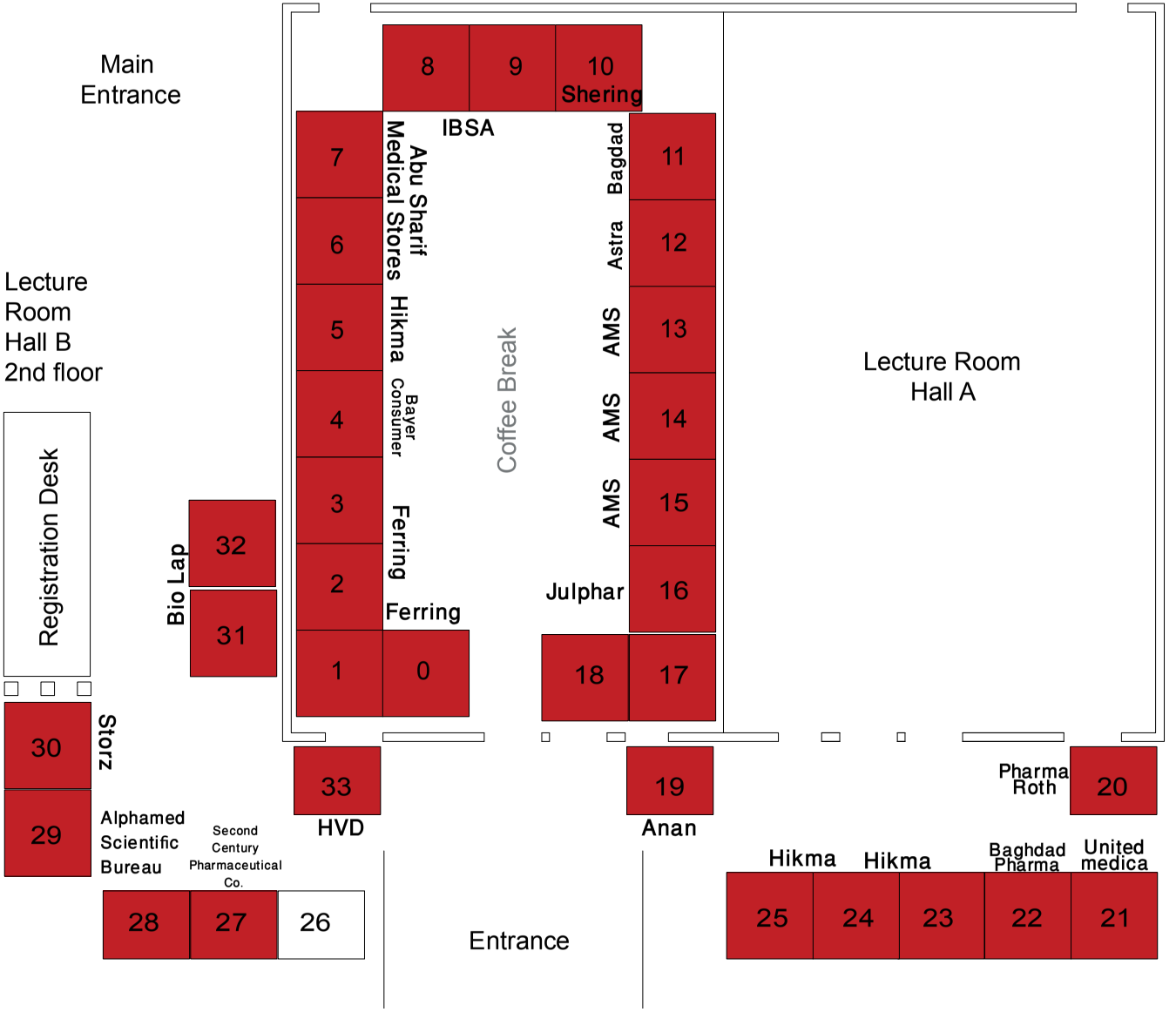
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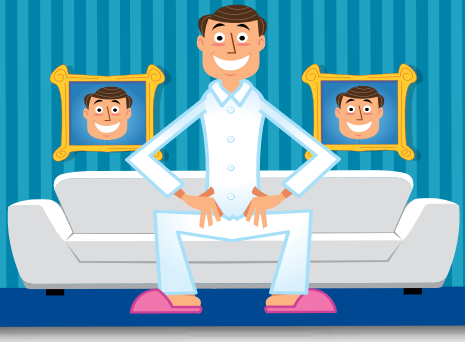

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