Accredited CME Hours

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

11th - 13th of April 2018, Divan Hotel - Erbil, Kurdistan

Progress for Safety

www.kisogconference.com

celine®

Why to go symptomatic when you can go goal- directed

*1st messenger deficiency	☑Solved
*2nd messenger deficiency	☑Solved
*Glucose Gate Responce	☑Solved
*Hyper androgenism	☑Solved

Welcome Note

On behalf of the Executive Committee,it's our privilege and great pleasure to welcome you to the 3rd Kurdistan-Iraq society of Obstetrics and Gynaecology conference.

kISOG Committee worked on Scientific Program, along with our Education Department, they have put together a robust education program designed to optimize your learning experience.

We are looking forward to a great meeting that features the very best in surgery, science, and research that is applicable to your practice.

Take the time to connect and reconnect with colleagues so we can all learn from each other.

Wishing you a wonderful conference and enjoyable time.

Dr. Ariana Khalis Jawad
President of the Conference
President of the Society

Committees

Executive Committee

Dr. Ariana Khalis Jawad **(President)**

Dr. Maeda Shamdeen
Dr. Zhyan Ahmed
Dr. Shahla Karem Alaf
Dr. Suham Ahmad Najar

Organizing Committee

Dr. Mahabad Saber Ali

Dr. Chnar Mustafa Ahmed
Dr. Ronak Ibrahem
Dr. Samira Salim
Dr. Baran Kamal
Dr. Zahida Harss Saaed
Dr. Khalida Mohamad Amin

Scientific Committee

Dr. Ariana Khalis Jawad

Dr. Mahabad Saber Ali
Dr. Ghada S. Alsakkal
Dr. Chro Fattah
Dr. Mariyam Baker
Dr. Vian Sabri
Dr. Avin Sadq
Dr. Trifa Yousif
Dr. Janan Noori
Dr. Sana Kamal
Dr. Lava Othman
Dr. Srwa Jamal
Dr. Awat Ibrahim
Dr. Fatima Kamal
Dr. Sazgar Abdulla

Research Committee

Dr. Shahla Karem Alaf

Dr. Nazar Polis
Dr. Srwa Khalid
Dr. Abubakir Majeed Salh
Dr. Amal Abdulhakeem Barwari

Committees

Social Committee

Dr. Shleer Faeq Gareb

Dr. Hala Jawdat Jawad
Dr. Sheelan Omer
Dr. Huda Ahmed Alnajar
Dr. Khalida Sliwa
Dr. Yasmeen A. Shakir
Dr. Saz Salh Qadr
Dr. Sahand Mauhamad Salh
Dr. Bayar Najat
Dr. Lava Tallat
Dr. Rozhan Yasin Khalil
Dr. Hasiba Hamadamen
Dr. Hangawo Hawiz
Dr. Sawsan Sabah
Dr. Suad Mustafa
Dr. Trifa Ahmed
Dr. Trifa Maghdid
Dr. Trifa Tahsin
Dr. Suzan Jauher
Dr. Qania Salim
Dr. Shilan Mahmod
Dr. Zhian Suar
Dr. Shadan Sherwan

Financial Committee

Dr. Sabrya Khidr Hamadameen

Dr. Jwan Omer
Dr. Runak Ali
Dr. Samiya Abdulkareem
Dr. Heave Muhamad Ameen

General Secretary

Vian Nihad Fattah

International Speakers

Azad Muhsin Hawizy	UK
Charles Walter Cox	UK
Felicity Sarah Plaat	UK
Fernando Sanchez Martin	Spain
Isam Lataifeh	Jordan
Jamil Sha'ban	Jordan
Martin Elmer Olsen	USA
Medhat Mohamed Hassenein	UK
Michel Abou Abdallah	Lebanon
Midia Alias	Australia
Mostafa Abdelmoghis	Egypt
Randall Watts Williams	USA
Rezan Gardy	UK
Rezan Abdulkadir	UK
Teddy Tadros	France

Local Speakers

Abbas A. Al-Rabaty
Amel A. Ahmed
Ariana K. Jawad
Chro N. Fattah
Ghada S. Alsakkal
Jinan Noori Hassan
Mahabad S. Ali
Maida Shamdeen
Maryam B. Mahmood
Omer Abdullah
Rozhan Y. Khalil
Saleem S. Qader
Shahla K. Alalaf
Srwa J. Murad
Srwa Khalid

Junior OBGYN Speakers

Diana Yousif
Lana Talaat
Lanja S. Hamid
Rana S. Waheeb
Sayran Ibrahem

International Speakers Bios

Azad Muhsin Hawizy – UK

MBChB, MSc, MD, FRCS Urol, FEBU.
Currently consultant urologist at Ipswich Hospital NHS Trust, UK. Specialist interest in Endourology and management of complex kidney stones and laparoscopic kidney surgery.

Completed medical degree at Salahaddin University and postgraduate training in the United Kingdom. MSc degree in urology from University College of London. Doctorates of Medicine from Cardiff University after completing three years research in molecular biology of prostate cancer. Higher training in urology leading to Fellowship in Royal College of Surgeons of Edinburgh and Fellow of European Board of Urology. Currently member of British Association of Urological Surgeons (BAUS), European Association of Urology (EAU) and American Urological Association (AUA).

Charles Walter Cox – UK

OBE TD FRCS(Ed) FRCOG.

- Obstetrician Gynaecologist Consultant from 1 February 1984-31 March 2017 Wolverhampton UK
- Honorary Professor Basra Medical College

- April 2018 Consultant Obstetrician and Gynaecologist at Adhbar Hospital outside Mosul with Aspen Medical an Australian company setting up Field Maternity Hospital with local medical, nursing and support staff.
- August 2017 Visiting consultant to the Falkland Islands.
- 2 October 2017 onwards locum consultant Bradford.
- Joint founder and instructor MOET course and Generic Instructor Course. (Run in Basra in 2004 x2 and 2005 x1. Invited faculty to ALSO course in Basra 2016.
- Attended the two previous Kurdistan Conferences.
- Founder member and director of the Baby LifeLine Charity training company.
- Interests labour ward emergencies and urogynaecology.
- (45 years in military reserve-March 2003 deployed with Field Hospital to Shaibah Basra Iraq. 2008 deployed to Afghanistan retired as Colonel)

Felicity Sarah Plaat – UK

Dr Felicity Plaat is a consultant anaesthetist at Queen Charlotte's Hospital - part of Imperial College Healthcare NHS Trust in London.

She specializes in obstetric anaesthesia and is current President of the Obstetric Anaesthetists' Association.

She lectures frequently in the UK and abroad. Her areas of special interest are high risk obstetrics, trauma management and team training in emergency care. She has published both in the medical and lay literature on these subjects.

She has defined standards for obstetric anaesthesia in the UK and regularly runs and instructs on training courses throughout the world.

She is on the editorial board of the International Journal of Obstetric Anaesthesia, British Journal of Anaesthesia Education and Anaesthesia News.

Fernando Sanchez Martin – Spain

MD, PhD.
He studied in the University of Salamanca to have the certificate of medicine and later he did the specialization in obstetrics and Gynaecology in Seville. From the very beginning of his practice, he was interested in the field of human reproduction and made an external fellowship in Human Reproduction in Norfolk, Virginia, USA with professor H. Jones. He had been working in reproduction since 1995 and is the medical director of GINEMED since 1998. Now the group runs 6 clinics in Spain and Portugal and is doing more than 4000 cycles of reproduction per year. He also is an associated professor of the University of Seville. He has more than 30 papers published and had participated, as a principal investigator, in 16 international studies. His main area of interest and investigation is male factor and implantation failure. He speak fluently Spanish, English, Italian and Portuguese.

Isam Lataifeh – Jordan

Senior Consultant of Obstetrics and Gynecology.
Consultant Gynecologic Oncology & Laparoscopic Surgery.
Chief, section of Gynecologic Oncology / King Hussein CancerCenter.

Former Chairman of Obstetrics and Gynecology Department / Jordan University of Science and Technology Member of International and European Society of Gynecologic Oncology.
Prof. Isam Lataifeh graduated in 1992 from Jordan University of Science and Technology, Jordan, he got the certificate of Higher Specialization in Medicine/ Obstetrics and Gynecology from Jordan University; Jordan in 1997. He got the Jordanian Board of Obstetrics and Gynecology in 1997. Awarded the Dipolma of Gynecologic Oncology from the Royal Australian and New Zealand College of Obstetrics and Gynecology in Melbourne/ Australia in 2005.

Jamil Sha'ban – Jordan

- Consultant Gynecologist & Obstetrics.
- Board member of German society of ob-Gyn.
- Member of the Jordan society of ob-Gyn.
- 1959-1965: MD-Medical school University of Heidelberg – Germany.
- 1972: German Board and PHD (Gynecology & Obsterics (Facharzt).
- 1973 -1996: Private clinic since 1996.
- 1999: Special training in Uro –Gyn. In Uppsala-Sweden by Prof. Ulmesten.
- Since 1999 Special interest in "Scientific miracle in the Holy Koran"
- And lecturing in Arabic, English and German Language.

Martin Elmer Olsen – USA

Dr. Martin Olsen is a senior academic Obstetrics and Gynecology physician in the United States. He has previously served as residency program director, university department chair and state officer for the American College of Obstetrics and Gynecology. He is co-inventor of a surgical simulation device known as Surgical Chloe. Dr. Olsen is the editor of multiple textbooks and the author of many medical journal articles. He has taught in multiple international venues including fourteen previous trips to Iraq and Iraqi Kurdistan.

Medhat Mohamed Hassenein – UK

MBChB CCST FRCOG.

He have been UK consultant in obstetrics and gynaecology for 16 years, his special interest has been Laparoscopic surgery for the sever cases of pelvic pain with endometriosis and different pelvic pathology, reconstructive pelvic surgery, Hysteroscopy surgery including different endometrial ablation modules and Hysteroscopy sterilisation colposcopy and menopausal clinics.

He have been the RCOG Preceptor in his previous hospital for MAS, supervising the juniors subspecialty training for advanced laparoscopic and Hysteroscopy surgery.

Invited by different countries in the Gulf and Middle East to lectures, run workshops and operate on complicated cases.

Authors and co-authors of several published books and papers.

Michel Abou Abdallah – Lebanon

Prof. Michel Abou Abdallah fertility specialist, fellow in Reproductive Endocrinology and Andrology from McGill University, Montreal, Canada.

As Reproductive Medicine specialist, he has devoted a great deal of time to infertility treatment, research, teaching and other academic activities in Canada, Lebanon, the Middle East and Africa.

He has authored and coauthored a large number of peer-review publications, along with a number of solicited reviews and popular press releases.

He has presented numerous abstracts and other presentations at a large number of national, international and professional scientific meetings all over the world.

Prof. Abou Abdallah's studies and clinical findings have been reported in the national and international journals and press.

Prof. Abou Abdallah, clinical Prof. of Reproductive endocrinology, is an executive and faculty member of the Canadian Foundation for Reproductive Medicine, Montreal/Toronto, Canada.

Currently, Prof. Abou Abdallah is serving as executive Director of the Middle East Fertility Society, he was the founder and past president.

Prof. Abou Abdallah, honorary member of the Argentinian Fertility Society, member of ESHRE and ASRM, is also serving as board member of the International committee of the American Society of Reproductive Medicine.

Prof. Abou Abdallah is worldwide recognized as authority in the field of human reproduction, gamete physiology, male infertility and assisted reproductive techniques.

Midia Alias – Australia

Dr. Midia Alias is a general obstetrician and Gynaecologist who deals with all women's health conditions with emphasis on overall wellbeing. Dr. Midia Alias has graduated from Salahaddin University/Erbil/ Iraq in 2000, moved to Australia in 2001 and continued her medical career, obtained her Diploma, advanced Diploma in O&G, then fellowship from Royal Australian College of Obstetrician and Gynaecologist (FRANZCOG),trained in various institutions in Victoria and New South Wales in Australia. Currently working at both Public and private hospitals in Melbourne.

Mostafa Adel Abdelmoghis – Egypt

- General laparoscopic surgeon
- Lecturer ; Delhi Univesrity - India

Randall Watts Williams – USA

MD, FACOG.
He is an obstetrician and gynecologist who graduated from the University of North Carolina with Honors in History and Zoology and received his medical training at the University of North Carolina where he was a Holderness Fellow.

Dr. Williams was appointed by Governor Eric Greitens to serve in his Cabinet as Director of Health and Senior Services (DHSS) and was subsequently unanimously confirmed by the Missouri Senate on March 9, 2017. He believes a fundamental tenet of effective leadership is to be readily available and accessible. He has visited all of Missouri's 115 counties to listen and learn from all of Missouri's citizens.

DHSS accomplishments to date with Dr. Williams include passage of Missouri's Good Samaritan Law and Universal Narcan Availability Law; working with Governor Grietens on the Executive Order establishing a statewide PDMP; holding opioid summits throughout the state; and bringing together all 115 Local Health Departments for the first time in more than a decade. The department is also working to increase the number of providers in rural and underserved areas; improve behavioral health services for veterans and their families; promote physical fitness and community engagement through the My Missouri Steps Up initiative; enhance interagency coordination and collaboration with the state Departments of Social Services and Mental Health; and improve all aspects of women's health, especially to reduce infant and maternal mortality. Dr. Williams' efforts to improve the health of Missourians extend from the Capital to the classroom: beginning in the spring of 2018, he'll be co-teaching a course in Public Service, Government and Public Health for the University of Missouri's Master of Public Health program.

Dr. Williams previously served as both the Deputy Secretary for Health and State Health Director in the Department of Health and Human Services in

North Carolina. His responsibilities there included developing, integrating and communicating state health policy and helping lead a 17,000 member agency with a 20 billion dollar budget that combined Medicaid, social services, public health and mental health services.

To help patients and families affected by the opioid crisis, Dr. Williams led efforts in North Carolina that resulted in the legislature voting unanimously to implement a statewide standing order to treat narcotic overdoses by making naloxone available to everyone in North Carolina under his authority. He also visited stakeholders and citizens in all 100 counties in the state during his time with the department.

Dr. Williams has also previously served on local and state boards of health, in addition to delivering 2000 babies as a practicing obstetrician. He also helped serve the medical needs of people in overseas conflict zones. His ongoing work has taken him to Iraq 12 times, and he has worked in Afghanistan, Libya and Haiti. Recognition of these efforts was reflected in his selection as Triangle Red Cross Humanitarian of the Year and the Raleigh News & Observer's Tar Heel of the Week.

He is an avid runner. Dr. Williams believes physical exercise contributes greatly to a sense of wellness and led a campaign to encourage families to run 5Ks for charity.

Rezan Gardy – UK

- Consultant Histo/Cytopathologist
- Frimley health foundation trust.
- Wexham Park Hospital .
- Cellular Pathology .

Rezan Abdulkadir – UK

She is a Consultant Obstetrician and Gynecologist at the Royal Free Hospital in London, UK, also a specialist consultant in women with bleeding disorders at the hospital, and an Honorary Reader with the University College School of Medicine. Dr Kadir has set up the first multi-disciplinary to provide comprehensive care for women in families with bleeding disorders. This clinic is also renowned nationally and internationally for providing training and leading clinical and laboratory projects in this field.

Dr Kadir is the chair of Women SSC of ISTH since 2014, has led several SSC projects, published guidance papers and successfully organized the last three Women SSC annual meeting in Milwaukee, Toronto and Montpelier. Dr Kadir is the Chair of the 'Women Bleed Too' Board of the Haemophilia Society, UK, which includes key professionals and women affected with bleeding disorders. She is also a member of several national and international societies, including the World Federation of Haemophilia, Women Health Issues in Thrombosis and Haemostasis, British Maternal and Foetal Medicine Society, the International Society of Ultrasound in Obstetrics and Gynaecology, and many others.

Dr Kadir is a co-author of Inherited Bleeding Disorders in Women, published in 2009. She has given presentations at numerous international congresses, and

has authored or co-authored over a hundred peer-reviewed publications on fetal medicine and bleeding disorders in obstetrics and gynecology. Dr Kadir has written national and international guidelines for management of obstetrics and gynecological problems in women with bleeding disorders, and has acted as a reviewer for several journals, including Haemophilia, JTH, STH, IJOG. O&G, JOG and others. Her work in the field of women and bleeding disorders has received international recognition and she is regarded as a world expert in the field. Dr Kadir was included in the 2009 edition of Who's Who in Medicine and Healthcare 2009–2010.

Teddy Tadros – France

Dr. Teddy Tadros is an Obstetrics & Gynecology and reproductive medicine consultant based in Beirut, Lebanon.

He pursued his medical studies at the Saint Joseph University of Beirut and Ob-Gyn residency at Hotel Dieu de France, Beirut. He also completed a fellowship in reproductive medicine at Antoine-Béclère hospital, Clamart, France and at Foch hospital, Suresnes, France.

Dr Tadros conducted a number of scientific works that culminated in international publications in peer-reviewed journals and communications in national and international scientific meetings. His scientific interests are focused on the hormonal and ultrasonographic markers of the ovarian follicle status in particular anti-Müllerian hormone.

Local Speakers Bios

Abbas A. Al-Rabaty - Iraq

- CABP 1993.
- Professor in Pediatrics College Of Medicine HMU
- Consultant Pediatrician and Neonatology Hawler DOH Raparrin Hospital
- Program director pediatrics department KBMS
- Erbil center director for Iraqi board for medical specializations – pediatrics.

Amel A. Ahmed - Iraq

She worked in numbers of Hospital and have experience and skill specially in obstetrics and gynecology which is her special branch of medicine, she is working in it for 6 years, and now a 4th year post graduate of Iraqi board study, in addition to that she have had skill in many field in general medicine.

Ariana K. Jawad - Iraq

Ariana Khalis Jawad Asst. Prof. founder and president of Iraqi Kurdistan Society of Obstetricians and Gynecologists (KISOG), Head, Supervisor and trainer in Kurdistan Board of Medical Specialist (KBMS) Hawler center.

She was member of the Kurdistan National Assembly since 2005 – 2009, Prior to joining the KNA, Dr. Jawad was director of Hawler Maternity Hospital and Head of Obstetrics and Gynaecology in Hawler Medical University.

She obtained her bachelors degree in medicine and general surgery from the Salaheddin University Medical School in 1992. She received the Arabic BOARD in OBGYN with honors in 2004.

She is an intentional members of ACOG & RCOG. She was also director of a local NGO that promoted women and youth empowerment.

Dr. Jawad conducted extensive research in women health.

Chro N. Fattah – Iraq

MBChB, DGO, MRCOG, MRCPI, MD

- College of Medicine -Salahaddin University.
- Higher diploma in Obstetric & Gynecology/ Baghdad University/1996.
- Master in Community Medicine-Hawler Medical University/2005.
- Director of Colposcopy clinic in Maternity hospital in Erbil 2006-2013.
- Lecturer in the College of Medicine- Hawler Medical University till 2016.
- Share in many researches & publications in Obstetric & Gynecology, & Community Medicine.

Ghada S. Alsakkal – Iraq

Consultant Obstetrician and Gynecologist.

Assistant Professors in the College of Medicine.

Chairperson of the Arabic Board of Obstetrics and Gynecology, Erbil center.

Graduated from the Medical College of Baghdad in 1984.

Got her Arabic board degree in Obstetrics & Gynecology in1991.

She is interested in doing complicated gynecological surgeries and difficult cesarean sections with abnormal placentation.

She published ten papers in different Iraqi Journals.

She supervised too many postgraduate students in the field of obstetrics & gynecology.

Women health and safety are the things she is always keen about.

She is ready to help her junior collogues at any time for the sake of optimum medical outcome.

Jinan N. Hassan – Iraq

Fellow of Iraqi board for medical specialization (FIBMS)/Iraqi board of obstetric and gynaecology 2013.

M.B. ch.B Degree from university of Duhok / College of medicine in (1995-2001).

Part 1 membership examination of royal college of obstetrician & gynaecologists Successfully passed part 1 done in erbil city –Erbil governorate/ IRAQ

Senior of Obstetric and Gynaecology at maternity hospital in Duhock city.

Lecturer at Duhok university /College of Medicine.

Mahabad S. Ali – Iraq

Mahabad S. Ali, Head of Gynecology department –MTH-ERBIL, Hospital manager assistant for scientific purposes-MTH-Erbil, specialist OBGYN in Maternity teaching Hospital – Erbil, Trainer for Kurdistan board for medical specialist, Member of Royal college of OGYN, Member of Kurdistan-Iraq

Society of Obstetriation and Gynecologists.

Maida Shamdeen – Iraq

Graduated from Mosul medical college, 1973, Degree good from the first quarter.
Postgraduate –MRCOG August 1983, Royal College of Obstetrics and Gynecology –London.
Member and fellow of –Royal College of Obstetrics& Gynecology FRCOG 2004

Prof. Dohuk Medical College 2013.

1 - Director of Kurdistan board OBG Oct. 2010-up to now
2 - Director of Iraqi board and Kurdistan board center in Dohuk center in Kurdistan October 2005-up to now.
3 - Senior lecturer in Dohuk medical college.
4 - Senior Consultant obstetrician and gynecologist in Azady general teaching hospital.
5 - Member of scientific committee in Dohuk medical college and Azady hospital from 2006 and up to now.
6 - Member of the scientific committee of Dohuk medical journal
7 - Representative of ministry of health for maternal mortality in Dohuk governate
8 - Head of infertility clinic in Azady hospital. April 2006 –up to now.
9 - head of department OBG Azady teaching hospital 2006 and up to now.

Supervised on 80 postgraduate student for Arabic, Iraqi and kurdestani board, and PhD student
Attend as a member of committee in desert presentation of 50 candidate as Msc and PhD
Researches Published: 23

Maryam B. Mahmood – Iraq

Head of center of Slemani KBMS/OBGYN

Rapporteur at department of OBGYN School of Medicine University of Sulaimani.

Lecturer at school of Medicine.

D.G.O (High Diploma in Gynecology and Obstetrics)

Board (Council of Iraqi Board for Medical Specialization /Department of Obstetrics and Gynecology)

Have many researches.

Omar Abdulla Khidhr - Iraq

CABA & ICU
2016 - 2018 Hawler Maternity Teaching Hospital
2013 - 2015 Koya General Hospital
2013 Finished arabic board of Anesthesia and Intensive care
2009-2013 Sho Anesthesia
2006 Graduated in College of Medicine at University of Sulaymania

Rozhan Y. khalil - Iraq

Rozhan yassin khalil has been working as an Obstetric and Gynecologist specialist since 2008 in Slemani Maternity Teaching Hospital. She earned MBChB in 2000 from Slemani University, she earned high degree diploma in Obstetric and Gynecology from Baghdad University in 2007. She earned board from Iraq Committee of Medical Specilization in Baghdad and got fellow ship of Iraqi Committee of Obstetric and Gynecology,in 2009 she earned Arabi Board and became fellow ship of Arabic Board of Obstetric and Gynecology in Syria .
As an educator she taught Obstetric and Gynecology residents, graduate students and supervisor for diploma and board student and she is a lecturer in University of Slemani School of Medicine since 2011.

Saleem S. Qader - Iraq

MBChB, MD, MSc, MPH, PhD, Swedish Board of General Surgery
President of Kurdistan Board of Medical Specialties
Consultant General Surgeon, Lecturer
Department of Surgery, Rizgary Teaching Hospital, Erbil, Iraq

Director and Founding Member of KOMAR (Kurdish Organization for Medical Research),Sweden
Director General, Head of Executive Committee and Founding Member of PAKY Hospital, Erbil
A Former Dean (Director General) of Medical Research Centre, Hawler Medical University, Erbil
A Former Director of Quality Assurance, Hawler Medical University, Erbil, Iraq
A Former Deputy Director of Rizgary Teaching Hospital, Erbil Iraq
He worked as a course leader and instructor of many courses in "Research Building Capacity and Good Clinical Course" in Medical Research Centre and Kurdistan Board of Medical Specialities.

He worked as a main supervisor/Trainer in General Surgery of 13 MSc and Board (Kurdistan, Iraqi and Arabic) students, in Rizgary Teaching Hospital. He worked as a Mentor and Co-supervisor of 5 PhD students in Karolinska and Lund Unversity, Sweden. He supervised 9 MPH students in Lund University, Sweden.

Dr Qader published 37 articles in Local, National and International journals and he got 2 Patents in Medicine and made presentations in many local and International conferences.

He wrote 6 books and around 200 articles in Kurdish and many TV interviews about Health Education and community mobilization in Kurdistan.

Dr Qader is a Chief Editor of Journal of Kurdistan Board of Medical Specialties. He was a member of Editorial Board Zanco Journal for Medical Sciences. He is a reviewer of 6 International Journals.

His Education:

- 12.06. 2011: Consultant General Surgeon, Ministry of Health, KRG, Erbil, Iraq
- April 2009: Swedish Board of General Surgery, Swedish Social Welfare Board, Sweden.
- December 2007: MD (Physician Authorization), Swedish Social Welfare Board, Sweden.
- September 2004: PhD in Experimental Surgery, Lund University, Lund, Sweden.

Thesis title: "Nitric Oxide Synthase in Pancreatic Islets During Trauma and Parenteral Feeding", can be reached in the Internet through the link: http://www.lub.lu.se/luft/diss/med_952/med_952_transit.html, It is published as a book and can be reached through www.amazon.com through this extension: https://www.amazon.com/Nitric-Oxide-Synthase-Pancreatic-Islets/dp/3639119657/ref=sr_1_3?ie=UTF8&qid=1523073831&sr=8-3&keywords=Saleem+Qader

May 2004: MPH (Master of Public Health), Lund University, Malmö, Sweden.

January 1997: Specialist General Surgeon, Rizgary Teaching Hospital, Erbil, Iraq.

December 1996: MSc in General Surgery, Salahaddin University, Erbil, Iraq.

June 1987: M.B.Ch.B., Baghdad University, Baghdad, Iraq.

Shahla K. Alalaf – Iraq

Shahla Alalaf, Clinical MD in OBGY. Is Professor in Obstetrics and Gynecology at College of Medicine, Erbil city, Kurdistan region, Iraq. She serves as the Head of department of Obstetrics and Gynecology, and the head of Iraqi Board for Medical specialization, Erbil center. Dr. Shahla's primary area of research has focused on the prevention of venous thrombosis in women suffered from recurrent miscarriages, pregnant women and women in need of surgical operations . She is the head of scientific committee in Kurdistan Iraqi society of obstetrician and gynecologists and through this position she managed to prepare many guidelines to the national Maternity Teaching Hospital to improve woman's health.

Srwa Khalid – Iraq

CCST (RCPI), MRCOG (UK), MRCPI (Dublin), BSCCP, BFS (Certified Trainer In IVF).
DRCOG, MB Ch B (Mosul/ Iraq), MB BCH BAO (Trinity College Dublin).
Consultant Obs & Gyn (UK & Ireland) With Special Interest In Minimally Invasive Surgery and Reproductive Medicine. She Was A Lecturer At The Royal College Of Surgeons Of Ireland Until September 2015 When Moved Back To Kurdistan. In Addition, She Taught At Trinity College-Dublin (TCD), University College Cork (UCC) And National University Of Ireland Galway (NUIG).
She Is Currently A Trainer At The Kurdistan Board For Medical Specialties. In Addition, She Is A Certified Colposcopist From The British Society Of Colposcopy And Cervical Pathology And A Certified Trainer And Member Of The British Fertility Society
Dr. Khalid Is An Avid Researcher With Numerous International Publications In World Leading Journals And Presentations At International Conferences With Awarded Prizes.

Junior OBGYN Speakers

Diana Yousif - Iraq

M.B.Ch.B. College of Medicine, Hawler Medical University 27th July 2009.
Registrar as senior House officer in Obstetrics and Gynecology department in Erbil Teaching Hospital Maternity from 1st October 2012 till today, Kurdistani board student of obs & gyn (my 5th year). Member of Kurdistan Medical Association. And Member of Kurdistan obs & gyn society.

Lanja S. Hamid – Iraq

5th year KBMS student. She works as senior a house officer in Obstetrics and Gynecology at Maternity Teaching Hospital /Erbil. She have received M.B.Ch.B from College of Medicine/Hawler Medical University on July 2007. Member of Kurdistan-Iraq Society of Obstetricians and Gynecologists (KISOG)

Rana S. Waheeb – Iraq

M.B.Ch.B Hawler Medical University.
Fifth stage final board student at KBMS.
Currently working at Maternity Teaching Hospital in Ebil.

Sayran Ibrahem – Iraq

Graduated from Hawler University for Medical Specailities (2008-2009) as M.B.ch.B
Now final stage kurdistani Board / Obstetric & Gynecology
Working in Maternity Teaching Hospital as senior house officer.

Scientific Program

Day 1: Wednesday 11th of April 2018

17:00 - 19:00	Registration
19:00 - 20:00	Opening Ceremony
20:00 - 20:30	Exhibition Opening and Reception

Day 2: Thursday 12th of April 2018

07:30 - 08:30	Registration		
First Session: 08:30 - 10:50 Matenal Mortality (Dr. Khawer Session)			
Chairman: Abdulhamaid Dabbagh - Charles W. Cox - Felicity S. Plaat - Rezan Kadir			
08:30 - 08:50	1	How the Obstetrician Can Gain from Close Working with the Anaesthetists	Charles W. Cox UK
08:50 - 09:10	2	Maternal Critical Care - The Anaesthetist as Peripartum Physician	Felicity S. Plaat UK
09:10 - 09:30	3	Recent Studies That Have Changed Management of Major Obstetric Haemorrhage	Felicity S. Plaat UK
09:30 - 09:45	4	Update Management Of Morbid Placenta Ion	Mahabad S. Ali Iraq
09:45 - 10:00	5	Anesthetic Management of Patients with Placenta Accreta and Resuscitation Strategies for Associates Massive Hemorrhage	Omer Abdullah Iraq
10:00 - 10:20	6	Learning Lessons from National Maternal Mortality Audits	Felicity S. Plaat UK
10:20 - 10:40	7	Public Policy to Decrease Maternal Mortality	Randall W. Williams USA
10:40 - 10:50	Discussion		
10:50 - 11:20	Coffee Break		

Second Session: 11:20 - 13:30			
Chairman: Isam Lataifeh - Basak Barzinjy - Baran Kamal - Srwa Khalid			
11:20 - 11:40	8	Prevention of Gynecology Malignancies	Isam Lataifeh Jordan
11:40 - 11:55	9	Management of Abnormal Cervical Smear	Srwa Khalid Iraq
11:55 - 12:15	10	Cervical Cancer during Pregnancy: Clinical Scenario	Isam Lataifeh Jordan
12:15 - 12:35	11	The AMH Employ in FSH Stimulated Cycles	Fernando S. Martin Spain
12:35 - 12:55	12	Surgery for Endometrial Cancer: Evidence Impact Practice	Isam Lataifeh Jordan
12:55 - 13:15	13	Breast Cancer Screening and New Genetic Testing	Rezan Gardy UK
13:15 - 13:22	14	Comparative Study of Cervical Pap Smear and Visual Inspection of the Cervix Using Acetic Acid to Detect Premalignant Disease of the Cervix	Rozhan Y. Khalil Iraq
13:22 - 13:30	Discussion		
13:30 - 14:30	Lunch Break		

Third Session: 14:30 - 16:40			
Chairman: Maida Shamdeen - Azad M. Hawizy - Shahla K. Alalaf - Zhyan Ahmed			
hikma. (Symposium) 14:30 - 15:00	15	UTI in Pregnancy	Jamil Sha'ban Jordan
15:00 - 15:20	16	Obesity in Pregnancy	Martin E. Olsen USA
15:20 - 15:35	17	CMV in Pregnancy	Abbas A. Al-Rabaty
15:35 - 15:55	18	Management of Renal Colic in Pregnancy	Azad M. Hawizy UK
15:55 - 16:10	19	Autoimmune Disease in Pregnancy	Shahla K. Alalaf Iraq
16:10 - 16:20	20	Maternal Obesity and Adverse Pregnancy and Perinatal Outcomes	Chro N. Fattah Iraq
16:20 - 16:27	21	Intra-Incisional Injection of Magnesium Sulfate for Post Cesarean Pain Management	Maryam B. Mahmood Iraq
16:27 - 16:34	22	Labour Outcome in Teenage in A Sample of Kurdish Pregnant Women in Maternity Teaching Hospital in Erbil City	Rana S. Waheeb Iraq
16:34 - 16:40	Discussion		
16:40 - 17:00	Coffee Break		

Fourth Session: 17:00 - 18:15			
Chairman: Michel Abou Abdallah - Medhat M. Hassenein - Ghada S. Alsakkal - Didan Ramzy			
17:00 - 17:20	23	Rational Management of Implantation Failure and Repeated Abortion	Fernando S. Martin Spain
17:20 - 17:40	24	Endometrial Receptivity	Michel Abou Abdallah Lebanon
17:40 - 17:47	25	Number Of Embryos Transferred After IVF And Good Perinatal Out Come	Lana Talaat Iraq
17:47 - 17:54	26	Obstetrics and Perinatal Outcomes of Dichorionic Twin Pregnancy Following ART Compared with Spontaneous Pregnancy	Diana Yousif Iraq
17:54 - 18:03	27	Diabetes Mellitus During Pregnancy Perinatal and Neonatal Outcome at Maternity Teaching Hospital/Erbil	Lanja S. Hamid Iraq
18:03 - 18:10	28	The Association of Beta Human Choroinic Gonadotropin with Preeclampsia and It Is Effect on Perinatal Outcome	Sayran Ibrahem Iraq
18:10 - 18:15	Discussion		

Day 3: Friday 13th of April 2018

07:30 - 08:30	Registration		
Fifth Session: 08:30 - 10:25			
Chairman: Fernando S. Martin - Zhiyan Baker - Safiya Abdulkareen - Lava Talat			
08:30 - 08:50	29	What is Reproductive Aging? Quantity vs. Quality	Michel Abou Abdallah Lebanon
08:50 - 09:10	30	New Automated Antimüllerian Hormone Assays Are More Reliable Than the Manual Assay in Patients with Reduced Antral Follicle Count	Teddy Tadros France
09:10 - 09:30	31	Time Interval between hCG Administration and Oocyte Retrieval Significantly Influences IVF-ET Results	Teddy Tadros France
09:30 - 09:45	32	Menopause and Women's Health in Later Life	Maida Shamdeen Iraq
09:45 - 10:05	33	Male Infertility	Azad M. Hawizy UK
10:05 - 10:12	34	Spontaneous Ovarian Hyperstimulation Syndrome: A Case Report	Amel A. Ahmed Iraq
10:12 - 10:19	35	Comparison of Uterine Artery Blood Flow in Fertile and Unexplained Infertility by Doppler Ultrasound Using Pulsatility Index PI and Resistance Index RI	Srwa J. Murad Iraq
10:19 - 10:25	Discussion		
10:25 - 10:45	Coffee Break		

Sixth Session: 10:45 - 12:40			
Chairman: Jamil Sha'ban - Chiman Khader - Awat Ibrahim - Nagham Yousif			
Abbott (Symposium) 10:45 - 11:15	36	The Role of Progesterone in Fertility and Early Pregnancy	Elham S. Al-Habeeb Iraq
11:15 - 11:45	37	Heavy MENSTRUAL BLEEDING - An Update on Management	Rezan Kadir UK
11:45 - 12:05	38	(Ultra Sound) Guided High Intensity Focused Ultrasound (USg HIFU)for Fibroids Treatment A Novel for Gynecologists	Jamil Sha'ban Jordan
12:05 - 12:25	39	Hormone replacement Therapy-what's new?	Medhat M. Hassenein UK
12:25 - 12:32	40	Knowledge,Attitude and Practice among Married Women Toward Family Planing in Shekhan City	Jinan Noori Hassan Iraq
12:32 - 12:40	Discussion		
12:40 - 14:00	Prayer and Lunch		
Seventh Session: 14:00 - 15:25			
Chairman: Randall W. Williams - Ali Al Dabbagh - Saleem S. Qader- Nazar P. Shabila - Lass Hawezy			
14:00 - 14:15	41	Public Policy and Programs to Help Senior Citizens	Randall W. Williams USA
14:15 - 14:30	42	Kurdistan Board of Medical Specialties	Saleem S. Qader Iraq
14:30 - 14:50	43	Obstetrics and Gynecology Education and Certification in the US	Martin E. Olsen USA
14:50 - 15:05	44	Multidisciplinary Training in Obstetrics	Charles W. Cox UK
15:05 - 15:20	45	Creating Public Health Policy	Randall W. Williams USA
15:20 - 15:25	Discussion		

Eighth Session: 15:25 - 16:15			
Chairman: Mostafa A. Abdelmoghis - Chro N. Fattah - Amel A. Ahmed			
15:25 - 15:45	46	Role of Laparoscopy in CSP	Mostafa A. Abdelmoghis Egypt
15:45 - 16:00	47	Cesarean Section Scar Pregnancy	Ghada S. Alsakkal Iraq
16:00 - 16:10	48	The Effect Of High BMI on the Outcome of Patients Undergoing Total Laparoscopic Hysterectomy	Midia Alias Australia
16:10 - 16:15	Discussion		
16:15 - 16:30	Coffee Break		
Ninth session: 16:30 - 17:45			
Chairman: Teddy Tadros - Ariana K. Jawad - Maryam B. Mahmood - Mahabad S. Ali			
16:30 - 16:50	49	Minimal invasive surgery in Gynecology	Mostafa A. Abdelmoghis Egypt
16:50 - 17:10	50	The Role of Office Hysteroscopy Surgery in Sub Fertility	Medhat M. Hassenein UK
17:10 - 17:30	51	The Challenge of Sepsis in Obstetrics	Charles W. Cox UK
17:30 - 17:40	52	New Classification of Premalignant Condition of Endomtrium	Ariana K. Jawad Iraq
17:40 - 17:45	Discussion		
Closing Remarks			

Abstracts

(1) How the Obstetrician Can Gain from Close Working with the Anaesthetists

Charles W. Cox - UK

Describing how preoperative assessment of potentially complicated cases improves decision making and outcomes.

To discuss team working in obstetric emergencies-human factors and who takes the lead in resuscitation.

The use of appropriate anaesthesia and analgesia.

Advances in obstetric anaesthesia and fluid management to aid intrauterine resuscitation of the fetus.

The emergency Caesarean section.

Post delivery intensive care the role of the obstetrician and obstetric anaesthetist in the high dependency or intensive care situation.

(2) Maternal Critical Care - The Anaesthetist as Peripartum Physician

Felicity S. Plaat - UK

Across the world the obstetric population is changing demographically. Women are becoming pregnant when older and with co-morbidities, increasing the need for higher than routine levels of care. Reports on maternal mortality suggest that in the majority of cases, care could be judged substandard. Studies of obstetric admissions to critical care units reveal that the majority are postpartum, suffering obstetric complications such as eclampsia and haemorrhage. These women often only require a short period of higher level care. In this presentation the advantage of providing critical care on Delivery suite and the role of the obstetric anaesthetist in delivering obstetric critical care will be discussed.

(3) Recent Studies That Have Changed Management of Major Obstetric Haemorrhage

Felicity S. Plaat - UK

Major obstetric haemorrhage is one of the main causes of maternal mortality and morbidity world wide. In the UK, although the proportion of deaths due to haemorrhage have decreased, in the majority of cases care is judged substandard. Recent studies in transfusion practice, near patient testing, antifibrinolytic therapy and cell salvage have altered the way massive obstetric haemorrhage is managed. There is growing, robust evidence and teamwork training of those involved in its management is key. The evidence behind recent changes in practice will be discussed with an emphasis on practical management.

(4) Update Management Of Morbid Placenta Ion

Mahabad S. Ali – Iraq

Placenta accreta is an obstetrical complication where the placenta becomes firmly adherent to the uterine wall. Placenta accreta can lead to considerable maternal morbidity and mortality due to hemorrhage, infection, or other surgical complications such as those resulting from hysterectomy.

Placenta accreta is becoming a more common complication of pregnancy and its prevalence is increasing due to the rise in the rate of deliveries by Cesarean section.

Prenatal diagnosis is important in optimizing the counseling, treatment, and outcome of women with placenta accreta. Surgical treatment for placenta accreta is commonly performed as hysterectomy. However, conservative management another approach for management.

A multidisciplinary integrated management strategy at an appropriate tertiary care center is essential, in order to reduce the mortality and morbidity associated with placenta accrete.

Conservative management of both abnormally adherent (placenta creta) and invasive placenta (placenta increta and percreta) defines all procedures that aim to avoid peripartum hysterectomy and its related morbidity and consequences. Four different primary methods of conservative management have been described in the international literature: (1) the extirpative technique (manual removal of the placenta); (2) leaving the placenta in situ or the expectant approach; with or without systemic methotrexate or uterine artery embolizatio (3) one-step conservative surgery (removal of the accreta area); and (4) the Triple-P procedure (suturing around the accreta area after resection).

The main aim of leaving the placenta in situ is mainly to decrease the risks of severe maternal morbidity during cesarean delivery; including increases the risks of massive obstetric hemorrhage and hysterectomy. Uncontrolled bleeding will lead to coagulopathy and increasing the risk of injuries mainly to the bladder and ureters ; Successful conservative management will also preserve fertility and thus reduce the impact on a woman's societal status and self-esteem associated with the loss of her uterus.

(6) Learning Lessons from National Maternal Mortality Audits

Felicity S. Plaat - UK

The UK has the longest running medical audit into maternal deaths worldwide, starting in 1952. Every death of a pregnant woman and within 1 year of giving birth are analysed by multidisciplinary assessors. Currently deaths are sub-divided into direct deaths associated with obstetric complications and indirect deaths. The latter are co-morbidities that are associated with or worsened by pregnancy.

The standard of care is categorised as good or substandard. If substandard, the assessors decide if different care would have changed the outcome. Each report includes 'lessons learned'.

Recent trends in maternal mortality in the UK and some specific 'lessons learned' will be discussed in the presentation.

(7) Public Policy to Decrease Maternal Mortality

Randall W. Williams – USA

The state of Missouri faces significant challenges in the area of maternal mortality. The national average for maternal mortality is approximately 20.7 deaths per 100,000 live births while Missouri's average is 32.6 per 100,000 according to the United Health Foundation's 2018 Health of Women and Children Report. This makes Missouri 42nd nationally for maternal mortality.

The majority of these deaths are preventable, especially those due to hemorrhage, or bleeding out. The leading causes of maternal death in Missouri are all cardiac-related, with embolisms caused by blood clots topping the list. The state's high rates of smoking and obesity during pregnancy put women at higher risk for those complications.

Missouri is working on a variety of strategies to combat this devastating issue. The Missouri Department of Health and Senior Services recently provided subject matter expertise to Representative Sarah Unsicker for House Bill 2303 to establish a Maternal Mortality Review Board within the Missouri Department of Health and Senior Services.

(8) Prevention of Gynecology Malignancies

Isam Lataifeh – Jordan

Of the types of gynecologic cancer, cervical cancer is perhaps the most straightforward in terms of prevention. Most cervical cancers stem from the human papilloma virus, a sexually transmitted infection, and there is a vaccine available for women between the ages of nine and 26 to prevent HPV. This vaccine can block up to 70 percent of cervical cancer cases. For the rest, regular Pap smears can detect cervical cancer in its earliest stages, giving the best prognosis possible.

To reduce the chance of developing any gynecologic cancer, health care professionals recommend doing regular Pap tests and then following up on any abnormalities those tests indicate. In addition, a diet rich in antioxidant-containing fresh fruits and vegetables and low in red meat and animal fat will decrease the chances of developing gynecologic cancer, particularly ovarian cancer. Researchers have reported that increased exercise can also lower the chances of developing gynecologic cancer. Weight control is a key as well: women with a body mass index of greater than 40 have a 60 percent higher risk of dying from all cancers than women of normal weight.

In addition, having at least one child (and, additionally, breastfeeding for a year) can help reduce the risk of developing ovarian cancer. Tubal ligation has also been shown to decrease the risk of ovarian cancer in some women.

(10) Cervical Cancer during Pregnancy: Clinical Scenario

Isam Lataifeh – Jordan

Cervical cancer during pregnancy is relatively uncommon. However, the incidence is expected to increase as more women delay childbearing. When preservation of the pregnancy is desired, optimal treatment is a major challenge to all. Whereas delay of treatment is an option for pre-invasive disease, and also small invasive carcinomas without lymph node involvement, management of tumours >2 cm remains experimental. Type of treatment needs to be individualized and depends mainly on gestational age, disease stage, and histology. Extensive counselling regarding the maternal and foetal risks is required. In this current review, we aim to summarize available data and treatment guidelines concerning cervical cancer in pregnancy. Controversies and research priorities are also identified.

(11) The AMH Employ in FSH Stimulated Cycles

Fernando S. Martin - Spain

With the introduction of AMH assay in the routine of the study of ovarian reserve a more accurate and personalized approach to patients is possible, separating patients in different groups.

High responders with an AMH value over 3 pg/ml must be stimulated with lower doses of FSH in an antagonist protocol to avoid the high risk of OHSS (Ovarian Hyper Stimulation Syndrome) and to have the opportunity of triggering with a agonist bolus.

Normal responders with levels between 1-3 ng/ml can be stimulated in a customized way depending the desires of patient and doctor to maximize the possibilities of a pregnancy and avoid complications and unnecessary cost in medications.

Expected low responders, levels between 1-0,5 ng/ml can be informed in advance to avoid excessive expectations of results and to customize a ovarian stimulation with some adjuvants, like testosterone in previous cycle.

Levels below 0,5 ng/ml require an individualized evaluation and explanation to patients previously to the initiation of a cycle.

We have to define what is the ideal number of follicles in an ovarian stimulation and according to AMH and body weight we can decide the dose of FSH.

(12) Surgery for Endometrial Cancer: Evidence Impact Practice

Isam Lataifeh – Jordan

Surgery is a fundamental part of the management of endometrial cancer (EC). The two principal goals of the surgery are:

(1) Removal of the cancer, and (2) accurate documentation of the extent of disease (staging). While the former may be limited to simple hysterectomy and removal of the ovaries, the latter is much more involved and includes pelvic washings, omental biopsy or complete omentectomy, pelvic lymph node dissection, and para-aortic lymph node dissection. In 1988, the International Federation of Gynecology and Obstetrics recommended that endometrial cancer be staged surgically. A wide range of surgical procedures have been offered to patients, from simple hysterectomy and bilateral salpingo-oophorectomy to HBSO with omentectomy, and retroperitoneal nodal evaluation that includes both pelvic and para-aortic lymph node dissection.

(2) The 2009 revision of the FIGO staging recommendations further separates patients with pelvic nodal involvement (IIIC1)and para-aortic nodal metastasis (IIIC2), emphasizing the differences in prognosis between these two groups. Currently, there are 2 options for surgical management of EC: (1) limited surgery including THBSO, and

(2) comprehensive surgical staging consisting of THBSO and surgical pathologic evaluation of pelvic and/or para-aortic lymph nodes, with omentectomy in type II EC.

(14) Comparative Study of Cervical Pap Smear and Visual Inspection of the Cervix Using Acetic Acid to Detect Premalignant Disease of the Cervix

Rozhan Y. Khalil - Iraq

Benign diseases of the cervix are common and are unusually asymptomatic or cause minor symptoms but must be differentiated from malignancy. Screening for premalignant disease of the cervix markedly reduces the deaths from cervical cancer.

Objective: The objective of this study is to compare the sensitivity, specificity, positive predictive value, negative predictive value of visual inspection of the cervix using acetic acid with Pap smear.

Study design and setting: This cross sectional study was done in sulaimania maternity teaching hospital throughout the period from (September 2012) to (February 2013).

Patient and methods: This include 115 samples, carried out in the Sulaimania Maternity Teaching Hospital, Pap smear samples were taken by the researcher. Samples were fixed in 95% ethyl alcohol and taken to the Pathology Department for interpretation. The cervix was then painted with 5% acetic fluid and observed for aceto-white lesions. Suspected areas were biopsied and transported to the Pathology Department for interpretation.

Results: There were 114 samples that were suitable for statistical analysis. The result of study revealed that sensitivity of visual inspection of cervix using acetic acid was 16%, specificity 71%, positive predictive value 3.13% and negative predictive value 93.9%.

Conclusions: Visual inspection of the cervix using acetic acid had a comparable result with pap smear, In this study there is no significant difference between the two methods, i.e. Both have almost similar results.

Key words: premalignant disease of cervix, Pap smear, visual inspection with acetic acid.

(16) Obesity in Pregnancy

Martin E. Olsen – USA

Obesity is a growing problem worldwide. Health effects vary with body fat content and fat distribution, but Body Mass Index over 30 meets the standard definition of obesity. This lecture will discuss co-morbidities associated with obesity in pregnancy along with societal factors that are seen with obese patients. Congenital anomalies associated with obesity in pregnancy include open neural tube defects, congenital heart disease, hypospadius, cystic kidney, clubfoot, omphalocele, and diaphragmatic hernia. Risks of stillbirth are increased, but evidence supporting early induction of labor is weak. Rates of Cesarean delivery are increased, but the complication rates for abdominal delivery are higher. Post-operative measures to prevent deep vein thrombosis are recommended. Post-partum hemorrhage, wound disruption, infection, venous thromboembolism, and Cesarean hysterectomy rates are all higher in obese patients. This discussion will also review pregnancy post bariatric surgery. With good preparation, facilities and physicians can work toward improved outcomes for obese pregnant patients.

(18) Management of Renal Colic in Pregnancy

Azad M. Hawizy – UK

The incidence of renal colic is estimated to be 1 in 1500 pregnancies; however it is the most common non-obstetric reason for hospital admission. It frequently presents during the second and third trimester. Pregnancy does not increase the incidence of urolithiasis despite the hormonal and anatomical changes.

Renal colic has been associated with pre-term labor, miscarriages, mild pre-eclampsia and caesarian deliveries. The diagnosis of renal colic during pregnancy can be challenging especially differentiating between physiological and pathological hydronephrosis. Ultrasound is the gold standard imaging investigation.

Renal colic during pregnancy should be managed in a multidisciplinary team including urologist, obstetrician, radiologist, anesthetist and neonatologist. Renal stones during pregnancy should initially be managed with good pain control, hydration and antibiotics if it is safe. Around 70-80% of stones pass spontaneously depending on the size and the site. However, if conservative management fails or the patient becomes septic or the kidney function deteriorates, active intervention would be mandatory. Surgical intervention could be temporary drainage with percutaneous nephrostomy or ureteric stent insertion. Primary ureteroscopy has become popular for management of renal colic during pregnancy as a diagnostic and definitive treatment for stones.

(19) Autoimmune Disease in Pregnancy

Shahla K. Alalaf - Iraq

Autoimmune disorders (AID) include approximately 80 different disorders, affecting a large number of the population. Individually, each affects a small number of individuals. An immune response to a self-antigen causes the disease pathology. It characterized by tissue damage, caused by self-reactivity of different effectors mechanisms of the immune system, namely antibodies and T cells. May be associated with genetic and/or environmental predisposition. Many lack treatments or cures, often contributing to increased morbidity and mortality. The relationship between pregnancy and autoimmune disorders seems to be bidirectional. Accordingly, AID may selectively affect women in their reproductive years and conversely pregnancy may affect the expression of AID. AID not only increases miscarriage risks but also reduces female fecundity and infertility treatment success.

During pregnancy, the fetus develops a separate circulatory system, however the fetus's and mother's blood often mix. Feto-maternal trafficking is known as microchimerism. Fetal components, such as DNA, may remain in the mother's system for decades after childbirth, while maternal components remain in the offspring as well. When the fetus's blood mixes with maternal circulation, an autoimmune response is initiated. The mother's immune system reacts to this blood as a foreign substance, releasing Autoantibodies.

(20) Maternal Obesity and Adverse Pregnancy and Perinatal Outcomes

Chro N. Fattah – Iraq

Introduction: Maternal obesity has become a global threat to population health and has a major public health burden during pregnancy and perinatal outcomes, the prevalence of maternal obesity has risen in the past two decade.

Material & methods: It is an observational cross sectional study was conducted at Sulaimani maternity teaching hospital/Kurdistan region of Iraq, from August 1st 2015-August 1st 2016. A total of 300 women of both prime and multigravida with singleton term pregnancy (37-42weeks), cephalic presentation, age (18-45) year included. Weight and height was taken from booking visit. The studied women were divided into three groups according to their BMI and followed up for maternal & neonatal complications, Data were analyzed by using statistical package for the social science version 21.

Results: Significant difference was found in mean age of the three groups with older women tend to become more obese (P<0.0010). There was significant association of obesity with increase parity (P<0.001). Obesity will increase the risk of gestational hypertension, gestational diabetes and antepartum hemorrhage that (P= 0.001, P<0.001, P=0.003) respectively. Moreover the rate of caesarean section increasing with higher BMI (P=0.004). Postpartum hemorrhage showed significant association with BMI (P=0.003). Obese women are more likely to give birth to macrocosmic babies and Admission to the Neonatal Intensive Care Unit.

Conclusions: Obesity increases the risk of delivery by caesarean section, associated with increased incidence of hypertension, gestational diabetes, post-partum hemorrhage and macrocosmic baby. Babies of obese women have a high incidence of admission to the neonatal intensive care unit.

(21) Intra-Incisional Injection of Magnesium Sulfate for Post Cesarean Pain Management

Maryam B. Mahmood - Iraq

Introduction: Cesarean section is estimated for about 30% of child births worldwide and it is one of the most common surgical procedures. Most women who have cesarean section suffer from incisional pain postoperatively. Pain relief after cesarean delivery is especially important as the consequences of inadequate pain relief are borne not only by the mother but by the newborn as well. Magnesium Sulfate (MgSo4) has analgesic benefits and used in post-cesarean pain management.

Objective: To determine the efficacy of subcutaneous injection of magnesium sulfate after skin closure in the postoperative pain management in women who performed elective cesarean section when compared with another group with elective cesarean who used placebo (normal saline).

Methods: The design study is a randomized, placebo controlled, single-blinded study with a total of 200 participants. Patients were randomly assigned to the groups. Those with odd numbers were assigned to the magnesium group and patients with even members assigned to the placebo group.

Results: The mean Visual Analogue Score (VAS) after 4 hrs., 8 hrs., 12 hrs., and 24 hrs were significantly less for the intervention (Magnesium) group when compared with the control (Normal Saline) at p-values of less than 0.0001.

Discussion and conclusions: The sense of pain in the postoperative intervention group was significantly less as compared to the control group (Normal Saline) no matter of the postoperative time. This shows the effectivity of magnesium sulfate on decreasing pain in postoperative patients and confirms the efficiency of magnesium sulfate when applied and injected to the skin subcutaneously after wound closure. We conclude that Magnesium sulfate is a safe and effective drug when it comes to postoperative pain management. Subcutaneous administration of magnesium sulfate in post cesarean section pain management can be used as a successful modality or method for pain management.

Key words: cesarean section, magnesium sulfate, pian

(22) Labour Outcome in Teenage in A Sample of Kurdish Pregnant Women in Maternity Teaching Hospital in Erbil City

Rana S. Waheeb - Iraq

Background and objectives: Maternal age at pregnancy put the lady at special risk for hazardous outcome of pregnancy. Teenage pregnancy is coming up as one of the most important public health problems all over the world with varying prevalence, and it is associated with significant pregnancy complications. Our objective is to evaluate the risks of adolescent pregnancy, assess and explore the occurrence of specific complications and compare pregnancy complications and labor outcome among adolescent in comparison to older control.

Patients and Methods: An observational comparative study extended from January 2016 to December 2017 In labour room in maternity teaching hospital Erbil city 572 nulliparous pregnant women were recruited and they are divided in to two groups.group one consist of 286 women aged between (15-19) years and group two consist of 286 women aged between 20-34 years.

Results: The study showed statistically significant difference between the two groups regarding educational state, alow educational level was more commonly found among teenage pregnant group with (p value 0.03).

Anemia was the only significant medical complication associated with pregnancy that was observed in teenage groups (P-value=0.04). Statistically significant differences was observed between both groups regarding low Apgar score at first min and NCU admission of neonates with a P-value of (p0.001),(0,001) respectively,there was a statistically significant association between early neonatal death and teenagers with a (p 0.001)

Conclusion: Adolescent pregnancy is a high risk condition as it is associated with adverse pregnancy outcomes in regard to maternal, neonatal complication as compared with adult control mothers.

(23) Rational Management of Implantation Failure and Repeated Abortion

Fernando S. Martin - Spain

Implantation Failure and Repeated Abortion are different in definition and implications but have a very similar way of management so we can have a guideline similar to both.

Implantation failure have a lack on consensus in definition, we consider it in a patient under 41 with at least of 5 embryos transferred in at least 3 different cycles and with oocytes coming from at least two different stimulations.

Repeated abortion is considered with at least two abortions, including biochemical ones.

The main thing in both cases is to have a complete anamnesis familiar, personal and of the couple looking for genetic, immunological and genetic problems.

We have to have a complete study at different levels, anatomical (looking to endometrium specially), genetically (Karyotypes, DNA fragmentation in male, FISH in ejaculated), Thrombophilia (genetic or acquired), Immunological status (Thyroid autoimmunity, Natural Killers, KIR receptors in female, HLA-C in the couple), Metabolic and endocrine status (TSH, AMH, Vitamin D).

With the results of all of them, we have to decide the right way to treat these complicated patients and give them a psychologic support in order to reach a healthy baby.

(24) Endometrial Receptivity

Michel Abou Abdallah – Lebanon

- The endometrium undergoes cyclic growth and differentiation in preparation for pregnancy.
- Synchronous events in the corpus luteum, endometrium, and embryo are critical to successful implantation.
- Estrogen is required for postmenstrual regeneration.
- Progesterone effects changes in the endometrium that are essential for successful implantation.
- Endometrial luminal epithelium acts as barrier to implantation except under appropriate and defined hormonal conditions.
- While nidatory E2 is critical for implantation in rodents, there are questions regarding whether estrogen is necessary at all during the receptivity phase in humans.
- The window of implantation is the period during which the endometrium is receptive to an embryo that has developed to be hatched blastocyst stage.
- Trophoblast interacts with endometrial cells to mediate implantation.

Basic science

- In the human, the embryo enters the uterine cavity at 72-96 hours after fertilization.
- Hatching of the embryo (escape from the zona pellucida) occurs by day 5 (about 110-120 hours after ovulation).
- Direct studies of human implantation sites suggest that embryos attach and implant a full week after ovulation.
- Observations in donor/ recipient cycles suggest a window of implantation spanning cycles days 20-24.
- Correspondingly, in normal women, implantation appears to occur at peak serum progesterone concentration around 7-10 days after ovulation.
- Pinopods are dome-like protrusions from the apical surface of luminal epithelial cells seen in the secretory phase. They may interact transiently with the embryo at implantation but appear not to be reliable markers of receptivity.
- Estrogen up-regulates expression in endometrium of the steroid receptors ERa and PR. At the time of implantation, both these receptors are lost from epithelial cells.
- Transcriptomics, proteomics, genetics, and other approaches have led to the identification of biomarkers with a high probability of being involved in implantation in humans. These include adhesion

molecules such as integrins and cadherins, and the secreted glycoproteins osteopontin, glycodelin, and calcitonin.

Clinical

- The traditional method of dating endometrium uses a series of defined histological criteria.
- Prospective, randomized re-examination of these criteria in normal fertile women has shown that they do not provide the accuracy or precision necessary to correctly assign the endometrium to a given day or series of days.
- Variability is highest during the time of implantation.
- Endometrial biopsy combined with histological dating fails to discriminate between fertile and infertile couples, and is not recommended for the routine evaluation of infertile women.
- Much has been learned about dysfunction of the endometrium and its consequences for implantation through the study of its structure and function in women with infertility or recurrent pregnancy loss.
- Women who conceive and implant at LH+10 or later exhibit a high miscarriage rate, suggesting that certain types of infertility or pregnancy loss result from defects in uterine receptivity associated with aberrant synchrony between the embryo, endometrium, and ovary.
- Loss of epithelial ERa and PR in endometrium correlates closely with the establishment of receptivity. A delay in acquisition of receptivity is associated with a correctable delay in the down-regulation of epithelial PR.
- Normal down-regulation of ERa during mid-secretory phase does not occur in some women with infertility, including those with PCOS and endometriosis. Failure of ERa down-regulation leads to uterine receptivity defects, as suggested by the loss of integrin.
- Altered progestin responses seen in endometriosis may be explained by abnormal expression of aromatase, leading to increased local estrogen production.
- PCOS patients exhibit elevated androgen receptor (AR) in their endometrium. Here, overexpression of steroid receptor coactivators may help explain prolonged estrogenic activity and a poor progesterone response.
- Future treatment options may include stronger progestins, antiestrogens (to block the receptor), or aromatase inhibitors.

(26) Obstetrics and Perinatal Outcomes of Dichorionic Twin Pregnancy Following ART Compared with Spontaneous Pregnancy

Diana Yousif - Iraq

Introduction: During the last decades, ART has been transformed from a miracle to a standard and become common part of medical practices now day

Objective: This study was performed to compare obstetrics and perinatal outcomes of dichorionic twin pregnancy following ART with spontaneous pregnancy.

Materials and Methods: In this cross-sectional study which was performed in In Erbil Maternity Teaching Hospital, 200 dichorionic twin pregnancy were classified in two groups: spontaneous group (n=121) and ART group (n=79). Basic criteria and obstetrics and neonatal outcomes information including demographic data, gestational age, mode of delivery, pregnancy complications (preeclampsia, gestational diabetes, preterm labor, anemia, blood transfusion,DVT, postpartum hemorrhage), neonatal outcomes (weight, first and fifth minute Apgar score, Neonatal Intensive Care Unit (NICU) admission, mortality, respiratory distress, and Sepesis) were recorded using a questionnaire.

Results: The rates (PIH), (GDM), (PPROM) were significantly higher in the ART group. but (PPH), blood transfusion, anemia, DVT were Not of significant differences, the majority of women in the ART group delivered by CS (72.2%), while only 27.3% of women in the spontaneous group. The main causes of CS in the whole sample were mal-presentation, and previous lower segment CS (LSCS).

For neonatal outcomes, the risk of preterm birth, very preterm birth, LBW, and congenital malformation, neonatal hospitalization (NCU), and moderately depress APGAR scores were markedly higher in ART group, while no significant differences were detected between regarding neonatal sepsis, respiratory distress syndrome (RDS), and survival. In our study was evident second twin has a poorer outcome than that of the first twin (49,50). This whether the pregnancy was conceived spontaneously, OR after ART.

Conclusion: With regard of significantly higher poor outcomes such as preeclampsia, gestational diabetes, low bith weight, and preterm labor in ART group, increasing delivery by cs and its complications, the couples should be aware of these potential risks before choosing ART.

(27) Diabetes Mellitus During Pregnancy Perinatal and Neonatal Outcome at Maternity Teaching Hospital/Erbil

Lanja S. Hamid, Srwa Khalid Ismael - Iraq

Background and objectives: The prevalence of diabetes during pregnancy is increasing in view of advanced maternal age, higher obesity rate and life style changes. This study is done to check the maternal, perinatal and neonatal outcomes in pregnancies affected by diabetes at Erbil maternity teaching hospital

Methods: Prospective cohort study done at Maternity teaching hospital/Erbil from June 2016 to December 2017 (18 months duration) where 216 patients recruited 108 pregnant women with diabetes and 108 non diabetic with the same demographic features.

Result: There was statistically significant difference between cases and controls in relation to maternal age, parity, gestational age, presence of preeclampsia and poly hydromnias in current pregnancy. Rate of caesarean section was high 61% in diabetic patients compared to 29.6 in control group. Furthermore there were higher adverse neonatal outcomes in terms of hypoglycaemia, hyperbilirubinemia, respiratory distress, and neonatal care admission.

Conclusion: Pregnancy outcome in women with diabetes mellitus is still unsatisfactory in term of high maternal, fetal and neonatal complication. Caesarean section was the commonest mode of delivery.

(28) The Association of Beta Human Choroinic Gonadotropin with Preeclampsia and It Is Effect on Perinatal Outcome

Sayran Ibrahem – Iraq

Backgroud: Exact aetiology of this potentially fatal disorder remains poorly understood. A number of theories have been put forward where different biochemical markers have been implicated in the causal association of preeclampsia.,An association has been reported between preeclampsia and elevated third trimester hCG levels, This

study was intended to find the association between serum b-hCG level and preeclampsia and its effect on perinatal outcome.

Materlials and methods: This case –control study was conducted on 50 pregnant women with severe preeclampsia,25 pregnant women with mild preeclampsia,and 50 normotensive pregnant women who were admitted to labour ward of maternity teaching hospital,,ERBIL/ KURDISTAN-IRAQ between jan 2016 to December 2016. The study subjects were selected on the basis of predefined eligibility criteria. The serum levels of b-hCG were compared between case and control groups,also maternal and perinatal outcome observed and recorded:

Results: The total number of the studied sample was 125 pregnant women. Their mean age + SD was 27 + 4.7 years, ranging from 20 to 39 years. The median was 27 years, with no significant difference in the age distribution of the three groups ($p = 0.759$). The majority of women (77.6%) were multiparous, with no significant difference in the parity distribution of the three groups ($p = 0.537$), the gestational age of 34% of women with severe PE was less than 37 weeks compared with 12% of women in each of the mild PE and normotensive groups ($p = 0.012$). mean bhcg titer among cases of severe PE was 37520.56 mliu/l, while cases of mild PE was 16487 miu/l and that of normotensives 11699.82 miu/l ($p < 0.001$). .,it is observed that their were no significant difference in perinatal out come,however those with b-hcg titer of > 40000 mliu/ml had lower APGAR in first min (=<6),birth wt of <2700g, less survival,regarding maternal outcome the observation was putting the spot on higher level of b-hcg associated with unfavorable outcome where eclamptic fit,abruption,DVT occurred at level of 40000 and more.

Conclusion: There was a significant difference between the b-hCG level in the preeclamptic women compared to the normotensive pregnant women,suggesting higher hormonal changes in cases of severe preeclampsia,with no significant difference in perinatal and maternal outcome except when b-HCG titer were higher than 40000mlIU/ml.

(29) What is Reproductive Aging? Quantity vs. Quality

Michel Abou Abdallah – Lebanon

- Quantity: decline in follicle number ultimately leads to menopause
- Quality: decreased implantation potential
  - Increase in meiotic non-disjunction
    - "Production-line" theory
    - Accumulated damage
    - Deficiencies of the granulosa cell function
- At the completion of this presentation, the participant will be able to:
  - Understand the difference between oocyte quantity and quality
  - Counsel women regarding the implications of ovarian reserve testing for infertility treatment
  - Utilize markers of ovarian reserve in developing a treatment plan

(30) New Automated Antimüllerian Hormone Assays Are More Reliable Than the Manual Assay in Patients with Reduced Antral Follicle Count

Teddy Tadros, Bruno Tarasconi, Jean Nassar, Jean-Luc Benhaim,Pharm.D., Joëlle Taieb, Pharm.D., and Renato Fanchin.

Objective: To compare the strength of the relationship between antral follicle count (AFC) and serum antimüllerian hormone (AMH) concentrations obtained with two automated and one manual AMH assays in three different AFC populations.

Design: Prospective cohort study.

Setting: University-affiliated IVF-ET center.

Patient(s): Frozen–thawed serum samples of 211 assisted conception candidates, aged 24–43 years.

Intervention(s): Serum AMH was measured using one manual (AMH Gen II) and two fully automated (Access AMH and Elecsys AMH) assays. Antral follicle count was performed under strictly standardized

conditions and sorted into three groups according to tercile values: low AFC (3–12 follicles; n = 73), intermediate AFC (13–20 follicles; n = 65), and high AFC (21–84 follicles; n = 73).

Main Outcome Measure(s): Strength of correlation between AMH levels and AFC.

Result(s): Overall, AMH levels were lower with Access AMH (-16%) and Elecsys AMH (-20%) than with AMH Gen II. Remarkably, the strength of correlations between AFC and circulating AMH levels was the same with the three assays (r = 0.83). Yet in the low AFC group, serum AMH levels obtained by Access AMH and Elecsys AMH showed a stronger correlation with AFC (r = 0.63 and r = 0.65, respectively) than the AMH Gen II (r = 0.52), a phenomenon that was not observed in the remaining AFC groups.

Conclusion(s): As compared with conventional AMH Gen II assay results, [1] serum AMH concentrations were -16% and -20% lower with Access AMH and Elecsys AMH, respectively; and [2] automated assays were more strongly correlated to AFC in the subset of patients with reduced follicle count.

Key Words: Antimüllerian hormone, antral follicle count, ovarian reserve, poor responders.

(31) Time Interval between hCG Administration and Oocyte Retrieval Significantly Influences IVF-ET Results

T. Tadros, L. Chenoz, M. Poulain, E. Adda-Herzog, JM Ayoubi, R. Fanchin

Study question: Do slight variations in the interval between hCG and oocyte retrieval (hCG-OR interval) influence IVF-ET results?

Summary answer: Roughly within a 34-39 hour frame, our data indicated that the shorter hCG-OR interval, the poorer IVF-ET results.

What is known already: For decades, in controlled ovarian stimulation (COS) cycles for IVF-ET, hCG-OR interval has been pragmatically set around 36 hours to mimic the physiological events occurring during the menstrual cycle. Yet, little attention has been paid, both in the literature and in the daily practice of IVF-ET clinics, on the possible impact of slight variations of such an arbitrary schedule on IVF-ET results. Indeed, the actual degree of flexibility offered to clinicians to properly schedule oocyte retrieval and the ideal hCG-OR interval remain to be set.

Study design, size, duration: We studied 616 COS cycles for IVF-ET. All patients received hCG (10,000 IU, IM) according to usual criteria of follicle maturation.

Participants/materials, setting, methods: Patients were sorted into 6 groups according to whether hCG-OR interval was 34.0-35.0 hours (n=48), 35.1-35.4 hours (n=89), 35.5-35.9 hours (n=186), 36.0-36.4 hours (n=180), 36.5-36.9 hours (n=69), and 37.0-39.0 hours (n=44).

Main results and the role of chance: As shown in the Table, whereas patients and COS characteristics were similar in all groups, we observed a remarkable stepwise increase in the number of mature oocytes and embryos obtained together with an increase in pregnancy rates from the 34.0-35.0 hours to the 37.0-39.0 hours groups. Incidentally, the prevalence of negative OR was comparable over the 6 groups.

	34.0-35.0 h	35.1-35.4 h	35.5-35.9 h	36.0-36.4 h	36.5-36.9 h	37.0-39.0 h	P
Ages (ys)	35.0 ± 0.7	35.0 ± 0.5	35.2 ± 0.3	34.5 ± 0.3	35.8 ± 0.5	35.7 ± 0.7	0.33
Serum AMH (ng/mL)	3.2 ± 0.4	4.3 ± 0.5	4.0 ± 0.2	3.9 ± 0.2	3.3 ± 0.5	3.9 ± 0.6	0.31
No. ≥16 mm follicles	6.0 ± 0.4	6.5 ± 0.2	6.1 ± 0.2	6.5 – 0.2	6.0 – 0.3	6.0 – 0.4	0.62
No. mature oocytes	6.8 – 0.5	8.5 – 0.5	8.5 – 0.3	9.5 – 0.3	9.3 – 0.6	9.6 – 0.6	<0.007
No. cleavage embryos	4.7 – 0.4	6.1 – 0.4	6.3 – 0.3	7.0 – 0.3	6.7 – 0.5	7.6 – 0.6	<0.002
Ongoing pregn. rate (%)	25.0	21.3	33.9	41.7	46.4	50.0	<0.001

Limitations, reasons for caution: The present study could not address the question of the influence of larger hCG-OR intervals (>39 hours) neither discriminating possible outcome differences inside the 37.0-39.0 hours group due to limited sample size. Further prospective studies, including larger populations, are needed to confirm and expand present findings.

Wider implications of the findings: Our data indicate that the mere adjustment of the hCG-OR interval can lead to a noticeable improvement in IVF-ET output. Whether present results may be extrapolated or not to cases in which GnRH agonist is used instead of hCG to prime OR should be addressed in future studies.

Trial registration number: Not Applicable.

(32) Menopause and Women's Health in Later Life

Maida Shamdeen - Iraq

Menopause is a natural stage in life and part of the ageing process. It marks the time when a woman's periods stop as her ovaries run out of eggs or stop producing eggs.

Our information hub about the menopause and health in later life aims to help you manage your way through this life stage, ensuring this natural process is as positive as possible. We also aim to support you to take prompt action if there are any signs of illness, helping you feel better informed when discussing any topics with a healthcare professional.

What is the menopause and when does it occur?
The menopause usually occurs in a woman's early 50s, but can happen earlier or later. Although the symptoms may go on for a number of years, menopause is said to have taken place when a woman has not had a period for 12 months.
What are the symptoms?
Each woman is different and will respond to the menopause in her own way - both physically and emotionally - to the changes that menopause brings.
Before the full onset of menopause there is a stage known as perimenopause. This can last for 4 to 5 years or longer. Not all women have symptoms at this stage, but some women may experience some of the following:
Change in menstrual cycle,Hot flushes and night sweats,Headaches or dizziness,Vaginal dryness,Difficulty sleeping,Mood swings,Memory problems,Loss of interest in sex and Weight gain
The different sections of our information hub link out to information about managing some of these symptoms, as well as other health concerns important to women at this stage of life and through to older age.Women's personal experiences of the menopause
NICE guideline: 'Menopause: diagnosis and management' and accompanying information for the public
Menopause can occur earlier than expected for some women. If it

happens before the age of 40, it is known as premature menopause or premature ovarian insufficiency (POI). In some women this can occur as a result of some form of surgical or medical treatment, and sometimes it can run in families.

Coclution: can be very difficult for women to come to terms with a diagnosis of premature menopause, especially if they haven't yet had a family and were hoping to do so in the future. Treatment in the form of HRT or combined hormonal pill to replace the ovarian hormones is recommended in these young women, both to help with any menopausal symptoms and to reduce the long-term risks such as cardiovascular disease and osteoporosis.

(33) Male Infertility

Azad M. Hawizy – UK

Infertility is the failure to conceive after one year of unprotected intercourse in sexually active couples. Infertility affects both men and women and male infertility accounts for 50% of cases. However, in 30-40% of cases, no male infertility associated factor is found. Both partners should be investigated simultaneously and female age is an important factor that affects variable assisted reproduction. Male infertility should be managed in centers where sperm cryopreservation facilities are available.

All men should undergo standard assessment including medical history, physical examination, ultrasound of the scrotum and semen analysis. Where semen analysis shows significant abnormalities, hormonal and genetic assessment is required.

It is important to differentiate between obstructive and non-obstructive azoospermia as the treatment is different. There are different sperm retrieval techniques such as percutaneous or micro surgical epididymal sperm aspiration, testicular sperm extraction, testicular biopsy and microdissection sperm retrieval.

Varicocele is a common genital abnormality found in men and may be associated with male subfertility. It is found in 25.4% of men with abnormal semen analysis. The exact association is unknown, however, meta-analysis showed semen improvement and sperm DNA reverse damage after varicocele treatment.

(34) Spontaneous Ovarian Hyperstimulation Syndrome: A Case Report

Amal Abdulhakeem Ahmed – Iraq

Ovarian hyperstimulation syndrome (OHSS) is extremely rare in spontaneous pregnancies. Spontaneous OHSS can result from glycoprotein hormones stimulating follicle-stimulating hormone receptors (FSHR). The ovarian hyperstimulation syndrome (OHSS) is the combination of increased ovarian volume, due to the presence of multiple cysts and vascular hyperpermeability, that result in the outflow of fluid from the intravascular space, with subsequent hypovolemia and haemoconcentration.

In most cases, the OHSS is an iatrogenic complication of ovulation induction. Severe OHSS remains one of the most important complications related with gonadotropin use in assisted reproductive technologies. The severe type is associated with morbidity, but rarely with mortality. Infrequently, it may be associated with spontaneous ovulatory cycles. This syndrome is generally described in multiple pregnancy, hypothyroidism and molar pregnancies.

The symptoms of spontaneous OHSS develop later than in iatrogenic OHSS: the syndrome occurs between 3 to 5 weeks of amenorrhea in iatrogenic cycle, and between 8 and 12 weeks of amenorrhea in spontaneous OHSS cases.

Presentation of Case: We report a twin pregnancy in which ovarian torsion and hemoperitoneum complicating OHSS were treated with left adnexectomy and aspiration. The only trigger for spontaneous OHSS in this case was high levels of chorionic gonadotropin hormone.

Discussion: Multiple pregnancy, gestational trophoblastic disease, primary hypothyroidism, thyroid-stimulating hormone/gonadotropin-secreting adenomas, and mutations of the FSHR gene may trigger spontaneous OHSS.

Conclusion: Spontaneous OHSS should be included in the differential diagnosis of acute abdomen in pregnant women; if spontaneous OHSS is diagnosed, the etiology should be determined in order to focus the treatment and avoid future complications.

(35) Comparison of Uterine Artery Blood Flow in Fertile and Unexplained Infertility by Doppler Ultrasound Using Pulsatility Index PI and Resistance Index RI

Srwa J. Murad - Iraq

Background: Infertility is inability to conceive after one year of regular intercourse. Unexplained infertility is present if the basic fertility investigations are normal.

Objective: The objective of this study is to investigate the use of uterine artery blood flow (pulsatility index, resistance index) as a cause of unexplained infertility and compare them to fertile women.

Patient and Methods: A prospective cohort study was performed on 70 patients (35 fertile and 35 with unexplained infertility patients) in Sulaymaniyah Maternity Teaching Hospital, Kurdistan Region, Iraq, during October 2016 to December 2017.

Transvaginal color Doppler ultrasound was done in the mid luteal phase (day 21-24) for uterine artery by using pulsatility index (PI) and resistance index (RI).

Result: The age of the cases ranged from 20 - 39 years. The uterine artery PI was significantly higher (P-value of <0.001) in the unexplained infertile women (mean ± SD = 2.78 ± 0.615) than fertile women (mean ± SD = 2.42 ± 0.325). The uterine artery RI was significantly higher (P-value of <0.001) in unexplained infertile group (mean ± SD = 0.899 ± 0.066) than fertile women (mean ± SD =0.83 ± 0.054).

Conclusion: Unexplained infertility associated with decreased uterine artery blood flow and increase uterine artery resistance (PI and RI) when compared with fertile women.

(37) Heavy MENSTRUAL BLEEDING - An Update on Management

Rezan Kadir – UK

Heavy menstrual bleeding (HMB) is defined as excessive menstrual blood loss (MBL) >80 mL per cycle, that interferes with a woman's physical, emotional, social wellbeing and quality of life. Aetiology is due to underlying uterine pathologies, coagulopathy, ovulation dysfunction, or iatrogenic. Up to 20% of women with HMB will have an underlying inherited bleeding disorder. HMB is also common in women receiving anticaogulant therapy, in particular those receiving direct oral anticoagulants (DOACs).

Assessment of HMB should entail a menstrual and gynaecological history and a bleeding score to distinguish those women who require additional haematological investigations. A pelvic examination and ultrasound scan help to rule out presence of any underlying pathology.

Management depends on the underlying cause and the woman's preference and her fertility wishes. Medical therapies include hormonal treatments; levonorgestrel-releasing intrauterine system (LNG-IUS) and combined hormonal contraceptives are most commonly used.

Haemostatic therapies include tranexamic acid and DDAVP (1-deamino-8-D-arginine). DDAVP is used for HMB associated with certain IBDs. These therapies can be used in isolation or in combination with hormonal treatments. HMB associated with certain severe IBDs may require factor concentrate administration during menses to alleviate symptoms.

Endometrial ablation is a minor surgical procedure that is associated with low operative morbidity and can be performed as an outpatient. Hysterectomy remains the definitive treatment of choice when medical therapies have failed and endometrial ablation is not suitable.

This presentation provides an update on investigations and management of women with HMB with a particular focus on women with bleeding disorders and those receiving anticoagulant therapy.

(38) (Ultra Sound) Guided High Intensity Focused Ultrasound (USg HIFU)for Fibroids Treatment A Novel for Gynecologists

Jamil Sha'ban – Jordan

Uterine fibroids are the most common benign tumors of the female genital tract. Traditional treatments are Hysterectomy, Hysteroscopy, Laparoscopy, Uterus Embolization, Endometrial Ablation, Mirena IUD, medical therapies.

Ultrasound guided high intensity focused ultrasound HIFU is a non invasive technique that can destroy the tumor through thermal ablation without the need of excision.

HIFU is increasingly being used worldwide to treat symptomatic uterine fibroids and adenomyosis due to its excellent therapeutic efficiency in controlling symptoms and its high safety record as out patient only with sedation.

Due to its accuracy, it does not cause damage to the surrounding or overlying tissue.

The procedure is safe, short, out patient, no anesthesia, no scars, no adhesions, further pregnancies are possible, quick recovery.

(39) Hormone replacement Therapy- what's new?

Medhat M. Hassenein – UK

Many concerns and controversial issues has been raised on the use of Hormone replacement therapy (HRT) since the publications of the Women Health initiative (WHI) and the million women studies

There are No question that HRT is very effective treatment to relief the post menopausal and post oophorectomy vasomotor symptoms, protect against osteoporosis and the role of combined HRT in reducing the risk of colorectal cancer on the other hand the alarming risk of breast cancer in particular with the combined HRT and the risk of coronary heart disease, stroke and deep vein thrombosis limited the use of HRT and raised the Questions

1 - which woman is suitable for HRT

2 - How long we can give HRT

3 - What are the alternative to HRT

Questions that will be addressed in the lecture

(40) Knowledge, Attitude and Practice among Married Women Toward Family Planing in Shekhan City

Jinan N. Hassan – Iraq

Background and Aim: We take a opportunity of important of performing a study on the knowledge, attitude and practice among married women of reproductive age group toward family planning In Shekhan City. The study aimed to determine the knowledge, attitude and practice among married women toward Family Planning in Shekhan City.

Methods: A cross sectional study was conducted of the women that lived in the centre Shekhan district. For this reason, a 350 married women aged between 15 to 49 years were included in this study. Along with the socio-demographic characteristics of the women, their Knowledge, Attitude and Practice among married Women toward Family Planning were evaluated with the help of predesigned questionnaire.

Results: We enrolled a total of 350 participants and the main socio-demographic characteristics of the study population were detected. The ages were varied between 15 and 49 years, the most encountered age group was 25–29 years (21.7 %). Religion of respondents were 194 (55.4%) Muslims53 (43.7%), Yazidi and 3(0.9%) Christians. One hundred eighty-three 183 women (52.3 %) had educational level of primary school, 332 (94.9 %) were household's wives. The high percentage of parity of participant married women was (5 and more) which record 107(30.6%), and nearly 63 (18%) of participants are pregnant at study time. Majority of participants think that family planning is useful. 162(46.3%) of the participants used one of family planning methods at study time and 188(53.7%) did not used, The most common methods used are male condom, IUCDs and contraceptive pills.

Conclusions: The study showed, in spite of having little of knowledge about family planning, utilization of contraceptives were less because of large family norm and one or both parents want more children, religious myth, cultural.

(41) Public Policy and Programs to Help Senior Citizens

Randall W. Williams - USA

Senior citizens are one of our greatest assets as more than one in four Missourians will be over age 65 by 2030. Caring for seniors while maintaining quality of life is a significant challenge. One way we do this is to keep people in their homes as an alternative to a nursing care facility, through the use of Home and Community Based Services. Each state uses a different model to determine the Level of Care for these services and Missouri is currently reevaluating how it determines these levels in an effort to maximize limited funding. Quality of care is also a significant issue: in 2017, AARP ranked Missouri 43rd in quality of life and care in nursing facilities and 47th for support of family caregivers. Missouri is working with nursing facilities to find ways to improve quality of care for patients, as well as looking at ways to increase family caregiver support through employer policies.

(42) Kurdistan Board of Medical Specialties

Saleem S. Qader – Iraq

Kurdistan Board of Medical Specialties (KBMS) found in 2008. It is a teaching/ training institute in different medical disciplines. It belongs to the Ministry of Higher Education and Scientific Research, Kurdistan Region, Iraq.

KBMS includes five faculties (Medicine, Surgery, Dentistry and faciomaxillary, Radiology and Pathology).

KBMS interacts with Kurdish, scientific culture and decision makers in the government. It is an important bridge among; health, environment and policy makers to achieve a clean and healthy society. It delivers research of high quality.

We want to stimulate non specialist physicians to get fellowship of KBMS. We want to cooperate with both Arab/ Iraqi Boards. Besides we want to take responsibility of Health service in the region.

Until now 4 cycles have been graduated from KBMS, including 166 students. We have 791 trainees in KBMS. We have 34 different medical specialties.

We started a new strategy in KBMS: in curriculum, conditions for acceptation in KBMS and the training programs. We started a course this year entitled; Research Building Capacity and Good Clinical Practice. In addition we manipulated the style of examination. Raising the awareness of our trainees about patient rights/ safety and privacy are important. Raising the level of health education in our society is part of our duty. We are want to open Clinical Research Centre (CRC). Bridging and engagement of both preclinical and clinical research are part of our mission. Industrialization and independency of KBMS are part of long term mission. Soon we will start Community Medicine Council (CMC) in KBMS and Community Medicine Society (CMS).

Activation of our communication with other universities and Ministry of Health is very important as they are our main stake holders and supporters.

Training of the nurses and other medical sciences (Microbiology and Biochemistry) are our next program in the future and giving them fellowship of KBMS.

At the end Patients Centered Approach and Student Center Approach are our new strategy in training of our trainees; we want to learn from them. Giving courses e.g. ATLS, ALS, PALS, BLS and BSS in the near future in KBMS and opining specialist training in Physiotherapy, Ophthalmology, Disability, Transfusion, Pediatric Surgery, Clinical Physiology and Critical Care and Intervention Radiology were decided.

(43) Obstetrics and Gynecology Education and Certification in the US

Martin E. Olsen – USA

The Unites States has developed a strong medical education system over the past several decades. This presentation will focus on mechanisms used in the US system to maintain educational quality and ensure that all Obstetrics and Gynecology trainees are trained in an environment of educational excellence. A brief discussion of physician credentialing after the completion of training is also undertaken. No medical educational system from any country can be copied exactly and transported to another country. But leaders in the Middle East and other areas of the world can, however, study the methods of medical educators around the globe as they strive to design educational formats that fit their citizen's needs.

(44) Multidisciplinary Training in Obstetrics

Charles W. Cox - UK

Back ground -Risk management, governance, Root Cause Analysis, risk to medical and midwifery staff (who can we blame?!), medico legal aspects.
Practical experience in Mosul April 2017
Reducing risk.
The Managing Obstetric Emergencies and Trauma course, ALSO, and PROMPT
Human factors training and Resilience training.
Involving 'junior' members of staff.
Making training 'fun', non-threatening and compulsory!
Does it make a difference?

(46) Role of Laparoscopy in CSP

Mostafa A. Abdelmoghis – Egypt

The incidence of cesarean scar pregnancy (CSP), which was extremely rare till recent times, has been rising steadily. We have more of such cases being published in medical literature now. A 38-year-old woman with a past history of previous three cesarean sections presented with five weeks pregnancy and complaints of bleeding per vaginum associated with mild lower abdominal discomfort. The diagnosis of CSP with a live fetus within the gestational sac was made on a transvaginal ultrasound examination and later confirmed with a magnetic resonance imaging (MRI). The management involved injecting potassium chloride into the gestational sac and a combination of local and systemic methotrexate administration. The patient was followed-up by monitoring the beta human chorionic gonadotropin level until it reached non pregnant level and followed-up with scan and MRI until complete resolution of the pregnancy sac. Due to the rarity of this condition, there are no specific guidelines available for its management.

Keywords: Pregnancy, Ectopic; Methotrexate; Dilatation and Curettage; Laparoscopy

(47) Cesarean Section Scar Pregnancy

Ghada S. Alsakkal – Iraq

Implantation of a pregnancy within a Caesarean fibrous tissue scar is considered to be the rarest form of ectopic pregnancy and a life-threatening condition.

The increasing incidence possibly reflecting the increasing number of Caesareans currently being performed as well as the more widespread use of the transvaginal scan allowing their earlier detection.

A review of 10 cases of CS scar pregnancy will be discussed and different modalities of treatment will be evaluated.

The types and the complications will be discussed.

A contemporary work-ups, including a high index of awareness, a detailed history and a skilful ultrasound examination for an early and accurate diagnosis are very helpful to prevent complications.

Healthcare professionals should be familiar with the possibility of untoward sequelae and how a modern work-up can help in guiding conservative options, thus reducing morbidity and preserving fertility.

(48) The Effect Of High BMI on the Outcome of Patients Undergoing Total Laparoscopic Hysterectomy

Midia Alias - Australia

Background: The role of total laparosopic hysterectomy(TLH) is to avoid abdominal hysterectomy where vaginal hysterectomy is contraindicated. Patients who undergo this minimally invasive approach have decreased rates of wound infections, decreased pain, shorter hospital stay and return to work sooner. A systematic review of obese patients (BMI >30 kg/m2) who undergo laparoscopic hysterectomy has shown an association with increased operating time, increased blood loss, increased complications rates and a greater likelihood of conversion to open procedure.

Our department routinely undertakes TLH procedures in patients with increased BMI, however we have never formally reviewed their intraoperative or post-operative outcomes.

Method: We conducted a retrospective audit of patients who underwent total laparoscopic hysterectomy between January 2014 and June 2016.

Results: 149 cases were identified with a mean age of 50, mean BMI of 32.5, and on average had already undergone 1.9 abdomino-pelvic surgeries. Main indications for surgery were menorrhagia(38%), maligancy(24%), post-menopausal bleeding(10%), and chronic pelvic pain(10%). The average operating time was 142minutes, average length of stay was 2.5 days, and only one patient need to 'return to theatre'. Intra-operative complications included; eight(5.3%) conversion to laparotomy, four(2.7%) bowel injuries, and two(1.3%) bladder injuries, however there was no incidence of vaginal cuff dehiscence or haemorrhage. Post-operatively only one patient required an ICU admission, one patient had an ileus, and two patients had acquired non-surgical site infections.

Discussion / conclusion: Intra-operative complication rates of coversion to laparotomy and bowel injury were found to be

higher compared to published data (5.3% versus 2.7-3.9% and 2.7% versus 0.2-0.4% respectively). This may be due to the study being underpowered or high BMI and multiple previous surgeries complicating the procedure in our patient population. Furthermore, there are multiple primary operators, but this is expected as we are a teaching hospital. Inpatient hospital stay appears to be prolonged and improvements in discharge planning may help optimise this outcome.

In conclusion, patient undergoing TLH in our hospital are obese and have low incidence of haemorrhage, urinary tract injury, and vaginal cuff dehiscence, however appear to have increased incidence of conversion to laparotomy.

(49) Minimal invasive surgery in Gynecology

Mostafa A. Abdelmoghis – Egypt

Indication of Laparoscopic abdominal cerclage Time of lap abdominal cerclage Effect of pneumoperitoneium on gravid uterus safe entry in pregnancy.

Minimal invasive surgery as in ALOD and a denxal mass preparation of patient before minimal invasive surgery .

(50) The Role of Office Hysteroscopy Surgery in Sub Fertility

Medhat M. Hassenein – UK

The impact of hysteroscopy surgery on cases with sub fertility are enormous and range from assessing the uterine cavity prior treatment, resection of uterine septum or sub mucous fibroid to Hysteroscopy sterilisation of cases with Hydrosalpinx prior IVF treatment. In this presentation we will look at what's new in hysteroscopy surgery, alternative treatments, the evidences and results of hysteroscopy surgery and has it made any effect to the fertility outcome

(51) The Challenge of Sepsis in Obstetrics

Charles W. Cox - UK

Part of a wider problem of national and international antibiotic resistance.

Maternal death and morbidity in the UK.

The Sepsis bundle and the Sepsis six.

Importance of the local microbiologist advising appropriate use of antibiotics.

The care of the acutely ill patient ' MEOWS' chart.

The importance of team working in the care of the septic patient.

Advances in the care of the patient with overwhelming sepsis.

(52) New Classification of Premalignant Condition of Endomtrium

Ariana K. Jawad – Iraq

Endometrial hyperplasia (EH) is a uterine pathology representing a spectrum of morphological endometrial alterations. It is predominantly characterized by an increase in the endometrial gland-to-stroma ratio when compared to normal proliferative endometrium.

Endometrial hyperplasia, particularly with atypia, is a significant clinical concern because it can be a precursor of endometrial cancer. Accurate diagnosis of precancerous lesions of the endometrium and exclusion of coexisting endometrial carcinomas are absolutely required for the optimal management of patients.

The incidence of endometrial hyperplasia is estimated to be at least three times higher than endometrial cancer.

The classification of endometrial hyperplasia has had numerous terminology. According to the classification of WHO94, based on glandular complexity and nuclear atypia, EH is divided into four groups: non-atypical endometrial hyperplasia (simple, complex) and atypical endometrial hyperplasia (simple, complex). Estimated risk of

progression of atypical hyperplasia to endometrial cancer is 8-29%. The American College of Obstetricians and Gynaecologists and the Society of Gynaecological Oncology states that endometrial intraepithelial neoplasia (EIN) classification is superior to the World Health Organisation (WHO 94) classification for histology of endometrial hyperplasia. However, the WHO classification system remains the most commonly used and reported in existing literature.

The new classification, WHO 2014, accepted by the International Society of Gynaecological Pathologists, divided hyperplasia into two groups: benign hyperplasia and atypical hyperplasia/endometrial intraepithelial neoplasia (EIN). The WHO 2014 schema is more likely to successfully identify precancerous lesions than the WHO94 classification and can reduce the likelihood of developing invasive endometrial cancer.

daflon® 500mg

micronized purified flavonoid fraction

Micronized

A unique micronized form and a comprehensive mode of action for a superior clinical efficacy

Chronic venous disease

2 tablets daily

Hemorrhoidal disease

up to 6 tablets daily

SERVIER

TOG ETHER TOWARDS BETTER HEALTH

PHILADELPHIA
Pharmaceuticals Co.

Doppel herz® aktiv

German engineering for your health

Cefodox®

Cefpodoxime (Proxetil)

Golden Standard for Post operative switching therapy

Cefodox® has comparable MIC values as ceftriaxone injection against different pathogens with excellent success rate after switch therapy

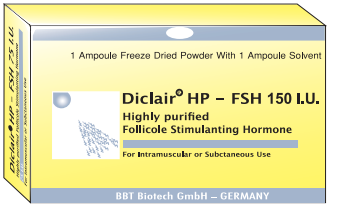
الدولية للدواء
Pharma International

BBT

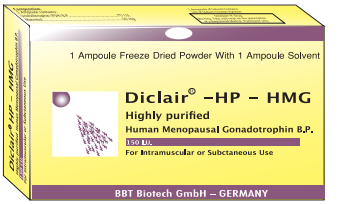
Highly Purified

BBT-Biotech

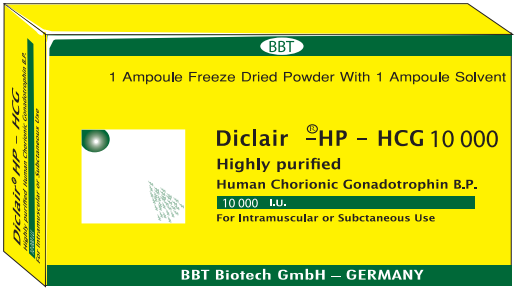
Diclair : HP FSH 75 I.U
HP FSH 150 I.U



Diclair : HP HMG 75 I.U
HP HMG 150 I.U



Diclair: HP HCG 1500 I.U
HP HCG 5000 I.U
HP HCG 10 000 I.U



BBT

BBT-Biotech GmbH - Germany

NO-VOMIT®

Ondansetron

نو.فوميت®

أوندانسيترون

Safe anti-emetic

RECOVER YOUR HEALTHY BALANCE

WITHOUT NAUSEA & VOMITING

استعيد توازنك الصحي

بدون أعراض الغثيان والإقياء

Kurdistan-Iraq Society of Obstetricians and Gynecologists

Acknowledges and Thanks the Following Companies for Their Generous Contribution

(Golden Sponsor)

surveal

(Silver Sponsor)

hikma.

(Other Sponsors)

Abbott

BAYER

SERVIER

AMS America Medic & Science

MERCK

PIONEER PiONEER Co. for Pharmaceutical Industries

Doppel herz aktiv

BBT

Pfizer Consumer Healthcare

HOZ GROUP

NORMON

Bio Vitane

الدولية للدواء Pharma International

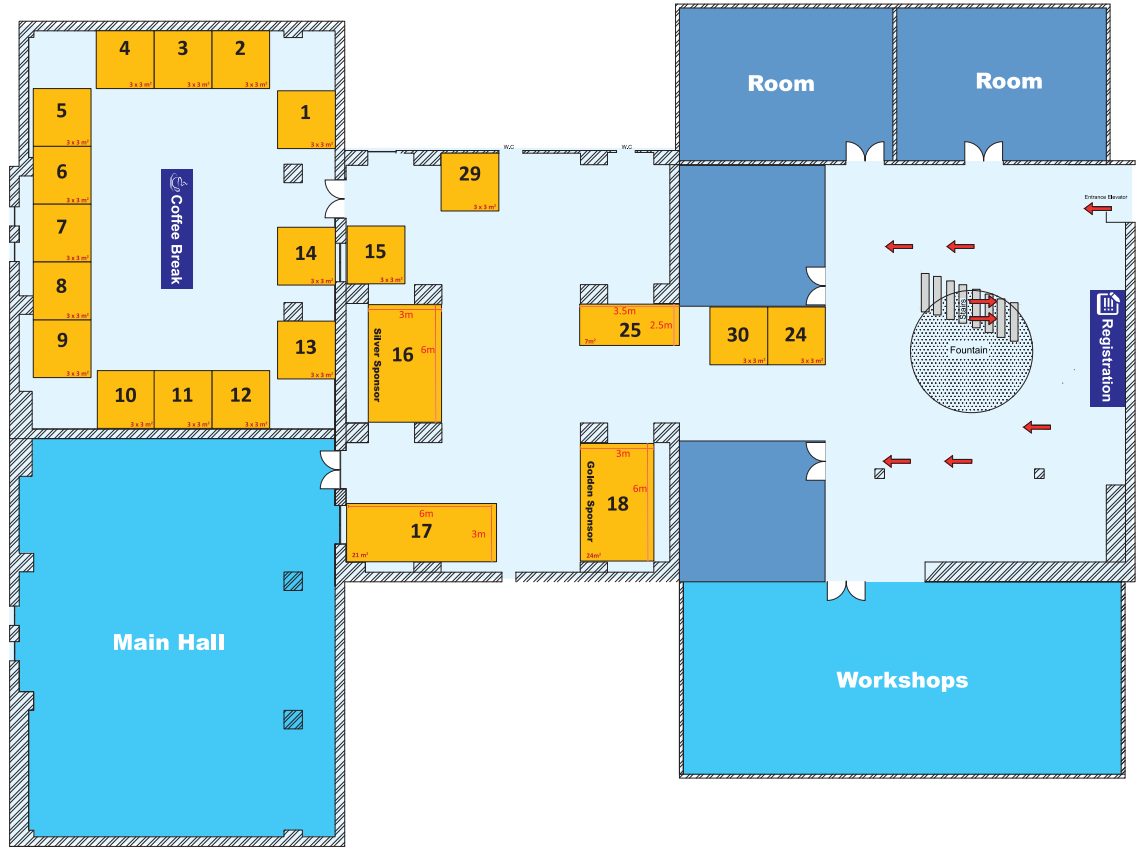
PHILADELPHIA

acino Switzerland

Roth Pharma Roth

FARABI Medical Genetics Laboratory

BOOTH	EXHIBITOR
1	Medical Nadin
2	AMS
3	
4	Hikma - Injectable line (HOZ Group)
5	Pharma International
6	Doppel Herz
7	Servier
8	BBT Diclair
9	Pheladilphia
10	
11	Bayer
12	Pfizer Consumer Healthcare
13	Bio - Vitans
14	Norman
15	MERCK
16	Hikma (Silver Sponsor)
17	Roth Pharma
18	Surveal (Golden Sponsor)
24	Acino Pharma
25	Pioneer
29	Abbott
30	FARABI Medical Laboratory



Notes

Notes

Who we are.

For 40 years, we've been creating high-quality medicines and making them accessible and affordable to the people who need them.

Headquarters:
London
Founded:
Jordan, 1978

+8,500
talented employees worldwide

+50
countries where we have operations

Nearly 30
manufacturing plants in 11 countries

7 R&D centres
worldwide

We develop, manufacture and market a broad range of branded and non-branded generic pharmaceutical products across the United States (US), the Middle East and North Africa (MENA) and Europe. We are also a leading licensing partner in MENA, and through our venture capital arm, are helping bring innovative health technologies to people around the world.

3 diverse and distinct business units

Injectables Generics Branded

hikma.

PHYSICIAN FORMULATED

Fertility Line

AMS®
America Medic & Science

TURN HOPE INTO HAPPINESS

Effective Ways To Naturally Boost FERTILITY

Men's Fertility

Women's Fertility

AMS®
America Medic & Science

America Medic & Science (AMS) LLC.
8321 219th St. SE. Woodinville, Washington. 98072
Toll Free 1.855.470.6722 | Office 1.425.558.5811 | Fax:1.425.558.5881
*inquiries@americamedic.com | **www.AmericaMedic.com***

MADE IN USA

The Organizers
Professional Conference Organizers
MENA
Since 1997

Iraq
Mobile : +964 (75) 10136345
M.R.F. Tower – Complex - E5
14 Floor- Office # 50

Jordan
Tel: +962 (6) 5654341-2
Mobile : +962 (79) 5727072
Asnad Building – Wadi Saqra Str. Complex # 231

UAE
Tel: +971 (55) 7091550
Two Four 54 P.O. Box: 769602
Abu Dhabi, UAE

Member of (Jordan Office)
IAPCO
International Association of Professional Congress Organizers
MEETING QUALITY

www.theorganizers-iraq.com