Hong Kong College of
Obstetricians and Gynaecologists

35TH ANNIVERSARY INTERNATIONAL CONFERENCE

24-26 November 2023
Hong Kong

e-Programme

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WELCOME MESSAGES

The Hong Kong College of Obstetricians and Gynaecologists (HKCOG) was established in 1988 to supervise and recognise postgraduate training in Obstetrics and Gynaecology. Before its establishment, Hong Kong had adopted the Royal College of Obstetricians and Gynaecologists (RCOG) system in the UK for accreditation of training. With Hong Kong returning to China in 1997 after more than 100 years of colonial rule, it was necessary to establish a local body to accredit our local specialists. The college's missions are to encourage the study and advancement of the science and practice of O&G in Hong Kong and to develop and maintain the good practice of O&G by ensuring the highest professional standards of competence and ethical integrity. HKCOG was one of the founding colleges of the Hong Kong Academy of Medicine, which was established in 1993. RCOG supported our establishment, and HKCOG and RCOG have worked closely since.

Time flies. 2023 is our 35th anniversary. With continued effort from all the fellows and members, HKCOG has served its role well throughout the years while expanding to take care of the rising needs in our specialty, such as the development of subspecialties, the emphasis on continuous medical education, the concerns on risk management, and the welfare of our young fellows and trainees etc.

Holding an international conference this year would be the best way to celebrate our anniversary. Having endured more than three years of COVID social distancing and quarantine measures, it's about time that we move away from ZOOM meetings and reconnect face to face. Despite many of us spending much time dealing with COVID work outside our specialty in times of global emergency, our profession has continued to strive to provide the best for our patients through research and development. Now, it's the time to come together to share our advances and celebrate our friendship.

This meeting will have a good mix of topics from all the subspecialties, with state-of-the-art lectures and forefront research presentations. We are privileged to have prominent speakers locally and from overseas, allowing plenty of opportunities to exchange ideas and foster collaborations.

We look forward to seeing you all at our 35th HKCOG anniversary conference and welcoming you to the Pearl of the Orient!

Dr. Karen KL Chan
Chairperson, Organizing Committee
HKCOG 35th Anniversary International Conference
President
Hong Kong College of Obstetricians and Gynaecologists

CONFERENCE INFORMATION

Conference Venue
Kerry Hotel, Hong Kong
Address: 38 Hung Luen Road, Hung Hom Bay, Kowloon Hong Kong SAR
Location & Transportation:
https://www.shangri-la.com/hongkong/kerry/about/map-directions/

Parking Information
Kerry Hotel
Valet parking: HK$80 per hour, minimum 2 hours

Carpark nearby - China Life Tower
08:00 – 20:00 $30 per hour, $180 per day
20:00 – 08:00 $15 per hour, $90 per day
https://www.carparkhero.com/car-park/china-life-centre/

Registration and Information Desks
The Registration & Information Desks are located at Pre-function foyer of Grand Ballroom, 2/F, Kerry Hotel Hong Kong and will be operated during the following hours:

Date	Time
24 November 2023 (Friday)	13:00 – 20:00
25 November 2023 (Saturday)	08:00 – 20:00
26 November 2023 (Sunday)	08:00 – 16:00

Official Language
The official language of the Conference is English.

Opening Ceremony & HKCOG Presidential Lecture
Date: 24 November 2023 (Friday)
Time: 18:00 – 19:00
Venue: Grand Ballroom 1 – 2, Kerry Hotel
Dress code: Business Attire
All participants are welcome.

Welcome Reception
Date: 24 November 2023 (Friday)
Time: 19:00 – 20:00
Venue: Grand Ballroom 4, Kerry Hotel
Dress code: Business Attire
All participants are welcome.

Faculty Dinner
Date: 24 November 2023 (Friday)
Time: 19:45 – 21:30
Venue: Grand Ballroom 3, Kerry Hotel
Dress code: Business Attire
By invitation only.

Conferment Ceremony & Gala Dinner
Date: 25 November 2023 (Saturday)
Time: 18:30 – 22:30
Venue: Grand Ballroom 1-3, Kerry Hotel
Dress code: Business Attire
By invitation / on ticket basis.

Exhibition
An exhibition featuring the latest products, equipment and educational materials in obstetrics and gynaecology will be held on 24 -26 November 2023 at Pre-Function Foyer and Harbour View Foyer of the Grand Ballroom, Kerry Hotel Hong Kong. The opening hours of the exhibition are:

Date	Time
24 November 2023 (Friday)	14:00 – 19:00
25 November 2023 (Saturday)	08:30 – 17:00
26 November 2023 (Sunday)	08:30 – 16:00

Poster Presentation
A TV kiosk is available at the Pre-function foyer for e-posters. Alternatively, e-posters can be found on the website starting from the conference period.

Badge Identification
Each participant will receive a name badge upon registration. All participants are requested to wear their name badges throughout the Conference and social programme. Only badge holders will be admitted to the Conference venue, meeting rooms and social programme.

Certificate of Attendance
E-certificate of attendance will be sent to those attended the Conference by email within one week after the Conference.

Wi-Fi
Free WIFI is available at the Conference venue.

Liability
The organisers will not be liable for personal accidents, or any loss or damage of private property during the Conference. Participants should make their own arrangements with respect to personal insurance.

Disclaimer
Whilst every attempt will be made to ensure that all aspects of the Conference announced will take place as scheduled, the Organizer reserves the right to make last minute changes should the need arise.

ACADEMIC ACCREDITATION

CME and CNE/PEM points have been accredited by the following colleges and programme for local delegates:
(as of 20 November 2023)

College/Association	CME/CNE Points Accredited				
	Max. for Course and Conference	24 November	25 November	26 November	Category and Remarks
CME					
The Hong Kong College of Anaesthesiologists	15	4	8	6	PP-NA
Hong Kong College of Community Medicine	10	4	6	5.5	PP-PP
The College of Dental Surgeons of Hong Kong	Pending	Pending	Pending	Pending	Pending
Hong Kong College of Emergency Medicine	12	4	6	5.5	CME-PP
The Hong Kong College of Family Physicians	10	2	5	5	OEA-5.02
The Hong Kong College of Obstetricians and Gynaecologists	16.5	5	6.5	5	PP-PP
The College of Ophthalmologists of Hong Kong	Pending	Pending	Pending	Pending	Pending
The Hong Kong College of Orthopaedic Surgeons	8	5	5	5	PP-B
The Hong Kong College of Otorhinolaryngologists	9	2	4	3	PP-2.2
Hong Kong College of Paediatricians	15	3	6	6	A-PP
The Hong Kong College of Pathologists	18	4	8	6	CME-PP
Hong Kong College of Physicians	5.5	1.5	2.5	1.5	PP-PP
The Hong Kong College of Psychiatrists	15.5	4	6	5.5	PP-OP
Hong Kong College of Radiologists	Pending	Pending	Pending	Pending	Pending
The College of Surgeons of Hong Kong	16	4	6	6	CME-PP
Medical Council of Hong Kong	10	3	5	5	CME-PAS-SIVECME
CNE/CEM					
Accredited by The Hong Kong College of Obstetricians and Gynaecologists	-	3	6.5	5	-

The final accreditations will be at the discretion of individual college / association.

ORGANIZING COMMITTEE & SCIENTIFIC COMMITTEE

Organizing Committee

Chairperson	Dr. Karen KL Chan
Committee Members	Dr. Raymond HW Li Prof. Liona CY Poon Dr. Sidney KC Au Yeung Dr. Ben CP Chan Dr. Jacqueline PW Chung Dr. Mona WC Lam Prof. Tak-Yeung Leung Dr. Danny TN Leung Dr. Wing-Cheong Leung Dr. Daniel Wong

Scientific Committee

Co-chairs	Dr. Raymond HW Li Prof. Liona CY Poon
Committee Members	Dr. Symphorosa SC Chan Dr. Charleen SY Cheung Dr. Crystal WL Cheung Dr. Ka-Wang Cheung Prof. Richard KW Choy Dr. Jacqueline PW Chung Dr. Annie SY Hui Dr. Catherine MW Hung Dr. Jennifer KY Ko Dr. Meliza CW Kong Dr. Mona WC Lam Dr. Wai-Lam Lau Dr. Wai-Hon Li Dr. Tsz-Kin Lo Dr. Teresa WL Ma Dr. Pauline PL So Prof. Wing-Hung Tam Dr. Kwok-Keung Tang Dr. Ka-Yu Tse Dr. Isabella YM Wah Prof. William SB Yeung Dr. Pong-Mo Yuen

LIST OF FACULTY

International Faculty

Dr. Rozi Aditya Aryananda
(Indonesia)

Prof. Phillip R. Bennett
(United Kingdom)

Dr. Anil Bhalla
(United Kingdom)

Prof. Sharon Cameron
(United Kingdom)

Prof. Zijiang Chen
(China)

Prof. Xiangdong Chen
(China)

Dr. Tomonori Hada
(Japan)

Dr. Verda J. Hicks
(United States)

Prof. Asma Khalil
(United Kingdom)

Dr. Anne Beatrice Kihara
(Kenya)

Prof. Mark Kilby
(United Kingdom)

Prof. Soo Chin Lee
(Singapore)

Prof. Christoph Lees
(United Kingdom)

Prof. Pisake Lumbiganon
(Thailand)

Dr. Louis Marcellin
(France)

Prof. Ben Mol
(Australia)

Prof. Yutaka Osuga
(Japan)

Prof. Dharmintra Pasupathy
(Australia)

Dr. Gang Peng
(China)

Dr. Ritsuko Pooh
(Japan)

LIST OF FACULTY

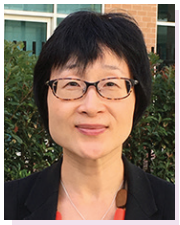
International Faculty

Dr. U.D.P. Ratnasiri
(Sri Lanka)

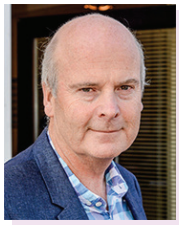
Dr. Isabelle Ray-Coquard
(France)

Prof. Dame Lesley Regan
(United Kingdom)

Dr. Evelien Roos
(The Netherlands)



Dr. Clara Ka-Lai Shek
(Australia)



Prof. Andrew Shennan
(United Kingdom)

Dr. Lay-Kok Tan
(Singapore)

Dr. Ranee Thakar
(United Kingdom)

Dr. Beverly Tsai-Goodman
(United Kingdom)

Prof. Hye-sung Won
(South Korea)

Prof. Huixia Yang
(China)

Prof. Jinglan Zhang
(China)

Prof. Lan Zhu
(China)

LIST OF FACULTY

Local Faculty


Dr. Karen KL Chan

Dr. Daniel Chan

Dr. Dorothy Chan


Dr. Symphorosa SC Chan

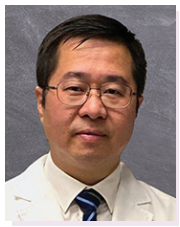

Dr. Charleen Cheung


Dr. Ka-Wang Cheung


Dr. Rachel Cheung

Dr. Vincent YT Cheung


Dr. Josephine Chong


Prof. Richard KW Choy

Dr. Mandy MY Chu


Dr. Jacqueline PW Chung

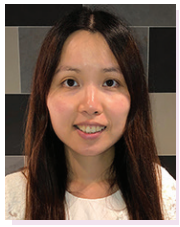
Dr. Amelia PW Hui


Dr. Annie SY Hui

Prof. Philip Ip

Dr. Anita Kan


Dr. Jennifer KY Ko


Dr. Meliza Kong


Dr. Mona WC Lam


Dr. Wai-Lam Lau

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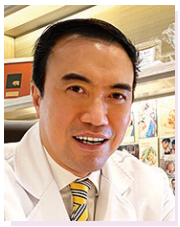
Local Faculty

Dr. Jacqueline HS Lee


Dr. Danny TN Leung

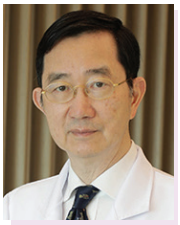
Dr. Ho-Kei Leung

Dr. Kwok-Yin Leung


Prof. Tak-Yeung Leung

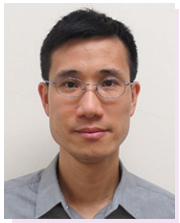

Dr. Wing-Cheong Leung


Dr. Raymond HW Li


Prof. Tin-Chiu Li

Dr. William WH Li


Dr. Sue Lo


Dr. Tsz-Kin Lo

Dr. Paulin Ma


Dr. Teresa WL Ma

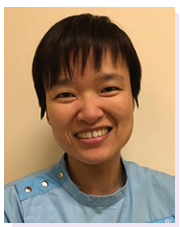

Prof. Ernest Ng


Dr. Tong-Yow Ng


Prof. Hextan Ngan


Dr. Siew-Fei Ngu


Prof. Liona CY Poon


Dr. Pauline PL So


Prof. Wing-Hung Tam

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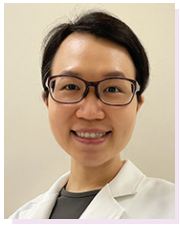
Local Faculty

Dr. Kwok-Keung Tang

Dr. William WK To



Dr. Ada WT Tse

Dr. Ka-Yu Tse

Dr. Isabella YM Wah

Dr. Osanna Wan

Dr. Alyssa Wong

Dr. Grace Wong

Dr. Lo Wong

Prof. William SB Yeung

Dr. Mandy CH Yu

Dr. Pong-Mo Yuen

DETAILED PROGRAMME

Day 1 - 24 November, 2023 (Friday)

Time	Grand Ballroom 1-2
14:00-14:30	**Welcome Refreshment**, Foyer
14:30-16:00	**Oral Abstract Presentation Session (Translational research and case reports)** *(Chairs: Prof. Ben Mol, Australia; Dr. Jacqueline PW Chung, Hong Kong)* Oral Presentation 1. Cervical tear following Arabin pessary placement for the prevention of preterm birth *Dr. Carmen SM Ng, Hong Kong (Ab. 101)* Oral Presentation 2. Joubert syndrome caused by novel compound heterozygous TMEM237 variants: a case report *Dr. Minh D-Thai, Vietnam (Ab. 59)* Oral Presentation 3. Angiogenic factor and anti-angiogenic factor in uterine remodeling of placenta accreta spectrum *Mrs. Prita Aji Malinda, Indonesia (Ab. 7)* Oral Presentation 4. E-cadherin in endometrial epithelial cell is a potential endometrial receptivitiy biomarker *Dr. Yin-Lau Lee, Hong Kong (Ab. 78)* Oral Presentation 5. Identification of pharmacologically active small molecules that induce spheroid attachment and embryo implantation in vitro and in vivo *Ms. Shuya Sun, Hong Kong (Ab. 47)* Oral Presenation 6. Optimizing the non-invasive preimplantation genetic testing in the laboratory *Dr. Judy FC Chow, Hong Kong (Ab. 64)*
16:00-17:00	**RCOG Keynote Session** *(Chair: Dr. Karen KL Chan, Hong Kong)* RCOG Keynote 1: Why do we need a women's health strategy? *Prof. Dame Lesley Regan, United Kingdom* RCOG Keynote 2: How to reduce OASIS and its consequences to women? *Dr. Ranee Thakar, United Kingdom*
17:00-17:30	**Coffee Break**, Foyer
17:30-18:00	**Plenary Lecture 1** *(Chair: Prof. Hextan Ngan, Hong Kong)* Over-medicalisation in women's health: is it our future? *Prof. Ben Mol, Australia*
18:00-18:30	**Opening Ceremony**
18:30-19:00	**HKCOG Presidential Lecture** Cervical Cancer Prevention - What are we up to ? *Dr. Karen KL Chan, Hong Kong*
19:00-20:00	**Welcome Reception**, Grand Ballroom 4
19:45-21:30	**Faculty Dinner**, Grand Ballroom 3

DETAILED PROGRAMME

Day 2 - 25 November, 2023 (Saturday)

Time	Grand Ballroom 4	Grand Ballroom 2-3	Grand Ballroom 1
07:30-08:30	**Light Breakfast**, Foyer		
08:30-09:00	**Plenary Lecture 2** *(Chair: Prof. Tak-Yeung Leung, Hong Kong)* Introduction of structured O&G training programme in China *Prof. Hextan Ngan, Hong Kong*		
09:00-09:30	**Plenary Lecture 3** *(Chair: Prof. Dame Lesley Regan, United Kingdom)* The Obstetrician-Gynecologist as Leader *Dr. Verda J. Hicks, United States*		
09:40-10:55	**Session 1: Fetal growth restriction** *(Chairs: Dr. Daniel Chan, Hong Kong; Dr. Pauline PL So, Hong Kong)* Screening, monitoring and diagnosis of FGR *Prof. Dharmintra Pasupathy, Australia* Prevention and treatment for intrauterine growth restriction *Prof. Christoph Lees, United Kingdom* Oral abstract presentation 7: Impact of immune imbalance on pregnancy outcomes in inflammatory bowel disease *Mr. Jin-Chuan Liu, Hong Kong (Ab. 62)*	**Session 2: Intrapartum care** *(Chairs: Dr. Sidney Au-Yeung, Hong Kong; Dr. Meliza Kong, Hong Kong)* Induction of labour – what's new? *Dr. U.D.P. Ratnasiri, Sri Lanka* Intrapartum ultrasound at second stage and beyond *Dr. Wai-Lam Lau, Hong Kong* Oral presentation 8: Patient satisfaction with informed consent for vaginal birth, a survey-based study *Dr. Yin-Fong Leung, Hong Kong (Ab. 27)* Oral presentation 9: Ultrasound assessment of progress in labour: a feasibility study *Dr. Nikki MW Lee, Hong Kong (Ab. 90)*	**Session 3: Endometriosis and uterine disorders** *(Chairs: Dr. Tomonori Hada, Japan; Dr. Pong-Mo Yuen, Hong Kong)* Endometriosis and infertility : when should surgery be done *Dr. Louis Marcellin, France* Evidence-based management of abnormal uterine bleeding in fibroids *Prof. Yutaka Osuga, Japan* Updates in management of adenomyosis *Dr. Louis Marcellin, France*
10:55-11:25	Coffee Break, Foyer		
11:25-12:40	**Session 4: Fetal therapy** *(Chairs: Prof. Mark Kilby, UK; Dr. Kwok-Yin Leung, Hong Kong)* Shunting for fetal pleural effusion *Dr. Ada WT Tse, Hong Kong* In utero therapy for fetal arrhythmia *Dr. Beverly Tsai-Goodman, United Kingdom* Oral presentation 10: Successful transvaginal amniotic shunt in lower urinary tract obstruction (LUTO) *Dr. Lisa Novianti, Indonesia (Ab. 105)*	**Session 5: Preinvasive lesions in the lower genital tract** *(Chairs: Dr. William WH Li, Hong Kong; Dr. Jacqueline HS Lee, Hong Kong)* Operationalize cervical cancer elimination in AOFOG *Prof. Pisake Lumbiganon, Thailand* Updated HKCOG guidelines for cervical cancer prevention and screening *Dr. Siew-Fei Ngu, Hong Kong* Oral presentation 11: Clinical presentation and long-term outcome of vulvar lichen sclerosus in adult Chinese women *Dr. Charleen Cheung, Hong Kong (Ab. 66)* Oral presentation 12: Evaluation of the concordance of primary human papilomavirus testing between self-collected and clinician-collected samples *Dr. Aaron Chan, Hong Kong (Ab.75)*	**Session 6: Infertility and assisted reproduction** *(Chairs: Prof. William SB Yeung, Hong Kong; Dr. Louis Marcellin, France)* Use of adjuncts in IVF *Prof. Ernest Ng, Hong Kong* Fertility Preservation in Female Cancer Patients: Empowering Reproductive Options *Dr. Jacqueline PW Chung* Oral presentation 13: Transcutaneous electrical nerve stimulation during oocyte retrieval: A randomised controlled trial *Dr. Jennifer Ko, Hong Kong (Ab. 80)* Oral presentation 14: A randomized controlled trial to compare the live birth rate of the first frozen embryo transfer following ovarian stimulation by the progestin-primed ovarian stimulation protocol versus the antagonist protocol in women with an anticipated high ovarian response undergoing in vitro fertilization *Prof. Ernest Ng, Hong Kong (Ab.35)*
12:55-13:25		**Lunch Symposium 2** *(Sponsored by CMR Surgical)* *(Chair: Dr. Karen KL Chan, Hong Kong)* An evolution in minimally invasive surgery in gynaecology: robotic surgery *Dr. Tong-Yow Ng, Hong Kong*	**Lunch Symposium 1** *(Sponsored by Cornwall HIFU Surgical Centre)* *(Chairs: Prof. Tak-Yeung Leung, Hong Kong; Dr. Eva CW Cheung, Hong Kong)* Pregnancy outcomes after ultrasound-guided high-intensity focused ultrasound (USgHIFU) treatment for uterine fibroids: experience of a single institution *Dr. Jordi Rodriguez, Spain*
13:25-13:45			**Hi-Fu Session** *(Chairs: Dr. Danny TN Leung, Hong Kong; Dr. Vincent Cheung, Hong Kong)* Principle of HIFU and clinical application on benign gynecological diseases *Prof. Xiangdong Chen, China*

Day 2 - 25 November, 2023 (Saturday)

Time	Grand Ballroom 4	Grand Ballroom 2-3	Grand Ballroom 1
13:45-14:45	**Session 7: Fetal anomalies** *(Chairs: Prof. Christoph Lees, UK; Dr. Isabella YM Wah, Hong Kong)* Normal and abnormal fetal cerebral cortical development *Dr. Ritsuko Pooh, Japan & Dr. Josephine Chong, Hong Kong* Logics of fetal cardiology *Prof. Hye-sung Won, South Korea & Dr. Beverly Tsai-Goodman, United Kingdom*	**Session 8: Cancer genetics** *(Chairs: Dr. Verda J Hicks, USA; Dr. Mandy MY Chu, Hong Kong)* Hereditary cancer syndromes beyond Lynch syndrome and HBOC *Prof. Soo-Chin Lee, Singapore* Endometrial cancer diagnosis beyond WHO classification 2020 *Prof. Philip Ip, Hong Kong*	**Session 9: Reproductive endocrinology** *(Chairs: Prof. Ernest HY Ng, Hong Kong; Dr. Jennifer Ko, Hong Kong)* Menopausal hormone therapy: friend or foe? *Dr. Sue Lo, Hong Kong* Management of recurrent miscarriage: how much should we do? *Prof. Dame Lesley Regan, United Kingdom*
14:45-15:15	Coffee Break, Foyer		
15:15-16:30	**Session 10: Hypertensive disorder in pregnancy** *(Chairs: Prof. Wing-Cheong Leung, Hong Kong; Dr. Tsz-Kin Lo, Hong Kong)* Use of biomarkers for short term prediction of preeclampsia *Prof. Andrew Shennan, United Kingdom* Safe ride in high tide - hypertensive emergency in pregnancy *Prof. Wing-Hung Tam, Hong Kong* Oral presentation 15: First-trimester preeclampsia screening: psychological impact on pregnant women throughout pregnancy *Ms. Sin-Ting Tai, Hong Kong (Ab.91)* Oral presentation 16: Single nucleotide polymorphisms and folate related biomarkers concentrations among Chinese preconception women: A genome-wide association study *Dr. Qinyu Yao, China (Ab. 89)*	**Session 11: Pelvic organ prolapse** *(Chairs: Dr. Symphorosa SC Chan, Hong Kong; Dr. Mandy CH Yu, Hong Kong)* Management of advanced stage of pelvic organ prolapse *Dr. Rachel Cheung, Hong Kong* Vaginal mesh use and national registry *Prof. Lan Zhu, China* Ultrasound imaging of synthetic implants in urogynecology *Dr. Clara Ka-Lai Shek, Australia*	**Session 12: Endoscopic and reproductive Surgery** *(Dr. Louis Marcellin, France; Dr. Kwok-Keung Tang, Hong Kong)* Modern management of uterine septum *Prof. Tin-Chiu Li, Hong Kong* vNOTES hysterectomy *Dr. Tomonori Hada, Japan* Contained morcellation *Dr. Pong Mo Yuen, Hong Kong*
16:40-17:10	**Plenary Lecture 4** *(Chair: Prof. Pisake Lumbiganon, Thailand)* Global disruptions as an opportunity in global women's health *Dr. Anne Beatrice Kihara, Kenya*		
17:10-17:40	**Plenary Lecture 5** *(Chair: Prof. Mark Kilby, UK)* Recent advances in fetal therapy *Prof. Tak-Yeung Leung, Hong Kong*		
18:30-22:30		**Conferment Ceremony & Gala Dinner**	

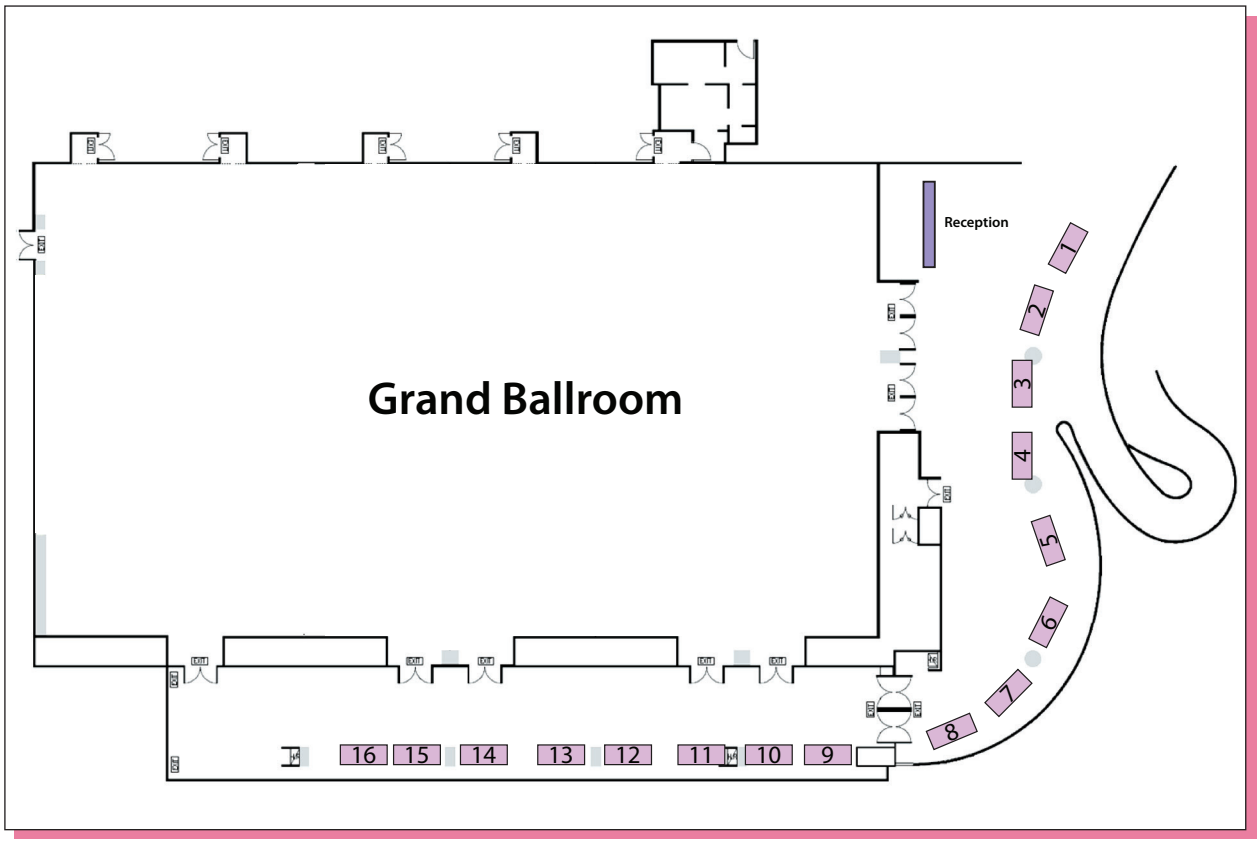
Day 3 - 26 November, 2023 (Sunday)

Time	Grand Ballroom 4	Grand Ballroom 2-3	Grand Ballroom 1
07:30-08:30	**Light Breakfast**, Foyer		
08:30-09:00	**Plenary Lecture 6** *(Chair: Prof. Andrew Shennan, UK)* Implementation of pre-eclampsia screening and prevention in Asia *Prof. Liona Poon, Hong Kong*		
09:00-09:30	**Plenary Lecture 7** *(Chair: Prof. Richard KW Choy, Hong Kong)* Improving the clinical utility of prenatal next generation sequencing investigation of the fetus with congenital malformations *Prof. Mark Kilby, United Kingdom*		
09:40-10:55	**Session 13: Critical care in obstetrics** *(Chairs: Prof. Wing-Hung Tam, Hong Kong; Dr. Lay-Kok Tan, Singapore)* Massive transfusion protocol *Dr. Lo Wong, Hong Kong* Application of POCT in the management of PPH *Dr. Anil Bhalla, United Kingdom* Oral presentation 17: Obstetric outcomes in Jehovah's Witnesses: a case-control study over fifteen years in a tertiary teaching hospital *Dr. Vivian WY Ng, Hong Kong (Ab. 71)* Oral presentation 18:Predicting major and severe postpartum haemorrhage during caesarean section for placenta praevia using a simple scoring model *Dr. William To, Hong Kong (Ab. 18)*	**Session 14: Perinatal genetics** *(Chairs: Prof. Richard KW Choy, Hong Kong; Dr. Anita Kan, Hong Kong)* Implementation of public funded genome sequencing in evaluation of fetal structural anomalies *Dr. Wing-Cheong Leung, Hong Kong* Concurrent non-invasive prenatal screening for genetic disorders of heterogenous etiologies: a prospective, multicenter cohort study *Prof. Jinglan Zhang, China* Invasive prenatal diagnosis, consensus and controversies *Dr. Pauline So, Hong Kong*	**Session 15: Acute gynaecology** *(Chairs: Prof. Yutaka Osuga, Japan; Dr. Vincent YT Cheung, Hong Kong)* Management of extrauterine pregnancy: lessons to learn *Dr. Jennifer Ko, Hong Kong* Caesarean scar pregnancy *Dr. Alyssa Wong, Hong Kong* Oral presentation 19: Association of vitamin D level and miscarriage rate in women presenting with threatened miscarriage to the early pregnancy assessment clinic *Dr. Tsz Ching Christy Lam, Hong Kong (Ab. 77)* Oral presentation 20: Women's perspectives on the use of karyotyping of the product of conception in explaining the cause of miscarriages *Dr. Wing Ching Cheung, Hong Kong (Ab. 53)*
10:55-11:15	**Coffee Break**, Foyer		
11:15-12:30	**Session 16: Preterm birth** *(Chairs: Dr. Ben CP Chan, Hong Kong; Dr. Annie SY Hui, Hong Kong)* Microbiome and preterm birth *Prof. Phillip R. Bennett, United Kingdom* Updates on Cervical Cerclage *Prof. Andrew Shennan, United Kingdom* Oral presentation 21: The Utility of First Trimester Cervical Length Measurement by Transvaginal Ultrasound in the Prediction of Preterm Birth - A Systematic Review and Meta-Analysis *Dr. Justin Li, Hong Kong (Ab. 40)* Oral presentation 22: Longitudinal evaluation of cervical length and shear-wave elastography in women with spontaneous preterm birth *Dr. Long Nguyen Hoang, Hong Kong (Ab.84)*	**Session 17: Innovation** *(Chairs: Dr. Raymond HW Li, Hong Kong; Prof. Liona Poon, Hong Kong)* Telemedicine in reproductive health *Prof. Sharon Cameron* Telehealth – a new door for safe O&G care? *Prof. Ben Mol, Australia* Oral presentation 23: Perception among pregnant women and feasibility of telehealth in obstetric services in Hong Kong *Dr. Ka-Wang Cheung, Hong Kong (Ab. 50)* Oral presentation 24: Smartphone electronic reminder to improve drug adherence during pregnancy: A randomised controlled trial *Dr. Mimi Seto, Hong Kong (Ab. 52)*	**Session 18: Free communications (Clinical)** *(Chairs: Prof. Pisake Lumbiganon, Thailand; Dr. Danny TN Leung, Hong Kong)* Oral Presentation 25.Associations between preconception alanine aminotransferase and glycometabolism profile during pregnancy: a community-based retrospective cohort *Mr. Yi Zhang, China (Ab.38)* Oral Presentation 26. The accuracy of self-collected vaginal samples in cervical cancer screening with dual stain p16/Ki-67 *Dr. Stanton Ho, Hong Kong (Ab.37)* Oral Presentation 27.HPV self-sampling for cervical cancer screening in Hong Kong *Ms. Ching Yin Chan, Hong Kong (Ab. 65)* Oral Presentation 28. Comparison survival after minimally invasive surgery versus abdominal radical hysterectomy for early-stage cervical cancer *Dr. Lisa Novianti, Indonesia (Ab. 104)* Oral Presentation 29. Parental folate cycle function before pregnancy and spontaneous pregnancy loss: a structural equation modelling approach *Mr. Xiaotian Chen, China (Ab.49)* Oral Presentation 30. Vitamin A and E concentration at early gestation and risk of early-onset atopic dermatitis *Dr. Yuanzhou Peng, China (Ab.51)* Oral Presentation 31.Decreased serum soluble programmed cell death ligand-1 level as a potential biomarker for missed miscarriage Vitamin A and E concentration at early gestation and risk of early-onset atopic dermatitis *Prof. Yao Wang, Hong Kong (Ab.86)*

Day 3 - 26 November, 2023 (Sunday)

Time	Grand Ballroom 4	Grand Ballroom 2-3	Grand Ballroom 1
12:30-13:00			**Lunch Symposium 3** *(Sponsored by Ferring Pharmaceuticals Ltd.)* *(Chairs: Prof. Andrew Shennan, UK;* *Dr. Ho-Kei Leung, Hong Kong)* The landscape on the ever increasing rate of PPH *Dr. Wing Cheong Leung, Hong Kong* Cost-effectiveness analysis of Carbetocin in prevention of PPH *Prof. Tak-Yeung Leung, Hong Kong*
13:30-14:30	**Session 19: Multiple pregnancy** *(Chairs: Dr. Wai-Lam Lau, Hong Kong;* *Dr. William To, Hong Kong)* Controversies in the management of twin pregnancy *Prof. Asma Khalil, United Kingdom* Delay interval delivery in pre- and prei-viable multiple pregnancy *Dr. Ka-Wang Cheung, Hong Kong* Oral presentation 32: Prediction of spontaneous preterm delivery in asymptomatic women with twin pregnancies using PAMG-1 and cervical length measurements *Dr. Meliza CW Kong, Hong Kong (Ab. 4)*	**Session 20: Pregnancy and the pelvic floor** *(Chairs: Dr. Evelien Roos, The Netherlands;* *Dr. Paulin Ma, Hong Kong)* Childbirth and pelvic floor trauma *Dr. Clara Ka-Lai Shek, Australia* Obstetric anal sphincter injury *Dr. Osanna Wan, Hong Kong* Oral presentation 33: An evaluation of the incidence of OASIS in the era of reducing episiotomy rate *Ms. Wenxuan Jiang, Hong Kong (Ab.100)*	**Session 21: Sexual and reproductive health** *(Chairs: Dr. Dominic FH Li, Hong Kong;* *Dr. Mona WC Lam, Hong Kong)* Safe abortion: new updates *Prof. Sharon Cameron, United Kingdom* Recent developments in contraception *Dr. Grace Wong, Hong Kong* Oral presentation 34: Advancement or delay of the next menstrual period after levonorgestrel emergency contraception is associated with the cycle day at administration *Dr. Raymond HW Li, Hong Kong (Ab.39)*
14:30-14:45	**Coffee Break**, Foyer		
14:45-16:00	**Session 22: Postpartum haemorrhage** *(Chairs: Dr. Teresa WL Ma, Hong Kong;* *Dr. Amelia PW Hui, Hong Kong)* Latest development for placenta accreta spectrum *Dr. Rozi Aditya Aryananda, Indonesia* What devices do we have for the management of PPH? Are they fit for purpose? *Dr. Meliza Kong, Hong Kong* Management of placenta acreta spectrum disorder – Experience in China *Prof. Huixia Yang, China*	**Session 23: Gynaecological malignancies** *(Chairs: Dr. Soo-Chin Lee, Singapore;* *Dr. Ka-Yu Tse, Hong Kong)* Endometrial carcinoma metastic or relapse setting *Dr. Isabelle Ray-Coquard, France* Ovarian sex-cord tumours *Dr. Isabelle Ray-Coquard, France* Oral presentation 35: Circulating tumour cells in gynaecological malignancies *Dr. Thomas KT Li, Hong Kong (Ab.14)* Oral presentation 36: Local experience on hyperthermic intraperitoneal chemotherapy (HIPEC) in advanced epithelial ovarian cancer *Dr. Shuk-Tak Kwok, Hong Kong (Ab.30)*	**Session 24: Paediatric and adolescent gynaecology** *(Chairs: Dr. Gang Peng, China, Dr. Dorothy Chan, Hong Kong)* Eliminating abuse, providing opportunities and restoring better health of adolescents *Dr. Evelien Roos, The Netherlands* Adolescent pregnancy in Hong Kong and across the globe *Dr. Charleen Cheung, Hong Kong* Oral presentation 37: Retrospective review on the management of Herlyn-Werner-Wunderlich syndrome *Dr. Karen Ng, Hong Kong (Ab. 79)* Oral presentation 38: Precocious puberty in a 2 years old girl with sclerosing stromal tumour of ovary: a case report *Dr. Dahlia Ningrum, Indonesia (Ab. 28)*
16:00-16:15	**Closing Ceremony**		

FLOOR PLAN WITH EXHIBITION INFORMATION



Company	Booth no.
Applied Medical Hong Kong Limited	8
Baxter Healthcare Limited	1
Bayer Healthcare Ltd	4
BGI Health (HK) Company Limited	3
CMR Surgical	6
Ferring Pharmaceuticals Ltd.	9
GSK	7
Hong Kong Red Cross	2
Johnson & Johnson (Hong Kong) Ltd.	12
Maternal-Fetal Medicine	16
Mead Johnson Nutrition (Hong Kong) Limited	14
Merck Sharp & Dohme (Asia) Ltd.	11
Organon Hong Kong Limited	10
Roche Diagnostics (Hong Kong) Ltd	5
Sonos Medical Limited	15
Zuellig Pharma Limited	13

Prof. Ben Mol

Professor
Department of Obstetrics and Gynaecology
Monash University
(Melbourne, Australia)

Over-medicalisation in women's health: is it our future?

Medicalisation is the process by which nonmedical problems become defined and treated as medical problems often requiring medical treatment. While diagnosis and treatment are offered in the assumption that hey good, they also have side effects. In situations where there is no burden of disease, or where treatment effect is limited or even absent, these side-effects might outweigh treatment benefits. Areas like infertility and pregnancy are specifically vulnerable for this phenomenon, as physiology and pathophysiology are close together, with subtle differences between them.

I will discuss examples from pregnancy and fertility care, discuss trends of interventions, and after some more philosophical considerations, come to conclusions.

Prof. Hextan Ngan

President
Family Planning Association of Hong Kong
International Society for the Study of Trophoblastic Disease
(Hong Kong)

Introduction of structured O&G training programme in China

With increasing knowledge and advancement in technology and skills, training in OG specialty needs to have a program not only on health and diseases control, but also on leadership, administration, ethics, research, teaching and training and holistic care.

In China, most hospitals have their own way of training of OG specialists though for the first 3 years, there is a structured basic training program which is a national programme organized by the Government. They need to pass a final assessment composed of written and OSCE. After these 3 years, the training model would be different. There is no formal national structured program on training or assessment within a time frame. There is a need for a structured program that can be implemented in all hospital to have standard set and examined to assure quality of the doctors not only satisfying local but also of international expectation. The Health Commission of Shenzhen Municipality together with the Shenzhen Medical Doctors' Association and the Hong Kong Academy of Medicine formed the SZ-HK Specialist Training Center on 2 July 2019 and the HKUSZH was invited to develop the programs in collaboration with international sister colleges or institutions.

The purpose is to develop a specialist training program that suits China and comparable to international training program. The HKCOG was invited to develop the program in OG and other subspecialties which were test run in the HKUSZH since 2019. The program was based on the HKCOG training programs with minimal modification to fit China. The HKUSZH has 2 trainees completed and passed the final examinations in 2023. The program in general OG was formally adopted for Shenzhen Standardized Specialist Training in SZ and a formal opening was held on 12 October 2023.

The journey is full of challenges and we look forward to a successful implementation in other SZ hospitals.

Dr. Verda J. Hicks

President
American College of Obstetricians and Gynecologists
(United States)

The Obstetrician-Gynecologist as Leader

As an Obstetrician-Gynecologist we are taught to use evidence-based medicine as foundation of the care that we provide our patients. Even though we may not consider ourselves as a leader, to our patients, their families, and their communities-- We Are Leaders. But, we are not trained in evidence-based leadership.
In addition, we must lead our profession to address the many challenges that are shared by us across the world that we practice in—maternal mortality, staffing shortages, challenges to reproductive rights, mental health, systemic racism and social determinants of health, equitable reimbursement, violence against providers, sexual assault/misogyny, and resultant burnout—as examples.
In this lecture we will address some examples of evidence-based leadership practice. The information and resources provided will be a starting point to accept the challenge to lead—To Lead From Where You Are.

We must lead in our practices, in our communities, and within our specialty or subspecialty. We can all lead around personal privacy protection and support evidence-based medicine. We can lead by calling out biases when we see them and recognize our own implicit biases. We can reach out to each other, communicate understanding of each other, help each other elevate each other, be kinder to each other—realizing that we are all living similar shared experiences in stressful times. We must respect and value those things that seem to apparently divide us, so that they do not permanently divide us.

No matter where we are on our career journey, we can lift up the mission of our profession as a first step in recognizing the leader in us.

Prof. Dharmintra Pasupathy

Professor
University of Sydney
(Australia)

Screening, monitoring and diagnosis of FGR

Fetal growth restriction is associated with adverse pregnancy and neonatal outcomes. These include but are not restricted to stillbirth, neonatal morbidity, and mortality. The detection of fetal growth anomalies has the potential to mitigate some of the associations observed. There has been much debate informed from continued research initiatives on the optimal approaches to screening and management of fetal growth restriction. In this presentation, Professor Pasupathy will summarise the evidence underpinning some of the key challenges in the management of fetal growth restriction.

Dr. U.D.P. Ratnasiri

Senior Obstetrician & Gynaecologist
Castle Street hospital for women
(Sri Lanka)

Induction of Labour, what is new?

Induction of labor refers to techniques for stimulating uterine contractions to accomplish delivery prior to the spontaneous onset of such contractions. The issues faced by women with historical IOL methods Hyperstimulation, Repeated cycles of PG, High oxytocin rates, Regular requirement of analgesia to cope up for pain, high cs rates with unsuccessful inductions. When the maternal/fetal risks associated with continuing the pregnancy are thought to be at least as great as the maternal/fetal/newborn risks associated with awaiting spontaneous onset of labor and delivery.

Induction of labour indications and timing: A systematic analysis of clinical guidelines shows substantial variation in clinical practice guidelines for indications for induction. WHO recommendations for induction of labour guidance recommends woman with uncomplicated pregnancy with known dates at 41 weeks for induction with low quality evidence and weak strength.

Induction is generally preferred when there are no contraindications to labor and vaginal birth, given the increased maternal risks associated with cesarean birth. A meta-analysis of six cohort studies in which the pregnancy outcomes of >66,000 patients undergoing elective labor induction at 39 weeks were compared with those of >584,000 patients undergoing expectant management beyond that gestational age, elective induction was associated with a significantly lower risk of cesarean birth, maternal peripartum infection, and adverse perinatal outcomes (respiratory morbidity, intensive care unit admission, perinatal mortality).

A favorable cervix is associated with a shorter duration of induction and higher likelihood of vaginal birth whereas the converse is true when the cervix is unfavorable. However, it should be noted that an unfavorable cervix does not mean that avoiding labor induction and managing the patient expectantly will result in a higher chance of vaginal birth; patients with unfavorable cervixes are still at increased risk for cesarean birth with expectant management, and the ARRIVE trial demonstrated that the cesarean birth rate was lower with induction regardless of cervical status,

Use of intravenous (IV) oxytocin plus amniotomy and use of vaginal misoprostol were the two approaches most likely to achieve vaginal birth within 24 hours.

Dr. Wai-Lam Lau

Consultant and Chief
Department of Obstetrics & Gynaecology
Kwong Wah Hospital
(Hong Kong)

Intrapartum ultrasound at second stage and beyond

Intrapartum ultrasound has been developed rapidly in the past 20 years. Currently, intrapartum ultrasound includes admission test, prior to induction of labour, first stage of labour, second stage of labour as well as postpartum ultrasound in modern labour wards. In this talk, I would like to focus on the second stage especially the "traffic light" algorithm in the clinical dilemma for the choice of operative deliveries. Apart from providing valuable supplementary information for clinical decisions, it could be useful for coaching and psychological support of the couple as well as clinical documentation & audit. For postpartum ultrasound, Point Of Care ultrasound including IVC (inferior venous cava) scan will be useful in those women with haemodynamic instability.

Dr. Louis Marcellin

Associated Professor
Department of Obstetrics and Gynecology and Reproductive Medicine
Cochin University Hospital
(France)

Endometriosis and infertility : when surgery should be done ?

Surgery is a suitable therapeutic option for endometriosis for the effective treatment of both pelvic pain and infertility. Surgery for endometriosis is performed by operative laparoscopy, except for in rare cases of DIE with multifocal lesions and numerous previous surgeries, which might require laparotomy. The conservative surgery is defined as the exeresis of endometriotic lesions without removal of the uterus and/or the ovaries. Importantly, in patients who undergo conservative surgery, pregnancy can occur shortly after the surgical procedure. The benefits of surgery for patients with infertility might be overestimated. For these patients, the indications for surgery and assisted reproductive technology (ART) are a matter of debate. Although some studies have indicated that endometriosis surgery before ART can be beneficial, insufficient data exists to recommend systematic surgery before ART to increase the chances of pregnancy. Notably, evidence suggests that a previous history of surgery for endometriosis, with or without ovarian surgery, might negatively affect ART pregnancy and live birth rates. Moreover, the management of ART failure is highly controversial. Only a small number of studies have reported that surgery can improve pregnancy rates after ART failure. In these situations, spontaneous conception was only rarely observed, and most pregnancies were obtained with additional ART after endometriosis surgery. Finally, anticipation of fertility preservation appears to be a priority if a parental project is planned before surgery.

Prof. Yutaka Osuga

President
Japan Society for Reproductive Medicine
Japan Society of Fertilization and Implantation
(Japan)

Evidence-based management of abnormal uterine bleeding in fibroids

Leiomyoma seems to be a most common cause of AUB, especially HMB. Many factors are involved in the formation and growth of uterine leiomyoma, such as genetic and epigenetic factors, epidemiologic factors, extracellular matrix, chemokines, and cytokines. In addition, estrogen and progesterone are the key drivers to develop fibroids. Regarding heavy menstrual bleeding, the increase in endometrial surface is one of the most plausible reasons. Fragile and engorged blood vessels may also be a cause. Other suggested mechanisms are defective decidualization, reduced vasoconstriction, reduced hemostasis, uterine venous ectasia, increase in TGFbeta3, endometrial inflammation, etc. For medical treatment of fibroids, COCs, progestins, LNG-IUS, SPRM, GnRH agonist, GnRH antagonist, and GnRH antagonist add-back are used. All COC, Progestin, and LNG are effective for reducing HMB, since the drugs make the endometrium thin. However, in terms of bulk-related symptoms, these drugs are not effective since they are unable to shrink the size of uterus. SPRM is a new class of progesterone receptor ligands. Ulipristal acetate (UA) is one of SPRMs, which works as progesterone antagonist in fibroid treatment. Compared to GnRH analogues, which mainly acts on the pituitary, SPRM acts on fibroid and the endometrium in addition to the pituitary. At the same time, UPA does not lower serum estradiol levels, while leuprorelin decreased them significantly. However, European Medicines Agency (EMA) issued a recommendation that UPA should be used in a very restricted manner due to its adverse effect of serious liver injury, which led to liver transplantation. Recently, oral GnRH antagonists have been developed and now they are in the market. Both GnRH agonists and GnRH antagonists finally suppresses estradiol levels. The difference is that GnRH agonist increases serum estradiol levels during the first one or two weeks, while GnRH antagonist quickly suppresses serum estradiol levels. Recently, GnRH antagonist with add-back therapy has been developed to overcome the problem of the bone loss associated with GnRH antagonist monotherapy. In GnRH antagonist with add-back, HMB reduces as well as the monotherapy while the bone less is much less than the monotherapy. However, size reduction of fibroid is little in GnRH antagonist with add-back therapy. For non-medical treatment of fibroid, hysterectomy, myomectomy, hysteroscopic resection, uterine artery emobolization, and focused ultrasound are used. Hysterectomy is a gold standard for those who don't need to preserve their fertility. In hysteroscopic surgery, hysteroscopic morcellation and bipolar resectoscope are the current standard. Using GnRH antagonist before surgery to reduce the size may make the surgeries easier. Uterine artery embolization (UAE) is another choice. Regarding, focused ultrasound, high intensity ultrasound (HIFU) is mainly performed in China and MRI guided focused ultrasound (MRgFUS) is in the rest of the world.

Dr. Louis Marcellin

Associated Professor
Department of Obstetrics and Gynecology and Reproductive Medicine
Cochin University Hospital
(France)

Updates in management of adenomyosis

Presence of endometriosis and adenomyosis in the same patient is not rare. Various forms of adenomyosis may be observed such as diffuse adenomyosis, focal adenomyosis, or more rarely, cases of cystic adenomyoma. The progress of imaging allows to affirm that adenomyosis ("endometriosis of the uterus") is present in 30% of women, regardless of their age. How to optimize the diagnosis of adenomyosis is of major impact on the therapeutic management. This point is crucial in the management of patients because adenomyosis, sometimes associated with endometriosis, is responsible for intense pain, heavy bleeding and affects fertility (reduced pregnancy rate and increased miscarriage rate). In daily practice, the management of patient affected with endometriosis is completely different according to presence of adenomyosis: (i) give priority to first-line medical treatment and postpone the time of surgery; (ii) in case of infertility, opt for ART with specific protocols.

Dr. Ada WT Tse

Associate consultant
Department of Obstetrics and Gynaecology
Prince of Wales Hospital
(Hong Kong)

Shunting for fetal pleural effusion

In this talk, the speaker will briefly go through the common etiologies of fetal pleural effusion. For severe pleural effusion, it may lead to fetal hydrops and fetal demise. There is a role of prenatal fetal therapy and there were various therapies described previous studies. The speaker will also go through the various therapies with their pros and cons. The speaker will explain why fetal pleural shunting is superior to the other therapies. The speaker will then have more detail discussion on the evolution of pleural shunting instruments used throughout the years. The speaker will compare the different pleural shunting instruments with their advantages and disadvantages in more detail, including possible complications. Last but not least, the speaker will provide some case examples for illustration of the technique on pleural shunting, as well as the technical challenges and how to tackle them.

Dr. Beverly Tsai-Goodman

Consultant Paediatric and Fetal Cardiologist
Royal Brompton Hospital
(United Kingdom)

In utero therapy for fetal arrhythmias:

Fetal arrhythmia occurs in around 2% of pregnancies and is defined as irregularity of the fetal heart rhythm with heart rates outside the normal range (110-180bpm).
In my talk, I will be showcasing the different types of fetal arrhythmias ranging from fetal tachycardia to fetal bradycardia including how to make the diagnosis. I will be discussing the different options of how best to manage the arrhythmia in utero and some of the challenges.

Dr. Siew-Fei Ngu

Clinical Associate Professor
Department of Obstetrics & Gynaecology
The University of Hong Kong
(Hong Kong)

Updated HKCOG guidelines for cervical cancer prevention and screening

The HKCOG Guidelines for Cervical Cancer Prevention and Screening was last updated in 2016. Since then, there have been several important new developments including Human Papillomavirus vaccines, the expanded role of HPV testing in screening, new technologies in HPV testing as well as new World Health Organization nomenclature for histological classification of cervical cancer and glandular lesion. In this talk, the summary of the updated guidelines will be presented.

Dr. Jacqueline PW Chung

Associate Professor
Department of Obstetrics and Gynaecology
The Chinese University of Hong Kong
(Hong Kong)

Fertility Preservation in Female Cancer Patients: Empowering Reproductive Options

This lecture explores the crucial topic of fertility preservation in female cancer patients. Fertility preservation refers to the various techniques used to protect and maintain a woman's reproductive potential before undergoing cancer treatment. The importance of fertility preservation for female cancer patients cannot be overstated, as cancer treatments such as chemotherapy and radiation therapy can have detrimental effects on fertility.

The lecture discusses the adverse impact of cancer treatments on fertility, including the potential for premature ovarian failure and infertility. It highlights the significance of addressing this issue, as many cancer survivors desire the opportunity to have children in the future. Various strategies of fertility preservation involving assisted reproductive technology are then presented, including embryo cryopreservation, oocyte cryopreservation, and ovarian tissue cryopreservation. Relevant regulations surrounding fertility preservation in the context of Hong Kong are addressed.

Dr. Jordi Rodriguez

Standing Board Member of the ISMIVS
International Society of Minimally Invasive and Virtual Surgery.
(Spain)

Pregnancy outcomes after ultrasound-guided high-intensity focused ultrasound (USgHIFU) treatment for uterine fibroids: experience of a single institution

Objective: To assess the impact of ultrasound-guided high-intensity focused ultrasound (UsgHIFU) ablation for uteine fibroids on fertility.

Material and methods: A retrospective observational study was conducted of 560 reproductive-age women with symptomatic uterine fibroids who underwent USgHIFU therapy at Mutua Terrassa University Hospital, Spain, between February 2008 and February 2018. We analyzed pregnancy outcomes including time to conception, pregnancy approach, gestational age, delivery mode, neonatal outcomes and complications during pregnancy and delivery.

Results: After USgHIFU treatment, 71 pregnancies were obtained in 55 patients. Of these, 58 (82%) cases were natural pregnancies and 13 (18%) were in vitro fertilization (IVF) pregnancies. The median time to conceive was 12 (range 1-72) months. There were 43 (61%) successful deliveries, including a twin gestation, 22 (31%) spontaneous abortions and 6 (8%) therapeutic abortions. The rate of full-term deliveries was 91% (39/43) and the remaining 9% (4/43) were preterm deliveries. Of the 44 live births, 25 (57%) were born vaginally and 19 (43%) by caesarean section. The complications reported included 3 women with retained placenta (7%), 2 with placenta previa (5%) and 1 with severe preeclampsia (2%). The mean birth weight was 3.1 (range1.4-4.3) kg, and except for a baby born with a tetralogy of Fallot, all newborns developed well without complications during postpartum and breast feeding.

Conclusion: Patients undergoing USgHIFU treatment of uterine fibroids can achieve full-term pregnancies with few intrapartum or postpartum complications. More studies are required to compare fertility and perinatal outcomes between patients who underwent or not USgHIFU.

Dr. Tong-Yow Ng

Honorary Associate Professor,
The University of Hong Kong
(Hong Kong)

An evolution in minimally invasive surgery in gynaecology: robotic surgery

Minimally invasive surgery (MIS) for gynaecology is well established. The benefits include smaller, less noticeable scars; shorter hospital stay; less pain and blood loss; and fewer complications such as surgical site infections.

Continuous improvements in technology including video-laparoscopy, safer fibreoptic lighting, have led to a wider adoption of MIS in gynaecology. Robotics assisted surgery (RAS) with its improved precision, flexibility, stability and surgeon autonomy have extended the range of procedures possible with MIS, and reduced the learning curve for gynaecological surgeons. However, the cost of the procedure for patients and the large footprint and costs of robotic systems for hospitals have hampered the wider adoption of RAS amongst gynaecological surgeons.

The CMR Versius Robotic System is a novel system newly introduced in Hong Kong. At Gleneagles Hospital Hong Kong, 54 gynaecological procedures including Robotic Assisted Hysterectomy, Myomectomy, Lymphadenectomy, Cystectomy and Ovarian Cancer Staging procedures have been done. The median age of patients is 50 years (25 – 86). The median duration of surgery is 178 minutes (88 – 374). Median blood loss is 100 mls. There were no complications within 6 weeks of surgery.

The continuous refinement of existing surgical robots making them smaller, lighter and easier to use, with more assistance features for surgeons, and at a reduced cost to patients will lead to a wider adoption of MIS for gynaecological patients. This will benefit patients, hospitals and health care providers.

Dr. Ritsuko Pooh

President
Fetal Diagnostic Center, Fetal Brain Center, CRIFM Prenatal Medical Clinic, Osaka (Japan)

Normal and abnormal fetal cerebral cortical development

Ritsuko Pooh graduated from both Law and Medical Departments. As an Obstetrician, she dedicated to clinical investigation on sonoembryology and neurosonography. She established CRIFM Prenatal Medical Clinic (https://fetal-medicine-pooh.jp/en/). Her neurosonograms are really scientific/artistic, and displayed at NIH in USA. She received the Alfred Alfred Kratochwil Award, Lifetime Achievement Award, and Sir William Liley medal. She published 173 articles and 4 books. She has also run the clinical genetic laboratory (Ritz Medical Co., Ltd.) for performing latest genetic examination, and established a new field of neurosonegenetics.

Prof. Hye-sung Won
Faculty Member
Asan Medical Center in Seoul
(South Korea)

Logics of fetal cardiology

As ultrasound technology has advanced, the accuracy of prenatal diagnosis, notably in the field of fetal echocardiography, has improved. Among the various congenital heart diseases, prenatal diagnosis is especially important for ductal-dependent congenital heart diseases (CHD). Since the closure of the ductus arteriosus in ductal-dependent CHD after birth can lead to neonatal cyanosis, pulmonary hypertension, and even death, a prepared delivery at a tertiary medical institution is necessary. This lecture will provide prenatal ultrasound diagnostic tips for ductal-dependent CHD such as complete transposition of the great arteries (d-TGA), hypoplastic left heart syndrome (HLHS), tetralogy of Fallot (TOF) with small pulmonary arteries, and pulmonary atresia with intact ventricular septum (PA-IVS).

Dr. Beverly Tsai-Goodman

Consultant Paediatric and Fetal Cardiologist
Royal Brompton Hospital
(United Kingdom)

Logistics of Fetal cardiology

The talk will be given jointly with Professor Won who will be concentrating on the antenatal consideration of duct dependent congenital heart defects. My talk will be concentrating on the perinatal and postnatal management of the following duct dependent lesions highlighting the importance of accurate antenatal diagnosis and discussing postnatal medical and surgical strategies:

1. Transposition of the great arteries(d TGA)
2. Hypoplastic left heart syndrome
3. Tetralogy of Fallot with small pulmonary arteries
4. Pulmonary Atresia with intact ventricular septum

Prof. Soo-Chin Lee

Head and Senior Consultant
Department of Haematology-Oncology
National University Cancer Institute
(Singapore)

Hereditary cancer syndromes: beyond Lynch syndrome and HBOC

Started since 2001, the National University Cancer Institute, Singapore (NCIS) Cancer Genetics Program provides genetic risk assessment, diagnosis and management of a broad range of hereditary cancer syndromes. While BRCA1/2 hereditary breast-ovarian cancer (HBOC) and Lynch syndromes are the most common conditions encountered, more than half the patients have other hereditary cancer syndromes. Among ovarian and endometrial cancer patients who underwent genetic testing and found with germline pathogenic mutations at our clinic, the most common implicated genes in ovarian cancer patients were BRCA1/2, followed by the mismatch repair genes (MLH1, MSH2, MSH6), RAD51C, RAD51D and BRIP1, while the most common implicated genes in endometrial cancer patients were mismatch repair genes. Beyond BRCA1/2 HBOC and Lynch syndrome, other hereditary cancer syndromes that increase risk of gynaecological cancers include Cowden (PTEN), Peutz Jeghers (STK11), Li Fraumeni (TP53) syndromes, as well as RAD51C, RAD51D and BRIP1 mutations. In addition, some hereditary cancer syndromes may manifest as benign gynaecological conditions but increases risk of non-gynaecological malignancies. For example, hereditary leiomyomatosis renal cell carcinoma (HLRCC) due to heritable mutations in the fumarate hydratase (FH) gene predisposes to young onset, multiple large uterine leiomyomas and renal cell carcinoma. Patients with familial adenomatous polyposis (FAP) may present to the gynaecologist with a benign pelvic desmoid tumor that causes compressive or obstructive symptoms that may be exacerbated in and around pregnancy; these patients are at significant risk for colorectal cancer and a clinical diagnosis can be readily made with detection of multiple colonic adenomatous polyps on colonoscopic examination. Clinicians should be aware of these rarer hereditary cancer syndromes as timely diagnosis can impact on the patient's management as well as have health implications on family members.

Prof. Philip Ip

Clinical Professor
Department of Pathology
The University of Hong Kong
(Hong Kong)

Endometrial cancer diagnosis beyond WHO classification 2020

The prognosis of endometrial cancers has historically been determined by the evaluation of histologic type, grade, and stage, and these factors contribute to the tailoring of treatment plans. Recently, molecular classification, pioneered by the four prognostic categories from The Cancer Genome Atlas Research Network: POLE ultramutated, microsatellite instability hypermutated, copy-number low, and copy-number high have been shown to independently predict outcome, correlate with biomarker expression, and predict response to adjuvant chemotherapy. These findings are incorporated into the World Health Organization Classification of Tumours of Female Genital Organs 2020 as well as the International Collaboration of Cancer Reporting system. In modern day pathology practice, it has become necessary to integrate the time-honored prognostic pathologic features with molecular classification in order to optimize patient management. This session aims to summarize the recent developments of prognostic features of endometrial cancers, focusing on the application of the molecular classification of endometrial cancers in clinical practice, the interpretation of necessary immunostains and molecular tests, and introducing biomarkers more readily available to practicing pathologists and clinicians.

Dr. Sue Lo

Senior Doctor
The Family Planning Association of Hong Kong
(Hong Kong)

Menopausal hormone therapy: friend or foe?

After the publication of the Women's Health Initiative (WHI) Hormone Therapy trials in 2002 and 2004, there was a rapid decline in the use of menopausal hormone therapy (MHT) due to concerns by both women and gynaecologists that MHT might cause cardiovascular diseases instead of preventing them. During the WHI trials, it was found that the risks of continuous combined oestrogen-progestogen therapy outweighed the benefits hence the trial was prematurely stopped after 5.2 years of follow-up. Although the risks and benefits of oestrogen-alone therapy were more balanced during intervention, this trial was also stopped after 7.2 years because of an increased risk of stroke in the treatment group. Subsequently, numerous subgroup analyses on primary and secondary outcomes during post-intervention and extended post-intervention phases have been published. Most risks and benefits from continuous combined oestrogen-progestogen therapy dissipated post-intervention except for the risks of cardiovascular diseases and breast cancer. Post-intervention with oestrogen-alone therapy showed significant reduction in breast cancer, and most other outcomes were neutral. At the same time, further studies were also conducted to evaluate whether outcomes would be different with different MHT doses, formulations and route of administration; with different timing of MHT initiation; and in women with different underlying risk factors. Twenty years after the publication of the WHI Hormone Therapy trials results, is MHT a friend or foe? Nowadays, most women seeking MHT to treat menopausal symptoms are aged less than 60 years. How can we tailor-make treatments to maximize their benefits and minimize their risks?

Prof. Andrew Shennan

Professor
King's College London
(United Kingdom)

Use of biomarkers for short term prediction of preeclampsia

The advent of testing for angiogenic biomarkers such as placental growth factor (PlGF) has transformed the ability to identify women at high risk of adverse outcomes in high income settings. Circulating angiogenic factors play a key role in the pathogenesis of PE, and angiogenic imbalance is more closely associated with the underlying aetiology of PE, compared to downstream features of disease such as hypertension and proteinuria. Abnormally low concentrations of pro-angiogenic placental growth factor (PlGF) and elevated anti-angiogenic soluble fms-like tyrosine kinase-1 (sFlt1) have been identified up to 10 weeks prior to the clinical onset of PE. There are now commercially available tests for these angiogenic biomarkers, which measure PlGF alone, or the ratio of sFlt1:PlGF. PlGF has high test performance (area under receiver operator curve (AUROC) 0.87, standard error 0.3) for delivery for confirmed preeclampsia within 14 days, outperforming all currently used diagnostic tests for suspected PE combined, including BP, proteinuria, or biochemical abnormalities. Normal maternal PlGF concentrations rule out the development of PE necessitating delivery within 14 days with high negative predictive value (NPV) of 0.98 (95% confidence interval (CI) 0.93 – 0.995%). This enables low-risk women to continue with routine surveillance while resource-intense, high-level surveillance can be directed to high-risk women with low PlGF, who have a shorter time to delivery and higher risk of complications. This talk will review the evidence and consider how these markers should be used.

Dr. Rachel Cheung

Consultant
Department of Obstetrics and Gynaecology
Prince of Wales Hospital
(Hong Kong)

Management of advanced stage of pelvic organ prolapse

Pelvic organ prolapse (POP) is a prevalent disease in women around the world, including Hong Kong. Around one third of women presented to our clinic with POP already at advanced stage ie. Stage III or IV prolapse with significant adverse impacts on their quality of life. Active management including vaginal pessary and surgical treatment have to be discussed to alleviate their symptoms and avoid complications.
For vaginal pessary, vaginal ring pessary is the commonest type of pessary used in Hong Kong. However, it was thought to be less effective in advanced stage of prolapse, or it was linked with much complications. Our study confirmed the efficacy of vaginal ring pessary in women with stage III POP in addition to pelvic floor exercise only and with low complication rates. And the introduction of using gellhorn pessary is promising in those who failed to retain ring pessary.

For prolapse surgery, the recurrence risk of prolapse was reported to be as high as up to 30% in the past with native tissue repair operation. Some women were hesitated to have operation for this reason. The use of synthetic mesh in prolapse surgery was with great debate in many countries and was suspended in areas. However, in Asia, including Hong Kong, this is still a valid option for women with advanced stage of prolapse. With appropriate patient sections and detail counselling, women should be offered with mesh operation to have significant reduction of the risk of recurrence after the prolapse operations.
Women with advanced stage of prolapse required an individualized treatment plan. The spectrum of treatment options for this group of women is wide and they should receive proper counselling concerning the use of vaginal pessary and various options of surgery.

Prof. Lan Zhu

Director
Department of Obstetrics and Gynecology
Peking Union Medical College Hospital
(China)

Vaginal mesh use and national registry

Background: Transvaginal repairs with synthetic mesh (TVM) are commonly used in pelvic organ prolapse (POP) treatment. Nevertheless, safety concerns, especially regarding mesh exposure rates, have arisen globally following the U.S. FDA's TVM usage ban.

Objective: To investigate TVM usage in POP surgeries and associated adverse effects.

Design，setting and participants: A national prospective registry study included 5621 TVM procedures 103 tertiary referral centers across China between July 1, 2019, and December 31, 2022.

Intervention: TVM repair for POP.

Outcomes Measures and Statistical Analysis: The primary outcome was the complication rate. Secondary outcome measures included efficacy and patient report outcomes. Descriptive statistics made and relationships with outcome analyzed using multivariable Cox regression and log-rank analysis.

Results: Patients were followed up for a median duration of 11.0 (range: 1.0~45.9) months, with perioperative complications observed in 3.9% (217/5621) of cases. Mesh exposure occurred in 83 instances, with an increased risk in patients who underwent a hysterectomy (HR 2.0, 95% CI 1.2-3.2, p=.004). Of these, 76 cases were less than 1cm2 and 46 were asymptomatic. These were managed with observation only, topical estrogen treatment, or mesh trimming. 7 patients (7/83, 8.4%) required subsequent surgery for partial mesh removal and mesh trimming under general anesthesia in the operating room. TVM repair exhibited high rates of anatomical cure (91.9%, 95% CI 90.2-93.3), subjective success (93.3%, 95% CI 92.3-94.2), composite surgical success (88.5%, 95% CI 86.8-90.0), and patient satisfaction (98.2%, 95% CI 97.6-98.7) 2 years postoperatively.

Conclusions: TVM repairs for POP treatment result in satisfactory anatomical and subjective outcomes with relatively low mesh exposure rates, particularly among sexually inactive patients. This study underscores the importance of continuous long-term safety monitoring of mesh use and identifying risk factors. It also highlights the need for evaluating clinical decision-making in POP management.

Dr. Clara Ka-Lai Shek

Associate Editor
Ultrasound in Obstetrics and Gynecology
(Australia)

Ultrasound Imaging of Synthetic Implants in Urogynecology

Childbirth is an important experience in a woman's life. Epidemiological studies, however, have shown that childbirth is an important risk factor for pelvic floor disorders. Parous women are more likely to experience pelvic organ prolapse and to suffer from urinary and faecal incontinence than nulliparous women. Several potential mechanisms may account for this link, and both pregnancy and the delivery process may play a role. During pregnancy exposure of pelvic tissues to reproductive hormones may favour elastolysis and collagen remodelling in response to pregnancy may alter the mechanical strength of pelvic floor. Furthermore mechanical effects of pregnancy may lead to increased distension of the levator hiatus and pelvic organ descent. While hormonal and mechanical effects of pregnancy may contribute to pelvic floor dysfunction, mode of delivery plays a central role in the link between childbirth and pelvic floor disorders, mediated by childbirth-related mechanical trauma. Obstetric anal sphincter tears and levator injuries are the two main forms of maternal birth trauma. The former is well recognised and has been extensively researched, trauma to the levator ani muscle is less well recognised which however may be more important. Only half of our midwifery colleagues have heard about the condition and only about half of O&G doctors considered themselves to be very well or well informed of levator trauma. A lack of understanding of maternal birth trauma among health care professionals can impact on women's care and can be due to a lack of teaching. Effort should be made to improve training and teaching on childbirth and pelvic floor trauma to help patient management and counselling.

Dr. Tomonori Hada

Director (Gynecology)
Yotsuya Medical Cube
(Japan)

vNOTES Hysterecomy

NOTES (Natural Orifice Transluminal Endoscopic Surgery) is a minimally invasive endoscopic surgical procedure performed via natural orifice such as the vagina, mouth, or anus. The vaginal approach in NOTES is called transvaginal NOTES or vNOTES.

Total vaginal NOTES hysterectomy (TVNH) and vaginally assisted NOTES hysterectomy (VANH) are the two main approaches for total removal of the uterus through the vagina in vNOTES. TVNH is performed endoscopically from the vaginal incision onward, and is necessary in rare cases such as cases of vaginal narrowness. I perform VANH.

In VANH, incision of vaginal fornix, and the opening of the Douglas pouch and the vesico-uterine pouch is performed vaginally. The uterosacral ligaments are also resected vaginally. The rest of the procedure is performed using laparoscopic techniques, although the amount of vaginal approach can vary. Today I will present key considerations for opening the Douglas pouch and vesico-uterine pouch, five key points for avoiding ureteral injury during parametrium resection, and the concept of vertically parametrium cutting.

Dr. Pong Mo Yuen

Director (Minimally Invasive Gynaecology)
Hong Kong Sanatorium & Hospital
(Hong Kong)

Contained Morcellation

Morcellation is the slicing of a large solid tissue into smaller fragments to allow removal from the abdominal cavity through a small incision. It is not confined to minimal invasive surgery. Contained morcellation, with or without the use of power morcellator, is performed in a separate and isolated compartment in the abdominal cavity to prevent spreading of tissue fragments and dissemination of cells. It also allows for a safe and complete removal of the tissue through small incisions. Contained morcellation for myomectomy and hysterectomy with a tissue containment system is recommended especially when power morcellator is used. However, cells and tissue spread occur at time of hysterotomy in myomectomy and dissemination cannot be totally avoided. The use of contained morcellation reduces the amount of tissue spread. A final irrigation and suctioning procedure after uncontained and contained morcellation may further reduce the risk of cell dissemination.

Prof. Mark Kilby

Honorary Consultant (Fetal Medicine)
Birmingham Women's and Children's Foundation Trust
(United Kingdom)

Improving the diagnostic accuracy and clinical utility of prenatal Next-Generation Sequencing investigation of the fetus with congenital malformations

Congenital malformations complicate up to 5% of all pregnancies and have increased perinatal mortality and morbidity. Up to 25% of structural anomalies detected by ultrasound are associated with chromosomal aneuploidy and copy number variants (CNVs). However, even when these are excluded there is an overall associated long-term morbidity.

Internationally, prenatal genomic sequencing, focusing on the exome (ES), is now commonly offered. The pre-tests selection of fetuses and the identification of a fetal phenotype by a multidisciplinary team of experts is key to increasing the diagnostic yield of such testing, which may be between 30-50%. However, many dysmorphic features are subtle and require expert ultrasonographic visualization, additional diagnostic imaging (i.e. MRI), and perhaps the use of AI technologies to optimize fetal selection for such testing.

Whereas ES evaluates only 1-2% of the whole genome containing 85% of pathogenic variants; the use of Whole Genome Sequencing can evaluate single gene variation, including splice site variants in both exonic and intronic regions. It has the potential to serve as an 'all-in-one' test assessing aneuploidy and unbalanced structural chromosomal anomalies and CNVs with high resolution. However, the post-test bioinformatic analysis, variant sorting, and 'calling' is critical for increasing pathogenic variant detection.

The Clinical impact and utility of such genomic testing is more than the diagnostic accuracy. It requires an understanding of the impact and variability of a genetic disease, as well as the options for intervention, place of delivery, and pre-and postnatal treatments, which are becoming increasingly available.

Dr. Lo Wong

Associate Consultant
The Chinese University of Hong Kong
(Hong Kong)

Massive transfusion protocol

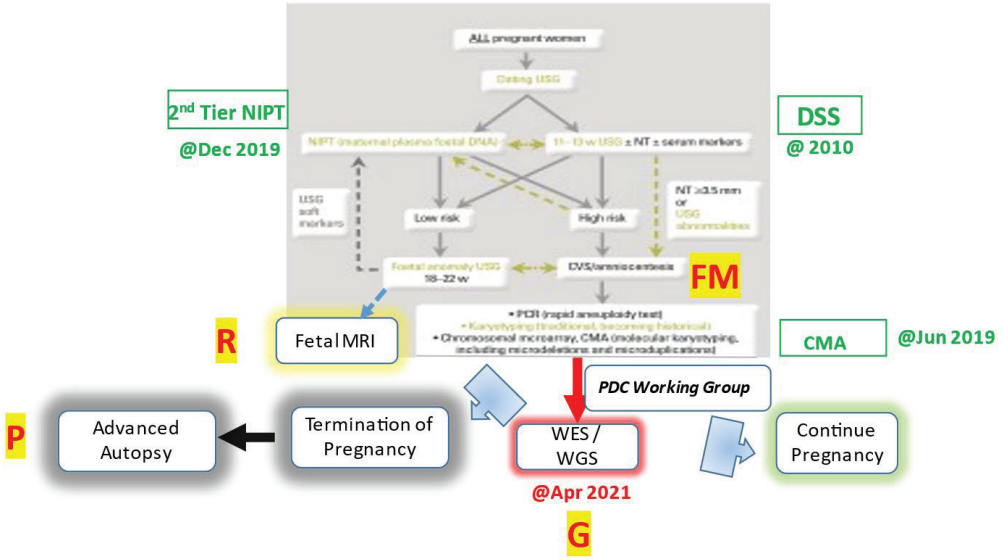
Obstetric hemorrhage remains a major cause of maternal mortality. Recent evidence suggests that early aggressive blood products replacement in massive hemorrhage can improve outcomes when compared with traditional resuscitation involving the use of large amounts of crystalloids and blood products replacement based on laboratory parameters. It can facilitate the resolution of coagulopathy, hypothermia and acidosis, and improve mortality in trauma patients. A Massive Transfusion Protocol provides a framework for systematic and co-ordinate management of patients with significant bleeding that require massive transfusion. Early recognition and activation, assessment and reassessment, bleeding control and haemostatic/ transfusion support are the key elements. It is evidence based and involve multidisciplinary approach to patient care and blood component support. We will share our experience with massive transfusion protocol use in a referral center with recent evidences and ongoing evaluation.

Dr. Wing-Cheong Leung

Consultant Obstetrician
Kwong Wah Hospital
(Hong Kong)

Implementation of Public Funded Genome Sequencing in Evaluation of Fetal Structural Anomalies

The Hospital Authority FMPRG (Fetal Medicine, Pathology, Radiology, Genetics/Genomics) programme is an online interactive platform for uploading special prenatal fetal medicine cases among the multi-disciplinary team members for sharing and voting to select appropriate cases for WES/WGS. The entire discussion and decision-making process can be completed online in a timely manner without the need of face-to-face meeting. And all the cases are archived on the website for education and research purposes together with secured patient privacy.



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Prof. Jinglan Zhang

Principal investigator
Fudan University
(China)

Concurrent non-invasive prenatal screening for genetic disorders of heterogenous etiologies: a prospective, multicenter cohort study

Jinglan Zhang[1], Yanting Wu[1], Songchang Chen[1], Qiong Luo[2], Hui Xi[3], Hua Wang[3], Dan Zhang[2], Chenming Xu[1], He-Feng Huang[1]

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Current non-invasive prenatal screening (NIPS) targets frequent chromosomal abnormalities such as Down syndrome, but numerous severe disorders with underlying single-gene defects are not included. A comprehensive NIPS which concurrently detects genetic diseases of diverse molecular etiologies would facilitate prenatal diagnosis and optimize prenatal management. However, the clinical validity and incremental detection yield for such a comprehensive screening approach has not been systemically assessed in prenatal care settings. In this prospective, multicenter study, pregnant women with elevated risks of fetal genetic disorders were enrolled for a newly developed NIPS, which encompassed three of the most frequent causes of human genetic disease: aneuploidies, microdeletions, and monogenic disorders. Cell-free DNA (cfDNA) from pregnant women's peripheral blood was extracted and enriched using coordinative allele-aware target enrichment (COATE) followed by high-depth targeted next-generation sequencing. The case series compared the cfDNA sequencing and the gold-standard invasive or postnatal diagnostic testing results for 1,090 qualified participants, resulting in the genetic diagnosis in 135 pregnancies with 98.5% (95% confidence interval or CI, 94.3%-99.7%) sensitivity and 99.3% (95% CI, 98.4%-99.7%) specificity. Of 876 fetuses with structural anomalies, 55 (56.1%) aneuploidies, 6 (6.1%) microdeletions, and 37 (37.8%) single-gene pathogenic variants were detected by NIPS. The detection rate of a diagnostic genetic variant was increased by 60.7% (from 61 to 98) when the targeted monogenic diseases were included along with chromosomal disorders. Notably, among the fetuses presenting skeletal abnormalities, 23.5% were attributed to single-gene defects while only 1.2% were due to chromosomal aberrations. Overall, this study shows that a comprehensive NIPS can accurately detect fetal genetic aberrations at both the chromosome and single-gene levels. In addition, we provided real-world clinical evidence that the inclusion of monogenic disorders to standard NIPS significantly improved the prenatal detection of human genetic disorders caused by heterogenous molecular etiologies.

Dr. Alyssa Wong

Honorary clinical assistant professor
The Chinese University of Hong Kong
(Hong Kong)

Caesarean scar pregnancy

Caesarean Scar Pregnancy (CSP) is a potentially dangerous consequence of a previous Caesarean section. A CSP occurs when the pregnancy is implanted on the uterine scar left behind after a previous Caesarean section. More cases have been reported, possibly due to an increased Caesarean section rate and increased awareness of the condition. The reported prevalence of the condition ranges widely in the literature. In a review, more than 10% of CSP were missed or misdiagnosed leading to serious complications. Diagnosis of the condition relies mainly on transvaginal ultrasound scanning. The following findings have been recommended: an empty uterine cavity with clearly visualized endometrium, an empty cervical canal, the gestational sac being present at the site of the niche, a thin or absent myometrium between the gestational sac and the bladder, presence of peritrophoblastic color doppler flow around the sac and a negative sliding sign. There is currently no consensus or established guideline on the optimal management of CSP. Numerous treatment options have been reported such as conservative management, uterine curettage, medical treatment with methotrexate, ultrasound guided local injection of methotrexate, hysteroscopic surgery, uterine artery embolization, laparoscopic surgery and hysterectomy. The challenges for the management of CSP will be discussed.

Prof. Philip R. Bennett

Professor
Department of Metabolism, Digestion and Reproduction
Imperial College London
(United Kingdom)

Microbiome and preterm birth

The 21st century has seen a dramatic improvement in our understanding of the human microbiome because the limitations of culture and microscopy-based investigations have been complemented by approaches based upon high-throughput sequencing of bacterial DNA. In the past decade, a large number of studies have associated the bacterial composition of the vaginal microbiome with a risk of preterm birth but are not consistent due to methodological and population differences. Nevertheless the broad themes which emerge are that Lactobacillus spp. depletion, and growth of bacterial vaginosis-associated anaerobic organisms is linked to the risk of euploid, but not aneuploid, miscarriage and both preterm pre-labour rupture of membranes (PPROM) and spontaneous preterm birth. In white European origin populations L. iners is also a risk factor for both cervical shortening and for preterm birth. It is the combination of an adverse microbiota and activation of the maternal innate immune system and complement pathways which underlies the risk. Several studies have shown that L. crispatus appears to be protective. L. crispatus produces lactic acid which acts to lower pH but also has direct anti-inflammatory properties. Co-occurrence network analysis shows that L. crispatus outcompetes other organisms. This arises from their production of specific antibiotic-like bacteriocidines and through sharing of glycan binding sites with other common vaginal organisms. Vaginal bacteria activate inflammation though Toll-like receptors (TLR) and sialic-acid-binding lectins (Siglac). L. crispatus expresses surface layer proteins (SLPs) which both block TLR signalling and activate anti-inflammatory C-type receptors (DC-SIGN). Microbiome analysis by DNA sequencing is time consuming and not sufficiently rapid for clinical use, however, ambient mass spectroscopy techniques are being developed, which can report both the structure of the vaginal microbiota, and the maternal immune response to it in a matter of minutes. Vaginal microbiome transplants are being developed, however, perhaps the most promising therapeutic avenue is live biotherapeutics containing L. crispatus, which do effectively displace dysbiosis, and colonise the vagina in pregnancy.

Prof. Andrew Shennan

Professor
King's College London
(United Kingdom)

Updates on Cervical Cerclage

Cervical cerclage is an established intervention for the management of pregnancies at high risk of preterm birth. Although studies exist to support its use in certain situations particularly in singleton pregnancies, many questions surrounding its use such as adjunct therapies and efficacy in specific subgroups of high risk women remain unanswered. This talk will assess the current evidence as well as areas where there is currently a paucity of data and an urgent requirement for further research.

Prof. Sharon Cameron

Consultant Gynaecologist
The University of Edinburgh
(United Kingdom)

Telemedicine in reproductive health

Telemedicine is the use of information and communication technology to improve patient outcomes by increasing access to care and medical information. Whilst telemedicine is not new, the introduction as a regular part of reproductive health care is relatively recent having increased markedly during the COVID-19 pandemic with the widescale adoption of telephone, internet and videocall consultations as an alternative to in person consultations. The option of having a consultation via telemedicine, helps reduce logistical and financial barriers to accessing care. A telemedicine consultation requires the same good communication skills as for an in-person consultation with the additional importance during telephone consultations of remaining attentive to verbal cues in the absence of visual ones.
Much evidence relating to telemedicine in reproductive health pertains to its use to deliver medical abortion. The body of research demonstrates that this model of care is safe, effective, acceptable to women and healthcare providers and provides a patient centred approach to care. Research has also shown that patients value the privacy, convenience and autonomy that the consultation by telemedicine offers. It has also been shown that it is cost effective to deliver abortion care this way compared to traditional in-person care in a UK setting. Both the WHO and RCOG guidelines recommend telemedicine delivery of abortion where possible and the RCOG have also produced a 'Best Practice paper' on telemedicine in abortion.

Of course, in-person consultations should still remain available for those who prefer this and are necessary for those who do not have telephones, internet access, or the ability to use digital technologies, effectively or confidentially. Ultimately telemedicine should strengthen reproductive health services rather than compete with them.

Prof. Ben Mol

Professor
Monash University
(Melbourne, Australia)

Telehealth – a new door for safe O&G care?

In response to the COVID-19 pandemic, many hospitals and health systems developed and implemented a new antenatal care schedule integrating telehealth across all models of pregnancy care. In an attempt to reduce mitigation of the corona-virus, face to face visits were reduced and replaced by telephonic or video
In Melbourne, we compared the conventional care period to the telehealth period. No significant differences were identified in the integrated care period with regard to the number of babies with fetal growth restriction (birthweight below the 3rd percentile; 2% in the integrated care period vs 2% in the conventional care period, p=0·72, for low-risk care models; 5% in the integrated care period vs 5% in the conventional care period, p=0·50 for high-risk care models), number of stillbirths (1% vs 1%, p=0·79; 2% vs 2%, p=0·70), or pregnancies complicated by pre-eclampsia (3% vs 3%, p=0·70; 9% vs 7%, p=0·15), or gestational diabetes (22% vs 22%, p=0·89; 30% vs 26%, p=0·06).

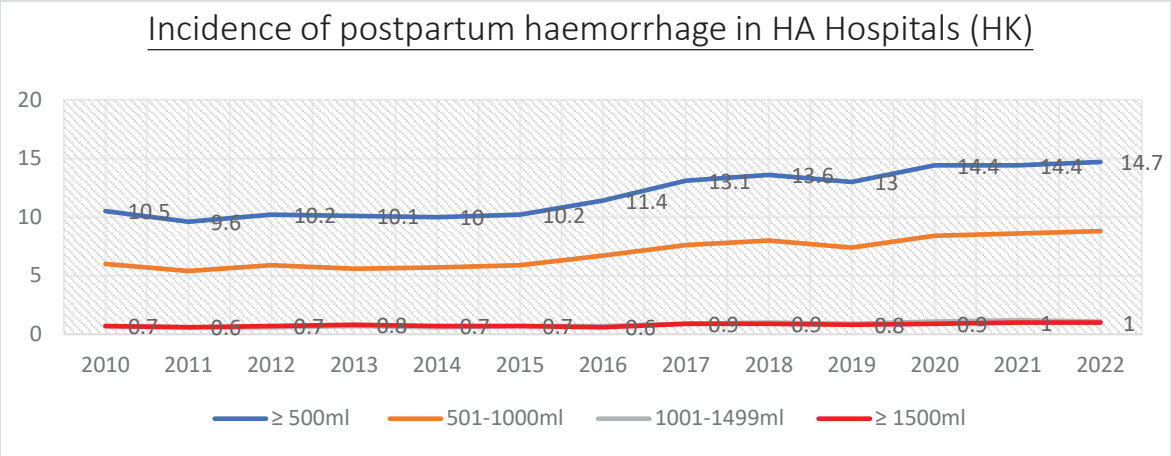
Interrupted time-series analysis showed a significant reduction in preterm birth among women in high-risk models (-0·68% change in incidence per week [95% CI -1·37 to -0·002]; p=0·049), but no significant differences were identified in other outcome measures for low-risk or high-risk care models after telehealth integration compared with conventional care.

Telehealth integrated antenatal care is going here to stay. It enables the reduction of in-person consultations by 50% without compromising pregnancy outcomes. This care model can help to minimise in-person interactions during future pandemics, but should also be considered in post-pandemic health-care models.

Dr. Wing-Cheong Leung

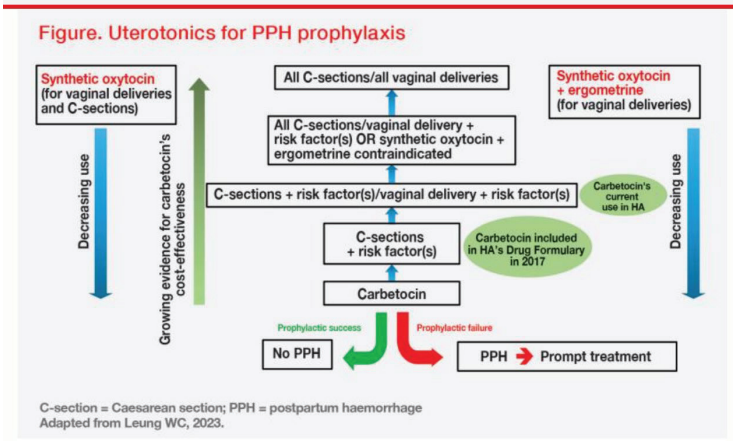
Consultant Obstetrician
Kwong Wah Hospital
(Hong Kong)

The landscape on the ever increasing rate of PPH



The incidence of PPH in HK is increasing progressively to a historical high of 14.7% in 2022. This increasing trend is indeed unexpected with increasing availability of uterotonics and use of second line measures such as balloon tamponade, compression sutures & others. Factors behind include increasing awareness with more open culture in reporting and higher maternal risk (advanced maternal age, previous Caesarean sections, etc).

A PPH Concern Group has been formed in 2023 under the COC O&G QA Subcommittee to look into this problem and to recommend solution. A comparative analysis is going to be performed using big data from CDARS to compare the maternal risk factors, intrapartum factors and maternal & baby outcomes among the eight HA Obstetrics Units from 2014 to 2022. Our hypothesis is that increasing use of Carbetocin as prophylaxis (? risk factors based vs. universal) with low threshold use of second line measures as early treatment of PPH could reduce the incidence of PPH. The result could be testified by the corresponding data from CDARS in the subsequent years.



Prof. Tak-Yeung Leung

Professor
Department of Obstetrics and Gynaecology
The Chinese University of Hong Kong
(Hong Kong)

Cost-effectiveness analysis of Carbetocin in prevention of PPH

Carbetocin, a long acting oxytocin analog, is known to be more effective than oxytocin in the prevention of postpartum haemorrhage (PPH) in high risk pregnancies. Recently, WHO also recommended carbetocin for prophylaxis in all births in contexts where its cost is comparable to other effective uterotonics. Recently there are a number of studies from the United Kingdom, Canada, India, as well as Hong Kong suggesting that carbetocin is cost-effective in different health care systems. Factors affecting its cost-effectiveness in real practice include not only the cost of the drugs, but also the incidences of different modes of birth and their associated risk of PPH, as well as the cost of the management of PPH and its associated complications. This review critically analyses the costs in the prevention and management of PPH, and explains why carbetocin remains to be cost-effective in different settings, even though it is more expensive than oxytocin.

Dr. Ka-Wang Cheung

Clinical associate professor
Department of Obstetrics and Gynaecology
The University of Hong Kong
(Hong Kong)

Delay interval delivery in pre- and prei-viable multiple pregnancy

Multiple pregnancy is associated with an increased risk of miscarriage; premature, preterm rupture of membranes and preterm birth. The risk of perinatal morbidity and mortality was inversely correlated to the gestational age of preterm birth.

The management of the pregnancy after delivery of the first fetus during second trimester miscarriage or very early preterm birth has not been well defined. Depending on the gestational age, termination of pregnancy before 24 weeks of gestation or immediate medical induction is an option due to the grave fetal prognosis and anticipated risk of ascending infection to the remaining fetus following cervical dilatation. However, this approach may potentially reduce the survival of the remaining fetus and be associated with significant perinatal morbidity and mortality with early preterm birth.

Delayed interval delivery of a second fetus in a multiple pregnancy was adopted in individual cases with the aim to improve the survival of the remaining fetus by prolonging the gestational age. It could an effective management option to increase the survival rate of the remaining fetus. However, the optimal management strategy for delay interval delivery remained controversial, especially on the role of tocolytics treatment and cervical cerclage. Given the rarity of suitable cases, a randomized controlled trial with international collaboration may be necessary. The current evidence, approach and clinical consideration of delay interval delivery will be discussed.

Dr. Clara Ka-Lai Shek

Associate Editor
Ultrasound in Obstetrics and Gynecology
(Australia)

Childbirth and Pelvic Floor Trauma

Childbirth is an important experience in a woman's life. Epidemiological studies, however, have shown that childbirth is an important risk factor for pelvic floor disorders. Parous women are more likely to experience pelvic organ prolapse and to suffer from urinary and faecal incontinence than nulliparous women. Several potential mechanisms may account for this link, and both pregnancy and the delivery process may play a role. During pregnancy exposure of pelvic tissues to reproductive hormones may favour elastolysis and collagen remodelling in response to pregnancy may alter the mechanical strength of pelvic floor. Furthermore mechanical effects of pregnancy may lead to increased distension of the levator hiatus and pelvic organ descent.

While hormonal and mechanical effects of pregnancy may contribute to pelvic floor dysfunction, mode of delivery plays a central role in the link between childbirth and pelvic floor disorders, mediated by childbirth-related mechanical trauma. Obstetric anal sphincter tears and levator injuries are the two main forms of maternal birth trauma. The former is well recognised and has been extensively researched, trauma to the levator ani muscle is less well recognised which however may be more important. Only half of our midwifery colleagues have heard about the condition and only about half of O&G doctors considered themselves to be very well or well informed of levator trauma. A lack of understanding of maternal birth trauma among health care professionals can impact on women's care and can be due to a lack of teaching. Effort should be made to improve training and teaching on childbirth and pelvic floor trauma to help patient management and counselling.

Dr. Osanna Wan

Council member
Hong Kong Urogynaecology Association
(Hong Kong)

Obstetric anal sphincter injury

Obstetrics anal sphincter injuries are serious perineal trauma after vaginal deliveries and its complications can be devastating to women's quality of life in both short and long term. It can lead to increased risks of pelvic floor injury, faecal or urinary incontinence, perineal pain, sexual dysfunction which could persist for years even after giving birth. Correct identification and prompt management are important to reduce the possible development of these consequences. Diagnosis and management especially for future mode of delivery should be individualized. There are development of different scan modalities and techniques in assessment of integrity of anal sphincters in recent years. A revision of diagnosis and update of management as well as review of evidence on its investigations and management will be discussed in this session of "Pregnancy and the pelvic floor – OASIS".

Prof. Sharon Cameron

Consultant Gynaecologist
The University of Edinburgh
(United Kingdom)

Safe abortion: new updates

Around 25 million unsafe abortions take place each year, making it one of the leading causes of maternal mortality and morbidity worldwide. These are largely preventable by providing safe abortion care in line with best practice guidelines. Recent updated guidance from the World health Organization (WHO) and Royal College of Obstetricians and Gynaecologists (RCOG) provides evidence-based recommendations on pre abortion care, medical and surgical methods and post abortion care. Both WHO and RCOG guidelines recommend telemedicine delivery of abortion where possible and the RCOG have produced a 'Best Practice Paper' on this. Research demonstrates that telemedicine medical abortion is safe, effective and provides a patient centred approach to care. Research has also shown that patients value the privacy, convenience and autonomy that the telemedicine consultation offers.

Minimising delays in access to abortion services is an important strategy to maximise efficacy of abortion. This is particularly important in highly restrictive settings where legislation prohibits abortion after the first weeks of pregnancy. In addition, at early gestations, there tends to be less pain and bleeding with medical abortion. A recent advance has been the development of clinical protocols for 'very early' medical abortion (VEMA), i.e. gestations less than 6 weeks when it is too early for an intrauterine pregnancy to be visible on ultrasound. Success of VEMA is presumed from a significant fall in serum human chorionic gonadotrophin from baseline. A number of observational studies have shown comparable rates of complete abortion with VEMA compared to when treatment is delayed until an intrauterine pregnancy can be confirmed. Studies have also indicated that VEMA is associated with fewer clinic visits and shorter time to diagnose ectopic pregnancies. A large (n=1500) multicountry RCT (Sweden, Finland, Norway Nepal, Scotland, New Zealand, Denmark) of VEMA compared to delayed treatment has recently completed and will report soon.

Dr. Grace Wong

Honorary Clinical Associate Professor
Department of Obstetrics and Gynaecology
The University of Hong Kong
(Hong Kong)

Recent developments in contraception

Despite the availability of different contraceptive methods with various delivery modes and duration of action, unintended pregnancy remains high. The search for ideal contraception that is affordable and readily available with high efficacy, reversibility, minimal or absent side effects and allows on-demand use is still on-going. The talk tries to highlight the recent developments in contraception including the use of more natural hormone like estetrol to reduce the unwanted risks, new studies on emergency contraception to improve on its efficacy and choice, the increase in the options of long-acting reversible contraception (LARC) in allowing convenience and the advancement of non-hormonal contraceptives. Need interest in male contraceptives including hormonal and non-hormonal under investigations will be explored to expand contraceptive choices beyond traditional female-centric methods, promoting shared responsibility and enhancing reproductive equity. These developments will heighten the reproductive choice and control of mankind and embracing diverse user needs.

Dr. Rozi Aditya Aryananda

Obstetrics and Gynaecology Specialist
(Indonesia)

Latest development for placenta accreta spectrum

Placenta Accreta Spectrum (PAS) is an abnormality in the placental implantation to the caesarean scar that frequently causes problems during caesarean section. The study of PAS has changed rapidly recently due to the increasing incidence of PAS in the world. Many controversies including the standard of clinical diagnosis, histopathology, ultrasound screening, and management of PAS may be confusing in some centers. There are two clinical classifications that are being widely discussed, the FIGO classification which focuses on clinicopathology, and the PAS topographical type classification which focuses on pelvic vascularity. Histopathology classification is also changed in concept since placenta percreta is not an abnormal placental invasion but correlates with uterine defect. One placenta can have all three types of PAS abnormalities resulting in various ultrasound signs and may lack clinical correlation during surgery in some studies.

Management of PAS is divided into 3 types, caesarean hysterectomy, left placental in situ, and one-step conservative surgery but there is no brief consensus on what is the optimal management for PAS. Another issue that is rarely discussed and often underreported especially in Low-Middle Countries is an emergency situation of PAS which leads to maternal mortality. This review will examine the controversy, ultrasound screening strategies, and new surgical staging of PAS in order to optimize PAS management based on hospital resources.

Dr. Meliza Kong

Consultant
Department of Obstetrics & Gynaecology
United Christian Hospital
(Hong Kong)

What devices do we have for the management of PPH? Are they fit for purpose?

Postpartum haemorrhage (PPH) is an important cause of maternal mortality and morbidity, accounting for up to 35% of all maternal deaths worldwide. Traditionally, if bleeding failed to be controlled by uterotonic drugs, hysterectomy will be performed as life-saving procedure. However, hysterectomy will lead to loss of future fertility potential to the woman, while performing hysterectomy during massive PPH often further increases blood loss particularly when there is co-existing disseminated intravascular coagulopathy. Hysterectomy also carries risks of visceral injury to the surrounding organs such as the ureters and urinary bladder. Therefore, conservative second-line surgical procedures including uterine compression sutures, uterine artery embolization and intrauterine balloon tamponade, has been developed to manage major PPH after failed medical treatment in the attempt to reduce the need for hysterectomy.

Intrauterine balloon tamponade systems are easy to insert and apply without the need of special expertise and have very few complications. There are various types of intrauterine devices used worldwide for PPH treatment, ranging from non-uterine-specific catheters such as the Foley catheter, Sengstaken–Blakemore oesophageal catheter, condom catheter, urological Rusch balloon to uterine-specific catheters such as the Bakri balloon, BT-Catheter, ebb's balloon and Zhukovsky obstetric balloon. The balloon tamponade system works by applying positive compression pressure on the vasculature of placental bed to achieve haemostasis.
In contrast, novel devices have been introduced in recent years to apply negative suction pressure into the uterine cavity to achieve haemostasis, including non-specific suction tube catheters, or specific modified Bakri balloon system and the Jada system.

The practical application of such devices as conservative second-line surgical management of major PPH will be reviewed and contrasted with their efficacy based on evidence from current literature.

Dr. Evelien Roos

Gynaecologist
TergooiMC
(The Netherlands)

Eliminating abuse, providing opportunities and restoring better health of adolescents

Violence against children, according to WHO, includes all forms of violence against people under 18 years old. Child violence, (online) abuse and sexual exploitation is a global emergency. This violence is shaping their lives and futures in profound and lasting ways. Poverty is commonly the main driver.
Globally, it is estimated that up to 1 billion children aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect in 2022 alone. This estimation has been magnified due to Covid-19, climate related and situations of armed conflict. In Hong Kong, the prevalence of child sexual abuse is 12%, 15% for girls and 9% for boys, and the statistics moved up in 2021.

Evidence from around the world shows that violence against children can be prevented. In 2016, WHO developed 7 strategies to end violence in children. For the healthcare professional is important to improve access to good-quality healthcare services to reduce the long-lasting effects of violence in addition to strengthen non-violent, respectful, positive and gender-equitable relationships for all children and adolescents in order to create a safe physical and social environment in clinics and to support parents and care givers.

When girls experience violence, this will impact their development, life-long health and well-being. Although the pain and tissue injury can completely heal in time, the psychological, social and medical consequences can persist through adulthood and are linked to poorer well-being. Child abuse is usually not a short-term problem, but requires different interventions at different times. The direct and indirect economic costs of the effects of abuse are substantial, and this violence not only undermines the potential of the individual but also the society.

Restoring better health is a process of building resilience and nurturing relationships such as parent-child relationships, family support and social support. Both promote mitigation and healing of the individual.

Dr. Charleen Cheung

Associate Consultant
Department of Obstetrics and Gynaecology
Queen Mary Hospital
(Hong Kong)

Adolescent pregnancy in Hong Kong and across the globe

Adolescent pregnancy occurs in girls aged 10-19 years. It is a global phenomenon. One in six adolescent girls and young women reported giving birth before age 18, and 2 million girls under age 15 become pregnant each year all over the world. Many adolescent pregnancies are unintended and may end up in abortions. The numbers are highly variable, by region where the girls belong to, and their educational and social background. In this presentation, we will review the various factors contributing to adolescent pregnancy, the biological, psychological and social consequences of adolescent pregnancy, from local perspectives and through a global lens.

Of note, adolescent pregnancy is often associated with high-risk behaviours. We carried out a 10-year review on teenage pregnancy in a university-affiliated tertiary hospital in Hong Kong. It was found out that repeat termination of pregnancy was common in this group. Regarding their contraceptive practice, nearly half of them did not use any form of contraception. Half of them were ever smokers. As many as 29% were screened positive for chlamydial infection, which was 5 times the prevalence (5.8%) of chlamydia infection in sexually active young women aged 16-26, and 20 times the overall prevalence (1.4%) of chlamydia infection in reproductive age women reported a population study in Hong Kong.

Adolescent pregnancy changes the life of the young woman. It jeopardises educational attainment and one's full potentials. The resulting social deprivation is often transgenerational. To combat this problem, societies should invest in girls' education including sexuality education, support girls' rights and empower them; men and boys should also be engaged in building gender equitable societies, preventing sexual violence or coercion. Provision of accessible sexual and reproductive health information and services would facilitate their choices, all in all, to optimise adolescent health and well-being.

FREE PAPER PRESENTATION (ORAL)

01	Cervical tear following Arabin pessary placement for the prevention of preterm birth *Dr. Carmen SM Ng, Hong Kong (Ab. 101)*
02	Joubert syndrome caused by novel compound heterozygous TMEM237 variants: a case report *Dr. Minh D-Thai, Vietnam (Ab. 59)*
03	Angiogenic factor and anti-angiogenic factor in uterine remodeling of placenta accreta spectrum *Mrs. Prita Aji Malinda, Indonesia (Ab. 7)*
04	E-cadherin in endometrial epithelial cell is a potential endometrial receptivitiy biomarker *Dr. Yin-Lau Lee, Hong Kong (Ab. 78)*
05	Identification of pharmacologically active small molecules that induce spheroid attachment and embryo implantation in vitro and in vivo *Ms. Shuya Sun, Hong Kong (Ab. 47)*
06	Optimizing the non-invasive preimplantation genetic testing in the laboratory *Dr. Judy FC Chow, Hong Kong (Ab. 64)*
07	Impact of immune imbalance on pregnancy outcomes in inflammatory bowel disease *Mr. Jin-Chuan Liu, Hong Kong (Ab. 62)*
08	Patient Satisfaction with Informed Consent for Vaginal Birth, a survey-based study *Dr. Yin-Fong Leung, Hong Kong (Ab. 27)*
09	Ultrasound assessment of progress in labour: a feasibility study *Dr. Nikky MW Lee, Hong Kong (Ab. 90)*
10	Successful transvaginal amniotic shunt in lower urinary tract obstruction (LUTO) *Dr. Lisa Novianti, Indonesia (Ab. 105)*
11	Clinical presentation and long-term outcome of vulvar lichen sclerosus in adult Chinese women *Dr. Charleen Cheung, Hong Kong (Ab. 66)*
12	Evaluation of the concordance of primary human papilomavirus testing between self-collected and clinician-collected samples *Dr. Aaron Chan, Hong Kong (Ab.75)*
13	Transcutaneous electrical nerve stimulation during oocyte retrieval: A randomised controlled trial *Dr. Jennifer Ko, Hong Kong (Ab. 80)*
14	A randomized controlled trial to compare the live birth rate of the first frozen embryo transfer following ovarian stimulation by the progestin-primed ovarian stimulation protocol versus the antagonist protocol in women with an anticipated high ovarian response undergoing in vitro fertilization *Prof. Ernest Ng, Hong Kong (Ab.35)*
15	First-trimester preeclampsia screening: psychological impact on pregnant women throughout pregnancy *Ms. Sin-Ting Tai, Hong Kong (Ab.91)*
16	Single nucleotide polymorphisms and folate related biomarkers concentrations among Chinese preconception women: A genome-wide association study *Dr. Qinyu Yao, China (Ab. 89)*
17	Obstetric outcomes in Jehovah's Witnesses: a case-control study over fifteen years in a tertiary teaching hospital *Dr. Vivian WY Ng, Hong Kong (Ab. 71)*
18	Predicting major and severe postpartum haemorrhage during caesarean section for placenta praevia using a simple scoring model *Dr. William To, Hong Kong (Ab. 18)*
19	Association of vitamin D level and miscarriage rate in women presenting with threatened miscarriage to the early pregnancy assessment clinic *Dr. Tsz Ching Christy Lam, Hong Kong (Ab. 77)*
20	Women's perspectives on the use of karyotyping of the product of conception in explaining the cause of miscarriages *Dr. Wing Ching Cheung, Hong Kong (Ab. 53)*

FREE PAPER PRESENTATION (ORAL)

21	The Utility of First Trimester Cervical Length Measurement by Transvaginal Ultrasound in the Prediction of Preterm Birth - A Systematic Review and Meta-Analysis *Dr. Justin Li, Hong Kong (Ab. 40)*
22	Longitudinal evaluation of cervical length and shear-wave elastography in women with spontaneous preterm birth *Dr. Long Nguyen Hoang, Hong Kong (Ab.84)*
23	Perception among pregnant women and feasibility of telehealth in obstetric services in Hong Kong *Dr. Ka-Wang Cheung, Hong Kong (Ab. 50)*
24	Smartphone electronic reminder to improve drug adherence during pregnancy: A randomised controlled trial *Dr. Mimi Seto, Hong Kong (Ab. 52)*
25	Associations between preconception alanine aminotransferase and glycometabolism profile during pregnancy: a community-based retrospective cohort *Mr. Yi Zhang, China (Ab.38)*
26	The accuracy of self-collected vaginal samples in cervical cancer screening with dual stain p16/Ki-67 *Dr. Stanton Ho, Hong Kong (Ab.37)*
27	HPV self-sampling for cervical cancer screening in Hong Kong *Ms. Ching Yin Chan, Hong Kong (Ab. 65)*
28	Comparison survival after minimally invasive surgery versus abdominal radical hysterectomy for early-stage cervical cancer *Dr. Lisa Novianti, Indonesia (Ab. 104)*
29	Parental folate cycle function before pregnancy and spontaneous pregnancy loss: a structural equation modelling approach *Mr. Xiaotian Chen, China (Ab.49)*
30	Vitamin A and E concentration at early gestation and risk of early-onset atopic dermatitis *Dr. Yuanzhou Peng, China (Ab.51)*
31	Decreased serum soluble programmed cell death ligand-1 level as a potential biomarker for missed miscarriage Vitamin A and E concentration at early gestation and risk of early-onset atopic dermatitis *Prof. Yao Wang, Hong Kong (Ab.86)*
32	Prediction of spontaneous preterm delivery in asymptomatic women with twin pregnancies using PAMG-1 and cervical length measurements *Dr. Meliza CW Kong, Hong Kong (Ab. 4)*
33	An evaluation of the incidence of OASIS in the era of reducing episiotomy rate *Ms. Wenxuan Jiang, Hong Kong (Ab.100)*
34	Advancement or delay of the next menstrual period after levonorgestrel emergency contraception is associated with the cycle day at administration *Dr. Raymond HW Li, Hong Kong (Ab.39)*
35	Circulating tumour cells in gynaecological malignancies *Dr. Thomas KT Li, Hong Kong (Ab.14)*
36	Local experience on hyperthermic intraperitoneal chemotherapy (HIPEC) in advanced epithelial ovarian cancer *Dr. Shuk-Tak Kwok, Hong Kong (Ab.30)*
37	Retrospective review on the management of Herlyn-Werner-Wunderlich syndrome *Dr. Karen Ng, Hong Kong (Ab. 79)*
38	Precocious puberty in a 2 years old girl with sclerosing stromal tumour of ovary: a case report *Dr. Dahlia Ningrum, Indonesia (Ab. 28)*

FREE PAPER PRESENTATION (E-POSTER)

Ab03	Patient satisfaction with ultrasound-guided manual vacuum aspiration in the management of first trimester pregnancy loss *Dr. Olivia SY Chau, Hong Kong*
Ab05	SACROCOCCYGEAL TERATOMA IN PRENATAL AND PERINATAL : A CASE REPORT *Dr. Ratkhiaber Asnawi, Indonesia*
Ab06	What is the Effectiveness on Pain Reduction and the Changes on Mode of Infant Feeding after Ultrasound Therapy for Lactating Mothers with Mammary Blocked Ducts? *Ms. Lai-Fong Ho, Hong Kong*
Ab08	Acute Postpartum Psychosis in Puerperal Sepsis Patient (A Case Report) *Dr. Mohammad Syarif Hidayatullah, Indonesia*
Ab09	The impact of elective single embryo transfer policy on the cumulative live birth rate and the multiple pregnancy rate of the first in vitro fertilisation cycle *Ms. Yeji Lim, Hong Kong*
Ab10	Calycosin from Astragalus membranaceus is therapeutic and synergizes with Cisplatin against chemoresistant ovarian cancer *Mr. Mingo MH Yung, Hong Kong*
Ab11	Does progesterone as predictive for a successful pregnancy along all age groups in fresh in vitro fertilisation/ intracytoplasmic injection transfer cycles? *Dr. Patricia NP Ip, Hong Kong*
Ab12	Restoring ovarian function by the treatment of ovary-derive cells *Dr. Yoon-Young Kim, South Korea*
Ab13	Warfarin-associated fetal intracranial hemorrhage: a case report and literature review *Dr. Libing Luo, China*
Ab15	Public fertility preservation service for cancer patients in Queen Mary Hospital *Dr. Dorothy TY Chan, Hong Kong*
Ab16	Objective and subjective outcome and complications of mid-urethral slings (retropubic and transobturator) for female stress incontinence after follow-up of 10 years *Dr. Carina Kwa, Hong Kong*
Ab20	Whole exome sequencing for detecting etiologies of non-immune hydrops fetalis *Dr. Chunchun Chen, China*
Ab21	Innovative Education Pathways: Navigating the Landscape of Complementary Learning in OBGYN Undergraduate Curriculum *Dr. Daniel Yim, Hong Kong*
Ab22	Highest chance combined screening results are associated with chromosome and structural differences outwith aneuploidy and increased nuchal translucency *Ms. Yin-Kwan Mok, Hong Kong*
Ab23	Tumor cell-derived CXCL10 triggers CD8+ T cell exhaustion in ovarian cancer *Ms. Runying Long, Hong Kong*
Ab24	Identification of PGM3 as a novel therapeutic target in ovarian cancer *Ms. Jiangnan He, China*
Ab25	Prediction of chemosensitivity to systematic treatments for ovarian cancer using patient-derived organoid models *Ms. Ruiqian Zhang, Hong Kong*
Ab26	Characterization of the regulatory mechanisms associated with reactive oxygen species (ROS) homeostasis in facilitating ovarian cancer chemoresistance *Ms. Minjun He, Hong Kong*
Ab29	Surveillance Program for Gynaecological Malignancies in Lynch Syndrome Carriers – A Single Center Experience *Dr. Man-Yee Chu, Hong Kong*

FREE PAPER PRESENTATION (E-POSTER)

Ab31	Fetal hyperthyroidism with maternal hypothyroidism: two cases of intrauterine therapy and review *Ms. Lu Hong, China*
Ab32	DO WE NEED AN ULTRASOUND EXAMINATION FOR EMERGENCY PLACENTA ACCRETA SPECTRUM? *Mr. Indra Mahyul, Indonesia*
Ab33	The evaluation of endometrial sampler SAP-1 in screening patients with general risk of endometrial cancer: a diagnostic test study *Dr. Hong Yu, Macau*
Ab34	Assessment of the prevalence of second stage Cesarean Section using a bubble chart *Dr. Catherine MW Hung, Hong Kong*
Ab36	Investigation of Lactobacillus, Lactate, and pH changes in regulating Human Endometrial Receptivity and predicting Pregnancy outcomes *Mr. Manish Kumar, Hong Kong*
Ab42	Study on the Influencing Factors of Menstrual Changes of Female Medical Workers after COVID-19 Infection and Their Correlation with Psychological Status *Ms. Hong Li, China*
Ab44	Homeostatic Model Assessment for Insulin Resistance is not an independent predictor of incident dysglycaemia or metabolic syndrome in women with polycystic ovary syndrome: a prospective observational study *Dr. Yu-Wing Tong, Hong Kong*
Ab45	Treatment outcome of Cesarean scar pregnancy under a novel classification system – the modified Delphi method *Dr. Kar-Kei Yung, Hong Kong*
Ab54	Enhance fertility *Dr. Thomas KT Li, Hong Kong*
Ab56	Birth preference in Chinese women with Fear of Childbirth: A cross-sectional study *Dr. Theodora HT Lai, Hong Kong*
Ab57	Congenital pulmonary airway malformation (CPAM), a retrospective clinical study from a tertiary center in China *Dr. Yuchun Zhu, China*
Ab58	Inappropriate sinus tachycardia in pregnancy: a little more than an exaggerated physiological response *Dr. Lee-Ting Kwong, Hong Kong*
Ab60	Single-cell analysis reveals the potential existence of epithelial stem/progenitor cells in human endometrial organoid *Mr. Jianlin Li, China*
Ab61	Three-dimensional endometrial co-culture model incoporating endometrial glandular organoid for studying estrogen induceded-endometrial gland development *Ms. Xintong Li, Hong Kong*
Ab67	Donor Human Milk Bank promote breastfeeding and Improving the Exclusive Breastfeeding in a Level III NICU : Experience From the University of Hong Kong-Shenzhen Hospital *Ms. Ting Su, China*
Ab68	A report of two rare cases of ovarian immature teratoma-associated anti-NMDAR encephalitis in girls *Ms. Yuting Zhang, China*
Ab69	Serial Case Report : Protein S Deficiency in Pregnancy, What Best Management in Satellite Hospital? *Dr. Qurrata Akyuni, Indonesia*
Ab70	Hypoglycemia in oral glucose tolerance test in pregnancy – a retrospective cohort study to evaluate maternal characteristics and neonatal outcomes *Dr. Vivian WY Ng, Hong Kong*

FREE PAPER PRESENTATION (E-POSTER)

Ab72	Sentinel lymph node biopsy in endometrial carcinoma *Dr. Hiu-Mei Luk, Hong Kong*
Ab73	Perception and Acceptance of Virtual clinic and COVID-19 vaccine in pregnant women *Dr. Joan KO Wai, Hong Kong*
Ab74	Multi-disciplinary planning and surgical treatment of intravenous leiomyomatosis - report of two cases *Dr. Tsz-Sam Hong, Hong Kong*
Ab76	Cumulative live birth rates of three in-vitro fertilization cycles in a university-affiliated reproductive medicine centre in Hong Kong *Dr. Evelyn Wong, Hong Kong*
Ab81	Association of baseline serum testosterone with ovarian reserve and responsiveness in women undergoing in vitro fertilization *Dr. Rebecca SF Wan, Hong Kong*
Ab82	A case of large fetal pericardial effusion managed by in-utero pericardiocentesis *Dr. Po-Lam So, Hong Kong*
Ab83	Accuracy of a paperless electronic reporting system versus conventional paper reporting in an andrology laboratory in Hong Kong *Dr. Kevin KW Lam, Hong Kong*
Ab85	Elucidating the Association between Sperm DNA Fragmentation and In-vitro Fertilisation Outcomes in the Hong Kong Population *Mr. Brayden KM Lee, Hong Kong*
Ab87	Retrospective review on management of imperforate hymen *Dr. Yat-Ka Yeung, Hong Kong*
Ab88	Neonatal outcomes of prenatally observed non-visualized cavum septum pellucidum *Dr. Jae-Yi Jeong, South Korea*
Ab93	Selective fetal reduction in multiply pregnancy: when, why and which methods: clinical experience *Dr. David Davarashvili, Georgia*
Ab94	A retrospective cohort study on using autologous iliotibial band for anterior vaginal wall prolapse *Dr. Mei-Chi Cheng, Hong Kong*
Ab95	Management of ovarian cysts in pregnancy - 12 year review in a tertiary centre *Dr. Chun-Yin Ng, Hong Kong*
Ab96	Successful prevention of recurrent gestational autoimmune liver disease by antepartum high-dose intravenous immunoglobulin - the first reported experience in a Chinese woman *Dr. Kar-Hung Siong, Hong Kong*
Ab97	Health awareness and perspectives on expanded carrier screening among consanguineous couples in Hong Kong *Dr. Kar-Hung Siong, Hong Kong*
Ab98	Accessory Cavitated Uterine Mass (ACUM) – a "missed" diagnosis? Report of two cases of diagnosis and management of ACUM *Dr. Francesca KY Lai, Hong Kong*
Ab99	A retrospective chart review on management and outcome of patients with cardiac disease in Queen Mary Hospital, Hong Kong *Dr. Kitty KW Ma, Hong Kong*
Ab103	Management of Severe Hemolytic Anemia with Negative Coombs Test in Pregnancy: A Case Report *Dr. Vashti Saraswati, Indonesia*
Ab106	MicroRNAs in spent culture media as potential biomarkers for embryo quality and implantation *Ms. Shanshan Zhang, Hong Kong*
Ab107	A randomized controlled study on the haemostatic effect of haemostatic sponge used in cervical biopsy *Ms. Hong Li, China*

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Reference: 1. Duphaston Hong Kong PI 2. Schindler AE. Progestational effects of dydrogesterone in vitro, in vivo and on the human endometrium. Maturitas, 2009;65S:S3-S11. 3. IQVIA MIDAS database Q3 2021 Release 4. Podzolkova N, Tatarchuk T, Doshchanova A, et al. Dydrogesterone treatment for menstrual-cycle regularization in routine clinical practice: a multicenter observational study. Gynecol Endocrinol 2016;32(3):246–9. 5. Tournaye H, Sukhikh GT, Kahler E, et al. A Phase III randomized controlled trial comparing the efficacy, safety and tolerability of oral dydrogesterone versus micronized vaginal progesterone for luteal support in in vitro fertilization. Hum Reprod 2017;32(5):1019–1027.

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Choose Lynparza™ for your BRCA-mutated mCRPC patients who have progressed following prior NHA treatment[1]

Lynparza™ is indicated as monotherapy for the treatment of adult patients with metastatic castration-resistant prostate cancer and BRCA1/2-mutations (germline and/or somatic) who have progressed following prior therapy that included a new hormonal agent[1].

Lynparza™ more than tripled median imaging-based PFS vs. physician's choice[2,,†]*

Lynparza™	*Physician's choice*
9.8 months	**3.0** months

HR=0.22; 95% CI: 0.15–0.32
Statistically significant

Lynparza™ increased median OS by 5.7 months vs. physician's choice[1,‡]

Lynparza™	*Physician's choice*
20.1 months	**14.4** months

HR=0.63; 95% CI: 0.42–0.95
Norminally statistically significant

Majority of patients stayed on Lynparza™ [3,§]

80% *of patients in the PROfound trial **remained on Lynparza™** without discontinuing due to adverse events[3,§]*

Test your prostate cancer patients for BRCA mutations

mCRPC=metastatic castration-resistant prostate cancer; NHA=new hormonal agent; OS=overall survival; PARPi=poly (ADP-ribose)polymerase inhibitor.

* Physician's choice refers to NHA, either enzalutamide (160 mg once daily) or abiraterone (1000 mg once daily, plus prednisone at a dose of 5 mg twice daily).

† Exploratory analyses for BRCA subgroup. The primary efficacy endpoint of the PROfound trial was imaging-based PFS in cohort A which included patients with BRCA or ATM mutations. Imaging-based PFS in cohort A was significantly longer in the Lynparza™ group than in the physician's choice group (7.4 months vs. 3.6 months; HR= 0.34; 95% CI, 0.25 to 0.47; P<0.001).

‡ Exploratory analyses for BRCA subgroup. The median OS in cohort A (patients with BRCA or ATM mutations) was a secondary endpoint of the PROfound trial, which the median OS was significantly longer in the Lynparza™ group than in the physician's choice group (19.1 months vs 14.7 months, HR=0.69; 95% CI, 0.50 to 0.97; P = 0.02).

§ In the overall population of PROfound, AE-related discontinuation rate was 20% with LynparzaTM vs 8% with control group. For LynparzaTM- treated patients, common AEs (≥15%) of any grade include anaemia, nausea, fatigue or asthenia, decreased appetite, diarrhea, vomiting and constipation. Anemia was the most common grade 3/4 AE for patients with LynparzaTM (22% vs 5 % with control group). Please refer to the full Prescribing Information for more details on safety of LynparzaTM.

References:
1. Lynparza™ Hong Kong Prescribing Information. 2. De Bono J, et al. N Engl J Med 2020; 382:2091-2102. 3. Hussin M, et al. N Engl J Med. 2020;383:2345-2357.

Presentation: Lynparza film coated tablet 100 mg or 150 mg. Indications: Monotherapy for the maintenance treatment of adult patients with advanced (FIGO stages III and IV) BRCA1/2-mutated (germline and/or somatic) high grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy; monotherapy for the maintenance treatment of adult patients with platinum sensitive relapsed high grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum based chemotherapy; in combination with bevacizumab for the maintenance treatment of adult patients with advanced (FIGO stages III and IV) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy in combination with bevacizumab and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a BRCA1/2 mutation and/or genomic instability; monotherapy for the treatment of adult patients with germline BRCA1/2-mutations, who have HER2 negative locally advanced or metastatic breast cancer. Patients should have previously been treated with an anthracycline and a taxane in the (neo)adjuvant or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should also have progressed on or after prior endocrine therapy, or be considered unsuitable for endocrine therapy; monotherapy for the maintenance treatment of adult patients with germline BRCA1/2-mutations who have metastatic adenocarcinoma of the pancreas and have not progressed after a minimum of 16 weeks of platinum treatment within a first-line chemotherapy regimen; monotherapy for the treatment of adult patients with metastatic castration-resistant prostate cancer and BRCA1/2-mutations (germline and/or somatic) who have progressed following prior therapy that included a new hormonal agent. Dosage: 300mg bd oral; for first-line maintenance treatment of BRCA-mutated advanced ovarian cancer, continue until radiological disease progression, unacceptable toxicity or for up to 2 years if there is no radiological evidence of disease after 2 years of treatment. Patients with evidence of disease at 2 years can be treated beyond 2 years; for combination with bevacizumab for the first-line maintenance treatment of high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer following completion of first-line platinum-based therapy with bevacizumab, the dose of bevacizumab is 15 mg/kg once every 3 weeks. Patients can continue treatment with Lynparza until radiological disease progression, unacceptable toxicity or for up to 2 years if there is no radiological evidence of disease after 2 years of treatment. Patients with evidence of disease at 2 years, who in the opinion of the treating physician can derive further benefit from continuous Lynparza treatment, can be treated beyond 2 years. Please refer to the product information for bevacizumab for the recommended overall duration of treatment of a maximum of 15 months including the periods in combination with chemotherapy and as maintenance; for maintenance treatment of platinum sensitive relapsed ovarian cancer, start no later than 8 weeks after completion of their final dose of the platinum containing regimen, continue until progression of the underlying disease or unacceptable toxicity; for gBRCA1/2-mutated HER2-negative metastatic breast cancer, continue until progression of the underlying disease or unacceptable toxicity; for first-line maintenance treatment of gBRCA-mutated metastatic adenocarcinoma of the pancreas, it is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity; for BRCA1/2-mutated metastatic castration-resistant prostate cancer, it is recommended that treatment be continued until progression of the underlying disease or unacceptable toxicity. Medical castration with luteinising hormone releasing hormone (LHRH) analogue should be continued during treatment in patients not surgically castrated; swallow whole and do not chew, crush, dissolve or divide tablets. Lynparza tablets should not be substituted for Lynparza capsules on a milligram-to-milligram basis. Contraindications: Hypersensitivity to any of its ingredients, during breast-feeding and for one month after last dose. Precautions: Should not be used in patients with haematological toxicity, pregnancy. Women should not become pregnant while on Lynparza and at the beginning of treatment. Male patients and their female partners of childbearing potential should use reliable contraception during therapy and for 3 months after receiving the last dose of Lynparza. Risk of myelodysplastic syndrome/acute myeloid leukemia, pneumonitis, embryofoetal toxicity. Cautious use in patients on statins, vaccines, immunosuppressant agents. May affect ability to drive or use machines. Interactions: Other anticancer medications; CYP3A inhibitors and inducers; substrates of CYP1A2, 2B6, 3A4; substrates of P-gp, BCRP, OATP1B1, OCT1, OCT2, OAT3, MATE1 and MATE2K; hormonal contraceptives. Undesirable effects: Decreased appetite, anaemia, headache, dizziness, dysgeusia, nausea, vomiting, diarrhea, dyspepsia, cough, dyspnoea, fatigue (including asthenia), upper abdominal pain, stomatitis, neutropenia, thrombocytopenia, leukopenia, rash, increased blood creatinine. Full local prescribing information is available upon request. API.HK.LTB.0421

Please visit contactazmedical.astrazeneca.com, for (1) enquiring Medical Information (MI), (2) reporting Individual Case Safety Report (ICSR) and/or (3) reporting Product Quality Complaint (PQC) to AstraZeneca Hong Kong Limited.

AstraZeneca

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Lynparza™
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tablets 100 mg 150 mg

HK-6104 12/10/2021 4IC_2022

BAYER : WORLD LEADER
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NO.1
Most prescribed
Contraceptive Pills in HK[2]

Bayer is a world leader in female hormonal contraception[2,3,4]

Well established COCs Extensive research in both clinical and real-world settings[6-36]

Broad user experience Trusted by millions of women in >100 countries collectively[3,4,5,37]

References:
1. Bayer WHC Leadership Messages 2020_Proof points. 2. IMS research data MAT Q4 2022 (Sales Value) with channel breakdown. 3. YAZ® Message Platform 2019. 4. YASMIN® Message Platform 2019. 5. Data on file 6. Bachmann G, et al. *Contraception* 2004;70:191-198. 7. Wang C, et al. *Zhonghua Fu Chan Ke Za Zhi* 2014;49:355-359. 8. Hernádi L, et al. *Contraception* 2009;80:18-24.. 9. Koltun W, et al. *Contraception* 2008;77:249-256. 10. Maloney JM, et al. *Obstet Gynecol* 2008;112:773-781. 11. Zhang GY, et al. *Chin J Dermatol* 2015;48:85-89. 12. Fu Y, et al. *Zhonghua Fu Chan Ke Za Zhi* 2014;49:506-509. 13. Pearlstein TB, et al. *Contraception* 2005;72:414-421. 14. Yonkers KA, et al. *Obstet Gynecol* 2005;106:492-501. 15. Anttila L, et al. *Contraception* 2009;80:445-551. 16. Klipping C, et al. *Contraception* 2008;78:16-25. 17. Klipping C, Marr J. *Contraception* 2005;71:409-416. 18. Bitzer J, et al. *Int J Womens Health* 2015;7:501-509. 19. Momoeda M, et al. *Int J Womens Health* 2014;6:989-998. 20. Dinger J, et al. *Obstet Gynecol* 2011;117:33-40. 21. Foidart JM, et al. *Eur J Contracept Reprod Health Care* 2000;5:124-134. 22. Huber J, et al. *Eur J Contracept Reprod Health Care* 2000;5:25-34. 23. Parsey KS, Pong A. *Contraception* 2000;61:105-111. 24. Fan GS, et al. *Clin Drug Investig* 2010;30:387-396. 25. van Vloten WA, et al. *Cutis* 2002;69(4 Suppl):2-15. 26. Thorneycroft IH, et al. *Cutis* 2004;74:123-130. 27. Endrikat J, et al. *Eur J Contracept Reprod Health Care* 2007;12:220-228. 28. Kelly S, et al. *Clin Drug Investig* 2010;30:325-336. 29. Kluft C, et al. *Contraception* 2006;73:336-343. 30. Gaspard U, et al. *Contraception* 2003;67:423-429. 31. Gaspard U, et al. *Contraception* 2004;69:271-278. 32. Dinger JC, et al. *Contraception* 2007;75:344-354. 33. Dinger JC, et al. *Contraception* 2016;378-385. 34. Dinger JC, et al. *Contraception* 2014;253-263. 35. Seeger JD, et al. *Obstet Gynecol* 2007;110:587-593. 36. Endrikat JS, et al. *Contraception* 2009;79:428-432. 37. YAZ family Periodic Benefit-Risk Evaluation Report/Periodic Safety Update Report version 26 (Oct 2021), p23 and page 28-29.

YAZ
Indication for Use: Yaz (drospirenone and ethinylestradiol) is indicated for conception control in women. **Composition:** 3.0 mg drospirenone and 0.020 mg ethinylestradiol in tablet form. Clinically relevant nonmedicinal ingredient: lactose monohydrate. **Posology and Method of Administration: Oral administration.** The patient may begin using Yaz on day 1 of her menstrual cycle or on the first Sunday after her period begins. If Yaz tablets are taken later than day 1 when first starting medication, an additional (barrier) method of birth control is recommended for the first 7 days of use. Tablets must be taken in the order directed on the package every day at about the same time. One hormone-containing light pink tablet is to be taken daily for 24 consecutive days, followed by one hormone-free white tablet daily for 4 consecutive days. **Contraindications:** Should not be used in women with a history of actual thrombophlebitis or thromboembolic disorders, actual cerebrovascular disorders, actual myocardial infarction or coronary artery disease or actual prodromi of a thrombosis; valvular heart disease with complications; presence of severe or multiple risk factor(s) for arterial or venous thrombosis; use with the Hepatitis C virus combination drug regimen ombitasvir, paritaprevir, ritonavir, with or without dasabuvir; active liver disease or history of, or actual benign or malignant liver tumors; known or suspected carcinoma of the breast; carcinoma of the endometrium or other known or suspected estrogen- dependent neoplasia; undiagnosed abnormal vaginal bleeding; steroid-dependent jaundice, cholestatic jaundice, history of jaundice in pregnancy; any ocular lesion arising from ophthalmic vascular disease, such as partial or complete loss of vision or defect in visual fields; known or suspected pregnancy; current or history of migraine with focal aura; history of or actual pancreatitis if associated with severe hypertriglyceridemia; renal insufficiency; hepatic dysfunction; adrenal insufficiency; hypersensitivity to this drug or to any ingredient in the formulation or component of the container. **Warnings and Precautions:** Combination oral contraceptives, including Yaz, should not be used by women who are over 35 years of age and smoke. Hormonal contraceptives **do not protect** against sexually transmitted infections (STIs) including HIV/AIDS. It is advisable to use latex or polyurethane condoms **in combination with** hormonal contraceptives to protect against STIs. Discontinue medication at the earliest manifestation of the following events: thromboembolic and cardiovascular disorders, conditions that predispose to venous stasis and to vascular thrombosis, visual defects (partial or complete), papilledema, ophthalmic vascular lesions, severe headache of unknown etiology or worsening of pre-existing migraine headache, increase in epileptic seizures. **Adverse effects:** ***Common:*** spotting, breakthrough bleeding, nausea and vomiting. For ***uncommon and rare adverse reactions,*** please refer to the full prescribing information. August 2019.Approval number: PP-YAZ-HK-0011-1

Yasmin
Indication for Use: Yasmin (drospirenone and ethinylestradiol) is indicated for conception control in women. **Composition:** 3.0 mg drospirenone and 0.030 mg ethinylestradiol in tablet form. Clinically relevant nonmedicinal ingredient: lactose monohydrate. **Posology and Method of Administration: Oral administration.** Tablets must be taken in the order directed on the package every day at about the same time. The patient may begin using on Day 1 of her menstrual, on Day 5, or on the first Sunday after her period begins. If the patient's period begins on Sunday, she should start that same day. If Yasmin tablets are taken later than Day 1 when first starting medication, an additional (barrier) method of birth control is recommended for the first seven days of use. One hormone-containing yellow tablet is to be taken daily for 21 consecutive days. Tablets are then discontinued for 7 consecutive days. **Contraindications:** Should not be used in women with a history of actual thrombophlebitis or thromboembolic disorders, actual cerebrovascular disorders, actual myocardial infarction or coronary artery disease or actual prodromi of a thrombosis; valvular heart disease with complications; presence of severe or multiple risk factor(s) for arterial or venous thrombosis; active liver disease or history of or actual benign or malignant liver tumors; known or suspected carcinoma of the breast; carcinoma of the endometrium or other known or suspected estrogen-dependent neoplasia; undiagnosed abnormal vaginal bleeding; steroid-dependent jaundice, cholestatic jaundice, history of jaundice in pregnancy; any ocular lesion arising from ophthalmic vascular disease, such as partial or complete loss of vision or defect in visual fields; known or suspected pregnancy; current or history of migraine with focal aura; history of or actual pancreatitis if associated with severe hypertriglyceridemia; renal insufficiency; hepatic dysfunction; adrenal insufficiency. Hypersensitivity to this drug or to any ingredient in the formulation or component of the container. **Warnings and Precautions:** Combination oral contraceptives, including Yasmin, should not be used by women who are over 35 years of age and smoke. Hormonal contraceptives **do not protect** against sexually transmitted infections (STIs) including HIV/AIDS. It is advisable to use latex or polyurethane condoms **in combination with** hormonal contraceptives to protect against STIs. Discontinue medication at the earliest manifestation of the following events: thromboembolic and cardiovascular disorders, conditions that predispose to venous stasis and to vascular thrombosis, visual defects (partial or complete), papilledema, ophthalmic vascular lesions, severe headache of unknown etiology or worsening of pre-existing migraine headache, increase in epileptic seizures. **Adverse effects:** ***Common:*** spotting, breakthrough bleeding, nausea and vomiting. For ***uncommon and rare adverse reactions,*** please refer to the full prescribing information. August 2019. Approval number: PP-YSM-HK-0050-1

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Quarry Bay, Hong Kong
Tel: (852) 8100 2755

Bayer Women's Health Hotline:
8100 2755

PP-YSM-HK-0075-1

Visanne®

Visanne® [Dienogest 2 mg]

has no restriction on the treatment duration of Endometriosis[1]

- **Effectively reduced the severity of endometriosis** and **endometriosis-associated pain** (around 80% patients experienced pain relief)[2]
- **Proven effectiveness in preventing recurrence of endometriosis after surgical treatment** (recurrence rate 4% in treatment group vs 69% in no treatment group at 5 years after surgery)[3]
- **Demonstrated a favorable safety** and **tolerability profile with long-term management**[4]

References:
1. Visanne HK PI 2021.
2. Techatraisak K, *et al. BMC WomensHealth*. 2019;19:68.
3. Ota Y, *et al. Journal of Endometriosis and Pelvic Pain Disorders*. 2015;7:63-67.
4. Moehner S, *et al. Journal of Endometriosis and Pelvic Pain Disorders*. 2021;13:104-110.

Visanne API Indication for Use: Treatment of endometriosis. **Composition:** Each tablet contains 2 mg dienogest and one of the excipients with known effect: 62.8 mg lactose monohydrate. **Posology and Method of Administration:** The dosage of Visanne is one tablet daily without any break, taken preferably at the same time each day with some liquid as needed. Tablets must be taken continuously without regard to vaginal bleeding. Treatment can be started on any day of the menstrual cycle. Any hormonal contraception needs to be stopped prior to initiation of Visanne. If contraception is required, non-hormonal methods of contraception should be used. Visanne is for oral use and can be taken with or without food. **Contraindications:** Visanne should not be used in the presence of or be discontinued immediately upon discovery of the following conditions: active venous thromboembolic disorder, arterial and cardiovascular disease, past or present (e.g. myocardial infarction, cerebrovascular accident, ischemic heart disease), diabetes mellitus with vascular involvement, presence or history of severe hepatic disease as long as liver function values have not returned to normal, presence or history of liver tumours (benign or malignant), known or suspected sex hormone-dependent malignancies, undiagnosed vaginal bleeding, hypersensitivity to the active substance or to any of the excipients. **Warnings and Precautions:** ***Serious uterine bleeding:*** In the event of anemia, discontinuation of Visanne should be considered; ***Changes in bleeding pattern:*** The majority of patients treated with Visanne experience changes in their menstrual bleeding pattern; ***Circulatory disorders:*** Treatment should be stopped at once if there are symptoms of an arterial or venous thrombotic event or suspicion thereof; ***Tumors:*** A hepatic tumour should be considered in the differential diagnosis when severe upper abdominal pain, liver enlargement or signs of intra-abdominal haemorrhage occur in women taking Visanne. ***Osteoporosis:*** In patients who are at an increased risk of osteoporosis a careful risk- benefit assessment should be performed before starting Visanne because endogenous estrogen levels are moderately decreased during treatment with Visanne; ***Other conditions:*** please refer to section 4.4 in the full prescribing information: ***Lactose:*** Patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucosegalactose malabsorption who are on a lactose-free diet should consider the amount contained in Visanne. **Adverse effects:** ***Common:*** breast discomfort, ovarian cyst, hot flushes, uterine / vaginal bleeding including spotting, weight increase, depressed mood, sleep disorder, nervousness, loss of libido, altered mood, headache, migraine, nausea, abdominal pain, flatulence, abdominal distension, vomiting, acne, alopecia, back pain, asthenic conditions, irritability. For ***uncommon and rare adverse reactions,*** please refer to section 4.8 in the full prescribing information. May 2021. Approval number: PP-VIS-HK-0050-1

Bayer HealthCare Limited

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PP-VIS-HK-0056-1

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Turnaround within **7 days.**

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✓22 types of autosomal trisomies
✓4 types of sex chromosome aneuploidies

Hong Kong Non-invasive Prenatal Genetic Testing Technology Patent

Certification Hong Kong Patent No.: HK119075841

Hong Kong Patent Approval

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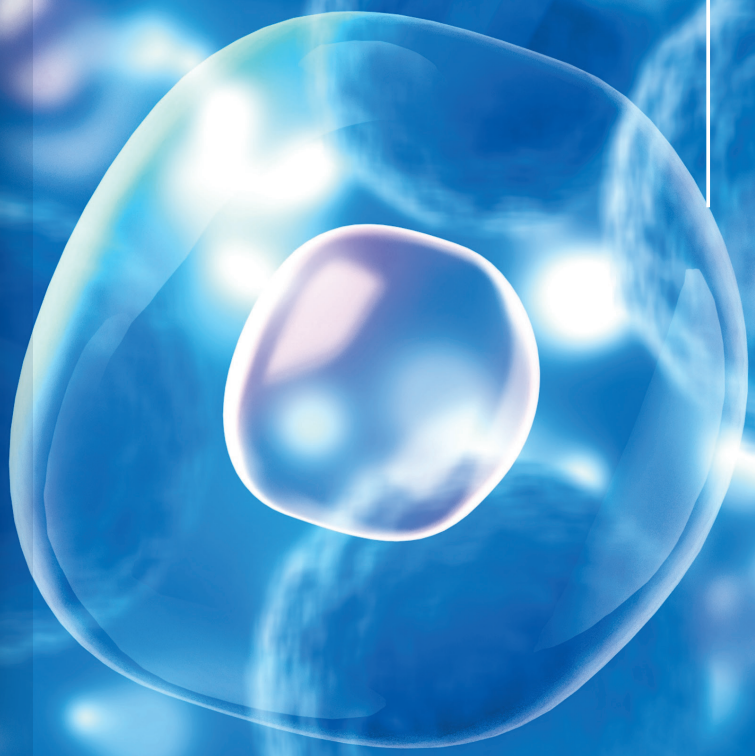
Cordlife Partners with SingHealth Duke-NUS Academic Centre to Advance Stem Cell Technology to First-In-Man Clinical Trial in Singapore



Expansion of Haematopoietic Stem and Progenitor Cells from Stored Umbilical Cord Blood with C7

As the operator of the largest network of stem cell banks in Asia, Cordlife Group has partnered with SingHealth Duke–NUS Academic Medical Centre ("AMC") to advance cord blood stem cell technology in a first-in-man clinical trial in Singapore. This technology involves using a newly identified synthetic compound, C7, to expand hematopoietic stem and progenitor cells (HPSCs) found in umbilical cord blood (UCB) ex-vivo. C7 is also the first patented small molecule that could expand HSPCs in UCB without the need to perform prior CD34/ CD133 based stem cell enrichment.

Once proven successful, the technology is expected to benefit patients suffering from blood cancers, such as leukemia, neuroblastoma, lymphoma, as well as other blood-related conditions, such as thalassemia and sickle cell disorder. This technology also provides a solution to enhance the cell dose of the UCB units for cell therapy. Although these patients can also be transplanted with stem cells from bone marrow or peripheral blood, cord blood stem cells have proven to be more superior, resulting in lower rate of rejection, infection and hospitalization. The matching requirement of cord blood is also less stringent, making it easier for patients to find a suitable match.

This is an exciting news for all Cordlife clients as they will have direct access to this novel technology once it is available. We hope that you too will find this news useful and relevant to your practice. We would be grateful if you could help us inform your patients of this good news so that they can make well informed decision for their baby.

References:
Bari, S., Zhong, Q., Fan, X., Poon, Z., Lim, A., Lim, T. H., Dighe, N., Li, S., Chiu, G., Chai, C., & Hwang, W. (2018). Ex Vivo Expansion of CD34+ CD90+ CD49f+ Hematopoietic Stem and Progenitor Cells from Non-Enriched Umbilical Cord Blood with Azole Compounds. Stem cells translational medicine, 7(5), 376–393. https://doi.org/10.1002/sctm.17-0251

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HealthBaby Biotech (Hong Kong) Co., Limited
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Hong Kong Science Park, Shatin, Hong Kong

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Committed to building families from *conception* to *birth*

About Ferring Pharmaceuticals

Ferring Pharmaceuticals is a research-driven, specialty biopharmaceutical group committed to helping people around the world build families and live better lives. Headquartered in Saint-Prex, Switzerland, Ferring is a leader in reproductive medicine and maternal health, and in specialty areas within gastroenterology and urology. Ferring has been developing treatments for mothers and babies for over 50 years and has a portfolio covering treatments from conception to birth. Founded in 1950, privately-owned Ferring employs over 7,000 people worldwide. The company has operating subsidiaries in more the 50 countries and markets its products in over 100 countries.

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HK-RMMH-2300005 Oct-2023

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Duratocin®
CARBETOCIN

From prevention of PPH due to uterine atony to *motherhood*[1]

A single dose of room-temperature **DURATOCIN** prevents postpartum haemorrhage in **C-section** and **vaginal delivery** through its long-lasting effects[1]

Disclaimers:
DURATOCIN is approved in Hong Kong and may not be approved in all countries. The local product information is available on the stand. Please refer to the full local product information approved by the local health authorities in your respective country of practice before prescribing.

Abbreviated Prescribing Information of DURATOCIN
Active Ingredient: Carbetocin. **Indications:** Prevention of postpartum haemorrhage due to uterine atony. **Dosage & Administration:** *Caesarean section under epidural or spinal anaesthesia* 100 mcg (1mL) IV slowly over 1 min. *Vaginal delivery* 100 mcg (1mL) IV slowly over 1 min or IM. **Contraindications:** Hypersensitivity. During pregnancy & labour before delivery. For induction of labour. Hepatic or renal disease. Serious CVD. Epilepsy. **Special Warnings and Precautions**: Must only be administered after delivery of infant & ASAP, preferably before delivery of placenta. Intended for single administration only. No data on additional doses of carbetocin or the use of carbetocin following persisting uterine atony after oxytocin. Monitor early signs of hyponatraemia e.g. drowsiness, listlessness & headache, particularly in patients receiving large vol of IV fluids. Use with caution in migraine, asthma, CVD or any state in which a rapid addition to extracellular water may produce hazard for an already overburdened system. Carefully monitor patients with eclampsia & pre-eclampsia. No studies on gestational DM. No established safety & efficacy, and dosage recommendation on adolescents. **Side Effects:** *IV* Headache, tremor, hypotension, flushing, nausea, abdominal pain, pruritus, feeling of warmth. *IM* Anaemia, headache, dizziness, tachycardia, hypotension, chest pain, nausea, abdominal pain, vomiting, back pain, muscular weakness, chills, pyrexia, pain. **Interactions:** Concomitant use w/ vasoconstrictors in conjunction w/ caudal block anaesthesia may lead to severe HTN. May enhance BP enhancing effect of ergot-alkaloids e.g. methylergometrine. Prostaglandins may potentiate effect of carbetocin. Some inhalation-anesthetics e.g. halothane & cyclopropane may enhance hypotensive effect of carbetocin, weaken effect of carbetocin & cause arrhythmias.

References: 1. Hong Kong Product Package Insert of DURATOCIN (Date of revision: JAN 2020)

For additional information, please consult the product package insert before prescribing.

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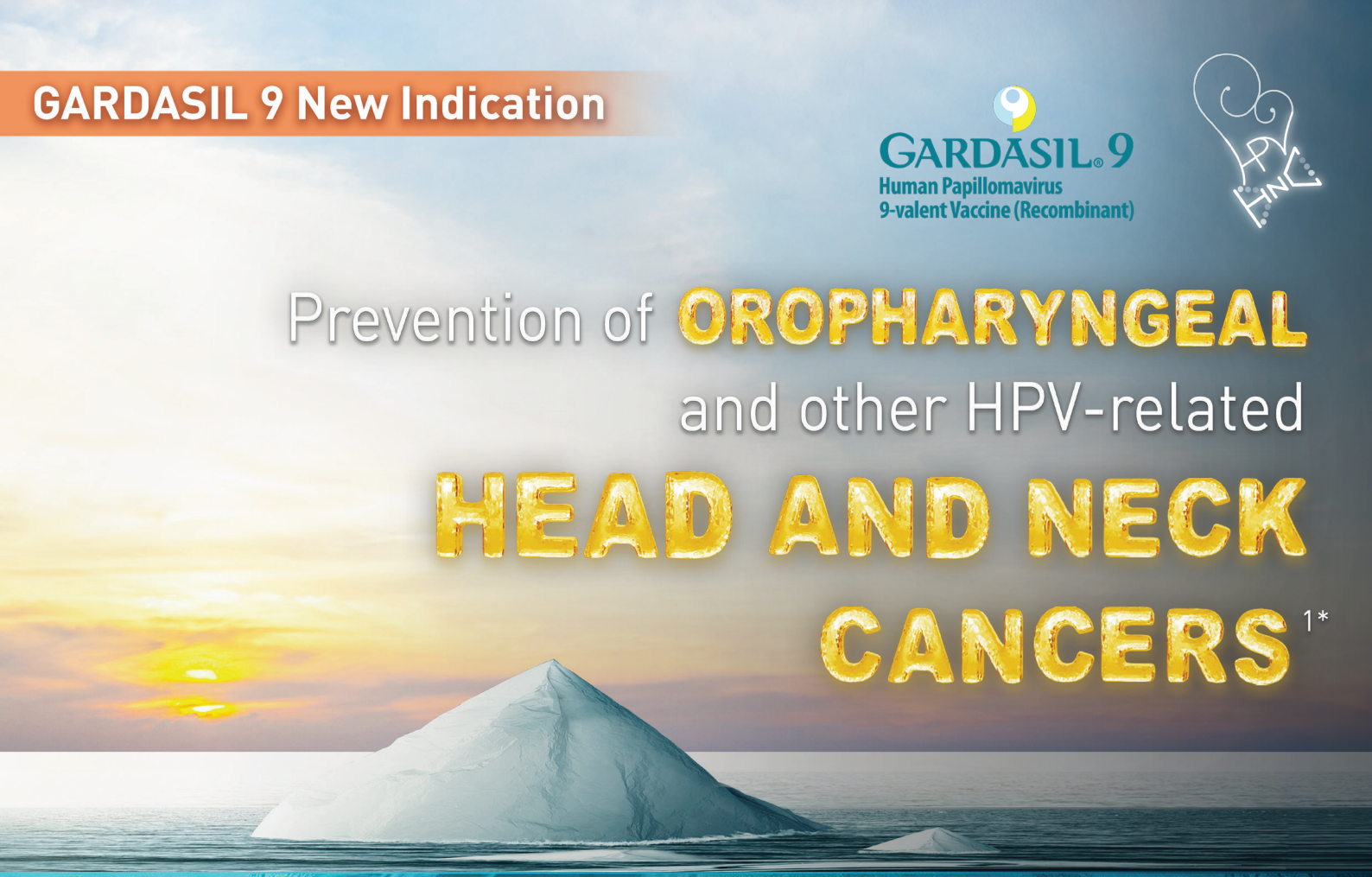
FERRING
PHARMACEUTICALS

HK-DUR-2300007 Oct-2023

GARDASIL 9 New Indication

GARDASIL® 9
Human Papillomavirus
9-valent Vaccine (Recombinant)

Prevention of OROPHARYNGEAL and other HPV-related HEAD AND NECK CANCERS[1*]



*caused by HPV types 16, 18, 31, 33, 45, 52 and 58, from the age of 9 through 45 years

References: 1. Hong Kong Product Circular (GARDASIL® 9 MSD) **2.** Centers for Disease Control and Prevention. Head and Neck Cancers. https://www.cdc.gov/cancer/headneck/index.htm Accessed on: April 13, 2023.

Selected Safety Information Indications: GARDASIL® 9 is indicated for active immunisation of individuals from the age of 9 years against the following HPV diseases: Premalignant lesions and cancers affecting the cervix, vulva, vagina and anus caused by vaccine HPV types. Genital warts (Condyloma acuminata) caused by specific HPV types. GARDASIL® 9 is indicated for active immunisation of individuals from the age of 9 through 45 years against the following HPV diseases: Cancers affecting the oropharynx and other head and neck sites caused by HPV types 16, 18, 31, 33, 45, 52, and 58. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. Individuals with hypersensitivity after previous administration of GARDASIL® 9 or Gardasil should not receive GARDASIL® 9. **Precautions:** The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of rare anaphylactic reactions following the administration of the vaccine. Vaccinees should be observed for approximately 15 minutes after vaccination. It is important that procedures are in place to avoid injury from fainting. Vaccination should be postponed in individuals suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a mild upper respiratory tract infection or low-grade fever, is not a contraindication for immunisation. As with any vaccine, vaccination with GARDASIL® 9 may not result in protection in all vaccine recipients. The vaccine will only protect against diseases that are caused by HPV types targeted by the vaccine. Therefore, appropriate precautions against sexually transmitted diseases should continue to be used. The vaccine is for prophylactic use only and has no effect on active HPV infections or established clinical disease. The vaccine has not been shown to have a therapeutic effect. The vaccine is therefore not indicated for treatment of cervical, vulvar, vaginal, anal, oropharyngeal and other head and neck cancers, high-grade cervical, vulvar, vaginal and anal dysplastic lesions or genital warts. It is also not intended to prevent progression of other established HPV-related lesions. GARDASIL® 9 does not prevent lesions due to a vaccine HPV type in individuals infected with that HPV type at the time of vaccination. Vaccination is not a substitute for routine cervical screening. Routine cervical screening remains critically important and should follow local recommendations. There are no data on the use of GARDASIL® 9 in individuals with impaired immune responsiveness. Safety and immunogenicity of a qHPV vaccine have been assessed in individuals aged from 7 to 12 years who are known to be infected with human immunodeficiency virus (HIV). Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, Human Immunodeficiency Virus (HIV) infection, or other causes, may not respond to the vaccine. This vaccine should be given with caution to individuals with thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. There are no safety, immunogenicity or efficacy data to support interchangeability of GARDASIL® 9 with bivalent or quadrivalent HPV vaccines. **Adverse events:** The most common adverse reactions observed with GARDASIL® 9 were injection-site adverse reactions and headache. These adverse reactions usually were mild or moderate in intensity. Very common (≥1/10) or common (≥1/100 to <1/10) side effects include headache, injection site pain, swelling or erythema, dizziness, nausea, pyrexia, fatigue, injection site pruritus or bruising, etc. For detailed adverse events, please consult the full prescribing information. **Before prescribing, please consult the full prescribing information.**

MSD

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Vitamin D DHA

100%
Recommended Daily Intake[1-4]

Per serving provides	
DHA	100 mg
Vitamin D	400 IU

* Source: Ipsos HCP Claim Study, 2022 (Hong Kong) during Jan – Mar 2022, interviewing 130 healthcare professionals (doctor or nurses) with specialty in obstetrics/ gynecology/ pediatrics in Hong Kong. Margin of error ±8.60% at 95% confidence level.

- Serve four drops twice daily to meet the recommended intake of DHA and Vitamin D established by the European Food Safety Authority (EFSA) and National Institutes of health (NIH) for 0-12 months infants respectively.

REFERENCES: 1. EFSA. EFSA J 2013;11:3408. 2. IOM (Institute of Medicine). Dietary reference intakes for calcium and vitamin D. Committee to review dietary reference intakes for calcium and vitamin D. Washington: National Academies Press; 2011. 3. Braegger C, et al. J Pediatr Gastroenterol Nutr 2013;56:692. 4. Saggese G, et al. Ital J Pediatr 2018;44:51.

IMPORTANT NOTICE: NESTLÉ® NANCARE® DHA & Vitamin D Drops is Food for special medical purpose. For the dietary management of breastfeeding babies or babies consuming infant milk formula with sub-optimal level of vitamin D.

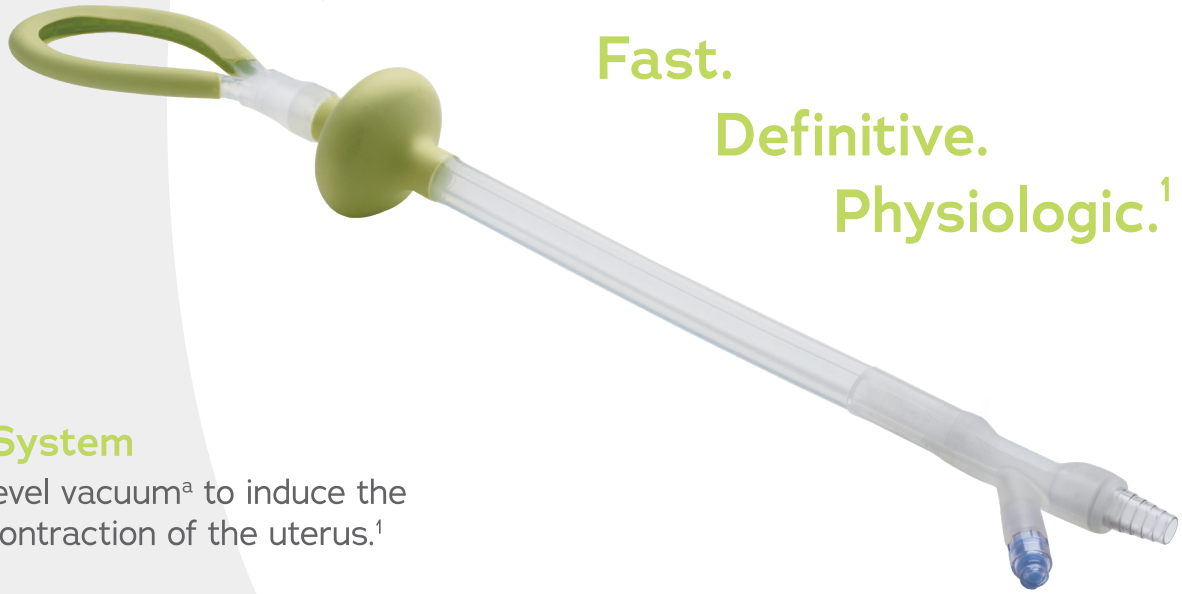
1 BRAND CHOICE*
Among healthcare professionals
One capsule a day containing
DHA + Multi Vitamins & Minerals
Perinatal multi-nutritional supplement

Contact US NOW

For any questions or inquires

Jada®

The Jada® System is intended to provide control and treatment of abnormal postpartum uterine bleeding or hemorrhage when conservative management is warranted.



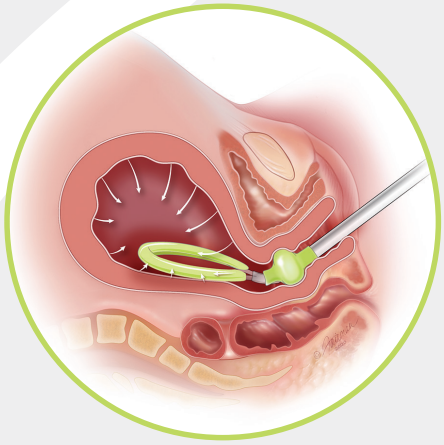
Fast. Definitive. Physiologic.[1]

The Jada System

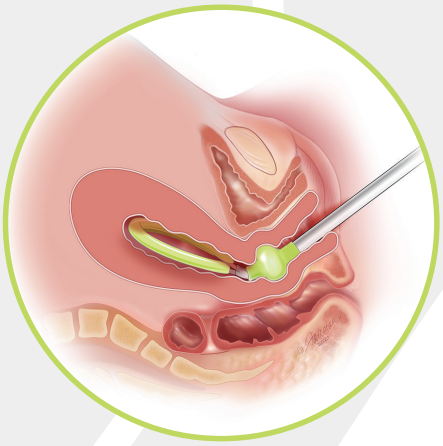
utilizes low-level vacuum[a] to induce the physiologic contraction of the uterus.[1]

94% Effectiveness

94% (n=100/106) of participants treated successfully in the PEARLE study with the Jada System (*P*<0.001).[1,b]



Low-level vacuum[a] induces collapse of the atonic postpartum uterus[1]



Contraction of the myometrium provides physiologic control of bleeding[1]

[a] 80 mm Hg +/- 10 mm Hg. The maximum vacuum pressure is 90 mm Hg. Do not increase the vacuum pressure higher than 90 mm Hg or tissue trauma may occur.

[b] Primary effectiveness was the control of postpartum hemorrhage, defined as the avoidance of non-surgical, second-line, or surgical intervention to control uterine hemorrhage.[1]

Reference: 1. D'Alton ME, Rood KM, Smid MC, et al. Intrauterine vacuum-induced hemorrhage-control device for rapid treatment of postpartum hemorrhage. *Obstet Gynecol.* 2020;136(5):882-891. doi:10.1097/AOG.0000000000004138

Please refer to the Jada System Instructions for Use for the indications, contraindications, warnings, precautions, and other important information at thejadasystem.com/ifu.

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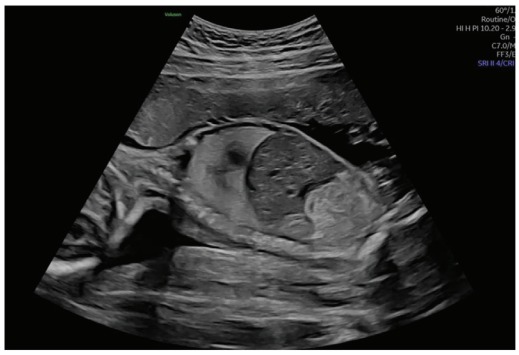
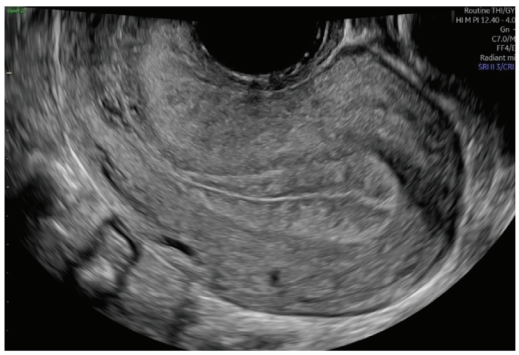
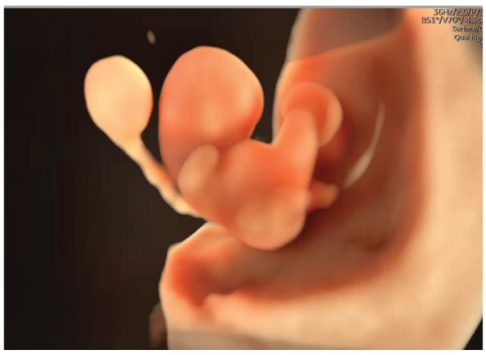
A variety of artificial intelligence (AI)-enabled tools can improve the efficiency of viewing fetal anatomy by up to 65 percent.

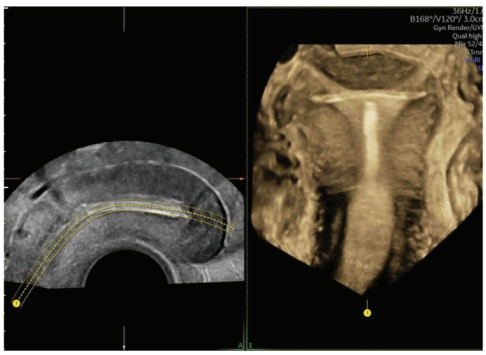
2D Imaging



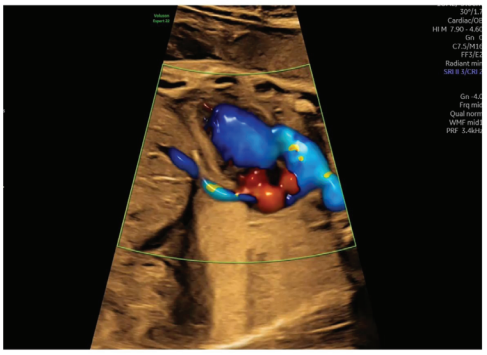


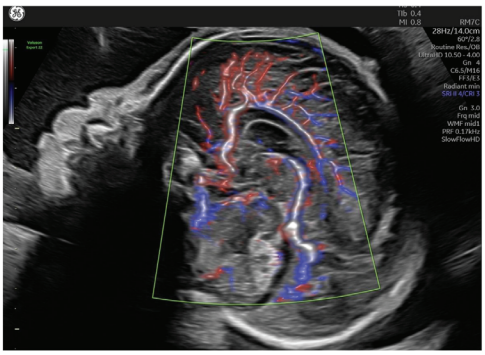
Volume Imaging





Color Imaging





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- ★ **It helps you make a more fulfilling family plan.**

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Ferinject® **O**PTIMIZES women's health[1-4]

Ferinject®'s **N**OVEL design allows for efficient delivery of iron[6-9]

References

1. Van Wyck DB, et al. Transfusion 2009;49(12):2719-28. 2. Breymann C, et al. Arch Gynecol Obstet 2017;45(4):443-453. 3. Froessler et al. Arch Gynecol Obstet. 2018; 298(1):75-82. 4. Seid MH, et al. Am J Obstet Gynecol 2008;199(4):435.e1-7. 5. Favrat B, et al. PLOS One 2014 21;9(4):e94217. 6. Ferinject® Hong Kong Prescribing Information, Oct 2020. 7. Funk F, et al. Arzneimittelforschung 2010;60(6a):345-53. 8. Neiser S, et al. Biometals 2015;28(4):615-35. 9. Beshara S, et al. Br J Haematol 2003;120(5):853-9.

Ferinject® Abbreviated Product Information

Note: Before prescribing, please read the Summary of Product Characteristics.

Pharmaceutical form: Ferric carboxymaltose as solution for injection/infusion. **Indications:** Ferinject® is indicated for treatment of iron deficiency when oral iron preparations are ineffective or cannot be used, or if there is a clinical need to deliver iron rapidly. The diagnosis of iron deficiency must be based on laboratory tests. **Administration:** The individual iron need for repletion using Ferinject® is determined based on the patient's body weight and haemoglobin (Hb) level. The table in the Summary of Product Characteristics should be used to determine the cumulative iron dose. A single Ferinject® administration should not exceed 15 mg iron/kg body weight (for administration by intravenous injection) or 20 mg iron/kg body weight (for administration by intravenous infusion), or 1,000 mg of iron (20 mL Ferinject®). The maximum recommended cumulative dose of Ferinject® is 1,000 mg of iron (20 mL Ferinject®) per week. **Contraindications, Warnings, Overdose:** The use of Ferinject® is contraindicated in cases of known hypersensitivity to Ferinject® or any of its excipients, known serious hypersensitivity to other parenteral iron products, anaemia not attributed to iron deficiency (e.g. other microcytic anaemia) and evidence of iron overload or disturbances in utilisation of iron. Hypersensitivity reactions have been reported after previous uneventful doses of parenteral iron complexes. Elevated risk of hypersensitivity reactions to parenteral iron complexes should be noticed in patients with immune or inflammatory conditions (e.g. systemic lupus erythematosus, rheumatoid arthritis). Parenteral iron must be used with caution in case of acute or chronic infection, history of severe asthma, eczema or other atopic allergies. Do not administer by subcutaneous or intramuscular route. Closely monitor patients for signs and symptoms of hypersensitivity reactions during and for at least 30 minutes following each administration. Stop treatment if hypersensitivity reactions or signs of intolerance occur. Facilities for cardio respiratory resuscitation and equipment for handling acute anaphylactic/anaphylactoid reactions should be available, including an injectable 1:1000 adrenaline solution. Additional treatment with antihistamines and/or corticosteroids should be given as appropriate. In patients with liver dysfunction, parenteral iron should only be administered after careful risk/benefit assessment. A single maximum daily dose of 200 mg iron should not be exceeded in haemodialysis-dependent chronic kidney disease patients. Monitor serum phosphate in patients who receive multiple administrations at higher doses or long-term treatment, and those with existing risk factors for hypophosphataemia. Discontinue use in patients with ongoing bacteraemia. Stop immediately in case of paravenous leakage. A careful benefit/risk evaluation is required before use during pregnancy and Ferinject® should not be used during pregnancy unless clearly necessary. Not recommended in children < 14 yr. Monitoring of iron parameters such as serum ferritin and transferrin saturation may assist in recognising iron accumulation. **Undesirable effects:** Common (1% to <10%): Hypophosphataemia, headache, dizziness, flushing, hypertension, nausea, injection/infusion site reactions. **Interactions:** Oral iron therapy should not be started for at least 5 days after the last administration of Ferinject®. **Legal category:** Prescription Only Medicine (POM). Date of preparation: October 2020. Full prescribing information provided upon request.

*For more information, please consult with the local representative.

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