The FOGSI-FIGO Connection

International Federation of Gynecology & Obstetrics

The Federation of Obstetric & Gynecological Societies of India

www.figo.org;www.fogsi.org;facebook page

NEWSLETTER Sep - 2014

Dear Fogsians,

Greetings and very warm regards to one and all.

The FOGSI-FIGO connection newsletter comes to you 3 times in a year, bringing you all the news of the activities being done by FIGO and how FOGSI is contributing in all the activities.

It's our sincere effort to keep FOGSIANS updated on the FIGO affairs.

We look forward to all your feedback, bricks and bouquets, suggestions and contributions.

Happy reading,

Dr. Narendra Malhotra

FOGSI Representative to FIGO
Past President FOGSI

Prof. Sir Sabaratnam Arulkumaran
President **FIGO**

FIGO Newsletter – President's message – August 2014

Dear friends and colleagues,

Our heart sinks when we see, hear and read about the distressing world news of civil unrests, wars, tragic shooting downs of passenger planes, the recent outbreak of the Ebola virus infection in Africa, natural disasters and large scale accidents with a high death toll of the innocent population. Those who are mostly affected with conflicts and natural disasters are women and children. I have received messages from many of you about the situations that affect your own region and your own people. FIGO offers our utmost sympathies. The larger issues that confront countries and regions are beyond the scope of our Federation; in fact, large nations and the UN are finding it difficult to grapple with the situation. We are a professional and not a political organization and in these situations, we urge the National O&G organizations to do their best to help their women and children. If other National O&G societies have the capacity to help in the humanitarian effort, we would welcome such efforts. The Asia and Oceania Federation of Obstetrics and Gynecology (AOFOG) has contributed significant funds and has worked with other

voluntary organizations to rebuild a school that was demolished in the Philippines. FIGO appreciate Professor Reddie Sumpaico – and his team for making such a valuable contribution.

Violence against women

Even in countries that are in a peaceful environment, violation of women's rights are beyond belief. Sex discrimination and violence starts before birth, through childhood, during adolescence and in adult life; sex-selected abortions, female genital mutilation, childhood marriage, labor and slavery, adolescent sexual violence, rape, honor and dowry-related killing, domestic and gender violence are every day news. Fundamental to these are lack of political will, poverty and lack of education and equality in the society. FIGO needs to join hands with similar-minded organizations and work with them to bring about some change by local action and advocacy. It is a mammoth task and one organization or organizations cannot bring about the needed change without political will. The FIGO executive board passed a resolution to establish a working group to see how best we can work with NGOs who are working in this area. FIGO would like each National Society to do some work in this area and to write to us as to what they are doing or planning to do and what has been achieved, so that we can learn lessons from successful projects and disseminate the information to other countries.

Executive board meeting of FIGO

We had a successful FIGO Officers and Executive Board Meeting in the first week of July in Tokyo, Japan. We are most grateful to the Japanese Society of Obstetrics & Gynecology (JSOG) for their tremendous hospitality. Our special thanks to the officers of JSOG for all the arrangements. On the first day, we had a successful educational seminar addressed by the JSOG and FIGO members.

The executive board members worked very hard over the two days with working coffee breaks and brief periods of 20 to 30 minute lunch breaks.

The executive board has decided to produce the FIGOs educational resource i.e. the entire content of the Global Library of Womens Medicine (www.glowm.com) i.e. 400+ chapters, several books, master classes, atlases and videos in a USB memory stick that can be downloaded to several computers in medical schools and hospitals and a DVD constituting of sixteen animated films that would be useful as counseling videos in antenatal clinics. A few copies of these would be sent to National Societies with the request they copy these and distribute them to their members with their National Society logos. National Societies may use their funds or get help from of suitable sponsors.

Maternal death surveillance and response (MDSR)

MDSR is a powerful tool to reduce morbidity and mortality. This was part of the activity in the eight countries that took part in the FIGO-LOGIC program (Leadership in Obstetrics & Gynaecology for Impact and change). The Federation of Obstetricians and Gynecologists of India produced a software to capture the data electronically and this was approved by the Government of India. This can be obtained through FOGSI for your own National use. FIGO urges National Societies to consider implementing MDSR; a plan can be made with the governments as to who will do it, how it would be continued/ maintained and the benefits audited. This should be an exercise to enhance services to improve womens health and not a faultfinding mission.

FIGO–SAFOG – SLCOG Conference – 31st October to 2nd November, 2014, in Colombo, Sri Lanka

SAFOG, SLCOG & FIGO invite you to participate in this

Picture of the executive board

important conference in Colombo Sri Lanka. The WHO, UNFPA, RCOG, RANZCOG, OGSM, OGSS, SIDRA, March of Dimes, JSOG, AOFOG and many other organizations are participating in this well-planned meeting. We would like to see as many as possible at the conference and if time permits, for you to enjoy what Sri Lanka has to offer by way of tourist attractions.

FIGO Triennial World Conference – 4th to 9th October, 2015 in Vancouver, Canada

There are several conferences around the world but the FIGO triennial conference is so special we would like as many of you as possible to attend. Please mark the above dates in your diary, visit the website- www.figo2015 to view the details of the conference that have been planned so far.

I join the officers, secretariat and the executive board to wish every one of you a happy summer break.

With kindest regards,

Professor Sir Sabaratnam Arulkumaran
President FIGO

GIAN CARLO DI RENZO

MD, PhD, FRCOG (Hon), FACOG (Hon),
HONORARY SECRETARY OF FIGO
University of Perugia, Perugia, Italy.

Prof. Gian Carlo Di Renzo is currently Professor and Chair at the University of Perugia, and Director of the Reproductive and Perinatal Medicine Center, Director of the Midwifery School, University of Perugia, in addition to being the Director of the Permanent International and European School of Perinatal and Reproductive Medicine (PREIS) in Florence.

Founder & Editor in Chief, Journal of Maternal Fetal and Neonatal Medicine

President, the International Society on Chocolate, Cocoa and Medicine (ISCHOM)

Secretary General, the New European Surgical Academy (NESA)

Professor, the State Universities of Moscow, Krasnodar and Tomsk, Russia; the University of Buenos Aires, Argentina; the International University of Dubrovnik, Croatia; the State University of Serbia, Belgrade, Serbia; the State University of Chisinau, Moldovia; the University of Kansas City Medical School, USA

Doctor Honoris Causa, Universities of Prague, Cluj Napoca, Athens and St. Petersburg

Academic Member, the Romanian Academy of Sciences & the Russian Academy of Sciences

Gold Medal of the Bangladesh Society of Ob/Gyn (1992), the Maratea Children Prize (1994), the Foundation Corradi Prize for "Scientific Research" (1998), the Liley Medal from the "Fetus as a Patient" International Society (2006), the Allan Chang Visiting Professorship (Hong Kong, 2007) and the Maternity Prize of the European Association of Perinatal Medicine in Istanbul (2008)

His scientific production comprises over 1200 papers of which more than 300 are in referred international journals and 80 books

Invited as speaker to more than 1300 international and national congresses, meetings and courses in 95 different countries.

Report on FIGO Ethics Committee

Dr. Duru Shah

Member of Ethics Committee, FIGO

As a member of the Ethics Committee of FIGO, I have participated in a meeting of the Ethics Committee held in London between 3rd and 4th March, 2014.

The Committee has finalized the following documents during the year from July 2013 to June 2014 and these were submitted to the Executive Committee of FIGO in July 2014 for acceptance. I am happy to let you know that all the Ethical Guidelines have been approved and are ready for publication in the FIGO Journal, to be released soon in 2014.

Guidelines of the Ethics Committee are prepared based on suggestions offered by the Committee members depending on what every member feels is important in his / her country. The lists of Guidelines finalized between July 2013 to July 2014 are as follows:-

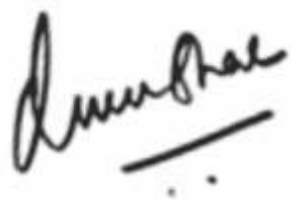
1. Ethical Considerations on the Health Consequences of Child or Adolescent Marriage*
2. Ethical Considerations Regarding Requests and Offering of Cosmetic Genital Surgery
3. Ethical Guidance on Healthcare Professionals' Responses to Violence Against Women*
4. Ethical Guidelines on Conscientious Objection in Training
5. Ethical Issues in Adolescent Pregnancies*
6. Ethical Issues after Sexual Assault*
7. Ethical Issues in Womens Post – Reproductive Lives*
8. Patients' Refusal of Recommended Treatment
9. Recommendations on Conflict of Interest, including Relationships with Industry

I have been a member of this committee since 2012 and have participated actively in the preparation of the following Guidelines, which have already been published and are available on the FIGO website at www.figo.org

1. Task Shifting in Obstetric Care - 2012.11.29*
2. Ethical Guidelines on Cord Blood Banking - 2012-11-29
3. Ethical Aspects of HIV Infection and Reproduction – 2012-11-29*
4. Ethical Issues in the Management of the Severe Congenital Anomalies- 2012.11.29*
5. Planned Home birth - 2012-11-29
6. Prenatal Diagnosis and Screening – 2012-11-29
7. Safe Motherhood & Newborn health - 2014-05-09

I would like to thank the Chair Dr. Bernard Dickens, Co-Chair Dr. Francoise Shenfield and the other Committee members i.e. Dr. Juan Carlos Vargas, Prof. Gamal Serour, Prof. Pak Chung Ho, Dr. Hannah Motshedisi Sebitloane along with the Consultants Prof. Joanna Cain and The Lord Patel, for their excellent guidance whilst preparing the guidelines, which need to be promoted by every FIGO Member Society to their members. I have tried to disseminate them wherever possible and request FOGSI to also make them available on the FOGSI website through a link to the FIGO website.

Yours sincerely,



Duru Shah

* These were the Guidelines which I was very keen to get prepared.

Report on FIGO Committee on Gynecologic Oncology Activities August 2014

Prof. Neerja Bhatla

Department of Obstetrics & Gynecology,
All India Institute of Medical Sciences, New Delhi.
Member, FIGO Gyn Oncology Committee

I. Education:

The major thrust of the FIGO Committee on Gynecologic Oncology has been on education. Members have worked on several important educational and academic initiatives:

1. The **Staging Classification for cancer of the ovary, fallopian tube and peritoneum has been revised** and published in the ***International Journal of Gynecology & Obstetrics 2014;124(1):1-5.*** The link below leads directly to the article. All members should use the revised staging classification henceforth.

   http://www.ijgo.org/article/S0020-7292(13)00520-1/fulltext<http://www.ijgo.org/article/S0020-7292(13)00520-1/fulltext>

2. **FIGO Guidelines on Hereditary Cancers** provide a complete overview on the current status of screening, prevention and management of hereditary cancers.

   http://www.ijgo.org/article/S0020-7292(13)00660-7/abstract

3. The **FIGO staging for carcinoma of the vulva, cervix, and corpus uteri** has been published as a ready reference:

   http://www.sciencedirect.com/science/article/pii/S0020729214000769

4. The FIGO Committee's position on safety of ***HPV vaccines*** was published after reviewing available data on post-marketing surveillance and research reports:

   http://www.ncbi.nlm.nih.gov/pubmed/24139200

II. FIGO Gyn Oncology Committee International Data Collection Initiative

There are four international databases that are collecting survival data but these are mostly limited to developed countries. For developing countries, very limited data is available.

It is intended to [1] perform a situational analysis of all institutions affiliated to our societies to establish what cancer care resources they have and then [2] select the best 10-15 institutions (representative of all five continents and confined to low and middle-income countries) to provide detailed, verifiable, prospective data on gynecological cancers.

Work on this has been initiated in collaboration with Prof. Xavier Bosch's group at the Catalan Institute of Oncology, Barcelona, Spain. The data collection forms have been developed and the project will be started very soon. Members interested in participating in this activity may contact me.

III. Future Plans

- Converting the FIGO Cancer Report into an e-learning tool.
- Projects on capacity building, advocacy for women and prevention strategies relating to cancer in low- and middle-resource countries.

iV. Meetings attended

- AOGIN Biennial Conference, April 25-27, Beijing, China
- IFCPC Conference, May 27-30, London, UK

Report on FIGO G.D.M Committee

By Hema Diwakars

Report On FIGO FETAL MEDICINE COMMITTEE

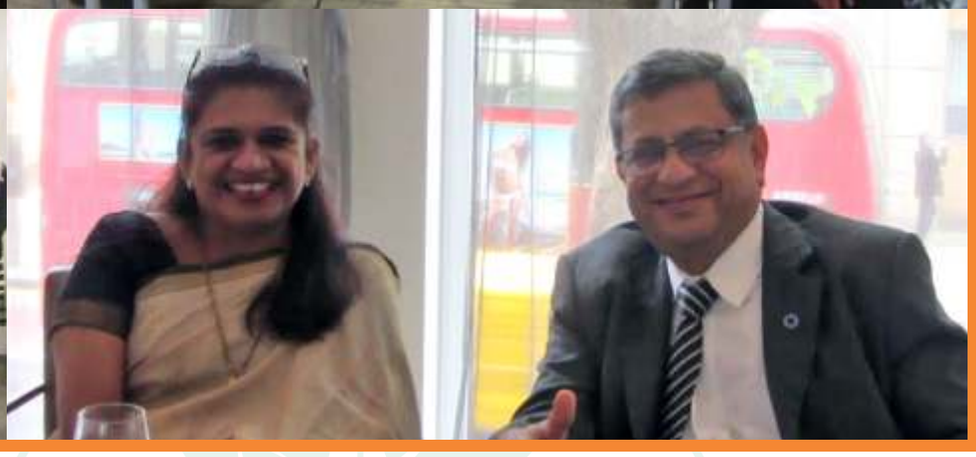
10-11 JAN 2014

MEMORIES OF LONDON MEETING (AT R.C.O.G) WORKING GROUP


07/05/2014


07/05/2014


08/05/2014



International Federation of Gynecology and Obstetrics

Working Group on Best Practice on Maternal-Foetal Medicine

Report by **Dr. Narendra Malhotra**

FIGO Good Practice Advice

1. Screening for chromosomal abnormalities and non invasive prenatal diagnosis and testing

Universal screening is a strategy applied to all individuals of a certain category to identify a high risk group to have an unrecognized disease in individuals without signs or symptoms of such disease (e.g. screening of all pregnant women to identify the high-risk group for fetal chromosomal abnormalities). A test used in a screening program, especially for a disease with low incidence, must have a high detection rate (DR) and low false positive rate (FPR). Prenatal diagnosis of fetal aneuploidies necessitates invasive testing, which is essentially carried out by chorionic villus sampling at 10–15 weeks gestation or amniocentesis at or after 16 weeks. However, invasive testing is expensive and can cause miscarriage in about 1% of pregnancies; it is therefore reserved for cases identified by screening as being at high-risk for aneuploidies.

First-trimester screening for trisomies 21, 18 and 13 by a combination of maternal age, fetal nuchal translucency thickness (NT), fetal heart rate (FHR) and serum-free β-human chorionic gonadotropin (β-hCG) and pregnancy-associated plasma protein-A (PAPP-A) can detect about 90% of cases of trisomy 21 and 95% of those with trisomies 18 and 13, at FPR of about 5%. The performance of first-trimester screening can be improved by expanding the combined test to include other first trimester sonographic markers, such as the presence or absence of the fetal nasal bone, measurement of fetal ductus venosus pulsatility index for veins (DV-PIV) and regurgitation across the tricuspid valve.

Some countries developed a national program of screening for trisomy 21 based on the combined risk test and the offer of invasive testing at a risk cut-off which aims to maintain the invasive test rate at 3% or less. In others, there are no national guidelines on screening and individual practitioners offer a variety of first and/or second trimester methods. Even worse, in some parts of Europe, the rate of invasive testing is in excess of 20% based mainly on maternal age.

Recently, screening for fetal aneuploidies based on the analysis of cell free DNA (cfDNA) in the plasma of pregnant women has been introduced into clinical practice. This can be undertaken from as early as the 10th week of pregnancy with results available approximately 1 week after maternal blood sampling. Evidence suggests that analysis of cfDNA in maternal blood can detect about 99% of cases of trisomy 21, 97% of trisomy 18, and 92% of trisomy 13, with respective FPRs of 0.08%, 0.15% and 0.2%.

At present, cfDNA testing is expensive and, therefore, widespread uptake of the test into routine clinical practice is likely to be contingent on the results of first-line screening by another method, preferably the first-trimester combined test, rather than as a primary method of screening. Such a strategy would also retain the advantages of first-trimester testing by ultrasound and biochemistry, including accurate pregnancy dating, early detection of many major fetal defects and prediction, with the potential of prevention, of a wide range of pregnancy complications, including preterm birth and preeclampsia.

The International Federation of Gynecology and Obstetrics (FIGO) recommends the following:

1. Maternal age has a low performance as a screening for fetal chromosomal abnormalities with a DR of 30-50% for FPR of 5-20%. Therefore, invasive testing for diagnosis of fetal aneuploidies should not be carried out by taking into account only maternal age.
2. First-line screening for trisomies 21, 18 and 13 should be achieved by the combined test, which takes into account maternal age, fetal nuchal translucency (NT) thickness, fetal heart rate (FHR) and maternal serumfree β-human chorionic gonadotropin (β-hCG) and pregnancy-associated plasma protein-A (PAPP-A). The combined risk test has a DR of 90% for trisomy 21 and 95% for trisomies 18 and 13, at FPR of about 5%.
3. The combined test could be improved by assessing additional ultrasonographic markers, including the fetal nasal bone and Doppler assessment of the fetal ductus venosus flow and tricuspid flow. If all those markers are included, the DR is increased to more than 95% and the FPR decreased to less than 3%.
4. Screening by analysis of cfDNA in maternal blood has a DR of 99% for trisomy 21, 97% for trisomy 18 and 92% of trisomy

13, at a total FPR of 0.4%.

5. Clinical implementation of cfDNA testing should preferably be in a contingent strategy based on the results of first-line screening by the combined test at 11-13 weeks gestation. In this case, we recommend the strategy below:

- Combined test risk over 1 in 100: the patients can be offered the options of cfDNA testing or invasive testing.
- Combined test risk between 1 in 101 and 1 in 2,500: the patients can be offered the option of cfDNA testing
- Combined test risk lower than1 in 2,500: there is no need for further testing.

Patients contemplating pregnancy termination following a positive result from cfDNA testing should be advised that the diagnosis should be confirmed by invasive testing before undertaking any further action.

2. Periconceptional folic acid for the prevention of neural tube defects

Neural tube defects (NTD) are severe birth anomalies, due to lack of neural tube closure at either the upper or lower end in the third to fourth week after conception (Day 26 to Day 28 post-conception).

NTD commonly occurs in all populations worldwide, especially in the low-and middle-income countries. Each year, more than 4,500 pregnancies in the European Union are affected by NTD. In the United Kingdom and Ireland, the prevalence of NTD declined from 4.5 per 1,000 births in 1980 to 1.5 per 1,000 in the 1990s. In contrast, in the rest of Europe the prevalence during the 1980s and thereafter, remained close to 1 per 1.000 births. In the USA, the incidence ranges from 1.4 to 1.6 per 1,000 live births and 0.8 per 1,000 births in Canada. In the Latin America, the prevalence was about 5 cases per 1,000 births in the Brazil Northeastern and South region, and in the Southeast, the prevalence was 1 per 1,000 births. In Mexico, the current prevalence is about 1 in 1,000 births.

There are several evidences supporting the hypothesis for the relationship between folate deficiency and NTD, such as: (a) RCT for the prevention of primary occurrence or recurrence has been confirmed that periconceptional acid folic supplementation reduces the rate of NTD with reduction rate of 72%, (b) folic acid antagonists (methotrexate, didhydrofolate reductase inhibitors and others) increase the risk for NTD; and, concentration of folate in red blood cells is lower in women who give birth to children with NTD.

Hence, folic acid supplementation is of great benefit, especially in developing country settings for several reasons. Firstly, the prevalence of NTD in developing countries is very high compared to the industrialised world. Secondly, folic acid supplements are readily available and affordable. Since iron supplementation is almost universally recommended in pregnancy, especially in developing country reproductive health programs, it would be convenient to combine the two interventions. Nevertheless, the keystone is pre-pregnancy administration of the synthetic folic acid supplement, which may not be easy in public health programs geared principally towards pregnant women.

The International Federation of Gynecology and Obstetrics (FIGO) recommends that (see also Table):

1. All women who plan to become pregnant or all women at childbearing age without contraceptive method and who do not present risk factors for NTD, should utilize 400 micrograms (0.4 mg) of synthetic folic acid, beginning at least 30 days before the conception and continue daily supplements throughout the first trimester of pregnancy.

2. All women in the reproductive age group should be advised about the benefits of folic acid supplementation during any medical appointment (e.g., birth control renewal, cervical cancer prevention clinic, yearly examination), especially if they are planning pregnancy in the near future, or they do not use any contraceptive method, or are using a contraceptive method that does not guarantee an optimal birth control.

3. The healthcare providers should inform the woman at counseling that:

a) The benefit of folic acid supplementation is not limited to the reduction of risk of NTD, but include possibly the reduction of risk of other adverse outcomes, including congenital heart defects, orofacial and cleft palate defects, low birth weight, preterm birth, and autism.

b) The folic acid supplementation of 400 mcg (0.4 mg) can be taken for years, without any known side effects, even in countries with mandatory staple food fortification.

c) The effects of higher intake of folic acid are not well known but include complicating the diagnosis of vitamin B12 deficiency; therefore, care should be taken to keep total folic acid consumption at less than 1 mg per day, except for women who are at high risk of having a pregnancy affected by a NTD.

4. Women who have risk factors should be advised that synthetic folic acid supplementation at a dose of 4,000 micrograms per day (4.0 mg) is recommended. It should start at least 30 days before the conception and continue as daily supplements throughout the first trimester of pregnancy.

5. The risk factors include women with:

a. NTD-affected previous pregnancy,
b. Partner affected by NTD
c. First degree relative which was affected by NTD,
d. Pre-pregnancy diabetes,
e. Epilepsy treatment with valproic acid or carbamazepine,
f. Use of folate antagonists (methotrexate, sulfonamides, etc)
g. Malabsorption syndrome,
h. Obesity (BMI >35 kg/m^2),

6. Finally, The International Federation of Gynecology and Obstetrics (FIGO) encourages all efforts of public agencies worldwide towards the development of more comprehensive programs to fortify food with synthetic folic acid and more vigilance in monitoring these programs.

Table: Summary of the International Federation of Gynecology and Obstetrics recommendations regarding the administration of folic acid to prevent NTDs

Population	Women who plan to become pregnant or are at childbearing age with no contraceptive method.
Recommendation	Daily supplementation of synthetic folic acid at a dose of 400 mcg.
Time Using Folic Acid	Supplementation should begin at least 30 days before conception and should be maintained for the first trimester of pregnancy.
Risk Assessment for NTD	High-risk factors include: NTD-affected previous pregnancy Partner affected by Spina bifida First degree relative affected by NTD Use of anticonvulsants. Pre-gestational diabetes. Obesity (BMI> 35 kg/m2). Use of folate antagonists (methotrexate, sulfonamides, etc.). Malabsorption syndromes (including pregnant women with a history of surgery for obesity).
Risk Assessment for NTD Note: The women in the high risk group should be instructed to use a daily dose of 4,000 micrograms (4 mg) for the same time recommended above.	
Recommendations from Other Associations	The American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, American Academy of Pediatrics, the National Institute for Health and Clinical Excellence (NICE) Guidance and many other organizations have similar recommendations

3. Cervical length and progesterone for the prediction and prevention of preterm birth

At least 15 million babies are born preterm worldwide each year. Preterm birth-related deaths are one of the leading causes of infant mortality; over one million babies die each year from preterm birth complications. The rates of preterm birth range from 5-18%; over 80% of preterm babies are born between 32 and 37 weeks of gestation. The sequelae of preterm birth include respiratory distress syndrome, necrotizing enterocolitis, neonatal sepsis, neurodevelopmental disabilities, cerebral palsy and neonatal death. Despite decades of research, high rates of preterm birth and infant mortality persist in both developed and developing countries.

A sonographic short cervix diagnosed by transvaginal ultrasound is the most powerful predictor of preterm delivery (50% of women with a cervical length <15 mm will deliver prior to 32 weeks of gestation). Randomized clinical trials and systematic reviews have demonstrated that vaginal progesterone reduces significantly the rate of preterm birth by 50% and reduces neonatal morbidity/mortality. The use of cervical length screening and vaginal progesterone is cost saving.

The International Federation of Gynecology and Obstetrics (FIGO) recommends the following (see also Table):

1. Sonographic cervical length measurement should be performed in all pregnant patients at 19 - 23, 6/7 weeks of gestation using transvaginal ultrasound. This can be done at the same time as the ultrasound performed for the anatomical survey.
2. Women with a sonographic short cervix (<25 mm) diagnosed in the mid-trimester should be offered daily vaginal micronized progesterone treatment for the prevention of preterm birth and neonatal morbidity.
3. The progesterone formulation to be used is vaginal micronized progesterone (200 mg vaginal soft capsules) nightly, or vaginal micronized progesterone gel (90 mg) each morning.
4. Universal cervical length screening and vaginal progesterone treatment (90 mg vaginal gel or 200 mg micronized vaginal soft capsules) is a cost-effective model for the prevention of preterm birth.
5. In cases in which a transvaginal ultrasound is not available, transabdominal ultrasound (with different cutoff) or other devices may be used as a screening tool to measure objectively and reliably the cervical length.

Table: International Federation of Gynecology and Obstetrics recommendations regarding the use of transvaginal sonographic cervical length and vaginal progesterone use for the prevention of preterm birth

Population	All pregnant women with a singleton gestation.
Recommendation	Tranvaginal sonographic cervical length measurement at 19 – 23, 6/7 weeks for all pregnant patients. Vaginal progesterone administered to women with a cervical length <25 mm.
200 mg vaginal soft capsules or 90 mg vaginal gel of micronised progesterone can be used for treatment.	
Time using progesterone	Treatment should begin at the time of the diagnosis of a short cervix until 36 6/7 weeks, labor or rupture of membranes.
Risk assessment	**Transvaginal sonographic cervical length on all patients regardless of obstetrical history.**
Other recommendations	When a transvaginal ultrasound is not available other devices may be used as a screening tool to measure objectively and reliably the cervical length.

THESE ADVICES HAVE BEEN PREPARED BY THE FIGO WORKING GROUP

" BEST PRACTICE IN MATERNAL-FOETAL MEDICINE" * AND ENDORSED BY THE FIGO EXECUTIVE BOARD IN JULY 2014

FIGO WORKING GROUP COMPONENTS:

G C DI RENZO (Chair)

Eduardo Fonseca – Brazil, Sonia Hassan – USA, Mark Kurtzer – Russia, Maria Teresa Leis – Mexico, Narendra Malhotra – India, Kypros Nicolaides – UK, Huixa Yang – China (Members)

Sabaratnam Arulkumaran (FIGO, UK), PierPaolo Mastroiacovo (Clearinghouse, Italy), Moshe Hod (EAPM, Israel), Yves Ville (ISUOG, France), Luis Cabero (FIGO CBET Committee, Spain), Claudia Hanson (FIGO Safe Motherhood Committee, UK and Tanzania), JoeLeigh Simpson (March of Dimes, USA)

(Experts representatives)

PLEASE NOTE THAT THESE ADVICES SHOULD NOT BE CONSIDERED AS STANDARDS OF CARE OR LEGAL STANDARDS IN CLINICAL PRACTICE

Women and children bear the brunt of climate change-world must act now

Dear Colleagues,

FIGO's sympathies extend to the millions affected by natural disasters and by ever-increasing wars, civil unrest and accidents. The Syrian situation, new unrest in Ukraine, and the Malaysia Airlines flight disappearance sadden us all. These high profile events obviously catch our eye, but there is a slow motion disaster of climate change that is concurrently in progress, which may not have caught the attention of busy obstetricians and gynecologists, among others. The Intergovernmental Panel on Climate Change (IPCC; **www.ipcc.ch/**) has published its latest report on the current and projected impacts of global warming and climate change, which The Lancet describes succinctly as 'the greatest threat to human health in the 21st century'.

The perils of global warming and climate change

I am one of 60 physicians and medical scientists who have called for an urgent response to climate change, with a signed letter appearing in The Times (UK) on 29 March, 2014. I would like to quote a sobering extract: 'As medical professionals, we call for immediate preventative action through a drastic reduction of greenhouse gas emissions and rapid transition to a zerocarbon world, at a pace far beyond that which is already planned. This will require transformative and radical change to energy policies, patterns of consumption, and transport systems, amongst other things. Such change may be considered disruptive and difficult, but such actions are necessary and can bring enormous benefits to human health and wellbeing, both in the short-term and in the years and decades to come. 'Never before have we known so much and done so little. Failing to act decisively and quickly will inevitably cause great suffering and potentially catastrophic consequences.' (The full text and list of signatories can be read at **www.sduhealth.org.uk/news/265/ipcc-report--no-one-will-be-untouched-by-climate-change-)**.

It is calculated that millions and millions would suffer as a result of this catastrophe – mostly women and children. We need to urge governments, the private sector and colleagues to become more reliant on alternative sources of energy. Even as individuals we can contribute by walking/cycling to work, using public transport, conserving energy at home and in the workplace, etc. I encourage FIGO Member Societies to take affirmative action on these issues, wherever and however they can. Small-scale actions can ultimately yield long-term results if enough efforts are concentrated.

The FIGO PPIUD project – L–R: Dr. Ruwan Pathirana (Member – SLCOG); Dr. UDP Ratnasiri (Chairman – Continuous Professional Development and Project Treasurer); Dr. Gamini Perera (Treasurer – SLCOG); Prof. Athula Kaluarachchi (Chairman – Education and Setting Standards); Dr. Deepthi Perera (Director MCH – Family Health Bureau); Dr. Kapila Gunawardena (President SLCOG) – behind; Prof. Malini (Workshop Facilitator) – front; Prof. Revathy (Workshop Facilitator) – front; Prof. Sir Sabaratnam Arulkumaran (Project Director); Dr. Sardha Hemapriya (Chairman – Regional Activities and Developments) – behind; Laura Banks (Project Manager); Prof. Hemantha Senanayake (Immediate Past President, Project National Coordinator); Dr. Rohana Haththotuwa

CHIEF EXECUTIVE'S OVERVIEW

Dear Colleagues,

We are now firmly in the cut and thrust of 2014, and I am sure that you and your organisations are as busy as ever! FIGO is certainly a hive of activity as the year continues apace. My year began with attendance at the World Health Organization's (WHO) Executive Board meeting in Geneva, in January – an important yearly event; it provided me with the opportunity to catch up with WHO colleagues, namely Dr. Marleen Temmerman, Elizabeth Mason, Carole Presern and Jantine Jacobi (of UNAIDS) to discuss numerous collaborative activities. An additional meeting with the President (Judith Shamian) and Chief Executive Officer (David Benton) of the International Council of Nurses (ICN) bore fruit – FIGO has now signed an MOU with the ICN, and it is hoped that it will develop a closer working relationship with this important body.

In February, I represented FIGO at the 'Building Academic Partnerships to train 1000+ OBGYNs in Sub-Saharan Africa' conference in Accra, Ghana. This special event brought together Obgyns from academic institutions in Sub-Saharan Africa, along with professional support organisations, policy-makers and funders to discuss ways to increase obstetric capacity in Sub-Saharan Africa. The meeting was a great step forward in promoting ob/gyn postgraduate training in Africa.

Khartoum welcomes AFOG General Assembly

In late February, I travelled to Khartoum to attend the General Assembly of the African Federation of Obstetrics and Gynecology (AFOG), FIGO's most recently recognised Regional Federation. This took place during the 26th Congress of the Sudanese Obstetrical and Gynaecological Society. The meeting was attended by representatives of 22 societies of African Obstetrics and Gynecology. Discussions to promote AFOG after establishing the Secretariat in Khartoum were useful and Committees were formed to follow up on selected activities pertaining to the region. Plans for holding the first AFOG meeting towards the end of 2014 were discussed. There was general enthusiasm from all those who participated to work together towards strengthening this important regional forum.

Outside the new AFOG Secretariat in Khartoum

AFOG group photo

Montreux hosts major WHO Working Group meeting

Professor Rushwan with Dr Marleen Temmerman (Head of WHO's Department of Reproductive Health and Research) in Montreux

In March, FIGO was invited by WHO to take part in a very successful Expert Working Group to revise the Medical Eligibility Criteria for Contraceptive Use (4th edition) and Selected Practice Recommendations for Contraceptive Use (2nd edition), in Montreux. Mid-March took me to New York, having been invited by Gynuity Health Projects (the supporters of our misoprostol initiative, through a grant from the Bill & Melinda Gates Foundation) to two complementary meetings that addressed the science and strategies for effective management of post-partum haemorrhage (PPH). FIGO's misoprostol project, due to end later this year, has been instrumental in advocating the use of misoprostol for PPH prevention and treatment, and disseminating related evidence-based information to a global community of health professionals and clinical policy-makers. Discussions with Gynuity senior management, President Beverly Winikoff and Director Rasha Dabash, focused on the progress of the FIGO misoprostol initiative, and its future direction.

2018 Congress travels

In late March, together with FIGO's Vice President and Meetings and Events Manager, I travelled to Brazil, Peru and Colombia to revisit the proposed sites for the 2018 Congress – Rio de Janeiro, São Paulo, Lima and Bogota. Due to the fast-moving pace of professional conference planning, these trips are necessary to obtain further useful information well in advance of future events. All countries provided us with an excellent updated overview. The 66th Annual Congress of the Japan Society of Obstetrics and Gynecology took palace in mid-April, and I was delighted to represent FIGO alongside other FIGO colleagues at its International Workshop for Junior Fellows. These workshops are a vitally important and precious opportunity for young Fellows to progress in their knowledge, and to gain confidence in their specialties. As always, we were the recipients of superb hospitality.

FIGO and Wellbeing of Women join forces to offer Academic Fellowship

Further to the recent signing of a Memorandum of Understanding, FIGO and Wellbeing of Women are delighted to announce an Academic Fellowship available for international candidates. A grant of up to £20,000 is available to enable a candidate in the field of obstetrics and gynecology to link up with academic mentors in the UK for a period of up to three years. The applicant will be based at an academic institution in a low/middle resource country and will have in place a funded research project which addresses a priority area for that country/region. The closing date is 3 pm on Friday 20 June 2014; full details and application forms are available from:

www.wellbeingofwomen.org.uk/research/figo-academic-fellowship/?menu=0c.

Retirement of FIGO's Administrative Director

Finally, I am sure that FIGO colleagues will be extremely saddened to learn that Mr. Bryan Thomas, FIGO's Administrative Director of nearly 17 years' standing, is retiring in the summer of 2014. Bryan has worked (with sterling support from Senior Administrator and Committee Manager Marie-Christine Szatybelko) at FIGO with consummate professionalism in a demanding role, and is held in great esteem by all who know him. It has been no easy brief to oversee such a complex, ever expanding and diverse organisation, but it is a role for which he has been uniquely suited. I know that you will all join me in wishing him a wonderful, well-deserved retirement. He is a well-travelled man, due to FIGO's international demands, but I know that he is keen to continue to explore the globe, albeit in a more relaxed fashion! We are delighted to announce that our new Administrative Director is Mr Sean O'Donnell. Sean has substantial senior management level experience in the charity, public and higher education sectors including at, most recently, Royal Holloway College, the University of London. He has also worked for Save the Children and Action for Children. He has significant experience of charity governance, administration, membership organisations, managing professional relationships, implementation of policy and management experience across human resources and finance. We are delighted to welcome him, and feel confident that he will bring a steadying hand to the reins as FIGO moves through a time of transition. You will meet Sean in the next issue. I wish you a very productive summer as we continue to work towards achieving our important goals.

Best wishes

Professor Hamid Rushwan
FIGO Chief Executive

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Readers are invited to refer items for consideration by email to **communications@figo.org** no later than Friday 20 June 2014 for the next issue.

The views expressed in articles in the FIGO Newsletter are those of the authors and do not necessarily reflect the official viewpoint of FIGO.

Produced and edited by Alexandra Gilpin at the FIGO Secretariat © FIGO 2014.

FIGO restates position on misoprostol for PPH

In March 2014, FIGO and the International Confederation of Midwives (ICM) released a joint statement: 'Misoprostol for the treatment of post-partum haemorrhage (PPH) in low-resource settings'.

The statement, recently endorsed by the FIGO Officers, was developed in close collaboration with ICM, Gynuity Health Projects and FIGO's Committee for Safe Motherhood and Newborn Health.

It is part of FIGO's ongoing collaboration with Gynuity Health Projects, which seeks to disseminate the latest evidence on using misoprostol to prevent and treat post-partum haemorrhage in settings where oxytocin is not available or feasible. It restates the approved FIGO Guidelines 2012 and calls for midwives and obstetricians to improve access to safe delivery services.

The statement is available on the FIGO website **(www.figo.org/news/joint_statements)** in English, Arabic, French, Spanish and Portuguese.

FIGO has also been raising awareness of the use of misoprostol for PPH through several recent high-profile panel sessions at the RCOG World Congress in India (March 2014) and the 13th NESOG national conference, Nepal (April 2014). A panel is also scheduled at the ICM's Triennial Conference in Prague next month.

Upeka de Silva, the FIGO Initiative's project manager, said: 'As new evidence on the use of misoprostol becomes available, FIGO will continue to disseminate the findings and support its Member Associations, as well as the wider healthcare community, to adapt their practices for the benefit of women giving birth in low-resource settings.'

PPIUD project implementation comprises four key areas

Advocacy: Securing support from the Ministry of Health and key health officials for the project and for inclusion of IUD into the menu of post-partum contraceptive methods offered.

Efforts to integrate PPIUD services into pre and in-service training curricula.

Training: Insertion immediately post-partum requires special training to ensure accurate insertion technique, safe insertion and infection prevention. Master trainers from each facility will be trained and undertake the responsibility to train those within their facility.

Training and capacity building of all health facility ante-natal and delivery team personnel on counselling women about the overall benefits of contraception, dispelling myths around IUDs, safe insertion and infection prevention and post-insertion counselling and care will also be undertaken, with particular focus on midwives, who play a crucial role in this area.

Research: A study to assess the rates of post-partum IUD continuation, expulsions and overall client satisfaction will be completed, with regular follow up of clients for a period of two years after delivery.

Monitoring and evaluation: Detailed client and provider data will be collected and analysed with a view to improving quality of care and provider performance.

As an added valuable component to the project, it also aims to improve the quality, scope and reliability of information available to healthcare professionals worldwide on all aspects related to family planning and safe abortion care through The Global Library of Women's Medicine (GLOWM) website, a global platform for knowledge transfer. A dedicated section on the GLOWM website on the topics of Family Planning and Prevention of Unsafe Abortion is now available at **www.glowm.com/FIGO_resources.**

New FIGO GDM Initiative kicks off in London

FIGO is proud to unveil a new initiative that seeks to produce, disseminate and implement evidence-based standards of care protocols on caring for women with gestational diabetes. The financial support secured from Novo Nordisk enables FIGO to bring together independent experts on gestational diabetes mellitus (GDM) to develop the tools needed by obstetricians and gynecologists and other key healthcare professionals for providing comprehensive maternal healthcare services.

Professor Hamid Rushwan, FIGO Chief Executive, said: 'There is now increased understanding of the negative impact that diabetes has on people's lives, life chances and overall wellbeing, with strong evidence to indicate that over 76 million women with diabetes or pre-diabetes [Impaired Glucose Tolerance – IGT] are of reproductive age and at risk of having their pregnancies complicated by hyperglycaemia.

It has been realised that a comprehensive resource setting out evidence-based guidance on screening, diagnosing and providing care for women with GDM remains unavailable to key healthcare professionals. As a response to this unmet need, FIGO is fully committed to promoting an integrated approach to maternal and child health services in this area.

An expert group representing FIGO regions will develop the Guidelines, with the involvement of the FIGO Committee for Safe Motherhood and Newborn Health and the FIGO Working Group on Best Practice on Maternal-Foetal Medicine. This group is due to meet in early May at the FIGO HQ, and we look forward to reporting on the planned activities in the next issue.

New FIGO Working Group sets its agenda for 2014

– Best Practice on Maternal-Foetal Medicine

The first meeting of the newly established FIGO Working Group on 'Best Practice on Maternal-Foetal Medicine' (chaired by Dr Gian Carlo Di Renzo, Italy – centre in photo) was held in early 2014 in London.

In 2014, the 'Best Practices' Group will focus on folic acid supplementation, prediction and prevention of pre-term birth and non-invasive prenatal diagnosis and testing.

Best Practice on Maternal-Foetal Medicine Working Group meeting (London)

'Saving Mothers' Lives': Bolivian society workshops highlight PPH

Since February 2013, free training in 'Post-Partum Haemorrhage: Prevention and Treatment' has been developed by the Society of Gynecology and Obstetrics of Santa Cruz (Bolivia), and has benefited nearly 900 health professionals, not only in the city, but also in the surrounding rural areas.

The principal objective of the workshops is to train those professionals who attend women in labour, teaching them techniques that can save a mother's life.

Dr Carlos Füchtner, Workshop Director – and the Executive Board representative of FIGO's Bolivian Member Society – said: 'The Society will certainly continue with this worthwhile project – we know that proper training of healthcare professionals results in fewer tragic deaths of mothers.'

He added: 'PPH is a major cause of maternal mortality, yet is highly preventable through skilled care. We hope that other national societies will be encouraged to start their own activities in this important area of women's health.'

Vancouver 2015: More details coming soon at www.figo2015.org

FIGO Vancouver
XXI FIGO World Congress of Gynecology and Obstetrics
4 - 9 October 2015

www.figo2015.org will soon carry more information on the next FIGO World Congress, providing an essential 'one-stop shop' for prospective attendees. Professor Hamid Rushwan, FIGO Chief Executive, said: 'FIGO is looking forward with enormous anticipation to this Congress. We know that Vancouver will be a superb host to our global guests, and our Scientific Programme is shaping up to be both stimulating and enriching to all levels of healthcare professionals.' He added: 'Detailed information about our sponsorship packages is available on the website: we know that many global names will be taking the opportunity to raise their profiles at this major triennial Congress, the largest event in its sector.'

Vancouver images are kindly supplied by © Tourism Vancouver and © Vancouver Convention Centre

Countdown to Vancouver 2015

2nd Announcement Brochure:
October 2014 (including Call for Abstracts, Provisional Programme, Registration and Accommodation details)

Registrations and Accommodation Bookings Open:
October 2014

Abstract Submissions Open: October 2014

Abstracts Due: 15 March 2015

Notification of Acceptance: 30 April 2015

Early Registration Deadline: 15 May 2015

Hotel Reservation Deadline: 31 August 2015

Congress: 4–9 October 2015

FIGO and FOGSI take the stage at 57th AICOG

L–R: Dr Malhotra, Professor Sciarra and Professor Di Renzo (Patna)

FIGO and FOGSI joined forces at the 57th All India Congress of Obstetrics and Gynaecology, Patna, India, in February 2014, for a special panel session entitled: 'FIGO Guidance for Clinical Practice' (Chairpersons: Dr. Suchitra Pandit, Dr. CN Purandare and Dr. Nozer Sheriar). The topics presented were: Fetal Testing (Professor Gian Carlo Di Renzo – FIGO Honorary Secretary); Evaluation of Modern Contraceptive Methods (Dr. Narendra Malhotra – FOGSI representative to FIGO); and Abnormal Uterine Bleeding (Professor John J Sciarra – FIGO Past-President).

Sri Lanka welcomes FIGO-SAFOG-SLCOG joint conference

(courtesy of conference organisers)

A special joint conference organised by FIGO and the South Asian Federation of Obstetrics and Gynaecology (SAFOG), in collaboration with the Sri Lanka College of Obstetricians & Gynaecologists (SLCOG), will be held at the Bandaranaike Memorial International Conference Hall, at Colombo, Sri Lanka, from 30 October to 2 November, 2014.

Visit **www.figo-safog2014colombo.org/index.html** for full details.

Diary Dates

30 October–2 November 2014
FIGO-SAFOG-SLCOG Conference (Colombo, Sri Lanka)
www.figo-safog2014colombo.org/index.html

22–24 May, 2014
First European Spontaneous Preterm Birth Congress (Svendborg, Denmark)
www.espbc.eu/

26–30 May, 2014
15th World Congress for Cervical Pathology and Colposcopy (IFCPC 2014)
(London, United Kingdom)
www.ifcpc2014.com/

28–31 May, 2014
13th Congress of the European Society of Contraception and Reproductive Health
(Lisbon, Portugal)
www.escrh.eu/events/esc-events/2014

4–7 June, 2014
XXIV European Congress on Perinatal Medicine (Florence, Italy)
www.ecpm2014.org/

10–13 June, 2014
70th Annual Clinical and Scientific Conference of SOGC
(Niagara Falls, Ontario, Canada)
www.sogc.org/events/annual-clinical-andscientific-conference-acsc-2014/

29 June–2 July, 2014
ESHRE 2014 (European Society of Human Reproduction and Embryology) (Munich, Germany)
www.eshre.eu/annual_meeting/page.aspx/11

22–26 July, 2014
AUGS/IUGA Joint Scientific Meeting
(Washington DC, USA)
www.iuga.org/general/custom.asp?page=2014meeting

28–30 August, 2014
9th Athens Congress on Women's Health and Disease (Athens, Greece)
www.womenshealth2014.com

17–20 September, 2014
13th European Congress of Paediatric and Adolescent Gynaecology (London, UK)
Joint RCOG/BritSPAG/EURAPAG Meeting
www.rcog.org.uk/events/13th-europeancongress-paediatric-and-adolescentgynaecology

18–21 September, 2014
2014 International Conference on Stillbirth, SIDS and Baby Survival
(Amsterdam, the Netherlands)
www.stillbirthalliance.org/.

FIGO accepts no responsibility for the accuracy of the external event information. Inclusion of any event does not necessarily mean that FIGO either endorses or supports it (unless otherwise stated).

Countdown to Vancouver 2015: preparations in full swing

The Preparation for the next FIGO World Congress in Vancouver (4–9 October, 2015) is well in hand, under the leadership of our various Congress Committees. The conference facilities are second to none, and the hotel accommodations exceptionally well appointed, and all well within walking distance. The Congress 'First Announcement' has now been released (see **www.figo2015.org** and **www.figo.org**), so I urge you to reserve the dates and join us for what will be a truly memorable event. I have no doubt it will be a great success and I want you, FIGO's valued colleagues, to play an integral part in that success.

FIGO Group Tour to Vancouver, CANADA

Those interested can please contact

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We are on Facebook pages (FIGO Connect-India).

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