

Pisake Lumbiganon
(IS1)



CURRICULUM VITAE

Pisake Lumbiganon , MD, MS(Penn), FRCOG(ad eundem)

- President, Asia Oceania Federation of Obstetrics and Gynecology (AOFOG)
- Professor of Obstetrics and Gynecology and former dean, Faculty of Medicine, Khon Kaen University
- Director, WHO Collaborating Centre for Research Synthesis in Reproductive Health
- Convenor, Cochrane Thailand
- Past President, Royal Thai College of Obstetricians and Gynaecologists

Operationalize cervical cancer elimination in AOFOG

*Pisake Lumbiganon, MD, MS(Penn), FRCOG (ad eundem)
President, Asia and Oceania Federation of Obstetrics and Gynecology*

Cervical cancer is a leading cause of mortality among women. In 2020, an estimated 604,000 women were diagnosed with cervical cancer worldwide and about 342,000 women died from the disease. Cervical cancer is the most commonly diagnosed cancer in 23 countries and is the leading cause of cancer-related death in 36 countries. The vast majority of these countries are in sub-Saharan Africa, Melanesia, South America, and Southeastern Asia.

The World Health Organization has recommended programmatic interventions over the life course to prevent HPV infection and cervical cancer. In May 2018, Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, issued a call to action for the elimination of cervical cancer and in November 2020, he launched the Global Strategy to accelerate the elimination of cervical cancer, including the following targets for each of the three pillars for 2030: (1) 90% HPV vaccination coverage of eligible girls, (2) 70% screening coverage with a high-performance test, and (3) 90% of women with a positive screening test or a cervical lesion managed appropriately.

The United Nations also focused on the elimination of cervical cancer as a public health concern and few years ago launched the UN Joint Global Programme on Cervical Cancer Prevention and Control. Myanmar and Mongolia were selected by the UN to be priority countries for cervical cancer elimination. At the country level, the focus is on three priorities: (1) human papilloma virus immunization for girls, (2) screening and treatment for cervical precancer for women, and (3) diagnosis and treatment of invasive cervical cancer, including palliative care, available to all women.

In January 2018, during the AOFOG Executive Board meeting in Penang, Malaysia, formally adopted cervical cancer elimination as a priority issue and in November 2019 the Manila Declaration was launched during the AOFOG Congress in Manila, Philippines.

During the AOFOG Actin Plan Meeting last July 23, 2022 in Bangkok, Thailand, a working group on cervical cancer elimination was established and chaired by Dr. Christia Padolina.

For Thailand, in October 2017, HPV vaccination for girls was included in the expanded program for immunization (EPI). On December 7, 2017, a memorandum of understanding was signed between the Royal Thai College of Obstetricians and Gynecologists and the Ministry of Public Health of Thailand to eliminate cervical cancer. In July 2020, the National Health Security Office started cervical cancer screening by HPV DNA as a health benefit for all eligible women. In March 2023, self-sampling HPV DNA screening was approved as a health benefit for eligible women. Social media, presenters, and village health volunteers are used to promote and increase the coverage of cervical cancer screening. Finally, trainings for colposcopy are organized regularly so that it is available in all provinces in Thailand.

Rohana Haththotuwa
(IS2)



CURRICULUM VITAE

Rohana Haththotuwa

- Founder Chairman, Ninewells CARE Mother & Baby Hospital
- Secretary General AOFOG
- Immediate Past President South Asian Federation of Obstetrics & Gynaecology (SAFOG)
- Immediate Past President, South Asian Federation of Menopause Societies
- Immediate Past President, World Gestoses Organisation
- Past Chair, Menstrual Disorders Committee FIGO
- Past President Sri Lanka College of O & G
- Past President Sri Lanka Menopause Society
- Member, WHO MPDSR Technical Working Group

Heavy Menstrual Bleeding- Strategies to Best Cure

Rohana Haththotuwa, Secretary General AFOG

Abnormal uterine bleeding (AUB) in nonpregnant girls and women of reproductive age; include abnormalities in frequency, regularity, and duration of menses, as well as bleeding that occurs in the days between the otherwise predictable onset of menstruation. When it has been present for the majority of the last six months its denoted as chronic AUB.

Heavy menstrual bleeding (HMB) is one of the components of AUB. When the amount of menstrual blood lost by a woman is of a volume sufficient to adversely impact her physical, emotional, social, or material quality of life, it is defined as heavy menstrual bleeding (HMB.). It can occur alone or in combination with other symptoms.

Acute Abnormal Uterine Bleeding refers to an episode of bleeding that is of sufficient quantity to require immediate intervention to prevent further blood loss.

The incidence and the symptoms of HMB appears to be under reported. This may be related to many factors of social ethnic and religious practices. In many societies there is a social aversion to discuss menses and many women perceive the excessive blood loss as normal. It may be normalized by the parents and the health care providers. These cultural beliefs in many countries could result in *preventing women obtaining proper information, leading to-delay in seeking treatment, non-acceptance of treatment, discontinuation of treatment & seeking traditional methods as treatment* HMB is a Prevalent condition in developing countries. Up to 28% of women ages 36-40 years in India (1) It has been reported that 9-20% lose menstrual blood > 80cc/cycle(2,3) and in the UK each year 5% women aged 30-49 present for care and 880,000 seek care for HMB (4). In an internet based survey done on women in 5 European countries to find the prevalence and impact of heavy menstrual bleeding (HMB) among women in Europe, and their experience of HMB assessment and management only 27.2% of the 4706 women who responded had experienced two or more HMB symptoms within the previous year. Of these women, 564 (46.0%) had never consulted a physician. Only 152 (46.1%) of the 330 patients with confirmed HMB had received prescription medication for iron deficiency. So many women affected by HMB do not seek medical help, and few of those who do consult physicians report that they have received appropriate treatment. HMB continues to be underdiagnosed and poorly treated(5). HMB impacts on the quality of life of adolescent girls and women disrupting woman's day to day activities, social, sexual & family life. Iron deficiency anaemia due to HMB is a significant problem in the developing countries and HMB could be a warning sign of a major condition like Fibroids, Endometrial carcinoma. For those who become pregnant, iron deficiency anemia (IDA) is associated with multiple adverse obstetric outcomes, and it could also have an irreversible negative impact on fetal neuro development.

Causes of HMB can be considered under the PALM COEIN classification according to the different age groups. In the Reproductive age group, the causes include, AUB – A, AUB -O, AUB-Lsm, AUB-C, AUB-I (anticoagulants), AUB-N. In the Premenarchial age group it could be due to AUB-O AUB-C or AUB-I (anticoagulants) & in the perimenopausal group the causes are AUB-O, AUB-I (anticoagulants)& AUB-M In two surveys done to find the prevalence of Von Willebrand's disease as a cause of HMB it has been found to be high as 13 -16.5% (6)

In developed countries **history and examination** is one of MANY tools clinicians can use to evaluate patients with HMB But as the access to investigations may be limited in developing countries, history and examination is the KEY to the diagnosis and management. It can give

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pointers to find the extent of bleeding, identify the potential pathology, identify factors which will influence treatment & obtain an idea about patient's concerns, expectations.

History will include, details of current episode, effects on quality of life, past menstrual history, past gynecologic history & past medical history. Physical examination should assess the hemodynamic stability, determine amount of bleeding, evaluate for genital trauma, vaginal/cervical lesions & determine the likely pathology.

Evaluation of the endometrial cavity, endometrium and the Myometrium should be done to determine the cause. Endometrial cavity is evaluated by trans vaginal ultrasound scanning, Infusion sonography and hysteroscopy. These would detect endometrial or submucous polyps, fibroids or any other intra cavitory lesions. Then the myometrium is evaluated by sonography or MRI. These would help to Identify and characterize leiomyomas.

- a. FIGO type (3 and up)
- b. Dimensions
- c. Location
- d. Margin between myoma and serosa

And to Identify and characterize adenomyosis. Also, to distinguish adenomyomas from leiomyomas.

Investigations to determine the effects of blood loss needs to be done.

Management

There are multiple barriers to the management in developing countries such as, women do not know consequences of heavy bleeding, delay in seeking treatment, lack of knowledge among women and providers about treatment method, limited availability of treatment options, cost of treatment & failure to follow up & continue treatment.

Medical or surgical methods are available for the management of HMB.

Medical management is decided on, based on medical history & the presence of contraindications to therapies.

Surgical management is indicated when its not suitable for medical management, failure of response to medical management and when patient is not stable clinically.

Choice of surgical management depends on

- Underlying medical condition and pathology
- Desire for future fertility

Long term maintenance therapy in chronic AUB

Iron Supplementation

Medical management is usually the first line and the mainstay of treatment. Choice of the drug depends on the availability, affordability, acceptability, and the effectiveness. To improve the success of the treatment it is necessary to individualise the treatment and involve the patient in decision making of choosing the drug. Drugs available for the treatment of AUB -E includes , Progestins , COX inhibitors, Anti fibrinolytics , contraceptives, Levnogesterol Intra uterine systems (LNG IUS) and Danazol with differing success rates. LNG IUS has shown a 80% reduction in bleeding volume in 3 months (7).

Procedural/Surgical management

- **AUB -E - Diagnostic and therapeutic Dilatation and Curettage (D&C).**

It has an advantage of been an effective method, but has been investigated less.

Has the advantage of preforming Histopathological evaluation to evaluate the endometrium.

It' s helpful to exclude AVM before procedure. Therapeutic effect lasts for same cycle and

next one cycle. It's valuable in low resource setting. But concomitant hysteroscopy is preferred.

- **AUB-P** – Can be best treated by hysteroscopically directed polypectomy. Blind removal leads to high failure rate with higher incidence of recurrence and also high rate of failure for HMB(8,9)
- **AUB- A**- Uterus sparing adenomyomectomy is the procedure of choice. Removal of the adenomyoma entirely from the myometrium by wide excision.
- **AUB -L** Depending on the site, size and the number of myomas they are managed by polypectomy, myomectomy or hysterectomy. Performed using, resectoscope, laparoscope or by Laparotomy depending on the situation.

Other Procedures

- **Endometrial ablation**- Would be helpful in AUB – E. Performed by destruction of the endometrium by application of various forms of energy directly to endometrium.
Pre-requisites- Failed other treatments or are contraindicated, Poor surgical candidates, completed their families & endometrial sampling reveals no evidence of uterine or endometrial malignancy.
- **Uterine Artery Embolization** -This is percutaneous image guided embolization of uterine arteries. Indications include, AUB-N (Arteriovenous malformation), AUB-L, AUB-A . Some of the complications encountered are
Post-embolisation syndrome with pain, nausea, vomiting, malaise, fever, femoral hematoma, non-purulent vaginal discharge, needing hysterectomy- infection/ necrosis with severe pain, amenorrhoea (5%), ovarian failure (1%)
- **Hysterectomy**- This is considered as the last resort: If future fertility not desired
Could be done by - laparotomy, vaginally, laparoscopically
Advantages include, it been a one-time permanent procedure, resulting in complete amenorrhea
Side effects are it's a major surgical procedure with attendant complications, psychosexual dysfunction and cultural issues of removing the uterus

Long term management-

Finally, the patient must be managed long term preventing any recurrence of HMB and preventing and treating any iron deficiency anaemia which would have resulted from the HMB.

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Krishnendu Gupta

(IS3)



CURRICULUM VITAE

Prof. Krishnendu Gupta

MBBS (Mangalore), DGO (Manipal), MD (Manipal), FICMCH, FICOG, FRCPI (Ireland), FRCOG (Ad eundem, UK), FACOG (Hon)

Professor & Unit Head,
Department of Obstetrics & Gynaecology,
Vivekananda Institute of Medical Sciences,
Ramakrishna Mission Seva Pratishthan, India.

Academic and administrative

- Professor & Unit Head, Dept of Obstetrics & Gynaecology, Vivekananda Institute of Medical Sciences (VIMS), Kolkata since 2002.
- Adjunct Professor, Dept of Obstetrics & Gynaecology, Kasturba Medical College (KMC), Manipal since 2017.
- International Lead Fellow for MRCPI Part II Obstetrics & Gynaecology OSCE/Clinical Examinations, RCPI, Dublin, Ireland since 2022.
- Deputy Secretary General, AOFOG, 2022– 2024.
- Chair – Climate Change & Pollution Working Group, AOFOG, 2022– 2024.
- Member – COVID-19 Advisory Group, AOFOG, 2020– 2024.
- FOGSI Representative to Asia Oceania Federation of Obstetrics & Gynaecology (AOFOG), 2020– 2023.
- Member – Climate Change and Toxic Environmental Exposures Committee, International Federation of Gynecology & Obstetrics (FIGO), 2021– 2025.
- Co-Chair – Women' s Sexual & Reproductive Rights Committee, South Asian Federation of Obstetrics & Gynaecology (SAFOG), 2021– 2025.
- Chair – Sexual & Reproductive Health Committee, AOFOG, 2019– 2022.
- Chairperson, Indian College of Obstetricians & Gynaecologists (ICOG), 2016.
- Vice President, The Federation of Obstetric & Gynaecological Societies of India (FOGSI), 2011.
- National Corresponding Editor, The Journal of Obstetrics and Gynaecology of India (JOGI), 2014– 2016, 2021– 2023 and 2024– 2026.
- Peer Reviewer: IJGO, JOGR, JOGI, JIMA.
- President, Indian Society of Perinatology and Reproductive Biology (ISOPARB), Kolkata Chapter, 2015– 2019.
- Chairman, Reproductive Endocrinology Committee, FOGSI, 2003– 2007.

Impact of Climate Change, Environmental Toxins and Pollution on the AFOFG region: What can OBGYNs do?

Prof Krishnendu Gupta

MBBS, DGO, MD, FICMCH, FICOG, FRCPI (Ireland), FRCOG (Ad eundem, UK), FACOG (Hon, USA)

*Professor & Unit Head, Dept of Obstetrics & Gynaecology, Vivekananda Institute of Medical College (VIMS),
Kolkata, West Bengal*

Deputy Secretary General, AFOFG, 2022 – 2024

Chair – Climate Change & Pollution Working Group, AFOFG, 2022 – 2024

Member – Climate Change and Toxic Environmental Exposures Committee, FIGO, 2021 – 2025

Climate change is a reality and occurring at a rapid pace. A recent assessment by the United Nations Intergovernmental Panel on Climate Change (IPCC) states that climate change is happening faster than expected and that the window to act is quickly closing.¹

The COVID-19 pandemic has forced the global community to face its universal vulnerabilities to the forces of nature. The experience of this dreadful pandemic has contributed to an outpouring of opinion that the next global disaster is not rooted in nature, but rather is the result of human activity changing the climate of the earth, a conclusion supported by abundant and credible scientific data.²

Climate change now appears to be the 'next pandemic' indeed, with increasing global temperatures and frequency and intensity of extreme weather events, changes in precipitation patterns and rising sea levels and huge impacts on human disease and mental health. These events are predicted to have devastating effects on global food and water supplies and quality, economic sustainability, forced population migrations, and civil conflict, and thus physical and mental health-related illnesses.³

More importantly, climate change poses the most significant threat to women's health and is expected to disproportionately affect women, unborn children, and children, making them vulnerable to numerous adverse health effects. Its sequelae may lead to a worldwide public health disaster whose impact will be widespread.

We are aware that heat and air pollution exposure can result in congenital health issues. From physiological problems to anatomical defects, alterations in the environment such as ambient temperature and particulate matter play a significant role in this process.^{4,5} Similarly, air pollution exposure has been linked to cardiac complications, alterations in the epigenetics, and other pregnancy problems.⁶

As women's healthcare providers in the AFOFG region, it is our responsibility to protect the health of our patients, and assist them through political advocacy, providing family planning services, focusing on nutrition with special emphasis on lifestyle counseling. If we strive to adopt definitive strategies to both empower our patients and educate ourselves, we will have the opportunity to mitigate the potentially devastating effects of climate change on women. In addition, FIGO joins a broad coalition of international researchers and the

medical community in stating that the current climate crisis presents an imminent health risk to pregnant women, developing fetuses, and reproductive health, and recognizing that we need society-wide solutions, government policies, and global cooperation to address and reduce contributors, including fossil fuel production, to climate change.⁷

Following the footsteps of FIGO and its vibrant Committee on Climate Change and Toxic Environmental Exposures (C2TE2),⁸ the efforts taken by AOFOG to establish the Climate Change & Pollution Working Group (CCPWG) in July 2022 and its role, objectives, focus and plans will be highlighted, in addition to sharing some personal experiences in this much needed area of focus.

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