Gynaecological Pain

Dr TC Pun

Hong Kong Pain Society Annual Scientific Meeting 2013

21 Sep 2013

Gynaecological Pain

- Introduction
- Prevalence and incidence
- Possible aetiological factors
- Initial assessment
- Investigation
- Treatment
- Referral to pain specialist
- Personal reflections

Introduction

- A personal perspective – cannot represent other Gynaecologists
- No declaration

The challenging patient

All doctors encounter patients whom they find personally or professionally challenging. Accepting and understanding why this happens can help in the management of their care. *Dr Mónica Lalanda* investigates

This is all part of the daily practice of being a doctor. However, as you know, traditional medical education has in the past failed to properly prepare new doctors for dealing with such sensitive situations. As you leave medical school you might be very well prepared to manage a patient with diabetes, but totally lost in front of a diabetic patient who becomes abusive or demanding. Thankfully, the situation is improving, with effective communication skills forming an increasingly important part of undergraduate medical training.

It is interesting to notice that the literature regarding challenging patients is limited, considering the widespread nature of the problem. The way it has been handled during the years is also a significant benchmark of the evolution of the relationship

Box 1: The classic four types of difficult patients[1]

- **DEPENDENT CLINGERS** – Repeated requests for attention, reassurance, urgent demands for explanation, affection and medication.
- **ENTITLED DEMANDERS** – Patients that exude an innate sense of deservedness; they use intimidation, devaluation, and guilt induction to place the doctor in the role of "the inexhaustible supply depot".
- **MANIPULATIVE HELP-REJECTERS** – Patients who return to the surgery again and again, almost smugly satisfied to report that, once again, the treatment or regimen hasn't worked. Their pessimism appears to increase in direct proportion to the doctor's effort and enthusiasm.
- **SELF-DESTRUCTIVE DENIERS** – Appear to find their main pleasure in defeating the physician's attempts to preserve their lives. This may represent a chronic form of suicidal behaviour.

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WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity

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Results: There were 178 studies (459975 participants) in 148 articles. Of these, 106 studies were (124259 participants) on dysmenorrhoea, 54 (35973 participants) on dyspareunia and 18 (301756 participants) on noncyclical pain. There were only 19/95 (20%) less developed and 1/45 (2.2%) least developed countries with relevant data in contrast to 22/43 (51.2%) developed countries. Meta-regression analysis showed that rates of pain varied according to study quality features. There were 40 (22.5%) high quality studies with representative samples. Amongst them, the rate of dysmenorrhoea was 16.8 to 81%, that of dyspareunia was 8 to 21.8%, and that for noncyclical pain was 2.1 to 24%.

Conclusion: There were few valid population based estimates of disease burden due to CPP from less developed countries. The variation in rates of CPP worldwide was due to variable study quality. Where valid data were available, a high disease burden of all types of pelvic pain was found.

- The variation in geographical distribution may be related to study characteristics, study quality, age groups included and definitions used rather than intrinsic differences between the prevalence of CPP between the different populations.
- Other plausible explanations might be differences in the prevalence of sexually transmitted infections, availability of medical and other resources or cultural differences.

(Latthe P, Latthe M, Say L et al 2006)

Local incidence

- 1869 new attendances from Jan to Jun 2012 to General Gynaecology Clinics

Diagnosis	n	%
Abnormal uterine bleeding	627	33.5
Termination of pregnancy	304	16.3
Adnexal cyst	151	8.1
Fibroid	150	8.0
Genital prolapse	78	4.2
Abdominal pain	60	3.2
Incontinence	59	3.2
Dysmenorrhoea	47	2.5
……		
Others - 1 wound pain after LSCS, 1 low back pain, 1 dysuria	31	1.7
……		
Perineal pain/vaginal pain	6	0.3

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May 2012

The Initial Management of Chronic Pelvic Pain

NHS Evidence
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Possible aetiological factors

- There is frequently more than one component to chronic pelvic pain. Assessment should aim to identify contributory factors rather than assign causality to a single pathology.
- At the initial assessment, it may not be possible to identify confidently the cause of the pain.

(RCOG 2012)

Possible aetiological factors

- Central and peripheral nervous system
- Endometriosis and adenomyosis
- Adhesions
- IBS and interstitial cystitis
- Musculoskeletal
- Nerve entrapment
- Psychological and social issues

(RCOG 2012)

Endometriosis and adenomyosis

- Pelvic pain which varies markedly over the menstrual cycle is likely to be attributable to a hormonally driven condition such as endometriosis(D)

Prevalence of Endometriosis in Asymptomatic Women

Jon M. R. Rawson, M.D., Ph.D.

Numerous studies have identified the presence of endometriosis by its "classic" morphologic characteristics in high-risk patient populations. Recent histologic documentation of "subtle" laparoscopic appearances of this condition suggests that many of the earlier studies may have underestimated its prevalence in the general population. We evaluated the frequency of endometriosis in 86 women who denied having the symptoms typical of the condition and who underwent laparoscopy for other indications (acute pain, sterilization, etc.). Of those patients, 65.3% were found to have definitive evidence of pelvic endometriosis (stage I, 32.5%; II, 9.3%, III, 1.1%; IV, 23%). The exclusion of nine patients whose only laparoscopic indication was infertility or tubal occlusion resulted in a 44% finding of endometriosis, while 39% of the patients with documented fertility exhibited endometriosis. Forty-four percent of a subset of asymptomatic women undergoing laparoscopic evaluation prior to vaginal hysterectomy were found to have evidence of endometriosis; all but one had stage I, judged amenable to laser excision. The data suggest that endometriosis may be a more common peritoneal finding in asymptomatic, fertile women than previously believed.

Introduction

The theory that retrograde menstruation may be one of the etiologies of endometriosis has been widely accepted since its proposal by Sampson in 1927.[1] Subsequently it was demonstrated that 90% of women with patent fallopian tubes will have backflow of menstrual blood into the peritoneal cavity.[2] Logically it seems that endometriosis should be a common finding in women having open fallopian tubes and uninterrupted menstrual periods. In fact, Williams et al reported finding endometriosis in 50% of 1,000 consecutive celiotomies.[3] Others have suggested that the condition is less prevalent in fertile women when the diagnosis is based on the laparoscopic appearance.[4-6]

The recent histologic documentation of multiple morphologic presentations of endometriosis,[7,10] coupled with the high prevalence of endometriosis observed at the time of laparoscopically assisted hysterectomy for unrelated gynecologic conditions,[11] suggest that studies utilizing only the classic appearance of the condition may underestimate its frequency.

The study described below was an attempt to further our knowledge of the prevalence of pelvic endometriosis in asymptomatic women based on the current awareness of the numerous morphologic appearances of the condition.

Materials and Methods

The study population consisted of 86 consecutive women undergoing laparoscopic pelvic evaluation or laparoscopically assisted hysterectomy for various indications (Table I). Patients were considered asymptomatic and included in the study if they denied having the symptoms typical of endometriosis, including chronic and/or cyclic pelvic pain, dysmenorrhea and deep dyspareunia. A systematic evaluation of all pelvic peritoneal surfaces was undertaken by the author, employing near-contact laparoscopy utilizing a double- or triple-puncture technique and an intrauterine manipulating cannula. All the lesions

Rawson 1991 J Reprod Med

Patients with diagnosis of adenomyosis at myomectomy

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INTRODUCTION: The finding of adenomyosis during attempted myomectomy is one of the most unwelcome results of gynaecological surgery. There is a scarcity of information on this group of patients.

METHOD: The operation records and pathology reports of patients undergoing myomectomy from 1996 to 2001 were reviewed. The records of patients who were found to have adenomyosis were studied and the findings reported.

RESULTS:

- 119 cases of myomectomies records identified
- 5 patients found to have adenomyosis during planned myomectomy
- Mean age 35(range: 33-39)
- None had delivery before
- One did not have abdominal pain and dysmenorrhoea
- USG in 4 patients suggestive of fibroids, in 1 patient suggestive of adenomyosis
- Average size of uterus – 16 weeks gravid size
- Biopsy of uterine wall – adenomyosis confirmed in 4 cases; adenomyosis confirmed in the remaining case only 16 months later(after hysterectomy; size of previous biopsy specimen (2 x 1.5 x 0.5cm)
- 3 of the patients had hysterectomies in the follow up period(17, 18 and 54 months); 1 defaulted follow up after 15 months, 1 discharged after 70 months

CONCLUSION:

- Adenomyosis during attempted myomectomy is not common
- May not have abdominal pain or dysmenorrhoea
- Diagnosis can be missed by ultrasound examination or even biopsy
- Many of these patients need hysterectomy on follow up

AOGS
ACTA Obstetricia et Gynecologica Scandinavica

AOGS ACTA COMMENTARY

Does pelvic venous congestion syndrome exist and can it be treated?

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Key words
Pelvic venous congestion syndrome, pelvic venous reflux, chronic pelvic pain, ovarian artery embolization, evidence based review

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Conflict of interest
The authors have stated explicitly that there are no conflicts of interest in connection with this article.

Abstract

Chronic pelvic pain (CPP) is a common and costly health problem in gynecology. Operative pathological findings are often absent. In some women with CPP, pelvic venous congestion has been reported; however, this observation has also been made in asymptomatic women. Thus, it is not clear whether pelvic venous congestion causes CPP and, if it does, whether it is a direct or indirect cause. Venography and non-invasive imaging methods are used for the diagnosis, but scoring systems have not been validated. The current mainstay of treatment is venography-controlled embolization, which is less invasive than surgical interventions. However, the only evidence on effectiveness comes from uncontrolled case series. A systematic review of causation evidence is needed to prove whether pelvic venous congestion causes CPP and whether embolization treatment is effective. In addition, if causation is established, good-quality primary randomized controlled trials on embolization may be required.

Adhesions

- There is no evidence to support the division of fine adhesions in women with chronic pelvic pain.(✓)
- Division of dense vascular adhesion should be considered as this is associated with pain relief.(✓)
- Residual ovary syndrome, trapped ovary syndrome

Nerve entrapment

- Nerve entrapment in scar tissue, fascia or a narrow foramen may result in pain and dysfunction in the distribution of that nerve.(D)

Psychological and social issues

- Enquiry should be made regarding psychological and social issues which commonly occur in association with chronic pelvic pain; addressing these issues may be important in resolving symptoms.(B)
- Depression and sleep disorders
- Sexual or physical abuse

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Initial assessment

- Adequate time should be allowed for the initial assessment of women with chronic pelvic pain. They need to feel that they have been able to tell their story and that they have been listened to and believed.(✓)
- Many women present because they want and explanation for their pain. Often they already have a theory or a concern about the origin of the pain. These ideas should ideally be discussed in the initial consultation .(✓)

Initial assessment

- The multifactorial nature of chronic pelvic pain should be discussed and explored from the start. The aim should be to develop a partnership between the clinician and woman to plan a management programme.(B)

A Randomized Clinical Trial to Compare Two Different Approaches in Women With Chronic Pelvic Pain

A. A. W. PETERS, MD, PhD, E. van DORST, MD, B. JELLIS, MD, E. van ZUUREN, MD, J. HERMANS, PhD, AND J. B. TRIMBOS, MD, PhD

One hundred six patients with chronic pelvic pain were randomly allocated to one of two treatment groups. In the standard-approach group, organic causes of pelvic pain were excluded first and diagnostic laparoscopy was routinely performed. If no somatic cause could be found, attention was given to other causes such as psychological disturbances. In the second group an integrated approach was chosen. From the beginning equal attention was devoted to somatic, psychological, dietary, environmental, and physiotherapeutic factors. In this group, laparoscopy was not routinely performed. Both groups were similar with respect to clinical characteristics of the patients and the severity of their pain as assessed by various pain parameters. Postcoital pain was reported by 27% of the patients. Twenty percent of the patients had had negative sexual experiences such as childhood sexual abuse or rape. Evaluation of the pain 1 year after the institution of treatment revealed that the integrated approach improved pelvic pain significantly more often than the standard approach for three out of four pain parameters ($P < .01$). Laparoscopy played no important role in the treatment of pelvic pain. It is concluded that equal attention to both organic and other causative factors from the beginning of therapy is more likely to result in a reduction of pelvic pain than is a standard approach. (*Obstet Gynecol 77:740, 1991*)

little improvement.[1] Traditional medical treatment for these problems includes hormonal manipulation and nonsteroidal anti-inflammatories, yet these are often not appropriate.

Because unresolved continuing pain is unacceptable to both the patient and her doctor, it is not surprising that eventually a decision to operate is frequently made. Numerous types of operations have been advocated for chronic pelvic pain, such as antefixation of the retroverted uterus, hysterectomy with or without unilateral or bilateral salpingo-oophorectomy, presacral neurectomy, and adhesiolysis. Follow-up studies with adequate assessment of the results of the surgical procedure are, however, lacking.[2] Somatic fixation is a real problem with such a unilateral somatic approach. On the other hand, addressing only the psychosocial or psychiatric aspects of chronic pelvic pain carries similar risks.

Chronic pelvic pain does not constitute a single, well-defined category of symptoms and findings on physical examination, nor is a single well-defined course of action the most appropriate way to deal with this complaint. During the past decade, the standard

disturbances. In this group, laparoscopy was routinely performed. In the other treatment arm, an integrated approach was chosen from the beginning. Guidelines for this approach followed the pain model as described for example by Loeser.[7] The model comprises four components: nociception, pain sensation, pain suffering, and pain behavior. In this arm, equal attention was devoted to possible organic, psychological, dietary, and environmental causes of the pain. A consultation with a physiotherapist was also routinely included. The physiotherapist examined physical ability with attention to the abdominal and pelvic-floor muscles. Provocation tests were performed. In this group, laparoscopy was not routinely performed.

- If the history suggests to the woman and the doctor that there is a specific non-gynaecological component to the pain, referral to the relevant healthcare professional – such as gastroenterologist, urologist, genitourinary medicine physician, physiotherapist, psychologist or psychosexual counsellor – should be considered, usually via the GP.(✓)

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Investigations

- Suitable samples to screen for infection, particularly Chlamydia trachomatis and gonorrhoea, should be taken if there is any suspicion of pelvic inflammatory disease.(✓)
- All sexually active women with chronic pelvic pain should be offered screening for sexually transmitted infections.(D)
- A positive endocervical sample supports but does not prove the diagnosis of PID. The absence of a result positive for Chlamydia trachomatis or gonococcus does not rule out the diagnosis of PID.

Investigations

- Transvaginal ultrasound scan is an appropriate investigation to identify and assess adnenal masses.(B)
- Transvaginal ultrasound scan and MRI are useful tests to diagnose adenomyosis.(B)
- MRI may be useful in the assessment of palpable nodules in the pelvis or when symptoms suggest the presence of rectovaginal disease. It may also reveal rare pathology.

Investigations

- Diagnostic laparoscopy has been regarded in the past as ‘gold standard’ in the diagnosis of chronic pain. It may be better seen as a second-line investigation if other therapeutic interventions fail.(D)
- Diagnostic laparoscopy may have a role in developing the woman’s beliefs about her pain.(✓)

Diagnostic laparoscopy

- 1/3 to 1/2 will be negative and much of the pathology identified is not necessarily the cause of pain
- Perhaps it should be performed only when the index of suspicion of adhesive disease or endometriosis requiring surgical intervention is high, or when the patient has specific concerns which could be addressed by diagnostic laparoscopy such as fertility

Psychological Medicine, 1997, **27**, 1041–1050. Printed in the United Kingdom

The psychological effects of laparoscopy on women with chronic pelvic pain

S. ELCOMBE,[1] D. GATH AND A. DAY

From the Department of Psychiatry, Warneford Hospital, Oxford

ABSTRACT

Background. Many women who undergo diagnostic laparoscopy for chronic pelvic pain do not have pelvic pathology. This has led to an interest in psychological factors that might contribute to their experience of pain. This study was designed to evaluate the effects of diagnostic laparoscopy on women with chronic pelvic pain and to explore possible psychological mechanisms.

Methods. Seventy-one women undergoing laparoscopy for chronic pelvic pain were randomly allocated to one of two groups waiting different lengths of time for laparoscopy. Women were interviewed before laparoscopy and were followed up 1 week, 3 months and 6 months afterwards. Pain was assessed with an interview measure, diaries and visual analogue scales.

Results. Pain reductions were observed from before to after diagnostic laparoscopy. Regression analysis was used to identify factors which predicted improvements in pain. The hypothesis that psychological factors would predict improvements in pain was confirmed. Pain improvements after laparoscopy were predicted by beliefs about pain and the change in each woman's evaluation of the seriousness of her condition. Other than baseline pain, these psychological variables were the only ones to emerge as predictors of pain change despite exploratory analysis of over 40 other variables.

Conclusions. Diagnostic laparoscopy can have beneficial effects in women with chronic pelvic pain. These effects appear to be the result of psychological mechanisms. Further investigation of these mechanisms could help in the understanding and treatment of women with chronic pelvic pain.

Available online at www.sciencedirect.com
ScienceDirect
European Journal of Obstetrics & Gynecology and Reproductive Biology 132 (2007) 214–219
ejog
European Journal of Obstetrics & Gynecology and Reproductive Biology
www.elsevier.com/locate/ejogrb

Chronic pelvic pain and quality of life after laparoscopy

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Received 4 July 2005; received in revised form 8 March 2006; accepted 19 April 2006

Abstract

Objectives: To examine the long-term relationship between chronic pelvic pain (CPP) and quality of life and see if this is affected by a negative laparoscopy result.
Study design: A postal questionnaire survey of CPP and quality of life in 63 women who underwent a diagnostic laparoscopy 12–18 months previously.
Results: Women with CPP still reported pain 12–18 months after laparoscopy and a significantly poorer quality of life than UK norms for women of a similar age. Factor analysis showed that reports of pain symptoms clustered into two dimensions: (1) pain associated with menstruation and (2) pain associated with sexual intercourse and bladder and bowel function. Most dimensions of quality of life were significantly associated with pain. However, 'role limitation due to emotional problems' and 'mental health' were only associated with pain due to sexual intercourse and bladder and bowel function. Pain and quality of life were not affected by laparoscopy result or follow-up appointment.
Conclusions: Women with CPP continue to have pain and a low quality of life 12–18 months after laparoscopy. Laparoscopy results and follow-up appointments do not appear to affect either pain symptoms or quality of life in the long term, although this may be confounded by women obtaining treatment elsewhere.

CA125

- Indicated in women with bloating, early satiety, pelvic pain or urinary urgency or frequency persistently or frequently(>12 times per month)

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Therapeutic options

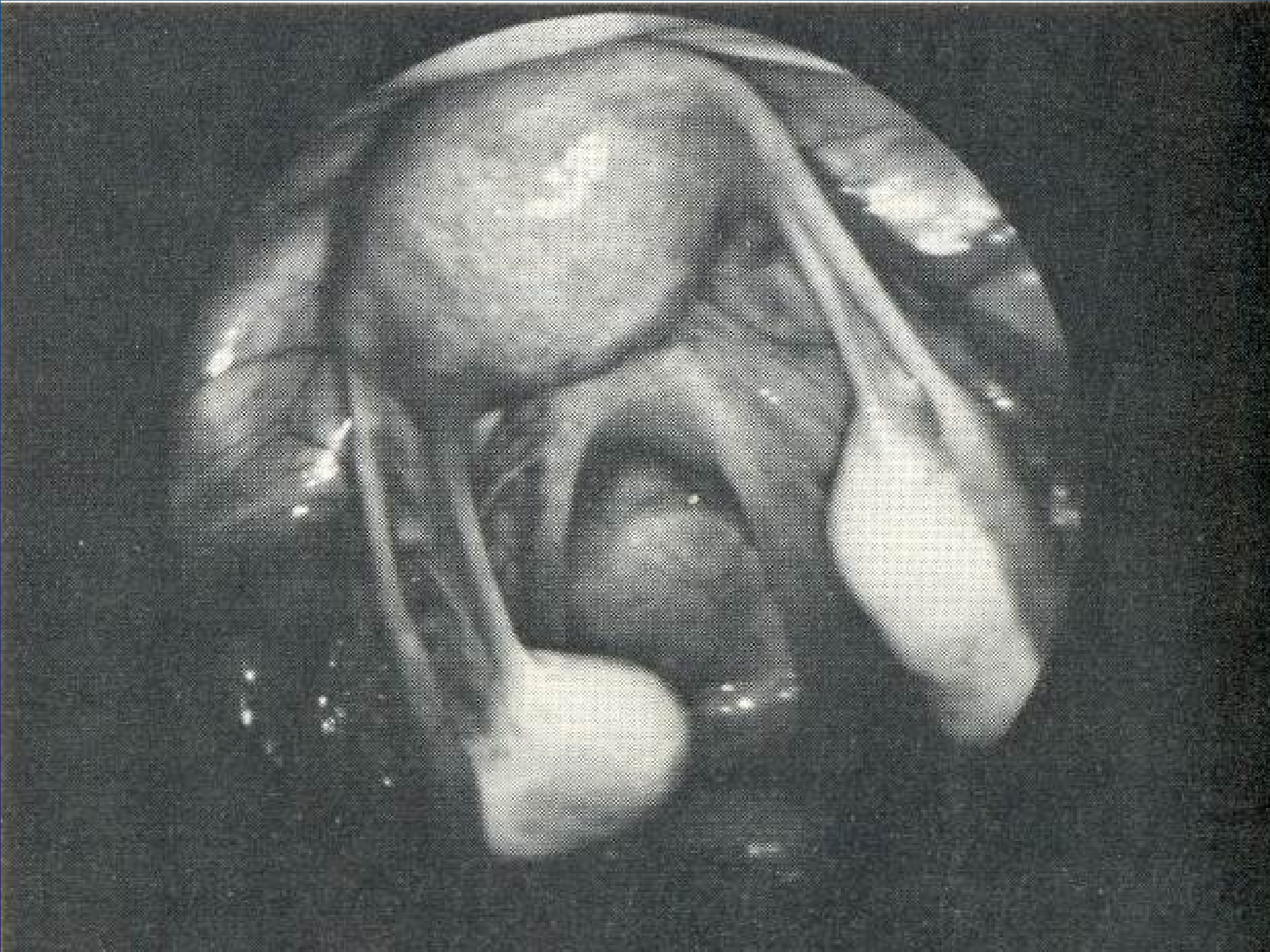
- Women with cyclical pain should be offered a therapeutic trial using hormonal treatment for a period of 3-6 months before having a diagnostic laparoscopy.(B)
- Women should be offered appropriate analgesia to control their pain even if no other therapeutic maneourves are yet to be initiated. If pain is not adequately controlled, consideration should be give to referral to a pain management team or a specialist pelvic pain clinic.(✓)

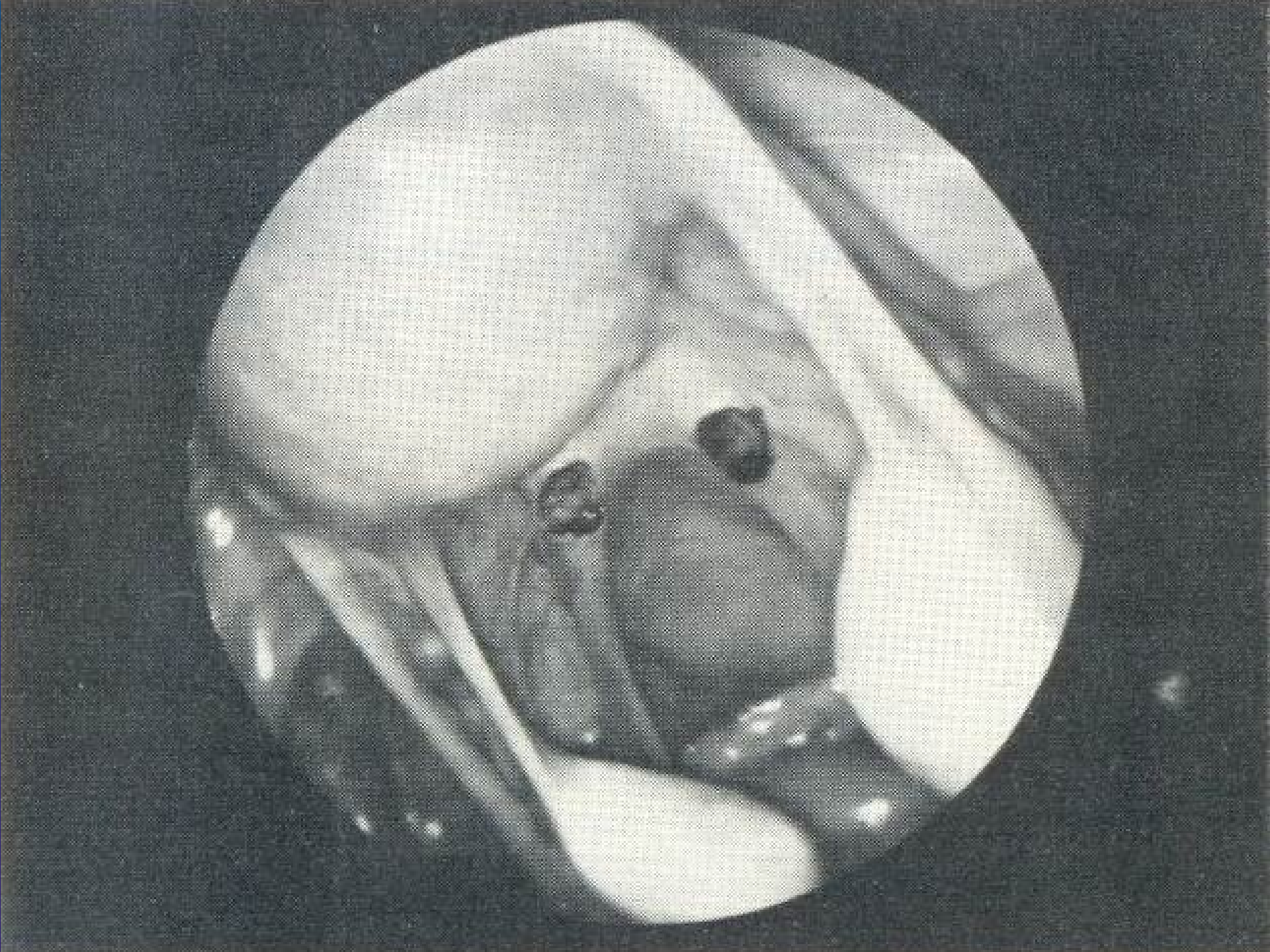
Therapeutic options

- Probably unwise for a general gynaecologist to prescribe opiods for regular use
- Nonpharmacological modalities may be helpful
- LUNA is ineffective

LUNA

- Laparoscopic uterosacral nerve ablation
- Interruption of the Lee-Frankenhauser sensory nerve plexuses





Human Reproduction Update, Vol.16, No.6 pp. 568–576, 2010
Advanced Access publication on July 15, 2010 doi:10.1093/humupd/dmq031

human reproduction update

Individual patient data meta-analysis of randomized evidence to assess the effectiveness of laparoscopic uterosacral nerve ablation in chronic pelvic pain

J.P. Daniels [1,2,*], L. Middleton [2], T. Xiong [3], R. Champaneria [1], N.P. Johnson [4], E.M. Lichten [5], C. Sutton [6], P. Vercellini [7], R. Gray [2], R.K. Hills [8], K.D. Jones [9], G. Aimi [7], and K.S. Khan [1] as the International LUNA IPD Meta-analysis Collaborative Group

METHODS: Electronic searches were conducted in the Medline, Embase, PsycInfo and Cochrane Library databases from database inception to August 2009. The reference lists of known relevant papers were searched for any further articles. Randomized trials comparing LUNA with no additional intervention were selected and authors contacted for IPD. Raw data were available from 862 women randomized into five trials. Pain scores were calibrated to a 10-point scale and were analysed using a multilevel model allowing for repeated measures.

RESULTS: There was no significant difference between LUNA and No LUNA for the worst pain recorded over a 12 month time period (mean difference 0.25 points in favour of No LUNA on a 0–10 point scale, 95% confidence interval: −0.08 to 0.58; $P = 0.1$).

CONCLUSIONS: LUNA does not result in improved chronic pelvic pain.

Key words: individual patient data / meta-analysis / chronic pelvic pain / dysmenorrhoea / neuroablation

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Referral to pain specialist

- Who should coordinate?
- ?Ongoing management

The challenging patient

All doctors encounter patients whom they find personally or professionally challenging. Accepting and understanding why this happens can help in the management of their care. *Dr Mónica Lalanda* investigates

This is all part of the daily practice of being a doctor. However, as you know, traditional medical education has in the past failed to properly prepare new doctors for dealing with such sensitive situations. As you leave medical school you might be very well prepared to manage a patient with diabetes, but totally lost in front of a diabetic patient who becomes abusive or demanding. Thankfully, the situation is improving, with effective communication skills forming an increasingly important part of undergraduate medical training.

It is interesting to notice that the literature regarding challenging patients is limited, considering the widespread nature of the problem. The way it has been handled during the years is also a significant benchmark of the evolution of the relationship

Personal reflections

- A lot to learn but the basic framework is in place
- ?lack of Practical experience and skill set
- ?relatively less common
- ?time factor
- ?financial return
- Better coordination
- Better management of pain to prevent persistence

Thank you

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