MINUTES OF THE ANNUAL GENERAL MEETING

of UPIGO, 6 & 7 July 2018 at the IBIS Tour Eiffel Cambronne Hotel,

PARIS (FRANCE)

Opening speech of the president: Athanasios CHIONIS

The president thanked the participants coming from Albania, France, Greece, Mali, Central African Republic, Burkina Faso, Mauritania and Chad.

Report of the secretary-general: Moustapha TOURE

In view of UPIGO's new vision to enlarge the association to new countries with concrete actions, the Secretary General has worked for the participation of midwives from some of the above-mentioned French-speaking African countries.

Report of the treasurer: Guy SCHLAEDER

The detailed assessment was presented in plenary meeting. The accounts are balanced and the treasurer proposed to call for contributions as follows: France 2800€, Mali 400€, Greece 950€, Albania 400€, Central African Republic 400€.

The scientific session was devoted to two main themes: preterm birth and basic midwifery ultrasound for midwives

1st MAIN THEME: BASIC OBSTETRICAL ECHOGRAPHY FOR MIDWIVES.

Presented by Dr LEVAILLANT in charge of ultrasound training at the French National College of Gynaecologists and Obstetricians.

On the basis of his experience, he has drawn up a few ultrasound-training outlines. For sub-Sahelian Africa, he insisted on the need to make a good inventory before launching the educational program: human resources, ultrasound equipment. He proposed training by synchronized video conferencing in the different countries.
Comments after discussions among UPIGO members: the feasibility of video conferencing seems difficult in light of the condition of the communication network in Africa. We are moving towards the organization of on-site training in Mali where midwives from different countries will be invited. The educational programme will imply an significant mobilization of financial resources from national and international partners (WHO, UNFPA, INGOs, European Union, manufacturers of ultrasound equipment).
The discussions focused on the following points:
Ultrasound in the delivery room - experience in Mauritania, by Rhokaya DIAWARA, midwife.
Within the framework of a project initiated by the authorities in collaboration with the French cooperation, twelve midwives have been trained in performing ultrasound for the diagnosis of common pathologies in gynaecology and obstetrics, to the satisfaction of all the parties involved. It was recalled that ultrasound should not replace the clinical examination in the delivery room, it is complementary to it. Its relevance and feasibility could allow better monitoring of labour. It is an invaluable aid to diagnosis and treatment.
Ultrasound training for midwives in France, by Catherine BURGY, midwife teaching at the École de Sages-femmes of Strasbourg.
From the practical point of view, midwives learn how to perform: localization of the placenta, assessment of amniotic fluid volume, assessment of foetal vitality, foetal biometry, diagnosis of foetal

presentation, early pregnancy dating before the 11th week, identification of gynaecological structures.

Midwives can perform gynaecological ultrasound examinations for ovulation monitoring, provided that their experience and training have considered adequate by the assisted reproduction doctors of their centre.

Midwives have the possibility to improve their skills within the framework of an interuniversitydegree (IUD) in gynaecological obstetrics and gynaecology. This IUD brings together midwives and doctors in the same teaching.

With or without a diploma in ultrasound, midwives must comply continuing education and assessment of professional practices in order to maintain and control their knowledge.

Remarks on the conditions of midwifery practice in rural and urban areas in Africa.

In urban areas, by Molobaly Diallo, midwife from Mali.

Midwives carry out activities related to the units in which they are assigned; those working in university hospitals receive continuing education. There are often too many of them.

In rural areas, by Honorine Soma from Burkina Faso.

In addition to traditional midwifery tasks, they have management tasks. They are often overwhelmed, there are a very insufficient number of them and they are working in ill-equipped structures. They lack continuous training and the daily grind is a big threat to their motivation.

2nd MAIN THEME: PREMATURE BIRTH

Immediate future of premature babies at the Gabriel-Touré University Hospital of Bamako by Moustapha Toure and F. DICKO

With the following results:

Premature birth rate: 63,9 %, 207 cases out of 324.

Mothers' ages range: 19-34 years
Educational background: 60,7% of women have never been in school
Origin: 25% of women gave birth at the university hospital, 47.2% at referral health centres
Modes of transport: 49% by ambulance,12,1 & by taxi, 25,1% on foot, 8,2% by personal vehicles
Treatment: no corticotherapy in 135 cases out of 207, i.e. 65,2%
Hypothermia in neonates: 84 cases out of 207 i.e. 40,6%
Cyanosis in neonates: 103 cases out of 207, i.e. 49,8%
Respiratory distress: 152 cases out of 207, i.e. 73.4%
Resuscitation procedures: 36 cases out of 207, i.e. 17,4%
Weight at birth between 1000 and 1500g: 104 cases out of 207, i.e. 50,2%
Mode of delivery: 51 C-sections out of 207 births, i.e. 24%
Blood culture: positive in 33 cases out of 207, i.e. 15,9% with presence of staphylococci in 44,22% (17/36)
Hypoglycaemia in preterm neonates: 41 cases out of 207, i.e. 20%
High case mortality rate: 105 cases out of 207, i.e. 50,7%
Observed risk factors: birth weight, number of antenatal care visits, infection, pregnancy term, mode of delivery, hypothermia, resuscitation
Conclusion
The mortality rate of premature birth is high at the Gabriel-Touré University Hospital. The risk factors are known. The results of this study must be reported to the authorities in order to implement an action plan.
Prediction and prevention of preterm birth complications, by A. CHIONIS.
The author reminded of the situation in Africa and Europe, where the prevalence rate is 18 and 5 % respectively, with 15 million premature babies per year worldwide.
It is the main cause of mortality among children under 5.

Short- and long-term complications were highlighted.

Short-term complications

Hypothermia, respiratory abnormalities, cardiovascular abnormalities, colitis, infection, retinopathy of prematurity

Long-term complications

Hospitalizations, neurodevelopmental outcome, chronic health issues, growth impairment, impairment of lung function, effect on adult health, insulin resistance, hypertension and vascular changes reproduction

Preterm birth is a multifactorial syndrome caused by genetic, hormonal, social and environmental factor.

20% of preterm birth is iatrogenic.

80% of the preterm birth is spontaneous.

Risk factors for preterm birth:

Non-modifiable risk factors

Prior preterm birth, African-American race, age <18 or >40 years, poor nutrition/low pre-pregnancy weight, low socio-economic status, cervical injury/surgery or anomaly, short cervix, uterine anomaly or fibroid.

Premature cervical dilatation (>2cm) or effacement (>80 percent), overdistended uterus (multiple pregnancy, polyhydramnios), periodontal disease, vaginal bleeding, excessive uterine activity.

Modifiable risk factors

Cigarette smoking, substance abuse, suboptimal prenatal care, short interpregnancy intervals, anaemia, bacteriuria/urinary tract infection, genital infection, strenuous work, high personal stress.

The treatment modalities in relation to progesterone and cervical cerclage have been defined taking certain parameters into consideration (term of pregnancy, cervical length).

NOVELTIES IN GYNAECOLOGY, by Jean-Jacques BALDAUF

Ob-gyn department at Strasbourg Hautepierre University Hospital

New developments in gynaecology will be presented this year along three lines: de-escalation in surgery for pelvic gynaecologic cancers, fertility preservation and Fast-Track-Surgery.

De-escalation in gynaecologic pelvic cancers concerns the three most frequent pelvic cancers.

I. CERVICAL CANCER

Microinvasive stage IA1 and IA2

Therapeutic conization treatment is the diagnostic step and may be considered sufficient treatment in the case of a in sano excision and absence of lympho-vascular invasion.

For stage IA2, lymph node staging by sentinel node analysis is sufficient. Complementary simple hysterectomy is indicated in case of difficulties in subsequent monitoring (post-conization stenosis).

Stages IB1 and IIA2

Pelvic lymphadenectomy is the first therapeutic step. For this step, validation of the sentinel lymph node is in progress. In the case of pelvic lymph node involvement, a lymph node evaluation, either surgical (lumbo-aortic lymphadenectomy) or by PET scan, should allow to size the radiochemotherapy, which is the recommended treatment.

In the absence of pelvic lymphadenectomy (sentinel lymph nodes) surgery extended to the parameters is still the standard. Non-extension to the parameters is being studied for cancers starting less than 2 cm long, without lymph node involvement and without lymphovascular invasion (SHAPE protocol).

Enlarged trachelectomy is possible for cancers smaller than 2 cm.
Stages IIB and above

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Radiochemotherapy is the standard treatment. This treatment is dimensioned after lombo-aortic lymph node staging either surgically or by imaging.
Completion surgery is reserved for incomplete therapeutic responses.

II. OVARIAN CANCER

Exploratory laparoscopy is generally the first stage of therapeutic care both to evaluate the histological type and the possibility of complete intraperitoneal exeresis.
Immediate excision surgery is preferred in situations where complete excision can be achieved. Otherwise, neo-adjuvant chemotherapy followed by interval surgery as soon as radical intra-peritoneal surgical exeresis appears possible, is to be preferred.
The therapeutic value of pelvic and lombo-aortic lymphadenectomy has not yet been validated. This procedure is only envisaged in the absence of distant metastasis or supra-diaphragmatic involvement and only in situations where intra-peritoneal excision is considered complete.

III. ENDOMETRIAL CANCER

For low-risk or intermediate-risk cancers, pelvic lymphadenectomy is no longer required.
Conversely, for high-risk forms, lymphadenectomy must be pelvic and lumbo-aortic, especially for grade I endometrioid cancers in the case of multiple lymphovascular emboli.

Conversely, in the case of cervical involvement (stage II), extended hysterectomy is no longer required as a matter of principle, but will be performed if necessary to achieve marginal removal.

FERTILITY PRESERVATION

Preserving the fertility of women with pelvic cancers seems all the more legitimate as therapeutic progress allows a longer survival and even a more and more frequent cure.

Among the techniques currently available: embryo freezing, cryopreservation of ovarian tissue or oocyte vitrification, the latter technique has been possible in France since 2011 and represents a real technological breakthrough. Indeed, ultra-fast freezing results in 80 or even 90% survival rate after thawing, and is particularly suitable for situations without a partner and therefore without prior fertilisation. However, it requires ovarian stimulation and therefore a delay for the start of the carcinological treatment.

The table below compares the practical aspects of the three fertility preservation techniques.

Comparing the 3 techniques

	Ovarian tissue C	Embryonic C	Egg cell C
Puberty	No	Yes	Yes
Couple	No	Yes	Non
Ovarian Stim Delay	No	Yes	Yes
Surgery	Yes	No	No
Endocrine function	Yes	No	No
Therapy post chemo	Yes	No	No
Pregnant woman	Yes	No	No
Recurrence risk	Potential	No	No

Births	<40	>100 000	>1000

Simply put, in a woman of childbearing age, the choice depends primarily on the time available before the start of cancer treatment.

A period of three weeks makes it possible to consider ovarian stimulation with in vitro fertilisation and embryo conservation if a partner is present or oocyte conservation by vitrification in the absence of a partner.

The need for urgent treatment without a three-week delay necessitates the use of ovarian tissue preservation.

Regardless of the technique, the Edinburgh criteria published in The Lancet Oncology in 2005 allows for the selection of patients who may benefit from cryopreservation.

Edinburgh criteria :

- age < 30
- no previous chemo- or radiotherapy (exception for children < 15 with previous low chemo dose)
- realistic chance of long-term survival
- risk that the treatment may induce ovarian failure >50%
- information and consent obtained
- HCV, HBV and HIV negative serologies
- Childfree patients

STATUTORY GENERAL MEETING

• The report of the Secretary General was unanimously approved.

• The Treasurer's report was unanimously approved.

• The call for membership fees and the treasurer's proposals for rates per country were also unanimously approved.

• The secretary general is mandated to contact the president of the African Society of Obstetrics and Gynaecology to support the project of ultrasound training for midwives.

• We will explore the possibilities of financing and acquiring ultrasound equipment from European partners.

• The bureau has been fully renewed in its functions as follows:

• President : Athanassios CHIONIS (Greece)

. Vice-president: Per Francesco TROPEA (Italia)

• Secretary General : Moustapha TOURE (Mali)

• Treasurer and past-president : Guy SCHLAEDER (France)

• Scientific Advisor: Jean-Jacques BALDAUF (France)

• For the next General Assembly, the main themes selected are :

Training of midwives to perform basic ultrasound, coordination M.TOURE

Experience in East Africa: E.Neuenschwander CH

Diabetes and pregnancy: A. CHIONIS

Adnexal masses: A. CHIONIS

Malaria and pregnancy: A. SEPOU

Novelties in Gynecology : J.J. BALDAUF

The next General Assembly will be held on 25 and 26 October 2019 in Strasbourg (France).

List of participants present in Paris: ALBANIA: Gjergji THEODHOSI -

AUSTRALIA : Nesrin VAROL - CENTRAL AFRICAN REPUBLIC: Abdoulaye SEPOU ; Patricia Regina PEPA-MAYKO– GREECE : Athaniassios CHIONIS, Antonios KOUTRAS – France : Jean-Jacques BALDAUF; Catherine BURGY; Guy SCHLAEDER; J.M. LEVAILLANT – MALI : Moustapha TOURE; Molobaly DIALLO midwife; Binta AWE midwife; Walidé SISSOKO midwife. MAURITANIA: Rokhaya DIAWARA midwife – BURKINA FASO: Honorine SOMA midwife.

At the end of the General Assembly, the participants warmly thanked Past President Guy Schlaeder for his kind welcome and his excellent organisation.

- MT/ GS 14/9/19