A MEETING ORGANISED BY THE OBSTETRICS & GYNAECOLOGY SECTION

Dilemmas in reproductive health

Friday 18 May 2018
CPD: 2 credits
Dilemmas in reproductive health
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The aim of the meeting is to update clinicians regarding the current dilemmas in the management of women during their reproductive life.

Objectives

- Understand best practice in hormone replacement therapy
- Be aware of the current advances in laparoscopic and robotic surgery
- Understand the pros and cons of imaging in gynaecology

6.15 pm Registration and wine reception
7.00 pm Welcome
Dr Dudley Robinson, President, Obstetrics & Gynaecology Section, Royal Society of Medicine
7.05 pm Reading of the minutes
Mr Patrick O’Brien, Secretary, Obstetrics & Gynaecology Section, Royal Society of Medicine

Debate: This house believes that ultrasound offers the optimal imaging modality for gynaecological pathology

7.10 pm For: Mr Davor Jurovic, Consultant Gynaecologist, University College London
Against: Professor Andrea Rockall, Consultant Radiologist, Imperial College Healthcare NHS Trust

7.50 pm Hormone replacement therapy: Navigating the controversies
Mr Nick Panay, Consultant Gynaecologist, Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust

8.10 pm Point, counter point: Redefining the optimal surgical approach laparoscopic surgery
Mr Alan Farthing, Consultant Gynaecological Oncologist, Imperial College Healthcare NHS Trust

8.30 pm Robotic surgery
Mr Mark Slack, Consultant Urogynaecologist, Cambridge University Hospitals, Cambridge

8.50 pm Close of meeting
Click here for the evaluation survey link, certificates will be sent by email

We are grateful to Mylan for supporting this meeting.
We would like to thank Vitabiotics for providing goody bags.

SAVE THE DATE:

Presidential address: From ballroom dancing to marathon running - The history of women in sport
Friday 12 October 2018

BLOCK BOOKING FORMS WILL BE AVAILABLE FOR RSM MEMBERS TO BOOK FOR THE NEXT ACADEMIC YEAR

The RSM itself accepts no legal responsibility for the facts stated or opinions expressed during this meeting. It is the responsibility of any attendees to satisfy him/herself as to which part(s) of those facts/opinions should be relied on in any way whatsoever.
MR NICK PANAY, CONSULTANT GYNAECOLOGIST, IMPERIAL COLLEGE HEALTHCARE NHS TRUST AND CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Abstract

The adverse outcomes seen in the women’s health initiative (WHI) combined hormone therapy trial were mainly to an over-dosage of hormone therapy (HT) in a relatively elderly population. However, fundamental differences exist between conjugated equine estrogens and 17 beta estradiol and between medroxyprogesterone acetate and other progestogens. It is likely that these differences also contributed to the adverse outcomes in WHI, which were contrary to the cardiovascular benefits seen in previous observational trials. In addition to binding to the progesterone receptor, many progestogenic compounds also bind to the glucocorticoid, mineralocorticoid and androgen receptors. This can lead to unwanted effects such as unfavourable glucose metabolism, fluid retention, acne, weight gain. Recent studies of cardiovascular risk markers in younger women have therefore been designed using predominantly 17 beta estradiol and progesterone or dydrogesterone as primary interventions. Menopause societies are now advising that natural progesterone and dydrogesterone may have more favourable metabolic and breast effects compared to synthetic progestogens. Natural progesterone and dydrogesterone do not attenuate the beneficial effects of estradiol in reducing insulin resistance and arterial compliance. There also appear to be differential effects of progesterone and progestogens on breast tissue. Progesterone has a neutral and dydrogesterone
a pro apoptotic effect on breast epithelial cells, whereas androgenic progestogens such as medroxyprogesterone acetate appear to have a proliferative effect, possibly through non-specific effects on the glucocorticoid receptors and gene expression. This might explain the small increase risk in breast cancer promotion in some studies when synthetic progestogens are combined with estrogen. Observational data such as the French E3N cohort and the Finnish registry cohort suggest that women using natural progesterone and dydrogesterone are not at increased risk of breast cancer within the first 5 years of use; ideally these data will be confirmed in the future by definitive long term, randomised prospective studies.

Thus, replication of the physiological hormonal environment with estradiol and favourable types of progestogens and progesterone can maximise benefits and minimise side effects and risks of HT. It is time we moved away from the notion, often propagated by epidemiologists and the media, that all hormone therapy products have a single class effect.