44th Annual AOGD Conference 2022

Date: **12th & 13th November, 2022**
Venue: **India Habitat Centre, New Delhi**

Organised by
Maulana Azad Medical College & Lok Nayak Hospital, New Delhi

Conference Theme
Quality care for women: Sharing vision, Sharing solutions

Souvenir & Book of Abstracts

Safeguarding women and their Doctors

AOGD SECRETARIAT
Department of Obstetrics and Gynecology
Maulana Azad Medical College & Lok Nayak Hospital
Jawahar Lal Nehru Marg, Delhi-110 002
Email: aogdmamc2022@gmail.com | www.aogd.org | M: 9717392924

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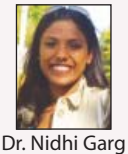

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44th Annual AOGD Conference 2022

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From the AOGD Office


Dr. Asmita M. Rathore


Dr. Y. M. Mala


Dr. Deepti Goswami

Dear friends

Greetings from AOGD Secretariat!

It's a great pleasure to welcome you for the 44th annual AOGD conference to be held on12th and 13th November at India Habitat Centre. After two years of uncertainty of COVID Pandemic and virtual interactions, we look forward to meeting you all in person. The theme of the conference is **''Quality care for women: Sharing vision, Sharing solutions"**. The national & international experts as faculty and thoughtfully curated scientific programme with amalgamation of 10 pre-congress workshops, orations, keynote lectures, panel discussions and debates will provide a wonderful opportunity to upgrade our existing knowledge and share experiences. The quiz on 'Genetics in ObGyn Practise' will be an exciting experience. The competition papers showcasing work of young researchers is a unique feature of our AOGD conferences along with free communications from our members. The E souveneir and abstract book brought out by editorial team will treasure our memories of the event.

The pleasant weather of November, ambience of India habitat Centre will be great place to meet friends and social networking. I am sure this meeting on one of the largest academic platform for knowledge exchange will be grand experience and Team AOGD is eagerly waiting to welcome you.

With best wishes

Dr. Asmita M Rathore, President
Dr. Y M Mala, Vice President
Dr. Deepti Goswami, Secretary

From the Editor's Desk

Dr. Madhavi M. Gupta
Editor

Dr. Nalini Bala Pandey

Dr. Reena Rani

Co-Editors

Greetings to all and a warm welcome to the conference !

The editorial team is happy to present the souvenir and the book of abstracts for the 44th annual AOGD conference to be held on the 12th & 13th November at the India Habitat Centre.

The entire team of AOGD at MAMC has been working relentlessly for last couple of months to give you an experience to cherish.

Academic conferences are an important part of learning. They offer doctors and scientists an opportunity to present their work, collaborate with fellow researchers, build connections and mentor young researchers. Our young, budding professionals have been very enthusiastic in submitting their research which covers a wide range of topics in both Obstetrics & Gynaecology. It is encouraging to see their passion.

The committees for free communications and competition papers were faced with the humungous task of sorting out over 200 submissions.

My sincere thanks to co-editors, Dr Nalini Bala Pandey, and Dr Reena Rani for their meticulous and timely work.

This issue of conference souvenir and the book of abstracts is inclusive of the AOGD Bulletin for month of November 2022.

My special thanks to our publisher, Mr Rakesh Ahuja and his team especially Mr Sandeep Rai for the excellent work and meeting the deadline.

Looking forward to shared learning

Yours in health

Dr. Madhavi M Gupta
Editor

Amit Singla, IAS
अमित सिंगला, भा. प्र. से.
Secretary (Health & FW)
सचिव (स्वास्थ्य एवं परिवार कल्याण)

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आईपी एस्टेट, नई दिल्ली-110002
ROOM No. 907/908, 9th LEVEL, A-WING, DELHI
SECRETARIAT, I.P.ESTATE, NEW DELHI-110 002
Tel. 011-23392017: e-mail: pshealth@nic.in

D.O. No. **PS/HFW/2022/prsecyhfw/11032**
Dated: **07-11-2022**

MESSAGE

I am extremely glad to know that the Department of Obstetrics & Gynaecology, Maulana Azad Medical College and Lok Nayak Hospital of Delhi is organizing 44th Annual conference of AOGD with the theme "Quality care for women: Sharing Vision, Sharing Solutions" on 12th& 13th November 2022.

The health status of women marks the wellness of a nation. The Government of Delhi is determined to improve the maternal and child health by implementing policies to reduce maternal morbidity and mortality. These endeavors are important steps to achieve high quality care for women and new born in line with the targets set under the Sustainable Development Goals.

The theme of the conference is apt in today's scenario that we need to update our knowledge and skills to deliver high quality services. This academic bonanza will be a feast for the participants with exchange of ideas, experiences and insights from national and international faculty.

I congratulate the organizers for planning this academic event and extend my best wishes for a grand success.

(Amit Singla)
Secretary (Health & FW)

From the President FOGSI

Dear Friends,

Greetings!

With great pleasure, I invite you all to the 44th Annual Conference of Association of Obstetricians & Gynaecologists of Delhi (AOGD) to be held in the capital city of India on 12th and 13th of November 2022. The conference theme - "Quality Care for Women - Sharing vision, Sharing solutions" is very close to my heart as it reverberates my theme for the year too.

The conference has an extensive academic program covering wide range of topics in obstetrics, gynaecology, infertility and endoscopy. Many stalwarts from all over the country and eminent international faculty will be sharing their knowledge and experiences. I love Delhi, it's a city where ancient and modern blend seamlessly together. November is perfect weather to enjoy this magnificent city.

This year my FOGSI slogan is Swasth Nari, Sukhi Nari. My CSR activity is defined as Badlaav (Change) including three arms - Ekikaran (integration of thought and action), Samanta (equality of treatment irrespective of economic status) and Takniki (technology to achieve these objectives). These academic conferences will be a step ahead towards making a difference in women care in our country. I would like to request you all to join forces and become a volunteer for our Badlaav initiative by conducting free gynecology checkups in your clinics on 18th of every month.

My best wishes are with Dr. Asmita Rathore and Team AOGD for grand success of this unique conference. I am sure she and her team will go extra miles to make this a memorable experience for everyone!!

Dr. Hrishikesh D. Pai

President FOGSI

Dr. Ritu Arora
M.D. (Ophthal), DNB
DEAN

सत्यमेव जयते

Maulana Azad Medical College &
Associated Hospitals:
- Govind Ballabh Pant Institute of Postgraduate Medical Education and Research
- Lok Nayak Hospital
- Guru Nanak Eye Center

2, Bahadur Shah Zafar Marg,
New Delhi - 110002 (India)
Ph. : 91-11-23231478, 23231438
Fax: 91-11-23235574 Ext.: 101-102
Email : deanmamc.2012@gmail.com

7th November 2022

MESSAGE

It gives me immense pleasure to applaud the Department of Obstetrics and Gynaecology Maulana Azad Medical College for organising the 44th Annual Conference of the Association of Obstetricians and Gynaecologists of Delhi (AOGD) on12th and 13th November 2022 with the theme "Quality care for women: sharing vision sharing solutions". The theme resonates with the targets set under the sustainable development goals (SDGs) to provide high quality care for the woman and the newborn.

The Association of Obstetricians and Gynaecologists of Delhi (AOGD) is working tirelessly to achieve their immense commitment to promote quality health services for women. This conference will indeed serve as an intellectual bonanza for young and aspiring gynecologists from across the country and will empower them with a vision towards quality care.

I wish the organisers and the delegates a very successful and productive time at the conference.

R. Arora

(Dr. RITU ARORA)

DR. SURESH KUMAR
Medical Director, LNH
Dir. Prof. Medicine, MAMC
New Delhi - 110002

Lok Nayak Hospital
J.L. Nehru Marg, New Delhi - 110002
Govt. of NCT of Delhi
Ph. No. 011-23236000
E-mail : lnhmsoffice@gmail.com
drskumar31@yahoo.co.in

D.O. No. F.No. PS/MD/LNH/2022/1261

Dated 09/11/2022

Message for the 44th Annual Conference of the Association of Obstetricians and Gynaecologists of Delhi (AOGD)

I am extremely delighted to know that the Department of Obstetrics and Gynaecology Maulana Azad Medical College and Lok Nayak Hospital is organising the 44th Annual Conference of the Association of Obstetrics and Gynaecology of Delhi (AOGD) from 12th to 13th November 2022 on a very pertinent theme "Quality care for women: Sharing vision, Sharing solutions". Quality care is the new target to be achieved.

The Department has worked hard providing quality care to women during the COVID pandemic.The health of the mother is instrumental in deciding the good health of the generations to come.The theme echoes the sentiments of the nation to provide highest standards of care to it's citizens. The programme has been structured in a manner that delegates will enjoy and learn. The topics for the conference appear to justify the theme very well.

I convey my best wishes to the organising team for the huge success and hope that the delegates will be benefitted from the high standards of this academic feast.

DR. SURESH KUMAR
MEDICAL DIRECTOR
Dr. SURESH KUMAR
Medical Director
Lok Nayak Hospital,
New Delhi-110002

From the Patron

I am delighted to learn that the 44th annual conference of Association of Obstetricians & Gynaecologists of Delhi (AOGD) is being organised by the Dept. of Obst. & Gyn., Maulana Azad Medical College & Lok Nayak Hospital on 12th- 13th November 2022 at the India Habitat Centre, New Delhi. Members are welcome to attend this important annual academic event.

The theme of the conference is "Quality care for women: Sharing vision, Sharing solution". Quality care of patients is one of the principal goals of our profession. *"It is the quality of our work which will please God and not the quantity"* said Mahatma Gandhi.

The scientific program has been meticulously prepared to cover a wide range of important topics in Obst.& Gyn. Eminent speakers will deliver the prestigious orations and esteemed teachers will address the delegates on current important subjects. I am sure that the participants will enjoy and benifit greatly from the high standards of scientific deliberations.

Wish the Conference a grand success.

Prof. S. N. Mukherjee
Founder Member & Patron
AOGD

From the Patron

Dear Friends, Colleagues and young members of AOGD,

We are extremely delighted and happy to present a special & unique, 7 star package of 44th Annual AOGD conference with a very important theme, **Quality care for women: Sharing vision, Sharing solutions** organized by the department of Obstetrics and Gynecology, MaulanaAzad Medical College and Lok Nayak Hospital from 12th to 13th November 2022. The well chalked out scientific programme is a bouquet of 10 Pre-conference workshops, talks by renowned national and International faculty, FOGSI President's oration by Dr Hrishikesh Pai, AOGD past president's oration by Dr Achla Batra and Brigadier Khanna's oration. Key note addresses, debates, video session's, quiz on Genetics in Obs & Gynae-the new stethoscope and many more academic delights to quench your thirst for knowledge, upgrade your skills, improve your decision making, and sharpen your communication skills all set to meet day today challenges & emergencies pertaining to the health of the mother and the fetus. All this and much more to everyone's delight.

Our heartiest congratulations to the president AOGD Dr. Asmitha Rathore, Vice president Dr Y. M. Mala, Secretary Dr Deepti Goswami and their team for updating and improving skills and brilliant brain teazing recipes.

AOGD is one of the largest society of FOGSI and has undoubtedly evolved in to one of India's dynamic and respected professional organization with nearly 3,000 committed Obs & Gynae members working personally and collectively as a team towards the betterment of NARI'S (women's) health in India.

As AOGD approaches the grand mile stone of over 44 years of existence, it has successfully and continually contributed to the various key issues like academics, community health, research, social activities, health advocacy and policy making in collaboration with FOGSI and Government of India.

This year AOGD, with enthusiastic and earnest endeavors of each and every AOGD member will create a significant impact on the health and wellness of Indian women.

Our gratitude and regards to each one of you for your commitment, support and encouragement for the conference and we are sure enthusiasm will continue. Our useful assets of AOGD are head full of knowledge, heart full of love, ears ready to listen and hands willing to help others.

With Best Wishes & Loads of Love to all members.

Regards
Dr Prof Kamal Buckshee
Patron AOGD
Past President, FOGSI
Former Prof & HOD Obstetrics & Gynaecology, AIIMS, New Delhi

44th Annual AOGD Conference

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Free Communications
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AOGD 2022 Pre-Conference Workshops

9th November, 2022

Workshop	Time	Venue	Convener	Co- Convener
Hands on Workshop - Basic ultrasound skills for Obstetricians	10:00am-5:00pm	Department of Fetal Medicine , Rainbow Children Hospital, Malviya Nagar	Dr. Seema Thakur Dr. Chanchal	
A to Z of PPH	9:00am – 3:30pm	New ground floor lecture theater, Maulana Azad Medical College & LNH	Dr. Shashi Lata Kabra Dr. Shakun Tyagi	
Revise the Basics, Enhance the Skills. Cervical Cancer - Prevention and Screening	9:00am-3:00pm	Auditorium, Sir Ganga Ram Hospital	Dr. Mrinalini Mani Dr. Meenakshi Ahuja	Dr. Pinkee Saxena Dr. Divya Singhal

10th November, 2022

Workshop	Time	Venue	Convener	Co- Convener
Gynae Endoscopy: Rejuvenating Young Minds	9:00am - 5:00pm	Board Room, Director's wings, All India Institute of Medical Sciences	Dr. Neerja Bhatla Dr. Neena Malhotra	Dr. Garima Kachhawa Dr. Reeta Mahey
Optimizing emergency obstetric care. Point of care'- (POC) assessment and intervention	9:00am- 4:00pm	Lady Hardinge Medical College & SSKH	Dr. Reena Yadav Dr. Manju Puri	Dr. Ratna Biswas Dr. Swati Agrawal
Learn IUI. Trouble shooting and new regulations	9:30am-4:00pm	Auditorium, Max Hospital, Saket,	Dr. Manju Khemani Dr. Sunita Arora	Dr. Madhu Goel Dr. Nishtha Jaiswal

11th November, 2022

Workshop	Time	Venue	Convener	Co- Convener
Maternal Resuscitation	9:00am -1:00pm	Skill lab Administrative Block, 3rd Floor, University College of Medical Sciences & GTBH	Dr. Amita Suneja Dr. Kiran Guleria	Dr. Archana Chaudhary Dr. Shruthi Bhaskaran
Demystifying Ovary	9:00am – 5:00pm	Jaypee Siddarth, Rajendra Place, New Delhi	Dr. Surveen Ghumman	Dr. Deepti Goswami
Anorectal Disorders: A Primer for the Gynaecologist	1:00pm – 6:00pm	Working women, Auditorium Sir Ganga Ram Hospital	Dr. Geeta Mediratta	Dr. Chandra Mansukhani Dr. Shrihari Anikhindi
Gynae Oncosurgery (Live workshop)	8:30am -4:00pm	Old LT, behind OPD building Vardhman Mahavir Medical College & SJH	Dr. Sunita Malik Dr. Saritha Shamsunder	Dr. Archana Mishra

44th Annual AOGD Conference

12th & 13th November, 2022 | India Habitat Center, New Delhi

Association of Obstetricians and Gynaecologists of Delhi

Organized by: Department of Obstetrics & Gynaecology,

Maulana Azad Medical College & Lok Nayak Hospital, New Delhi

Quality Care for Women:Sharing Vision, Sharing Solutions

AOGD Annual Conference Fetal Medicine Workshop

Topic: Enhancing ultrasound skills for obstetricians

Date: 9th November 2022 (Wednesday) **Time 10:00 am-:5:00 pm**

Venue: Madhukar Rainbow Children's Hospital, Malviya Nagar, Delhi

(Registrations limited to 30 for hands-on session)

Organizing Chairpersons: Dr Seema Thakur, Dr Chanchal

Guest of Honour: Dr Asmita Rathore, President, AOGD

Time	Topic	Speaker
10:00-10:05 am	Welcome address	Dr Seema Thakur
MC: Dr Sakshi Goel Session 1: Getting ready for the hands-on experience		
Chairpersons: Dr Jayasree Sundar, Dr Rinku Sen Gupta, Dr Shivani Sabharwal		
10:00-10:25 AM	Revisiting PCPNDT and the new MTP Act	Dr Sangeeta Gupta
10:30-10:50 AM	Know your machine – knobology and transducers	Dr Ashok Khurana
10:50-11:00 AM	Q&A	
Chairpersons: Dr Meenakshi Bannerjee, Dr Neha Khandelwal, Dr Swati Sinha, Dr CS Mythreyi		
11:05-11:25 AM	Must obtain views at first trimester scan	Dr Chanchal
11:30-11:50 AM	Must obtain views in anomaly scan	Dr Poonam Tara
11:55-12:15 PM	How to measure fetal Dopplers	Dr Vandana Chadha
12:20-12:40 PM	Cervical screening and uterine artery Dopplers	Dr Manisha Kumar
12:45-12:55 PM	Q&A	
12:55-1:55 PM	Lunch	
2:00 – 5:00 PM	Session 2 - Live demo and Hands-on using simulators (batches of 6 each)	
Station 1	NT scan	Dr Akshatha Sharma Dr Jyoti Gupta Dr Gitanjali Behl
Station 2	Measuring Dopplers	Dr Reema Bhat Dr Savita Dagar Dr Vrunda Appannagri
Station 3	Fetal biometry, standard anatomical assessment	Dr Neha Gupta Dr Shreyasi Sharma Dr Saloni Arora
Station 4	Cervical screening and uterine artery Doppler	Dr Tina Verma Dr Gazala Shahnaz
Station 5	Diagnostic invasive procedures (simulator)	Dr Nandita Dimri Dr Sumitra Bachani Dr Apoorva Sharma

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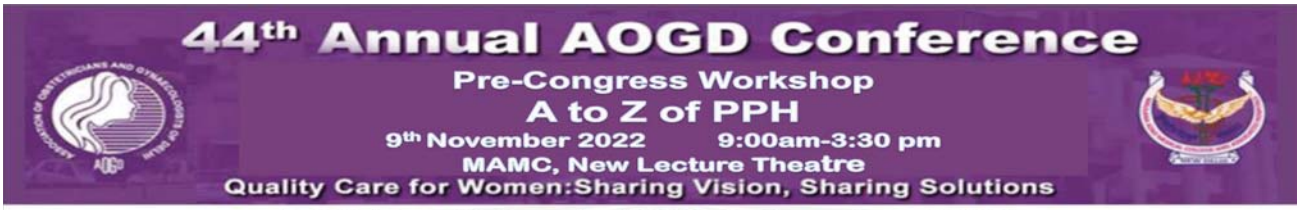

Conveners: Dr Shashi Lata Kabra Maheshwari, Dr Shakun Tyagi

Chief guest: Dr Sharda Jain Guest of Honour: Dr Raksha Arora Special guest: Dr Monika Suri

Experts: Dr Kiran Guleria Dr Jyotsna Suri Dr Krishna Aggarwal

PROGRAMME

MOC: Dr Surbhi Dr Yukti Wadhawan

9:00-9:30am	Pretest and Registration	
Session-1 Chairperson: Dr Anita Sabharwal, Dr Madhvi M Gupta, Dr Rachna Sharma, Dr Shikha Sharma		
9:30-10:00am	Prevention and management of PPH	Dr Shashi L K Maheshwari
10:00-10:15am	Blood component Therapy	Dr Arpita De
10:15-10:30am	Technique of Obstetric Hysterectomy	Dr Shakun Tyagi
10:30-10:45am	Expert comments plus Audience interaction	
10:45-11:15am	INAUGURATION	
Session-2(*VIDEO*) Chairpersons:Dr Latika Sahu, Dr Poonam Sachdeva, Dr Chetna A Sethi, Dr Pushpa Mishra		
11:15-11:30am	Stepwise Devascularization	Dr Soma Mitra
11:30-11:45am	Internal Iliac Ligation: Anterior and posterior approach	Dr Manju Puri
11:45-11:55am	Expert comments plus audience interaction	
11:55-12:30pm	PPH Drill: Dr Harvinder Kaur, Dr Divya Prasad, Dr Preeti G Jakhar, Dr Surbhi, Dr Richa Madan, Dr Shivangi Shree	
12:30-01:15pm	Post-test and Vote of thanks.	
	LUNCH	
01:15-03:30pm	*Session-3*: Hands on Training. *Venue:* Demonstration room	
1	PPH Toolkit	Dr Taruna Dua, Dr Poonam Kashyap, Dr Bidhisha Singha
2	NASG	Dr Sushma Singh, Dr Nalini B Pandey
3	Blood loss Estimation	Dr Yukti Wadhawan, Dr Niharika Dhiman, Dr Shalini Shakarwal
4	Demonstration and hands on Intrauterine Balloon Tamponade: Condom balloon, Chattisgarh balloon, Elawi balloon, Bakri balloon, UBT Pregna balloon	Dr Soma Mitra, Dr Yashika Gudesar, Dr Reena Rani, Dr Namita Jain
5	Demonstration and hands on Brace sutures (B Lynch, Hayman, Cho, Cervico-isthmic suture) Uterine artery ligation and Internal iliac artery ligation	Dr Shashi L K Maheshwari, Dr Usha Yadav, Dr Nidhi Garg

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44th Annual AOGD Conference

12th & 13th November, 2022 | India Habitat Center, New Delhi

Association of Obstetricians and Gynaecologists of Delhi

Organized by: Department of Obstetrics & Gynaecology,

Maulana Azad Medical College & Lok Nayak Hospital, New Delhi

Quality Care for Women:Sharing Vision, Sharing Solutions

"REVISE THE BASICS, ENHANCE THE SKILLS in Cervical Cancer Screening & Prevention"

A Hands on Colposcopy Workshop

Organised by

AOGD BREAST & CERVICAL CANCER AWARENESS PREVENTION SCREENING SUBCOMMIITTEE & DGF

At Sir Ganga Ram Hospital Auditorium, New Delhi on 09/11/2022, 9 am to 3pm

Conveners:

Dr Mrinalini Mani

Dr Meenakshi Ahuja

Co-Conveners:

Dr Pinkee Saxena

Dr Divya Singhal

Dr Mamta Dagar

Chief Guest:

Dr Neerja Bhatla

Guest of Honour:


Dr Achla Batra


Dr Jayashree Sood


Dr K Gujral

SCIENTIFIC PROGRAMME

Time	Topic	Speaker	Chairperson
9.00am-9.30am	**Welcome Address**	Dr Mrinalini Mani	
	Introduction of Guests	Dr Meenakshi Sharma	
	Session I		
9.30am-9.50 am	Why, how & whom to screen	Dr Mrinalini Mani	Dr Kawal Gujral, Dr Mala Srivastava
9.50am-10.10am	Insight in Colposcopy -	Dr Mamta Dagar	
10.10am-10.30am	Dealing with Abnormal Pap Smear-	Dr Sarita Shamsunder	
10.30am-10.50am	HPV Vaccination	Dr Meenakshi Ahuja	
10.50am-11.10am	Colposcopy in Difficult Situations	Dr Pinkee Saxena	
11.10am-11.30am	**Inauguration**		
11.30-11.50am	**Tea**		
	Session II		
11.50 am-12.20pm	Cervical Cancer Staging Guidelines- Updation & Implications	Dr Neerja Bhatla	Dr Harsha Khullar, Dr Achla Batra, Dr Manju Puri
Session III	**Hands on Stations**		
12.20am- 12.30pm	Distribution of Stations		
12.30pm -2.00pm	20 min each station	Dr M Mani-Supervision	
		Dr Meenakshi Ahuja	
		Dr Sujata Das	
Station II	LEEP	Dr Renuka Gupta	
		Dr Meenakshi Sharma	
Station III	Thermoablation	Dr Divya Singhal	
		Dr Vineeta Gupta	
Station IV	Colposcopy	Dr Pinkee Saxena	
		Dr Geetu Gaba	
2.00pm onwards	**LUNCH**		

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Quality Care for Women:Sharing Vision, Sharing Solutions

AOGD-2022:PRECONGRESS WORKSHOP

Gynae Endoscopy: Rejuvenating Young Minds

Thursday, 10th November 2022, 9.00 am-5.00 pm

Organized by

Department of Obstetrics & Gynaecology, AIIMS, New Delhi

In association with

AOGD Endoscopy Committee

ORGANIZING COMMITTEE

Conveners

Dr Neerja Bhatla

Dr Neena Malhotra

Co-Conveners

Dr Garima Kachhawa

Dr Reeta Mahey

AOGD Office Bearers

Dr Asmita M Rathore
President

Dr Y M Mala
Vice-President

Dr Deepti Goswami
Secretary

AOGD Endoscopy Committee

Dr Kanika Jain
President

Guests of Honour

Dr Alka Kriplani
Director & HOD
OBG
Paras Hospital

Dr Bhaskar Pal
President IAGE
(2022-23)

Dr Subhash Mallya
Chairperson FOGSI
Endoscopy Committee
(June 2021-Jan 2025)

Interesting Cases

- Total laparoscopic hysterectomy
- Laparoscopic myomectomy
- TLH with endometriosis
- Hysteroscopic septal resection
- Hysteroscopic myomectomy
- Hysteroscopic adhesiolysis
- Laparoscopic endometriotic cystectomy
- Laparoscopic ovarian cystectomy
- Laparoscopic cervical cerclage
- Laparoscopic sacrocolpopexy
- Laparoscopic sacrohysteropexy

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Optimizing Emergency Obstetric Care: Point of Care (POC) Assessment & Intervention

Venue : Medical Education Hall, Swam Jayanti Auditorium, Lady Hardinge Medical College **Date : 10/11/2022**

Guest of Honor : Dr Asmita Rathore, President AOGD
Convenor : Dr Reena
Co-convenor : Dr Ratna Biswas

Convenor : Dr Manju Puri
Co-convenor : Dr Swati Agrawal

Time	Topic	Time Duration	Speaker	Chairpersons
9:00 AM -9:10 AM	Welcome Address		Dr Reena	
9:10 AM- 9:40 AM	**Session 1 : Maternal Sepsis: Tackle it Early**			**MOC :Dr Kanika Dr Anamika**
9:10 AM - 9:25 AM	Rapid Clinical Assessment Tools	12 min +3	Dr Kiran Aggarwal	Dr Amita Suneja Dr Prabha Lal Dr Vidhi
9:25 AM- 9: 40 AM	First Hour Bundle	12 min +3	Dr Manju Puri	
9:45 AM -11:00 AM	**Session II : Cardio-Respiratory Evaluation of the Dyspnoeic Gravida**			
9:45 AM—10:05 AM	POC Tools : ECG , CXR , ABG and their Interpretation - What an Obstetrician Must Know	17+3 min	Dr Nishant	Dr Abha Singh Dr Anshu Gupta Dr Muntaha
10: 05AM -10:20 AM	Cardiopulmonary Biomarkers : A Diagnostic Aid	12 +3 min	Dr Nitin	
10:20 AM -10:35 AM	Skill enhancing Video Session : Lung Scan & IVC Collapsibility	12 +3 min	Dr Ratna Biswas	
10:35 AM -11:00 AM	Emergent Cardiopulmonary Assessment with POCUS	20 +3 min	Dr Rajesh Pandey	
11:00 - AM - 11:15 AM	**Tea Break**			
11:15 AM-11:45 AM	**Session III : Point of Care Assessment in Perioperative Haemorrhage**			**MOC: Dr Triveni : Dr Kanika**
11:15 AM -11: 30 AM	Viscoelastic tests (TEG , ROTEM , platelet function test) – Current Application & Future Direction	12+ 3min	Dr Geeta Mediratta	Dr Maitree Dr Swati Dr Anuradha
11:30 AM -11: 45 AM	Rapid USG in Shock and Hypotension (RUSH) (Video session)	12+3 min	Dr Nalini Bala Pandey	
11:45 AM -12:45 PM	**Session IV: Preeclampsia – POC Tests as Adjunct to Clinical Assessment**			
11:45 AM -12: 00 PM	Role of Biomarkers	12+3 min	Dr Reena	Dr Achla Batra Dr Harsha Gaikwad Dr Meenakshi
12:00 PM -12:12 PM	Eyes-Window to the Brain: Utility of Opthalmic Artery Doppler (Video Session)	10+2 min	Dr Sharda Patra	
12:12 PM -12:25 PM	Emerging role of Optic Nerve Sheath Diameter Assessment (Video Session)	10 + 3 min	Dr Anil	
12:25 PM -12:40 PM	Detecting the Fetus at Risk- Uterine Art /Umbilical Art/ MCA Doppler (Video Session)	12+3 min	Dr Manisha Kumar	
12:45 PM- 1:15 PM	**Inauguration**			**MOC: Dr Swati Dr Shilpi**
1:15 PM- 2:15 PM	**Lunch**			
2-:15 PM – 4:00 PM	**Session V: Station Based Interactive Workshop**			**MOC: Dr Deepika Dr Aishwarya**
	1. Lung Scan & IVC Collapsibility 2. Opthalmic Artery Doppler 3. Optic Nerve Sheath Diameter 4. RUSH Protocol 5. ABG : Case Based Scenarios		Dr Ratna Dr Sharda Patra Dr Nishant Dr Anil Dr Nalini Bala Pandey	
4:00 PM -4:15 PM	Vote of Thanks			Dr Ratna

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Quality Care for Women: Sharing Vision, Sharing Solutions

AOGD PRE-CONGRESS WORKSHOP

LEARN IUI - TROUBLESHOOTING AND NEW REGULATIONS

10th November | 9.30-16.00 | **Venue:** Max Saket Auditorium

Chief Guest

Dr. Kamal Buckshee

Convenors

Dr. Manju Khemani

Dr. Sunita Arora

Co-Convenors

Dr. Madhu Goel

Dr. Nishtha Jaiswal

Time	Agenda	Panelists
9:30 – 9:45	Optimization & investigations before IUI	**Speaker:** Dr. Manju Khemani **Chairpersons:** Dr. Nishtha Jaiswal, Dr. Rashmi Malik, Dr. Sonia Naik
9:50 – 10:05	Patient selection in IUI – The right decision	**Speaker:** Dr. Renu Misra **Chairpersons:** Dr. Jyoti Bhaskar, Dr. Birbala Rai, Dr. Kavita Aggarwal
10:10 – 10:30	Oral Ovulogens in IUI and how to monitor	**Speaker:** Dr. M Gouri Devi **Chairpersons:** Dr. Poonam Goel, Dr. Achla Batra, Dr. Divya Pandey
10:35 – 10:55	Gonadotropins in IUI	**Speaker:** Dr. Abha Majumdar **Chairpersons:** Dr. Sonia Malik, Dr. Pikee Saxena, Dr. Anuradha Kapur
11:00 – 11:15	Inauguration and Lamp lighting	**Chief Guest:** Dr. Kamal Buckshee
11:15 – 11:25	Address by Chief guest	**Chief Guest:** Dr. Kamal Buckshee
	Address by Chairperson infertility committee	**Chairperson Infertility committee:** Dr. Manju Khemani
Panel discussion		
11:30 – 12:30	Troubleshooting in IUI	**Moderators:** Dr. Sunita Arora, Dr. Vandana Bhatia **Experts:** Dr. Bindu Bajaj, Dr. Brig. Sharma **Panelists:** Dr. Jyoti Malik, Dr. Puneet Arora, Dr. Shweta Gupta, Dr. Shalini Chawla, Dr. Bela Makhija, Dr. Meenu Handa, Dr. Gunjan Gupta
12:30 – 13:00	Q&A	
13:00 – 14:00	Lunch	
Expert Session		
14:00 – 14:30	Setting up an IUI Lab and Prerequisites as per new ART Law	**Speaker:** Dr. Pankaj Talwar **Chairpersons:** Dr. Sharda Jain, Dr. Madhu Goel
Let's learn Andrology | Coordinators: Dr. Madhu Goel, Dr. Nishtha Jaiswal		
14:30 – 14:45	Semen analysis & instructions for semen collection	**Speaker:** Mr. Ram Prakash **Chairpersons:** Dr. Garima Kapoor, Dr. Bindu Bajaj
14:45 – 15:45	Hands on semen preparation and sperm function test	Intertech team
15:45 – 16:00	Q&A open forum	

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Quality Care for Women:Sharing Vision, Sharing Solutions

12th & 13th November, 2022 | India Habitat Center, New Delhi

PRE CONFERENCE AOGD WORKSHOP

DEMYSTIFYING THE OVARY

Organised by MAX Healthcare
Max Hospital

DATE: **11 th November 2022.** ***TIME:*** **9:00 AM - 5:00 PM**

VENUE: **Hotel Jaypee Siddharth, East Patel Nagar (Near BLK)**

Organised by - MAX Superspeciality Group of Hospitals, Delhi

Dr Surveen Ghumman
Convenor

Prof Deepti Goswami
Co Convenor

9:00 – 9:05 AM Registration and Welcome address		
SESSION I: 9:05- 9:40 AM (35 Min) **WHEN CAN WE BLAME THE OVARY ?**		
Chairperson: Dr Bela Makhija, Prof Indu Chawla, Dr Anuradha Kapur,		
9:05 – 9: 20 AM (15 Min)	When can we blame the ovary for Pregnancy Loss	**Prof Bindu Bajaj**
9:20 – 9:35 AM (15 Min)	When can we blame the ovary for Hirsutism and acne	**Dr Renu Mishra**
9:35-9:40 (5 min)	**Discussion**	
Tea: Ongoing		
SESSION II 9:40- 10:55 AM(75 Min) **DEMYSTIFYING PCOS**		
Chairperson: Dr Poonam Khera, Dr Sohani Verma, Dr Divya Singhal, Dr Maninder Ahuja		
9:40-9:55 AM	Clomiphene Resistant PCOS	**Prof Kuldeep Jain**
9:55 – 10:10 AM (15 Min)	Approach to Polycystic Ovary Syndrome in Obese Adolescents	**Dr Monika Gupta**
10:10 – 10: 25 AM (15 Min)	Spirinolactone in PCOS – Alone or in combination – Do we need to look into it further?	**Dr Vidushi Kulshrestha**
10:25- 10:40 AM (15 Min)	Microbiome and PCOS: Future Aspects of incorporating novel treatment in your practice	**Dr Sweta Gupta**
10:40 -10-:55 AM (15 Min)	Discussion	
SESSION III 10:55 AM – 12:05 PM(75 min) **THE AGING OVARY**		
Chairperson: Prof Sudha Prasad, Dr Anita Sabharwal, Dr Shweta Mittal, Dr Kiranjeet Kaur		
10:55-11:10 AM (15 Min)	Are Endocrine disrupters and autoimmune factors perpetrators of aging the ovary before time?	**Prof Achla Batra**

11:10- 11:25 AM (15 Min)	New insights into the genetic basis of Primary Ovarian Insufficiency	**Dr Seema Thakur**
11:25 -11:40AM (15 Min)	HRT for women with Primary Ovarian Insufficiency	**Prof Nutan Agarwal**
11:40 -11:55 AM (15 Min)	Making the ovary young – Is rejuvenation possible?	**Prof Neena Malhotra**
11:55 AM – 12:10 PM (15 Min)	Discussion	
SESSION IV:12:10-1:10 PM(60 min) **REPRODUCTIVE ENDOCRINOLOGY OF THE OVARY**		
Chairperson: Prof Asmita Rathore, Dr SN Basu, Dr Mala Shrivastava, Dr Rupali Bassi		
12:10- 12:25PM (15 Min)	Interpreting AMH in clinical practice - Knowing the finer points	**Dr Surveen Ghumman**
12:25-12:40 PM (15 Min)	Androgens in ovarian health and disease – A double edged sword	**Dr Abha Majumdar**
12: 40- 12:55 PM (15 Min)	Relating Reproductive Endocrinology of the ovary to Sonographic and doppler findings in ovulation induction	**Prof Manju Puri**
12:55 - 1: 10 PM (15 Min)	Discussion	
1:10 – 1:25 PM–Inauguration		
1.00-2.00PM	**Lunch**	
SESSION V- 2:25-3:05 PM (40 min) **UNIQUE OVARIAN SCENARIOS**		
Chairperson: Prof Deepti Goswami, Dr AG Radhika, Prof Ratna Biswas		
2:20 – 2:35 PM (15 Min)	Ovarian Torsion – An emergency with serious long term consequences	**Dr Reena Rani**
2:35-2:50 PM (15 Min)	Ovarian Fibrosis: A Phenomenon of Concern	**Prof. Kiran Guleria**
2:50- 3:05 PM (10 Min):	Discussion	
SESSION VI 3:05- 3:45 PM(40 min) **PREVENTIVE MEDICINE FOR THE OVARY – BRIDGING KNOWLEDGE GAPS AND FACILITATING INFORMED DECISIONS.**		
Chairperson : Prof Neera Aggarwal, Prof Neeraj Goel, Dr Neeti Tiwari, Dr BhavnaBanga		
3:05- 3:20 PM (15 Min)	Elective Egg Freezing: What you need to know to counsel your patients who are deferring pregnancy	**Dr.(Col) Pankaj Talwar**
3: 20-3:35 PM (15 Min)	Ovarian Transposition – Should we make it a routine prophylactic surgery in Patients planned for Pelvic Radiotherapy in nulliparous.	**Prof Amita Suneja**
3:35 – 3: 45 PM (10 Min)	Discussion	
SESSION VII -3:45- 5:00 PM (75 min) **PANEL DISCUSSION: DEMYSTIFYING OVARIAN MASSES**		
3:45-4:45 PM (60 min)	**Panel Discussion**	
Moderator	Dr Bindiya Gupta/ Dr Kanika Batra	
Experts	Dr Sonia Malik, Dr Malvika Sabharwal	
Panelist	Dr Dinesh Kansal, Dr Sonia Naik, Prof Leena Wadhwa, Prof RenuTanwar, Dr Nidhi Khera, DrShalini Khanna, Dr Neha Kumar, Dr Sarika Gupta	
4:45 – 5:00 PM (15 min):	**Viewpoint of Experts**	
5:00PM:	Vote of Thanks	
4-5 PM :	Tea (Ongoing)	

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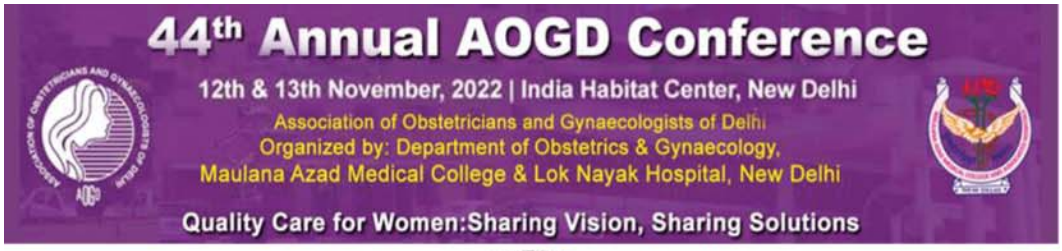

AOGD 2022 ANNUAL CONFERENCE

In Association with Department of Obstetrics and Gynaecology VMMC & Safdarjung Hospital

PRECONFERENCE LIVE/VIDEO OPERATIVE WORKSHOP IN GYNAE ONCOSURGERY

Date : 11TH November 2022 Friday ,Time: 8:30 am-4 pm

Venue: Old LT 1, Behind New OPD Building, VMMC & Safdarjung Hospital, New Delhi

Dr Sunita Malik
Rrganising Chairperson
Chairperson Gynae Oncology Committee, AOGD 2021-23
Professor, ESIC MCH
EX. Professor & Unit Head, Dept.OBGY VMMC & Safdarjung

Dr Anjali Dabral
Professor and HOD
Obs & Gynae
VMMC and Safdharjung

Dr Saritha Shamsunder
Convenor
Consultant & Professor, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi, India

Dr Archana Mishra
Co Convenor
Professor
Vardhman Mahavir Medical College and Safdarjunf Hospital New Delhi

Operating Faculty

Dr Somashekhar S.P.
Consultant – Surgical & Gynaecological Oncology
Chairperson – Medical advisory Board
Global Director – Aster International Institute of Oncology – GCC & India

Dr Rupinder Sekhon
Senior Consultant & Chief Gynaecologic Oncology,
Rajiv Gandhi Cancer Institute & Research Centre, Delhi

Dr Vijay Zutshi
Senior Consultant Gynae Oncology/ Gynaecology
Metro Super-speciality Hospital & cancer center,
Preet Vihar ,Delhi

Faculty

Dr Manash Biswas
Director, Gynae Onco surgery
Max Institute of Cancer Care
Max Super speciality Hospital
Saket, New Delhi

Dr Neerja Bhatla
Prof and HOD
AIIMS, New Delhi

Dr Ritu Nair Misra
Prof , Radiodiagnosis
VMMC and Safdarjung Hospital

Dr Swati Bhan
Assistant Professor
Anaesthesia
VMMC and Safdarjung Hospital

Dr (Prof) Mala Srivastava
Head of Gynae Oncology Unit
Senior Consultant & Prof Sir Ganga Ram Hospital, New Delhi

Master of Ceremony : Dr Nishi Choudhary & Dr Ritu Aggarwal

Time	Topic	Speaker	Experts	Chairpersons
8:20 AM	Welcome and Overview of workshop	Dr Sunita Malik		
8:30-9:30 AM	Session 1: Revisiting the Basics			Dr Renu Arora Dr Anjali Dabral Dr Chintamani Dr K Usha Rani
8:30-8:45 AM	Surgical Anatomy of the Abdomen & Pelvis	Dr Manash Biswas		
8:45-9 :00 AM	Types of Hysterectomy	Dr Neerja Bhatla		
9:00-9:15 AM	Imaging in Gynaecological Malignancy	Dr Ritu Nair Misra		
9:15-9:30 AM	Energy Sources	Dr Mala Srivastava		
9:30-10 AM	Inauguration			
10 AM -1:00 PM	Session : 2 Live Surgery			
	OT 1	OT 2		
OT Coordinators	Dr Sarita Singh	Dr Upma Saxena	Expert Comments	
Anaesthetic Consultant	Dr Bajaj	Dr Usha Dr Ranju		
Session Coordinators	Dr Sarika Gupta	Dr Sharda Patra	Dr Y M Mala Dr Kanika B Modi	
	Radical Hysterectomy & Pelvic Lymphadenectomy	Cytoreductive Surgery for Advanced Ovarian Cancer		
Operating Faculty	Dr Rupinder Sekhon	Dr Somashekhar SP		
	Dr Saritha Shamsunder	Dr Archana Mishra		
1:30-2:00 PM	Session 3			Gp Captain Dr J C Sharma Dr Sunita Yadav Dr Shruti Bhatia
1:30 -1:45 PM	Anaesthesia for Gynae Oncosurgery	Dr Swati Bhan		
1:45-2:00 PM	Preventing and Managing Complications	Dr Sunita Malik		
2:00 -4:00 PM	Session 4 : Live Surgery /Videos			
	Radical Vulvectomy+ Inguinofemoral Lymphadenectomy	Staging Laparotomy	Expert Comments	
Operating Faculty	Dr Vijay Zutshi	Dr Somashekhar SP	Dr Gauri Gandhi Dr Seema Singhal Dr Kanika Gupta	
	Dr Archana Mishra	Dr Saritha Shamsunder		
Session Coordinators	Dr Urvashi Miglani	Dr Satinder Kaur		
Vote of Thanks : Dr Saritha Shamsunder				

Conference Secretariat
AOGD Secretariat
Room No- OG-14, 1st Floor
Department of Obstetrics and Gynaecology
Maulana Azad Medical College & Lok Nayak Hospital
New Delhi-110002
TeL: 9717392924

Official Conference Managers
Project Manager | Bharat Sawhney
MEC-9, A Unit of Universal Conferences & Travels
C-200, Naraina Industrial Area, Phase - I
New Delhi – 110028
+91-11-41419910 / 45149910
aogdconf22@aogd.orgbharat.sawhney@mec-9.com

44th Annual AOGD Conference

12th & 13th November, 2022 | India Habitat Center, New Delhi

Association of Obstetricians and Gynaecologists of Delhi

Organized by: Department of Obstetrics & Gynaecology,

Maulana Azad Medical College & Lok Nayak Hospital, New Delhi

Quality Care for Women:Sharing Vision, Sharing Solutions

Dr. Asmita M. Rathore — **President AOGD** → Dr. YM Mala — **Vice President AOGD** → Dr. Deepti Goswami — **Secretary AOGD**

UROGYNAECOLOGY SUB-COMMITTEE OF AOGD

AOGD-PRE CONGRESS WORKSHOP

ANORECTAL DISORDERS: A PRIMER FOR THE GYNAECOLOGIST

11th November 2022 Time: 1 pm – 6 pm

Venue: Sir Ganga Ram Hospital, Auditorium

Convenor - Dr. Geeta Mediratta

Co-Convenors – Dr. Chandra Mansukhani, Dr. Shrihari Anikhindi

	Registration & Lunch 1 pm to 1.30 pm		
Time	**Topics**	**Speakers**	**Chairpersons**
1.30 PM -1.40 PM	INAUGURATION & WELCOME		
	Session 1 (1.40 pm to 3 pm)		
1.40 PM - 1.55 PM	APPLIED ANATOMY OF PERINEUM AND ANORECTAL COMPLEX- WHAT A GYNAECOLOGIST SHOULD KNOW	**Dr. Karishma Thariani**	Dr. Kanwal Gujral Dr. Varun Dugal Dr. Shrihari Anikhindi Dr. Amita Jain Dr. Archana Kumari
1.55 PM -2.25 PM	IMAGING ASSESSMENT OF THE ANAL SPHINCTER	**Dr Hans Peter Dietz**	
2.25 PM -2.45 PM	ANORECTAL PHYSIOLOGY AND BASIC PRINCIPLES OF ANORECTAL MANOMETRYINCLUDING EQUIPMENT/ RECORDING OF PRESSURES	**Dr. Rajesh Sainani**	
2.45 PM -3 PM	**DISCUSSION**		
	Session 2 (3pm to 4.15 pm)		
3 PM - 3. 20 PM	DEMONSTRATION OF HRAM- VIDEO	**Dr. Shrihari Anikhindi**	Dr. Harsha Khullar Dr. Achla Batra Dr. J.B Sharma Dr. Sandhya Jain Dr. Rajesh Kumari
3.20 PM -3.40 PM	CLASSIFICATION TERMINOLOGY FOR ANORECTAL MANOMETRY (London classification)	**Dr. Shobna Bhatia**	
3.40 PM - 4 PM	UTILITY OF ANORECTAL MANOMETRY AND INTERPRETATION & ANALYSIS OF HRAM IN PATIENTS WITH ANORECTAL DYSFUNCTION	**Dr. Nitesh Pratap**	
4 PM -4.15 PM	**DISCUSSION**		
	Session 3 (4.15 pm to 5.30 pm)		
4.15 PM - 4.35 PM	PHYSIOTHERAPY IN MANAGEMENT OF ANORECTAL DYSFUNCTION	**Dr. Rebekah Das**	
		Experts	**Discussants**
4.35 PM -5.30 PM	**ROUND TABLE DISCUSSION WITH EXPERTS**	**Dr. Vijay Arora** **Dr. V.K Mallik** **Dr. Shobna Bhatia** **Dr. Rajesh Sainani** **Dr. Shrihari Anikhindi** **Dr. Zubin Sharma**	Dr. Geeta Mediratta Dr. Chandra Mansukhani Dr. Ranjana Sharma Dr. Sonal Bathla Dr. Uma Rani Swain Dr. Monika Gupta
	VISIT TO G I PHYSIOLOGY LAB		

Conference Secretariat

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aogdconf22@aogd.orgbharat.sawhney@mec-9.com

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Quality Care for Women:Sharing Vision, Sharing Solutions

AOGD MULTIDISCIPLINARY SUB-COMMITTEE

PRE CONFERENCE AOGD WORKSHOP

MATERNAL RESUSCITATION: ACTION IN TIME SAVES LIVES

Organised by: Departments of Obstetrics & Gynaecology and Anaesthesiology & Critical care, UCMS & GTB hospital, Delhi -110095

Friday, 11th November, 2022, 09:00am to 01:00pm

Venue: Skill Lab, Administrative block, 3 rd floor, GTB Hospital

Dr Amita Suneja
Convener

Dr Kiran Guleria
Convener

Dr Archana Chaudhary
Co-convener

Dr Sruthi Bhaskaran
Co-convener

Scientific Programme			
9:00AM - 9:30AM	Registration		
9.30AM- 10.00AM	Inauguration		
Time	**Topic**	**Speaker**	**Chairperson**
10. 00AM- 10.20AM	Causes of maternal collapse and early identification of at risk patients	Dr Chhavi S. Sharma	Dr Amita Suneja Dr R.S. Rautela Dr Medha Mohta Dr Kiran Agarwal
10.20AM -10.40AM	Approach to a collapsed maternal patient (BLS algorithm)	Dr Rashmi Salhotra	
10:40AM- 11.00AM	Perimortem Cesarean delivery (PMCD) - WHY, WHEN & HOW	Dr Rashmi Malik	Dr Kiran Guleria Dr Asha Tyagi Dr Abha Sharma Dr AG Radhika
11AM – 11.15AM	**Q & A**		
11.15AM- 11.45AM	**Tea break**		
11.45AM -12.05PM	AED demonstration and Summary of BLS algorithm with integration of PMCD	Dr Geetanjali Chilkoti	Dr Sangeeta Gupta Dr Leena N Sreedhar Dr Prachi Renjhen
12.05PM-12.15PM	Video presentation (Integrating the BLS and PMCD)	Dr Deepti Agarwal	Dr Raka Guleria Dr Renu Arora Dr Rekha Bharti
12:15PM – 12:25PM	Balloon Tamponade-Video Presentation	Dr Upasana Verma	
12.25 PM Onwards	Hands on skill stations Integrated BLS - 4 stations PMCD- 1 station Balloon Tamponade- 1 station	Dr. Rashmi Salhotra Dr Chhavi Sharma Dr Geetanjali Chilkoti Dr Deepti Agarwal Dr Archana Chaudhary Dr Sruthi Bhaskaran Dr Anshuja Singla	Dr Jaya Chawla Dr Nupur Gupta Dr Nalini Bala Pandey
01:00 PM onwards	**Lunch**		


Invitation
The Organizing Committee cordially invites you for the inauguration of the 44th Annual AOGD Conference in the gracious presence of
CHIEF GUEST:
Shri Amit Singla, IAS
Secretary Health and Family Welfare,
Govt of NCT Delhi
GUEST OF HONOR:
Dr. Hrishikesh Pai
President FOGSI
SPECIAL GUESTS:
Dr. Ritu Arora
Dean, Maulana Azad Medical College
Dr. Suresh Kumar
Medical Director,
Lok Nayak Hospital
Time : 12.15 -1.15 PM, 12th November 2022
Venue: Jacaranda Hall, Indian Habitat Centre
Please join us for lunch at Maple Room
Dr. Asmita M. Rathore
President AOGD
Dr. Y.M.Mala
Vice- President AOGD
Dr. Deepti Goswami
Secretary, AOGD

44th Annual AOGD Conference
Scientific Programme
12th November 2022 (Day 1)

HALL A [Jacaranda] **Hall Incharge**- Dr. Poonam Kashyap, Dr. Priyanka Ahuja				
	8:00 am - onwards	**REGISTRATION**		
Sessions	**Time**	**Topic**	**Speaker**	**Chairperson**
Session 1	**9:00 - 10:00 am**	**Early Pregnancy**		
	9:00 - 9:15 am	Inverting the Pyramid of Antenatal care	Dr. Sangeeta Gupta	Dr. Renu Arora Dr. Krishna Agarwal Dr. Poonam Laul Dr. Shelly Arora
	9:15 - 9:30am	Supporting early pregnancy: Role of Progesterones	Dr. Nutan Agrawal	
	9:30 - 9:45 am	Cross talk between Reproductive & Fetal medicine	Dr. Chanchal	
	9:45 - 10:00 am	Audience interaction		
Session 2	**10.00 - 11.00 am**	**Fetal Medicine**		
	10.00 - 10.15 am	Dilemmas of Genetic sonogram	Dr. Seema Thakur	Dr. Poonam Tara Dr. Upma Saxena Dr. Akshata Sharma Dr. Sangeeta Bhasin
	10.15 - 10.30 am	Prenatal genomics - Challenges for obstetricians	Dr. Madhulika Kabra	
	10.30 - 10.45 am	Discordant Dichorionic Twins	Dr. Manisha Kumar	
	10.45 - 11.00 am	Audience interaction		
Session 3	**11:00 - 11:45 am**	**Key Note Addresses**		
	11.00 - 11.20 am	Intricacies in Myomectomy	Dr. Alka Kriplani	Dr. Neera Agarwal Dr. Mala Shrivastav Dr. Malavika Sabharwal
	11.20 - 11.40 am	Placenta Accreta Spectrum : Primary hysterectomy revisited	Dr. Reva Tripathi	
	11.40 - 11.45 am	Audience interaction		
Session 4	**11:45 - 12:15 am**	**FOGSI President Oration**		
		Artificial Intelligence in OBGY	Dr. Hrishikesh Pai	Dr. S. N. Mukherjee Dr. Swaraj Batra Dr. Suneeta Mittal Dr. Asmita Rathore
	12:15 - 1:15 pm	***Inauguration***		
	1:15 - 2:00 pm	***Lunch***		
Session 5	**2:00 - 2.40 pm**	**International Faculty - Guest Lecture**		
	2:00 - 2:30 pm	Making Labour Safe	Prof. Sir S. Arulkumaran	Dr. Kamal Buckshee Dr. S.N. Basu Dr. Indu Chawla
	2.30 - 2.40 pm	Audience interaction		
Session 6	**2.40 - 3.20 pm**	**International Faculty - Guest Lecture**		
	2.40 - 3.10 pm	PCOS - Phenotypes & Nuances of Management	Prof. G.S.Conway	Dr. Sohani Verma Dr. Deepti Goswami Dr. Kaberi Banerjee
	3.10 - 3.20 pm	Audience interaction		
Session 7	**3.20 - 3.50 pm**	**Medical Ethics**		
	3.20 - 3.45 pm	Medicolegal and Ethical issues in ObGyn	Dr. R.K. Gupta	Dr. Satyajit Dr. Arti Tandon Dr. Anita Sabharwal
	3.45 - 3.50 pm	Audience interaction		
Session 8	**3.50 - 4.20 pm**	**Debate**		
		Antenatal Corticosteroids between 34 -36 weeks	For: Dr. Sandhya Jain Against: Dr. Nidhi Khera	Dr. Abha Sharma Dr. Jyoti Bhaskar
Session 9	**4.20 - 5:00 pm**	**AOGD GBM**		

44th Annual AOGD Conference
Scientific Programme

12th November 2022 (Day 1)

HALL B [Silver Oak] **Hall Incharge -** Dr. Renu Tanwar, Dr. Chetna Sethi				
	8:00 am -onwards	**REGISTRATION**		
Sessions	**Time**	**Topic**	**Speaker**	**Chairperson**
Session 1	**9:00 - 10:00 am**	**Video Session**		
	9:00 - 9:15 am	Complications of laparoscopy	Dr. Bijoy Nayak	Dr. Pratiksha Gupta Dr. Dinesh Kansal Dr. Garima Kachhawa Dr. Harsha Gaikwad
	9:15 - 9:30 am	Hysteroscopy: Interesting cases	Dr. Manju Khemani	
	9:30 - 9:45 am	Vaginal sacrospinous fixation	Dr. Manju Puri	
	9:45 - 10:00 am	Audience interaction		
Session 2	**10.00 - 11.00 am**	**Benign Gynaecology**		
	10.00 - 10.15 am	Managing AUB in women on anticoagulants	Dr. Radhika A.G.	Dr. Anjali Dabral Dr. Surveen Ghumman Dr. Pankaj Talwar Dr. Sonia Naik
	10.15 - 10.30 am	SPRM for fibroids - The Pendulum swings	Dr. Anjila Aneja	
	10.30 - 10.45 am	Medical management of Endometriosis	Dr. Renu Misra	
	10.45 - 11.00 am	Audience interaction		
Session 3	**11:00 - 11:45 am**	**Key Note Addresses**		
	11.00 - 11.20 am	Intricacies in Myomectomy	Dr. Alka Kriplani	Dr. Neera Agarwal Dr Mala Shrivatav Dr. Malavika Sabharwal
	11.20 - 11.40 am	Placenta Accreta Spectrum : Primary hysterectomy revisited	Dr. Reva Tripathi	
	11.40 - 11.45 am	Audience interaction		
Session 4	**11:45 - 12:15 pm**	**FOGSI President Oration**		
		Artificial Intelligence in OBGY	Dr. Hrishikesh Pai	Dr. S. N. Mukherjee Dr. Swaraj Batra Dr. Suneeta Mittal Dr. Asmita Rathore
	12:15 - 1:15 pm	***Inauguration***		
	1:15 - 2:00 pm	***Lunch***		
Session 5	**2:00 - 2.40 pm**	**International Faculty - Guest Lecture**		
	2:00 - 2:30 pm	Making Labour Safe	Prof. Sir S. Arulkumaran	Dr. Kamal Buckshee Dr. S.N. Basu Dr. Indu Chawla
	2.30 - 2.40 pm	Audience interaction		
Session 6	**2.40 - 3.20 pm**	**International Faculty - Guest Lecture**		
	2.40 - 3.10 pm	PCOS - Phenotypes & Nuances of Management	Prof. G.S.Conway	Dr. Sohani Verma Dr. Deepti Goswami Dr. Kaberi Banerjee
	3.10 - 3.20 pm	Audience interaction		
Session 7	**3.20- 4.00 pm**	**Infertility**		Dr. Sonia Malik Dr. Neeta Singh Dr. Renu Tanwar
	3.20 - 3.35 pm	Pre- IVF work-up & Role of ERA	Dr. Alka Prakash	
	3.35 - 3.50 pm	Diminished ovarian reserve – Fertility management	Dr. Leena Wadhwa	
	3.50 - 4.00 pm	Audience interaction		
Session 8	**4.00 - 5. 00 pm**	**Quiz**	Quiz Masters: Dr. Pushpa Mishra Dr. Nidhi Garg	
		Genetics in OBGY Practice		

4th Annual AOGD Conference
Scientific Programme
13th November 2022 (Day 2)

HALL A [Jacaranda] **Hall Incharge** - Dr. Poonam Kashyap, Dr. Kamna Dutta				
	8.00 am onwards	**REGISTRATION**		
Sessions	**Time**	**Topic**	**Speaker**	**Chairpersons**
Session 1	**9.00 - 10.00 am**	**Labour**		
	9.00 - 9.15 am	Cervical ripening – What's new?	Dr. Monika Bhatia	Dr. Shashilata Kabra Dr. Raka Guleria Dr. Shakuntla Kumar Dr. Shikha Sharma
	9.15 - 9.30 am	Pre-viable PROM- Dilemmas in management	Dr. Reema Bhatt	
	9.30 - 9.45 am	Massive obstetric haemorrhage- Helplines beyond blood products	Dr. Madhavi M. Gupta	
	9.45 - 10.00 am	Audience interaction		
Session 2	**10.00 - 11.00 am**	**Safe practices in OBGY**		
	10:00 - 10.15 am	Surgical safety check list	Dr. Chitra Setya	Dr. Anjali Tempe Dr. Jyoti Sachdeva Dr. Monika Suri Dr. Latika Sahu
	10.15 - 10.30 am	MTP beyond 24 weeks- Intricacies & implications	Dr. Sumitra Bachani	
	10.30 - 10.45 am	Communication Skills	Dr. Leena Sreedhar	
	10.45 - 11.00 am	Audience interaction		
Session 3	**11:00 - 11:30 pm**	**Medical disorders in Pregnancy**		
	11.00 - 11.10 am	Newer Insulins in Diabetic Pregnancy	Dr. Poonam Kashyap	Dr. Meenakshi Sharma Dr. Shakun Tyagi Dr. Tarini Taneja
	11.10 - 11.20 am	Raised TSH – When to treat?	Dr. Kamna Dutta	
	11.20-11.30 am	Audience Interaction		
Session 4	**11:30 - 12:15 pm**	**Key Note Addresses**		
	11.30 - 11.50 am	HPV vaccination – An update	Dr. Neerja Bhatla	Dr. V. L Bhargava Dr. Deepika Deka Dr. Sunita Malik
	11.50 - 12.10 am	Abnormal Doppler in Normally grown & Growth restricted fetuses	Dr. Anita Kaul	
	12.10 - 12.15 am	Audience interaction		
Session 5	**12:15 - 12.45 pm**	**AOGD Past President Oration**		
		Eradication of Anemia- Roadmap ahead	Dr. Achla Batra	Dr. Sharda Jain Dr. Vandana Bagga Dr. Abha Singh Dr Harsha Khullar
Session 6	**12.45 - 1.15 pm**	**Brigadier Khanna Oration**		
		Prevention, Diagnosis & Treatment of Obstetric Anal Sphincter Injuries	Dr. N. Raja Maheshwari	Dr. S.B. Khanna Dr. Pratima Mittal Dr. Sudha Prasad Dr. Y.M.Mala
	1:15 - 2:00 pm	***Lunch***		
Session 7	**2:00 - 3:15 pm**	**Competition Papers** **Judges** - Dr. Sunesh Kumar, Dr. K. Gujral, Dr. Pushpa Singh, Dr. Vijay Zutshi		
Session 8	**3:15 - 4:00 pm**	**Panel discussion**		
		Critically sick obstetric patient – Saving mothers	**Moderators:** Dr. Taru Gupta Dr. Rekha Bharti	**Panelists:** Dr. Kishore Rajurkar Dr. Nalini B. Pandey Dr. Rachna Agarwal Dr. Shilpa Ghosh Dr. Vidushi Kulshreshta Dr. Shivani Agarwal
Session 9	**4.00 - 4.45 pm**	**High risk pregnancy**		
	4.00 - 4.15 pm	Triaging women with non-severe Preeclampsia	Dr. Rinku Sengupta	Dr. Ratna Biswas Dr. Mamta Dagar Dr. Rajni Mittal
	4.15 - 4.30 pm	Cholestasis of pregnancy- When to induce?	Dr. Jharna Behrua	
	4.30 - 4.45 pm	Audience interaction		
	4.45 - 5.30 pm	**Valedictory**		

4th Annual AOGD Conference
Scientific Programme
13th November 2022 (Day 2)

HALL B [Silver Oak] **Hall Incharge** - Dr. Renu Tanwar, Dr. Neha Varun				
	8.00 am onwards	**REGISTRATION**		
Sessions	**Time**	**Topic**	**Speaker**	**Chairpersons**
Session 1	**9.00 - 10.00 am**	**Urogynaecology**		
	9.00 - 9.15 am	Urinary microbiome : Novel insights	Dr. Prachi Renjhen	Dr. Sonal Bathla Dr. Chandra Mansukhani Dr. Poonam Goel Dr. Richa Sharma
	9.15 - 9.30 am	Nonsurgical management of Uterovaginal Prolapse	Dr. Ranjana Sharma	
	9.30 - 9.45 am	Surgical management of SUI	Dr. Monika Gupta	
	9.45 - 10.00 am	Audience interaction		
Session 2	**10.00 - 11.00 am**	**Gynae-Oncology**		
	10:00 - 10.15 am	Endometrial cancer - Role of molecular Profiling	Dr. Sharda Patra	Dr. Shalini Rajaram Dr. Rupinder Sekhon Dr. Manash Biswas Dr. Sabhyata Gupta
	10.15 - 10.30 am	Borderline ovarian tumors -Management issues	Dr. Gauri Gandhi	
	10.30 - 10.45 am	Vulvectomy - Indication & techniques	Dr. Reena Yadav	
	10.45 - 11.00 am	Audience interaction		
Session 3	**11:00 - 11.30 am**	**Debate**		
	11:00 - 11.20 am	Cord blood banking: is it over-hyped ?	Yes: Dr. Aruna Nigam No: Dr. Meenakshi Ahuja	Dr. Seema Sharma Dr. Jaya Chawla
	11.20 - 11.30 am	Discussion		
Session 4	**11:30 - 12:15 pm**	**Key Note Addresses**		
	11.30 - 11.50 am	HPV vaccination – An update	Dr. Neerja Bhatla	Dr. V. L. Bhargava Dr. Deepika Deka Dr. Sunita Malik
	11.50 - 12.10 am	Abnormal Doppler in Normally grown & Growth restricted fetuses	Dr. Anita Kaul	
	12.10 - 12.15 am	Audience interaction		
Session 5	**12:15 - 12:45 pm**	**AOGD Past President Oration**		
		Eradication of Anemia - Road-map ahead	Dr. Achla Batra	Dr. Sharda Jain Dr. Vandana Bagga Dr. Abha Singh Dr. Harsha Khullar
Session 6	**12:45 - 1:15 pm**	**Brigadier Khanna Oration**		
		Prevention, Diagnosis & Treatment of Obstetric Anal Sphincter Injuries	Dr. N. Raja Maheshwari	Dr. S.B. Khanna Dr. Pratima Mittal Dr. Sudha Prasad Dr. Y.M. Mala
	1:15 - 2:00 pm	***Lunch***		
Session 7	**2:00 - 3:15 pm**	**Mixed bag**		
	2.00 - 2.15 pm	Stepwise devascularization	Dr. Sumita Mehta	Dr. Sangeeta Gupta [ESIC] Dr. Geeta Mediratta Dr. Shivlata Gupta Dr. Priti Dhamija Dr. Col. M. Tangri
	2.15 - 2.30 pm	Genital tuberculosis - Latest updates	Dr. Kiran Guleria	
	2.30 - 2.45 pm	Acute abdomen: Role of laparoscopy	Dr. Kanika Jain	
	2.45 - 3.00 pm	Cervical cerclage	Dr. Kavita Agarwal	
	3.00 - 3.15 pm	Audience interaction		
Session 8	**3:15 - 4:00 pm**	**Panel discussion**		
		Fertility preservation in Gynae cancers	**Moderators:** Dr. Amita Suneja Dr. Bindiya Gupta	**Panelists:** Dr. Saritha Shamsunder Dr. Sunita Arora Dr. Seema Singhal Dr. Niharika Dhiman Dr. Urvashi Miglani Dr. Kanika Batra Modi
Session 9	**4.00 - 4.45 pm**	**Adolescence & Menopause**		
	4:00 - 4.15 pm	HRT in Primary prevention – Current concepts	Dr. Kiran Agarwal	Dr. Neema Sharma Dr. Anita Rajorhia Dr. Mrinalini Mani
	4.15 - 4.30 pm	Contraception in adolescence: Consent & concerns	Dr. Anshul Grover	
	4.30 - 4.45 pm	Audience interaction		
	4.45 - 5.30 pm	**Valedictory**		

FREE COMMUNICATIONS : D1 - 12th Nov 22				
Date	**Time**	**Oral Presentation- Judges** [Hall C-Maple]	**E Poster - Screen 1- Judges** [Foyer - Jacaranda]	**E Poster Screen 2 - Judges** [Foyer - Silver Oak]
Day-1 12 Nov 2022 Saturday	09.00 - 10.00 AM	Dr Neeru Kiran Dr Poonam Sachdeva Dr Seema Prakash	Dr Deepa Gupta Dr Kanika Chopra Dr Nidhi Choudhary	Dr Meenakshi Sabharwal Dr Meenakshi Singh Dr Sujata Das
	10.00-11.00 AM	Dr Bindu Yadav, Dr Nidhi Agrarwal Dr Shelly Singh	Dr Auditi Narayan Dr Parul Prakash Dr Usha Raina	Dr Chandan Dubey Dr Neha Pruthi Tandon Dr Neha Varun
	03.45 - 04.45 PM	Dr Archana Mishra Dr Geetu Gaba Dr Nilanchali Singh	Dr Aishwarya Kapur Dr Anshuja Singla Dr Vidhi Chaudhary	Dr Nishtha Jaiswal Dr Pakhee Aggarwal Dr Pooja Thukral
	04.45 - 05.30 PM	Dr Divya Pandey Dr Shalini Chawla Khanna Dr Swati Agarwal	Dr Karishma Dr Sarita Singh Dr Shilpi Nain	Dr Deepali Garg Dr Triveni Dr Yukti Wadhwan

FREE COMMUNICATIONS : D2 - 13th Nov 22				
Date	**Time**	**Oral Presentation** [Hall C-Maple] **Judges**	**E Poster - Screen 1** [Foyer - Jacaranda] **Judges**	**E Poster - Screen 2** [Foyer - Silver Oak] **Judges**
Day-2 13 Nov 2022 Sunday	08.30 - 09.30 AM	Dr Garima Kapoor Dr Preeti Singh Dr Reena Rani	Dr Deepika Meena Dr Rhythm Ahuja Dr Shristi Agarwal	Dr Meenu Chaudhary Dr Balkesh Dr Sonia Dhiman
	09.30 - 10.30 AM	Dr Anuradha Dr Bhanu Priya Dr Shalini Shakarwal	Dr Anju Singh Dr Seema Rawat Dr Yogita Parashar	Dr Priyanka Mathe Dr Rinchen Dr Yashica Gudesar
	10.30-11.30 AM	Dr Jyoti Meena Dr Mala Shukla Dr Rachna Sharma	Dr Archana Kumari Dr Namita Jain Dr Nazia Parveen	Dr Chetna A Sethi Dr Juhi Dr Upasana Verma

Competition papers

Page (45-49)

S. N	Name	Abstract Title	Institute	Email
1	Dr Noopur Chawla	Impact of action taken in response to stillbirth audit: A success story	Lady Hardinge Medical College & SSK Hospital	noopurchawla11@gmail.com
2	Dr Amrita Patel	Chromo colposcopy with fluorescein sodium for detection of premalignant and malignant lesions of cervix	University College of Medical Sciences & Guru Teg Bahadur Hospital	patelamrita92@gmail.com
3	Dr Shivangi Mangal	Implementation Of Systematic Childbirth Education through a Birth Planning Visit at a tertiary care hospital in India: A Quality Improvement Project	All India Institute of Medical Sciences	shiva.mangal98@gmail.com
4	Dr Abhilasha	Does endometrial thickness and embryo grade affect pregnancy outcomes in ivf cycles?	Maulana Azad Medical College and associated Lok Nayak Hospital	drabhilasha96@gmail.com
5	Dr Vinodita Puri	Assessment of Menopausal symptoms using Menopause Rating Scale and their association with Serum Vitamin D levels	Lady Hardinge Medical College & SSK Hospital	drpuri.lhmc@gmail.com
6	Dr Astha Sharma	Prediction of complications of preeclampsia using the fullpiers high risk predictive model	VMMC and Safdarjung Hospital	sharmaastha56@gmail.com
7	Dr Pooja Sharma	Evaluation of maternal serum fetal hemoglobin and alpha-1-microglobulin levels in pre-eclampsia	University College of Medical Sciences & GTB Hospital	poojasv.32@gmail.com
8	Dr S. Noorul Fazila	Elective induction of labour at 39 weeks versus expectant management in low-risk nulliparous women	Hamdard Institute of medical sciences	15fazilas@gmail.com

Schedule of Oral Session Presentation on 12th November, 2022

Session-1 (Gynae oncology)

Date: **12th November, 2022;** Time: **9.00 am - 10.00 am** **Page (52-55)**

Oral Paper No	Name	Abstract Title
Oral 1	Dr Sana Ahmed	Evaluation of serum biomarkers human epididymis protein 4 and fibrinogen in endometrial cancer
Oral 2	Dr Rachita Garg	Comparison of Conventional Pap Smear with Liquid Based Cytology in the detection of Cervical Intraepithelial Neoplasia and Cervical Cancer
Oral 3	Dr Madhu Shree RG	Knowledge Attitude and Practice About Cervical Cancer Prevention
Oral 4	Dr Swati Tomar	Clinico-pathological Characteristics and Prognosis of Ultra-high-risk Gestational Trophoblastic Neoplasia: Experience from a Tertiary Care Centre
Oral 5	Dr Poonam Kashyap	Retrospective analysis of etiology and management of large ovarian masses
Oral 6	Dr Archana Mishra	Feasibility of Mobile ODT Enhanced Visual Assessment for triaging screen positive women
Oral 7	Dr Ira Arora	Comparison Of Modified IFCPC 2011 Nomenclature V/S Swede Score in Diagnosing Premalignant Lesions of Cervix
Oral 8	Dr Nilanchali Singh	Screening for Mental Health Disorders and Neurochemical Correlates in Gynecology Cancer Survivors: A Cross-Sectional Study from a Tertiary Care Center in India

Session- 2 (Maternal and Fetal Medicine)

Date: **12th November, 2022;** Time: **11.00 am - 11.00 am** **Page (55-59)**

Oral paper No	Name	Abstract title
Oral 1	Dr Nikita Madan	Cerebroplacental Ratio as a predictor of perinatal outcome in Hypertensive Disorders of Pregnancy and Its Comparison with the constituent Doppler Indices
Oral 2	Dr Aparna Setia	Prenatal Diagnosis of Gene Disorders: A Prospective Observational Study
Oral 3	Dr Rohini Gaonkar	Shock Index During Immediate Postpartum Period after Uncomplicated Vaginal Delivery and Caesarean Delivery
Oral 4	Dr Minal	Immuno-Modulatory Effects of Raised Bilirubin in Pregnancy Outcomes
Oral 5	Dr Priyanka Lader	Role Of Shock Index in Predicting Maternal Outcome in Postpartum Haemorrhage
Oral 6	Dr Anamika Baghel	Glycaemic Variability and 24 Hours Ambulatory Glucose Profile in Gestational Diabetes Mellitus and its Correlation with Feto-Maternal Outcome
Oral 7	Dr Prateeksha BS	Mode Of Delivery and Pelvic Floor Disorder Symptoms in Primigravida Women in Postpartum Period
Oral 8	Dr Puja Yadav	Pro-calcitonin Levels in Maternal Serum and Cord Blood as Marker for Diagnosis of Early-Onset Neonatal Sepsis.
Oral 9	Dr Divya Meena	Substance use during Pregnancy and its Effects on Mother and Fetus

Session- 3 (Benign Gynaecology)

Date: **12th November, 2022;** Time: **03.45 pm - 04.45 pm** **Page (59-63)**

Oral Paper No	NAME	Abstract Title
Oral 1	Dr Pankhuri Jain	Addressing The Adenomyosis Enigma: A Clinico- Pathological Co-Relation
Oral 2	Dr Priyanka Singrore	Correlation of Obesity Indices and Inflammatory Markers with Severity of Lower Urinary Tract Symptoms in Females
Oral 3	Dr Mahua Das	Diagnostic Evaluation of Unexplained Infertile Women for Chronic Endometritis by Endometrial Histopathology and Immunohistochemistry
Oral 4	Dr Vidushi Gupta	Is Ovarian Reserve Associated with Body Mass Index and Obesity in Infertile Women? A Cross Sectional Study
Oral 5	Dr Geetanjali Singh	Title: Preoperative Management of HMB due to leiomyoma with Depot Leuprolide and Oral Norethisterone- A Randomized Control Trial
Oral 6	Dr Nutan Sahu	Evaluation of Young Girls with Delayed Menstrual Cycles and Identifying the Population at Risk
Oral 7	Dr Neha Bharti	Uro-Gynae Evaluation in Postmenopausal with Lower Urinary Tract Symptoms (LUTS)
Oral 8	Dr Purnima Kiran Gautam	Association Of Novel Markers with Anthropometric Parameters and Cardiovascular Risk Indicators in Women with And Without PCOS - Cross Sectional Comparative Study

Session- 4 (Maternal and Fetal Medicine)

Date: **12th November, 2022;** Time: **04.45 pm - 05.30 pm** **Page (63-66)**

Oral paper No	Name	Abstract title
Oral 1	Dr Soni Kumari	Role of NT-PROBNP for Prediction of Feto-maternal Outcomes in Preeclampsia with Severe Features
Oral 2	Dr Yashi Nagar	Middle Cerebral Artery Pulsatility Index for Prediction of Successful induction of Labor in post-dated Pregnancy
Oral 3	Dr Vandana N A	NT-proBNP as a Novel Marker for the severity of Hypertensive Disorders in Pregnancy
Oral 4	Dr Gunjan Sharma	Evaluation of New Innovation: Continuous Glucose Monitoring v/s Self-Monitoring of Blood Glucose for Management of Pregnant Diabetic Women on Insulin
Oral 5	Dr Ankita Chonla	Maternal Near Miss in a Tertiary Care Hospital: A Retrospective and Prospective Observational Study
Oral 6	Dr Preeti Singh	Can SFILT /PLGF Ratio Help in Triaging Patients in Second Trimester with High Risk Factors of Preeclampsia and Help Us in Improving Maternal Outcomes
Oral 7	Dr Sakshi Nischal	Third Trimester Obstetric Ultrasound for Risk Stratification of Fetuses with Estimated Fetal Weight less than 40th Centile
Oral 8	Dr Nutan Agarwal	Innovative Technique of Amniotic Fluid Index (AFI) measurement by two pockets and establishing normal values in Level 1 (11-13+6 Weeks) Ultrasound and Correlation of AFI to Congenital Malformation

Session -5 (Gynae Endoscopy and Miscellaneous)

Date: **13th November, 2022;** Time: **08.30 pm - 09.30 pm** **Page (66-70)**

Oral Paper No	NAME	Abstract Title
Oral 1	Dr Avir Sarkar	Comparing The Effect of Laparoscopic Salpingectomy Using Harmonic Versus Bipolar Energy on Ovarian Reserve in Patients with Hydrosalpinges: A Parallel Two Arm Randomized Controlled Trial
Oral 2	Dr Manasi Deoghare	Efficacy Of Laparoscopic Davydov's Vaginoplasty in Patients with Absent Vagina: A Follow Up Study
Oral 3	Dr Arifa Anwar	Minimally Invasive Surgical Management of Postpartum Pyo-peritoneum: Our Experience
Oral 4	Dr. Tasneem Jahan Sarkar	Total Hysterectomy with Bilateral Salpingectomy; Effect on Ovarian Reserves: A Prospective Observational Study
Oral 5	Dr Lekshmi SA	Pattern Of Progression of Labor in Indian Women at A Tertiary Care Centre
Oral 6	Dr Radhika Aggarwal	Tele-Anc Model in Public Sector in India: A Feasible Option to Sustain Quality Antenatal Care
Oral 7	Dr Monika	Role Of Neutrophil to Lymphocyte and Platelet to Lymphocyte Ratio as a Predictor of Preterm Premature Rupture of Membrane
Oral 8	Dr Priyanka Shanker	Evaluation Of Presepsin Levels in Pregnancy Associated Sepsis

Session-6 (Miscellaneous)

Date: **13th November, 2022; ;** Time: **09.30 pm - 10.30 pm** **Page (70-73)**

Oral paper No	Name	Abstract Title
Oral 1	Dr Saumya Rajput	Comparative Study of Elective Induction of Labour At 39 Versus 40 Completed Weeks in Low-Risk Pregnant Women
Oral 2	Dr Kajal Kesharwani	Perinatal Outcome Following Fresh and Frozen Embryo Transfer in Ivf Cycle
Oral 3	Dr Sakshi Aggarwal	Association Of Preterm Placental Calcification with Uterine Artery Doppler Changes in Fetal Growth Restriction
Oral 4	Dr Astha Jain	Efficacy Of 7 Point Blood Glucose Profile in Initiating Management of Gestational Diabetes Mellitus in Indian Population - A Randomised Control Trial
Oral 5	Dr Shailja Jha	Comparison Of Fetomaternal Outcome in Women with Preterm Premature Rupture of Membranes on Expectant Management Versus Delivery At 34 Weeks
Oral 6	Dr Preeti Thakur	Hematological Markers: A New Diagnostic Modality for Intrahepatic Cholestasis of Pregnancy?
Oral 7	Dr Manisha Patel	Role Of Hematological Inflammatory Markers in Intrahepatic Cholestasis of Pregnancy
Oral 8	Dr Nalini Bala Pandey	Implementation Of Clinical Practice of Obstetrics National Early Warning Scoring (ONEWS) In the Obstetrics and Gynaecology Emergency Department (ED) of a Tertiary Care Center in North India - A Quality Improvement (QI) Initiative

Session-7 (Miscellaneous and Population Stabilization)

Date: **13th November, 2022;** Time: **10.30 pm - 11.30 pm** **Page (74-77)**

Oral paper No	Name	Abstract Title
Oral 1	Dr Karishma Singh	Role of Maternal Anogenital Distance Measurement on Prediction of Perineal Tears During Vaginal Delivery
Oral 2	Dr Mansvi Raghav	Comparison Of Dipsi and Who Criteria for Diagnosis of Gestational Diabetes by Assessment of Feto-Maternal Outcomes
Oral 3	Dr Kajal Baleja	Cervical Funneling for Prediction of Vaginal Delivery in Term Nulliparous Women Undergoing Induction of Labor
Oral 4	Dr Triveni GS	To Determine the Factors Influencing Access to Emergency Services by Obstetric Patients During Covid 19 Pandemic
Oral 5	Dr Ishita Gupta	Study Of Acceptance of Contraception in Post-abortal period in Tertiary Care Hospital
Oral 6	Dr Anuradha Sharma	Knowledge Attitude and Practices of Contraception Among Married Women of Reproductive Age
Oral 7	Dr Mohit Mann	Acceptance And Continuation of Contraceptive Methods following second Trimester Abortion: 6 Months Follow Up
Oral 8	Dr Surbhi	Acceptance Of Contraception after Second Trimester Abortion

Schedule of Poster Presentation on 12th November, 2022

Session 1 A (Obstetrics)

Date: **12th November, 2022;** Time: **9.00 am - 10.00 am** **Page (80-83)**

Poster no	Name	Abstract Title
P-1A/OP-1	Dr Duha Qari	Bilateral Retinal Detachment in Pre-Eclampsia - A Case Report
P-1A/OP-2	Dr Aparna Setia	Case Of Jaundice in Pregnancy: A Diagnostic Dilemma
P-1A/OP-3	Dr Mansi Kumar	Study Of Maternal and Fetal Outcomes in Obese Women
P-1A/OP-4	Dr Lovely Singh	Association Of Lipid Profile of Infertile Men with Abnormal Semen Parameters
P-1A/OP-5	Dr Vijaita	Knowledge Attitude and Practice Towards Breastfeeding Among Postnatal Mothers in Tertiary Care Centre
P-1A/OP-6	Dr Tanya Singhal	Facilitators And Barriers in Acceptance of Covid 19 Vaccine Among Pregnant Women in India: A Cross-Sectional Study
P-1A/OP-7	Dr Duha Qari	Rising Trend in Ectopic Pregnancy: A Clinical Study at a Tertiary Care Hospital
P-1A/OP-8	Aditi Rathi	Postpartum Maternal Collapse: A Case Report
P-1A/OP-9	Dr Supriya Singh	Right Interstitial Ectopic Pregnancy in A 27-Year-Old Female: A Case Report
P-1A/OP-10	Dr Pankhuri Jain	Conservative Management of Caesarean Scar Pregnancy: A Case Presentation

Session 2 A (Obstetrics)

Date: **12th November, 2022;** Time: **11.00 am - 11.00 am** **Page (84-88)**

Poster no	Name	Abstract Title
P-2A/OP-1	Dr Aparajita Soni	Study of Association of Cerebroplacental Ratio with Adverse Perinatal Outcome in Term Appropriate for Gestational Age Fetuses
P-2A/OP-2	Dr Apoorva Singh	To Find an Association Between Hypothyroidism and Gestational Diabetes Mellitus
P-2A/OP-3	Dr Nupur Sagar	Effect of Fever on Maternal and Fetal Outcome in Pregnant Women Beyond 28 Weeks of Gestation
P-2A/OP-4	Dr Umaira Fathima Rm	Prevalence Of Gestational Diabetes Mellitus (GDM) In Intrahepatic Cholestasis of Pregnancy (IHCP)
P-2A/OP-5	Dr Preeti Gahlawat Jakhar	Role of Folic Acid & B12 in Pregnancy and Abortion
P-2A/OP-6	Dr Mallary Chandravadia	Knowledge Attitude and Practices of Antenatal Care Among Women Attending Lok Nayak Hospital
P-2A/OP-7	Dr Rapaka Gowri	Invasive Prenatal Diagnostic Procedures: A Single Centre Experience
P-2A/OP-8	Dr Shubhadeep Bhattacharjee	Whether BMI Calculated from Data Collection of Height and Weight Parameters Affect the Various Outcomes of Assisted Reproduction?
P-2A/OP-9	Dr Nayana DH	SLE During Pregnancy Maternal and Perinatal Outcome in Tertiary Hospital
P-2A/OP-10	Dr Sumedha Sharma	Covid 19 Vaccination in Pregnancy: Attitude Practice and Concerns

Session 3 A (Obstetrics)

Date: **12th November, 2022;** Time: **03.45 pm - 04.45 pm** **Page (88-92)**

Poster no	Name	Abstract Title
P-3A/OP-1	Dr Divya Prasad	Risk Stratification Scores in Predicting Adverse Cardiac Outcomes in Pregnant Women with Congenital Heart Disease
P-3A/OP-4	Dr Divith Khagraj	Oxytocin Alone Versus Dinoprostone Insert Followed by Oxytocin for Inducing Labour in Term Prelabour Rupture of Membranes (Term Prom)
P-3A/OP-5	Dr Aishwarya Yadav	To Compare Feto-Maternal Outcomes of Pregnancies Complicated by Superimposed Preeclampsia on Chronic Hypertension Vs Preeclampsia
P-3A/OP-6	Dr Nalini H	Treating Severe Hypertension in Pregnancy
P-3A/OP-7	Dr Anjali Sinha	Case Report of Atypical Eclampsia with Status Epilepticus
P-3A/OP-8	Dr Kanika Chopra	A Retrospective Study of The Comparison of Maternal Outcomes in In-Vitro-Fertilization Pregnancy Versus Spontaneous Conception
P-3A/OP-9	Dr Nausheen Anis	To Evaluate Disability and Functioning of Women with Low-Risk Pregnancy Using World Health Organisation (WHO) Disability Assessment Schedule 2.0 (WHODAS 2.0)

Session 4 A (Obstetrics)

Date: **12th November, 2022;** Time: **04.45 pm - 05.30 pm** **Page (92-95)**

Poster no	Name	Abstract Title
P-4A/OP-1	Dr Aditi Goyal	Caesarean Scar Ectopic Continues to Be a Challenge
P-4A/OP-2	Dr Neha Bhardwaj	Ambient Air Pollution - A New Intrauterine Environmental Toxin for Preterm Birth and Low Birth Weight
P-4A/OP-3	Dr Poonam Jakhar	Critical Appraisal of Causes Interventions and Outcome of Maternal Near Miss in A Tertiary Care Hospital
P-4A/OP-4	Dr Jyoti Chugh	Fetal cardiac rhabdomyoma: Ultrasound, autopsy, histopathology and genetic analysis
P-4A/OP-6	Dr Apoorva Hans	A Study of Pattern and Distribution of Congenital Malformations and Birth Defects with Antenatal Associations

Session 1 B (Gynaecology)

Date: **12th November, 2022;** Time: **9.00 am - 10.00 am** **Page (95-99)**

Poster no	Name	Abstract title
P-1B/GP-1	Dr Neha Varun	Early Diagnosis and Appropriate Management of Atypical Mullerian Malformations: Need of the Hour
P-1B/GP-2	Dr Tanya Singhal	Obstructed Hemivagina And Ipsilateral Renal Agenesis (OHVIRA) Syndrome in An Adolescent Girl; A Case Report
P-1B/GP-3	Dr Bhawna Arora	Is Liverpool Normogram of Uroflow Patterns Applicable to Indian Women?
P-1B/GP-4	Dr Namita Jain	Abdominal Wall Endometriosis: Experience at A Tertiary Care Centre
P-1B/GP-5	Dr Ashima Gupta	Effect Of Music on Anxiety in Women Undergoing Colposcopy: A Randomized Controlled Trial
P-1B/GP-6	Dr Arpita Joshi	Impact Of Menopausal Symptoms on Quality of Life and Health Care Seeking Behaviour in Postmenopausal Women
P-1B/GP-7	Dr Jyoti Kumari	Effect Of Yoga on Clinical Biochemical and Doppler Parameters in Infertile Women with Polycystic Ovarian Syndrome
P-1B/GP-8	Dr Megha Mittal	An Audit on Factors Delaying Time to Chemotherapy in Stage IIB-IV Ovarian Cancer Patients
P-1B/GP-9	Dr Anjali Sarkar	Evaluation Of Vulvar Disorders Using Vulvoscopy Index And N- S-P Scheme Using Three Rings Vulvoscopy (TRIV)
P-1B/GP-10	Dr Mona Rani	Correlation Of Endometrial Thickness by Transvaginal Sonography with Histopathology on Endometrial Biopsy in The Postmenopausal Women with Postmenopausal Bleeding

Session 2 B (Obstetrics)

Date: **12th November, 2022;** Time: **11.00 am - 11.00 am** **Page (100-104)**

Poster no	Name	Abstract Title
P-2B/OP-1	Dr Shivani Mane	An Audit on Success Rate of Medical Management of Ectopic Pregnancy in A Tertiary Care Center, New Delhi.
P-2B/OP-2	Dr Meenakshi Karan	In Vitro Fertilization Pregnancy Outcome in Levothyroxine Treated Women with Hypothyroidism Compared to Women Without Having Thyroid Dysfunction Disorders
P-2B/OP-3	Dr Megha Gupta	Maternal Resuscitation and Post Cardiopulmonary Resuscitation Survival of Mother
P-2B/OP-4	Dr Yashvi Dagar	Feto-Maternal Outcomes in Twin Pregnancy
P-2B/OP-5	Dr Shivani Mane	Contraceptive Practices and Reproductive Outcomes in Women Managed for Ectopic Pregnancy.
P-2B/OP-6	Dr Kiran Dhawan	Maternal Near Miss
P-2B/OP-7	Dr Anjali Chandra	First Trimester Mean Arterial Pressure for Prediction of Pre-Eclampsia
P-2B/OP-8	Dr Ashika Happy	To Study the Effect of Umbilical Cord Length on Perinatal Outcome
P-2B/OP-9	Dr Sanskriti Garg	Impact of WHO Labour Care Guide on Mode of Delivery in Low-Risk Nulliparous Females in Spontaneous Labour
P-2B/OP-10	Dr Shruti Kumari	Correlation Between Ultrasound Doppler Placental Histopathology and Perinatal Outcome in Pregnancies with Small for Gestational Age

Session 3 B (Obstetrics)

Date: **12th November, 2022;** Time: **03.45 pm - 04.45 pm** **Page (104-106)**

Poster no	Name	Abstract Title
P-3B/OP-1	Dr Ayushi Hada	Risk Factors Associated with Surgical Site Infections (SSI In Caesarean Section in A Tertiary Level Hospital
P-3B/OP-2	Dr Gaganpreet Jaur	Iron Prophylaxis in Nonanemic Pregnant Women: Boon or Bane?
P-3B/OP-4	Dr Nalini Bala Pandey	Seizures in Pregnancy: A Diagnostic Dilemma
P-3B/OP-6	Dr Hansika Anuragi	Mifepristone-Misoprostol Combination Versus Misoprostol Alone for Termination of Pregnancy with Intrauterine Fetal Demise
P-3B/OP-7	Dr Ana Fatima	Case of Hydrocephalus and Congenital Heart Disease- Prenatal Diagnosis and Post-Natal Course
P-3B/OP-8	Dr Saloni Kamboj	Amenorrhea With Raised Beta-HCG: Can It Be a Predicament for Obstetrician ???
P-3B/OP-9	Dr Kiran Chittala	Successful Antenatal Management of Fetal CCAM in Twin Pregnancy: A Case Report

Session 4 B (Obstetrics)

Date: **12th November, 2022;** Time: **04.45 pm - 05.30 pm** **Page (107-108)**

Poster no	Name	Abstract Title
P-4B/OP-1	Dr Azmat Mantoo	Analysis Of Caesarean Sections Among Primigravida "Changing Trends in Indications in Our Setup
P-4B/OP-2	Dr Azmat Mantoo	Successful Outcome of Heterotopic Pregnancy
P-4B/OP-3	Dr Pooja Paswan	Impact Of OSA in Hypertensive Disorders of Pregnancy and Its Feto-maternal Outcome.
P-4B/OP-4	Dr Nikita Madan	Determinants And Incidence of Perinatal Asphyxia in Full Term Live Births in A Tertiary Care Hospital
P-4B/OP-5	Dr Arti Gatam	Early Diagnosis of Placenta Accreta in Case of Mid-trimester Post-abortal Haemorrhage with Previous 3 Cesarean Sections.

Schedule of Poster Presentation on 13th November, 2022

Session 5 A (Obstetrics)

Date: **13th November, 2022;** Time: **08.30 pm - 09.30 pm** **Page (109-113)**

Poster no	Name	Abstract Title
P-5A/OP-1	Dr Anuradha Sharma	Maternal And Fetal Outcome in Pregnancy with History of Arteriovenous Malformation (AVM)
P-5A/OP-2	Dr Shweta Prasad	A Nightmare in Obstetricians Practice
P-5A/OP-3	Dr Rashi Saini	Isolated Fetal Ventriculomegaly: Antenatal Evaluation and Postnatal Follow Up (Case Series)
P-5A/OP-4	Dr Soni Kumari	Peripartum Pubic Diastasis with Bladder Injury: A Rare Case Report
P-5A/OP-5	Dr Bhawna	Hyperemesis Gravidarum: A Case Report
P-5A/OP-6	Dr Jaladarshini N	Shock Index as A Predictor of Maternal Outcome in Postpartum Period
P-5A/OP-7	Dr Harshiba Kaur	Dyssegmental Dysplasia Silverman Handmaker Type: Variant of Unknown Significance or Likely Pathogenic Variant?
P-5A/OP-8	Dr Poornima Sharma	Intrauterine Transfusion: Our Experience at Tertiary Care Hospital
P-5A/OP-9	Dr Soni Kumari	Case Report- Pregnancy with Multicystic Dysplastic Kidney Disease
P-5A/OP-10	Dr Shilpi Nain	Reducing Anaemia at Childbirth in Booked Pregnant Women: A Quality Improvement Initiative

Session 6 A (Obstetrics)

Date: **13th November, 2022;** Time: **09.30 pm - 10.30 pm** **Page (113-117)**

Poster no	Name	Abstract Title
P-6A/OP-1	Dr Shreya Kushwaha	Antenatal Detection and Prognostication of Congenital Diaphragmatic Hernia: A Case Series
P-6A/OP-2	Dr Roohat Parveen	A Pregnant Woman's or Deal with Cerebellar Hemangioblastoma: A Case Report
P-6A/OP-3	Dr Pragya Saini	Psoriasis In Pregnancy-A Case Report
P-6A/OP-4	Dr Janithya Pujari	Study Of Clinical and Biochemical Variables in Maternal Near Miss in Women with Hypertensive Disorders of Pregnancy
P-6A/OP-5	Dr Drishti Malhotra	Macrosomia With Intrauterine Demise: Management Dilemma
P-6A/OP-6	Dr Nikita Sharma	Factor XI Deficiency in Pregnancy: One in A Million Case
P-6A/OP-7	Dr Sunita Yadav	Scar Ectopic: Report of A Rare Case
P-6A/OP-8	Dr Akansha Yadav	Intra Parenchymal Haemorrhage in Pregnancy: A Diagnostic Dilemma.
P-6A/OP-9	Dr Tanya Mudgal	Heterotopic Pregnancy: Often an Overlooked Obstetric Condition
P-6A/OP-10	Dr Ankati Majumder	Dress Syndrome in Pregnancy

Session 7 A (Obstetrics)

Date: **13th November, 2022;** Time: **10.30 pm - 11.30 pm** **Page (117-121)**

Poster no	Name	Abstract Title
P-7A/OP-1	Dr Sreeba KV	Anti-Kell Antibody in Pregnancy
P-7A/OP-2	Dr Dhruthi S	Case Report of a Rare Presentation of Tubercular Meningitis in Postpartum Female
P-7A/OP-3	Dr Mansi Garg	SLE and HIV: A Deadly Duo for The Foetus
P-7A/OP-4	Dr Reena Meena	Pregnancy in Uncorrected Tetralogy of Fallot (TOF): A Case Report
P-7A/OP-5	Dr Nidhi Jain	Spontaneous Hemoperitoneum in Pregnancy with Abruption: A Case Report
P-7A/OP-6	Dr Yashi Nagar	Pregnancy With Neurosurgical Emergency: A Team Effort
P-7A/OP-7	Dr Kajal Baleja	A Rare Manifestation of Dengue Haemorrhagic Shock in Reproductive Age Group Woman
P-7A/OP-8	Dr Gaurav Wadhwa	Rare Case of Tubo-Ovarian Mass with Torsion in Pregnancy
P-7A/OP-9	Dr Penzy Goyal	Diagnostic Dilemma Between Occipital Encephalocele and Cystic Hygroma
P-7A/OP-10	Dr Megha Gupta	Maternal Resuscitation and Post Cardiopulmonary Resuscitation Survival of Mother

Session 5 B (Gynaecology)

Date: **13th November, 2022;** Time: **08.30 pm - 09.30 pm** **Page (121-125)**

Poster no	Name	Abstract Title
P-5B/GP-1	Dr Maninder Ghotra	A Rare Presentation of Uterine Leiomyoma: Pseudo-Meig's Syndrome.
P-5B/GP-2	Dr Kaavya Sreedhar	Osseous Metaplasia of Endometrium: A Case Report
P-5B/GP-3	Dr Divya Meena	Perrault Syndrome: A Case Report
P-5B/GP-4	Dr Nidhi Gupta	A Young Nulliparous Infertile Female: An Unusual Adnexal Mass
P-5B/GP-5	Dr Naseema Syed	Synchronous Endometrial and Ovarian Cancer
P-5B/GP-6	Dr Ayushi Hada	Recurrent Ovarian Torsion in An Adolescent
P-5B/GP-7	Dr Anshul Kulshreshtha	Laparoscopic Assisted Removal of Giant Cervical Fibroid by Exsection: A Surgeon's Plight (Video Presentation)
P-5B/GP-8	Dr Shalini Parashar	Ruptured Corpus Luteal Cyst in Women on Anticoagulant Therapy-A Case Series
P-5B/GP-9	Dr Smriti Thakur	Labial Agglutination in A Pubertal Girl-A Case Report
P-5B/GP-10	Dr Seema Singhal	Haemato-Myeloid Malignancies Masquerading as Gynaecological Masses: A Rare Yet Existing Entity

Session 6 B (Gynaecology)

Date: **13th November, 2022;** Time: **09.30 pm - 10.30 pm** **Page (125-128)**

Poster no	Name	Abstract Title
P-6B/GP-1	Dr Amanat Kullar	Uterine Prolapse in Pregnancy.
P-6B/GP-2	Dr Asmita Anand	A Large Para Ovarian Cyst with Torsion
P-6B/GP-3	Dr Megha Mittal	Radiological And Surgical Correlation of Peritoneal Carcinomatosis Index for Epithelial Ovarian Cancers
P-6B/GP-4	Dr Anshul Bhartiyam	Large Twisted Sub-serosal Fibroid with Acute Intestinal Obstruction
P-6B/GP-5	Dr Rashmi Saxena	A Rare Case of Exceedingly Huge Round Ligament Leiomyoma Presenting As Ovarian Neoplasm.
P-6B/GP-6	Dr Peuly Das	Yolk Sac Tumor in A 22-Year Female
P-6B/GP-7	Dr Nirupama Gupta	Experience At One Stop Centre
P-6B/GP-8	Dr Sangeeta Kumari	A Rare Presentation of Structural Abnormalities of Uterus in Young Girls
P-6B/GP-9	Dr Niharika Sharma	Utero-cutaneous Fistula: A Rare Complication of Adenomyosis Surgery
P-6B/GP-10	Dr Vishwani Khurana	Unusual Case of Ovarian Torsion with Multiple Dermoid

Session 7 B (Gynaecology)

Date: **13th November, 2022;** Time: **10.30 pm - 11.30 pm** **Page (128-133)**

Poster no	Name	Abstract Title
P-7B/GP-1	Dr Soni	Carcinoma Endometrium with Solitary Vulvo Vaginal Metastasis: A Rare Presentation
P-7B/GP-2	Dr Monika	Monomanual Monodigital Examination for Diagnosis of Pelvic Floor Myofascial Spasm
P-7B/GP-3	Dr Nikita Saxena	Paraovarian Cyst with Tubal Torsion: A Rare Cause of Acute Abdomen
P-7B/GP-4	Dr Mamta Tyagi	Magic Needle - Port Closure Needle
P-7B/GP-5	Dr Jaspreet Kaur	Unusual Bilateral Ovarian Metastasis from Primary in Gastrointestinal Tract
P-7B/GP-6	Dr Rini K	Venous Thromboembolism in Ovarian Cancer
P-7B/GP-7	Dr Akanksha Gupta	Endometrial Stromal Sarcoma Masquerading as Rectovaginal Endometriosis
P-7B/GP-8	Dr Anushka Gupta	Primary Bilateral Ovarian Burkitt Lymphoma; A Rare Case in Gynaecologic Oncology
P-7B/GP-9	Dr Vaishnavi Jayaram	Synchronous Endometrial Carcinoma and Ovarian Neuroendocrine Tumour: A Rare Case Report
P-1B/GP-10	Dr Akanksha Pandey	Presentation Of Benign Epithelial Neoplasm with Recurrence of Abdominal Lump in Early Post Op Period
P-7B/GP-11	Dr Supriya Singh	Population Stabilization: Challenges Ahead for Delhi
P-7B/GP-12	Dr Tanya Grover	Robert Uterus: Causing Intractable Dysmenorrhea and Chronic Pelvic Pain

Competition Papers

CP - 1

Impact of action taken in response to stillbirth audit: A success story

Noopur Chawla, Manju Puri, Manisha Kumar, Milo Suka, Gaganpreet Kaur
Lady Hardinge Medical College , New Delhi, India

Introduction: The identification of Fetal Growth Restriction (FGR) is of paramount importance to prevent stillbirths. FGR is a preventable and modifiable risk factor which constitutes a major proportion of stillbirths.

Objectives: Study the impact of intra-facility interventions on the modifiable factors causing stillbirths (SB), using point of care quality improvement (POCQI) methodology.

Methods: Stillbirth data during the nine months pre-intervention period was reviewed to identify the common preventable causes. Two interventions, namely ultrasound at 34-36 week gestation and intrapartum monitoring on a common customized labor chart for all health care providers were done. Post-intervention data was collected to observe the impact of theinterventions.

Results: The stillbirth rate reduced from 212/5940 deliveries (35.7/1000) in the pre- intervention period to 165/5993 deliveries (27.7/1000) in the post intervention period (p=0.011). The intra-facility failure to identify FGR significantly reduced in the post intervention group (p=0.033), leading to 63% (RR- 0.37) reduction in its risk. Using a common customized labour chart, led to a significant decline in the inadequate monitoring as a provider related cause of stillbirth (p< 0.001) leading to its 42% decline as contributor to modifiable cause of SB (RR-0.48).

Conclusion: Reviewing the perinatal death surveillance response (PDSR) data, identifying gaps in care and using improvement methodology for instituting corrective measures play an important role in reducing intramural stillbirths.

CP – 2

Chromo Colposcopy with Fluorescein Sodium for Detection of Premalignant and Malignant Lesions of Cervix

Amrita Patel, Amita Suneja, Rashmi Malik, Bindiya Gupta, Sonal Sharma
University College of Medical Sciences & Guru Teg Bahadur Hospital Dilshad Garden, New Delhi, India

Background: Currently identification of abnormal areas on colposcopy is based on staining with 3-5% acetic acid (A.A) which has several limitations. Hence new staining agents are needed to improve sensitivity and specificity. This study aimed to find diagnostic accuracy of Fluorescein sodium (FNa) staining during colposcopy in diagnosis of premalignant andmalignant lesions of cervix.

Methods: This study included 120 screen positive women. Colposcopy was done by conventional method with 3% A.A. this was followed by application of 0.06% FNa after washing the cervix with normal saline. Observations for FNa staining were made under blue filter and directed biopsies were taken from Acetowhite and fluorescent green areas. Benign lesions were considered as disease-negative and LSIL, HSIL, and IC as disease-positive. Correlation between FNa and A.A. was determined by kappa statistics.

Results: The mean age was 39.59±10.73yr and median parity was 2. Out of 120 patients, 57 had benign lesions, 18 had LSIL, 33 had HSIL and 12 had IC. Detection rate of disease-positive cases by FNa and A.A. was 98.41% vs 68.25%(p-value<.001). Sensitivity and Specificity were 98.41% Vs 64.91& 85.71% Vs 35.09%; Positive and negative likelihood ratios were 2.8 vs 1.32& 0.02 vs 0.41; positive and negative predictive values were 75.60% vs 59.30% & 97.30%vs 68.90%. Diagnostic accuracy of FNa and A.A. was 82.50% vs 61.60%.

Conclusion: Our study suggested that using FNa as a contrast agent during colposcopy results in greater accuracy for detection of premalignant and malignant lesions of the cervix as compared to A.A.

CP - 3

To Assess the Impact of Implementation of Systematic Childbirth Education Through A Birth Planning Visit on the Outcome and Experience of Childbirth: A Quality Improvement Project

Shivangi Mangal, K Aparna Sharma
All India Institute of Medical Sciences, New Delhi, India

Introduction: Antenatal education is an essential part of antenatal care. They are usually provided while making birth plans for women in birth plan

clinics. The birth plans include information on role of birth companions, processes of normal labour, pain relief, birthing positions, possiblecomplications during labour, different methods of operative delivery and breastfeeding.

Methods: Study rationale: Despite the available evidence on the benefits of birth plans, no formal birth planning regarding prenatal exercises, birth companion, mode of delivery, labour analgesia and postpartum contraception was provided to the antenatal women at our department.

This quality improvement project was aimed at inculcating the practice of formulating birth plans for expectant mothers in their third trimester with respect to the five mentioned components.

We aimed to increase the number of booked antenatal women who had a birth plan counselling visit from existing zero to 50% in 10 months. Quality Improvement team was formed. Problems were analysed using a fishbone chart. Infographics and checklists were made and the team leader initiated counselling. Change ideas including motivating residents to refer women for counselling, redistribution of OPD rooms, and training of family planning staff were executed in multiple plan-do-study-act cycles.

Results: After 5 PDSA cycles, median increased from baseline of 0 to 50% in 10 months which was sustained for 6 months. There was improvement in acceptance of all components except birth companion availability.

Conclusion: Methodological use of staff with training and motivation of healthcare workers resulted inestablishing the practice of counselling in antenatal OPD.

CP – 4

Does Endometrial Thickness and Embryo Grade Affect Pregnancy Outcomes in IVF Cycles?

Abhilasha, Anjali Tempe
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: The monetary cost, time and emotional investment involved in one cycle of IVF is significant, justifying the need for higher IR. Therefore, it is necessary to analyse the factors required for successful outcome.

Aims and objectives: To assess the role of endometrial thickness and embryo grading in pregnancy outcomes of fresh IVF cycles.

Materials and methods: A retrospective cohort study was conducted at IVF centre of a tertiary care hospital. Case records of 114 patients, who had fresh IVF cycles were analysed. Endometrial thickness (ET) was calculated on the day of HCG trigger (in mm). Embryos were graded as grade A, B, and C, that are based on and similar to the SART embryo classification of good, fair and poor quality embryo. Primary outcome of the study was to calculate the clinical pregnancy rate (CPR).

Results: A positive association was present between the ET and CPR. A cut-off value ofmore than 8mm of ET showed significant difference in the pregnancy outcomes (CPR=40.4%; p=0.002).

Comparison of CPR of the different embryo grades that were transferred did not show any statistically significant difference (p=0.450).

Conclusions: ET is an important factor affecting the outcome of fresh IVF cycles. A cut-offof more than 8mm of ET indicated better clinical outcomes.

The morphological grading of an embryo does help in selection when there are multiple embryos to select from. However, there is no significant difference in positive and negative results of the grade A or grade B quality embryos.

CP - 5

Assessment of Menopausal symptoms using Menopause Rating Scale and their association with Serum Vitamin D levels

Vinodita Puri, Kiran Aggarwal, Rajeev Goyal, Anuradha Singh, Aprajita GuptaLady Hardinge Medical College, New Delhi, India

Introduction: During menopause, there is gradual decline in oestrogens levels which results inincrease in bone turnover, decrease in bone mineral density, musculoskeletal discomfort, mood disturbances and increases the risk of metabolic and cardiovascular disease. This physiological transition can negatively affect quality of life, professional and personal relationships.

Objective: To see the relationship between Menopause Rating Scale scores and serum Vitamin D levels.

Methods: This is a cross-sectional study which includes 200 women between 45 to 72 years, with amenorrhea for >12 months. Menopause rating scale was used to record and correlate common symptoms. Serum Vitamin D levels measured via

blood sample using ECLIA, normal values taken as 30 to 70 ng/ml. They were correlated with severity and prevalence of symptoms.

Results: Majority of women had attained Menopause by the age of 50 years (123, 61.5%) 144 out of 200 women had Serum Vitamin D levels of <20 ng/ml. On the severity scale 34.5% participants had no to mild symptoms. The majority (130, 65%) had experienced moderate symptoms. Only one had severe symptoms. A strong statistically significant negative correlation was found between MRS Total Score and S. Vitamin D levels (rho = -0.67, p = <0.001). For every 1 unit increase in MRS Score, S. Vitamin D decreases by 0.57 units.

Conclusion: Vitamin D supplementation has the potential to act as a replacement or adjuvant of HRT for mild to moderate symptoms and even to prevent symptoms all together. Hence more studies are required in this direction.

CP - 6

Prediction of Complications of Preeclampsia Using the Fullpiers High Risk Predictive Model

Astha Sharma, .Jyotsna Suri , Sumitra Bachani, Divya Pandey, ZebaKhannam

Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

Introduction : This study was conducted to evaluate how the preeclampsia integrated estimate of risk (fullPIERS)model performs in the prediction of adverse maternal and fetal outcomes when the predictor variables are obtained within 24-h of admission for preeclampsia.

Objective: To determine the probability of complications in preeclamptic women using fullPIERS model within the first 24 hours of admission and to evaluate the predictive value of each individual component of the fullPIERS model for complications of preeclampsia.

Methods: A prospective cohort study on 256 women who fulfilled definite inclusion and exclusion criteria was conducted. Subjects were monitored for clinical symptoms of preeclampsia, biochemical parameters, and adverse maternal and neonatal outcomes from 48 hours to 7 days. A percentage predictive probability was calculated using the fullPIERS calculator. ROC curve was used to find out area under curve of fullPIERS model. ROC curvewere also used to analyse individual fullPIERS model.

Results: 39.5%(n=101)suffered adverse maternal complications,46.9 %(n=120) suffered adverse fetal outcome while 62.1%(159) had any adverse feto-maternal complications. The model had a good discriminatory ability with an AUROC of 0.843 (95% CI)(0.789, 0.897) for predicting complications at any time from 48 hours to 7 days. At a cutoff (%) of ≥5.9, it predicts any adverse maternal outcome with a sensitivity of 60%, and a specificity of 97%. The cut off calculated for predicting any feto-maternal outcome was 4.9 with high specificity of 96% and low sensitivity of 44%.

Conclusion: Hence fullPIERS model is a very good predictive model to rule in adverse maternal outcome.

CP - 7

Evaluation of Maternal Serum Fetal Hemoglobin and Alpha-1-Microglobulin Levels in Pre-Eclampsia

Pooja Sharma, Rachna Agarwal, Mrinalini Kotru, Rajarshi Kar, Sandhya Jain

University College of Medical Sciences & GTB Hospital, New Delhi, India

Background & Objectives: Pre-eclampsia is associated with increased levels of fetal hemoglobin (HbF) and alpha-1-microglobulin (A1M) in maternal circulation. Increased HbF induces inflammation and endothelial damage, leading to hypertension and proteinuria. A1M is a physiological antioxidant that increases in pre-eclampsia against increased oxidative stress. In our study, we aimed to investigate the role of HbF and A1M in pre-eclampsia and compare their levels with controls.

Methods: This observational case-control study included 45 cases and 45 controls. Cases were defined as women diagnosed with pre-eclampsia for termination of pregnancy at ≥28 weeks of gestation while controls were normotensive healthy pregnant women. Maternal serum samples were taken in plain vials, centrifuged, stored at -20°C and further analysed using ELISA kits.

Results: The mean value of serum HbF levels was significantly higher (p<0.001) in cases (7.60±1.9 ng/mL) than in controls (5.44±1.02 ng/mL). The mean value of serum A1M levels was also found to be significantly higher (p<0.001) in cases (23.10±2.5 ng/mL) than in controls (15.44±3.25 ng/mL). No significant difference was found on comparing serum HbF and A1M levels between early vs late-

onset pre-eclampsia and non-severe vs severe pre-eclampsia.

Conclusion: Our study suggested that increased serum HbF may contribute to the pathophysiology of pre-eclampsia. There is also a possibility of reducing HbF by recombinant A1M which can aid in the treatment of pre-eclampsia.

CP - 8

Elective Induction of Labour at 39 Weeks Versus Expectant Management in Low-Risk Nulliparous Women

S. Noorul Fazila

Hamdard Institute of Medical Sciences, New Delhi, India

Introduction: Timing of delivery is a vital component of pregnancy and its outcome. An increase in morbidity and mortality exists on both ends of gestation preterm and postterm. The objective of this study was to perform a comparative analysis of elective induction of labor at 39 weeks gestational age among low risk nulliparous women singleton pregnancies to expectant management.

Aim & Objectives: To compare the maternal and neonatal outcomes in induced labour at 39 weeks withexpectant management.

Methodology: Randomized control study from January 2021- February 2022. Low-risk nulliparous, singleton live pregnancy with cephalic presentation at >38 weeks were included. Women not consenting, high risk pregnancy, contraindications to vaginal delivery, unreliable dates were excluded. Randomized into Group A - Low-risk nulliparous, singleton live pregnancy with cephalic presentation induced at 39+3weeks.Group B - Low risk nulliparous expectantly followed and induced after 41 weeks .

Result: A total of 300 women were included in the study, 147 were included in group A and 153 in Group B. Caesarean section rate was 25.2% in Group A compared to 24.8% in Group B. Neonatal morbidity increased in Group B (27.5%) compared to Group A (15.6)% and p-valueof < 0.013.

Conclusion: Elective induction at 39 weeks of gestation did not increase cesarean rates & had better neonatal outcomes than the expectant group. Elective induction of labor should be a shared decision-making process with informed consent.

Oral Presentation

Abstracts of Oral Paper Presentation on 12 November, 2022

Session-1 (Gynae oncology)

Oral - 1

Evaluation of serum biomarkers human epididymis protein 4 and fibrinogen in endometrial cancer

Sana Ahmed[1], Bindiya Gupta[1], Rajarshi Kar[2], Priyanka Gogoi[3], Vinita Jaggi[4]
[1]Department of Obstetrics and Gynecology, [2]Department of Biochemistry, [3]Department of Pathology, University College of Medical Sciences and GTB hospital, [4]Delhi State Cancer Institute, Delhi, India

Objectives: To establish human epididymis protein and fibrinogen as diagnostic biomarkers for endometrial cancer and correlate the levels with the stage, grade, myometrial invasion and Lymph vascular invasion of the cancer.

Method: 60 patients (30 cases and 30 controls) with endometrial cancer and benign endometrial pathology respectively were recruited in this case control study. HE4 and fibrinogen levels were estimated in both groups. The diagnostic value was assessed by a receiver operating curve, sensitivity, specificity, positive predictive value, negative predictive value and accuracy.

Results: A combination of HE4 and fibrinogen fared better than either biomarker alone in diagnosing endometrial cancer (area under the receiver operating curve: HE4 and fibrinogen = 0.8588, fibrinogen=0.81 and HE4=0.6861). At a cut-off level of 239 pmol/L for HE4 and 342.5mg/dL for fibrinogen, the sensitivity was 60% and 73.33% respectively and specificity was 76.67% and 83.33%, A PPV of 72% and 81.48%, NPV of 65.71% and 75.76% and accuracy of 68.33% and 78.33% for HE4 and fibrinogen respectively were obtained.

Conclusion: The combined evaluation of HE4 and fibrinogen could provide gynaecologic oncologists with information to diagnose endometrial cancer by a less invasive method and could also improve decision making for the intervention to be undertaken in confirmed cases of endometrial cancer.

Oral - 2

Comparison of Conventional Pap Smear with Liquid Based Cytology in the detection of Cervical Intraepithelial Neoplasia and Cervical Cancer

Rachita Garg, Gauri Gandhi. Krishna Agarwal, Niharika Dhiman
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Cervical Cancer is the fourth most common cancer-affecting women worldwide with 528,000 new cases every year. Almost one fifth of all new cases are diagnosed in India. It is a preventable cancer, since it is preceded by a long pre-invasive phase in the form of Cervical Intraepithelial Neoplasia (CIN), which is curable if detected by screening.

Objective: Comparison of Conventional Pap Smear and Liquid Based Cytology (LBC) in the detection of CIN 1 or worse.

Method: 457 subjects were recruited and screened by Conventional Pap smear and LBC. ASCUS or worse was taken as cytology positive. All who tested positive underwent colposcopy directed biopsy. Sensitivity and Specificity was calculated and compared for both methods, using histopathology as gold standard.

Results: Out of 457 samples, 4.3% were positive by the Conventional method and 7.2% by LBC. All of them underwent colposcopy and biopsy. Taking CIN 1 or worse, sensitivity of Conventional Pap Smear and LBC was 75% and 100% respectively and specificity 85.8% and 73% respectively. However, for high-grade lesions, LBC was more sensitive (100% versus 14.2%) with comparable specificity (96.4% versus 97.5% respectively).

Conclusion: Thus, to detect CIN 1 or worse, LBC is more sensitive and Conventional smear is more specific. However, LBC is more sensitive as well as specific for the detection of high-grade lesions. Conventional smears miss some high-grade lesions due to higher number of unsatisfactory smears. LBC should be the screening modality of choice for the screening of cervical cancer.

Oral – 3

Knowledge Attitude and Practice about Cervical Cancer Prevention

Madhu Shree R G, Gauri Gandhi, Krishna Agarwal, Niharika Dhiman
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Background: Cervical cancer is the second most common cancer among women worldwide. The most common cause of cervical cancer related deaths in India is due to late diagnosis. The most effective method of cervical cancer prevention is by educating the people about screening tests and vaccination. Hence, this study was conducted to assess KNOWLEDGE, ATTITUDE and PRACTICE about cervical cancer prevention.

Objective: To assess Knowledge about cervical cancer, to assess Practice about cervical cancer prevention and to assess their willingness to participate in HPV vaccination and Screening.

Method: A cross sectional survey was conducted in 600 women between 20-65yrs attending Lok Nayak Hospital. Information was gathered by a questionnaire assessing the knowledge, attitude, and practices regarding cervical cancer.

Results: Of the 600 women interviewed, 56% had knowledge about cervical cancer and 35.3% knew it could be preventable. 25.6% had knowledge about HPV vaccine and 36.6% of them had heard about cervical cytology. 3% of the participants had already taken HPV vaccine and 8% participants had Cervical Cytology testing done in the past, 33.5% were willing to get vaccinated and 55.4% were willing to undergo screening.

Conclusion: The overall Knowledge about Cervical Cancer and its Prevention is very inadequate but the Practice regarding Prevention is worse. Therefore, the gap between Knowledge and Practice needs to be bridged even amongst those who have any Knowledge regarding this cancer.

Oral – 4

Clinico-pathological Characteristics and Prognosis of Ultra-high-risk Gestational Trophoblastic Neoplasia: Experience from a Tertiary Care Centre

Swati Tomar[1], Seema Singhal[1], Sachin Khurana[2], Lalit Kumar[2], Neena Malhotra[1], Neerja Bhatla[1]
[1]Department of Obstetrics and Gynaecology, [2]Department of Medical Oncology, Dr BRAIRCH, All India Institute of Medical Sciences, New Delhi, India

Introduction: Women with gestational trophoblastic neoplasia (GTN) FIGO score of >12 as well as those with high tumour burden and extensive metastases comprise the ultra-high-risk subgroup.

Objective: To study the clinical characteristics, treatment efficacy and prognosis of ultra-high risk GTN patients.

Methods: This retrospective study was conducted between 2016 to 2019. Medical records of ultrahigh risk GTN were reviewed. Clinical details, FIGO risk score; relapse and oncological outcomes were investigated.

Results: A total of 16 ultra-high-risk GTN were identified. Mean age of patients was 31.8±8.1 years. Mean duration of GTN diagnosis since prior pregnancy was 6.6 months (range 2-13). Seven patients had distant metastases and various sites were liver (4), brain (2) and vagina (1). Four (25.0%) women had >1 site of metastases. Uterine invasion was also seen in 7 women. Complete remission was achieved in 9/16 (56.2%), disease relapsed in 6/16 (37.5%) and 1/16 (6.2%) died of disease. Of relapsed case, 3 (50.0%) patients had chemotherapy resistant disease. For relapsed disease, complete response was achieved after second, third- or fourth-line chemotherapy in 6, 3 and 2 women, respectively. Two women underwent salvage hysterectomy and one lung metastectomy for disease control. The overall 3-year survival rate approached 93.7%. Poor response predictors were brain or liver metastases.

Conclusion: Management and outcomes of ultra-high-risk GTN differ from other high-risk GTN and need multidisciplinary team with critical care expertise. The treatment requires multiple lines of chemotherapy with manageable toxicity to achieve complete remission. Salvage surgery in resistant disease may improve prognosis.

Oral – 5

Retrospective analysis of etiology and management of large ovarian masses

Poonam Kashyap
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Objective: To evaluate the etiology and management of large ovarian masses in patients who underwent surgery.

Materials and Methods: 18 patients with large ovarian mass who underwent surgery were studied retrospectively from Jan 2019 to October 2022. Patient's age, presenting symptoms, operative procedures, postoperative treatment, and results of histopathologic examinations and outcome were obtained from the medical record and analysed. The management and follow up of the patient were evaluated.

Results: The mean age of the patients was 43years. The most common symptom was abdominal pain, as recorded in 10(55.5%) patients and distension of abdomen in 8(44.4%) cases. Out of 18, 6(33.3%) were benign, 3 (16.6%) were borderline and 9(50%) were malignant. The histopathologic diagnoses for the epithelial tumors included 4 serous cystadenomas (22.2%) and 2(11.1%) mucinous cystadenomas, and 3(16.6%) serous tumors of borderline malignancy, 4(22.2%) serous cystadenocarcinomas and 3(16.6%) mucinous cystadenocarcinoma and 2(11.1%) were immature teratoma.1 patient (5.5%) had bilateral disease. Out of 9 malignant, 8 (44.4%) required chemotherapy. The mean tumour diameter was 23.9±0.6 cm (20-35cm). The mean cancer antigen (CA) 125 level was significantly higher, and ascites was more frequently detected in malignant tumours compared to benign.

Conclusion: Epithelial tumours comprise a significant proportion of ovarian masses in reproductive age group. Borderline tumours are also common among large ovarian masses, although the presence of ascites and elevated CA 125 may present malignancy in large ovarian tumours. The preoperative work up of the patient is important to diagnose and to exclude malignancy.

Oral - 6

Feasibility of Mobile ODT Enhanced Visual Assessment for triaging screen positive women

Archana Mishra, Saritha Shamsunder, Anita Kumar, Ranji Beriwal, Charanjeet Ahluwalia, Sujata Das
Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

Introduction: The goal of cervical cancer screening is to detect precancerous precursor lesions that can be treated in the preinvasive stage. Colposcopy is important for triaging of any abnormal cervical screening test. Scarcity of trained Colposcopists and colposcopy centres is a big hurdle to screening programs in lower and middle-income countries.

Objectives: To assess the performance of the Mobile ODT Enhanced Visual Assessment against the gold standard of histopathology.

Material and Methods: A cross sectional observational study was conducted on women referred to our colposcopy clinic following an abnormal screening test. Colposcopy examination was performed by trained physicians using the mobile optical device technologies (ODT) Enhanced Visual Assessment (EVA) system and the images were saved. The physician colposcopy impression was recorded, biopsy performed if any aceto-white lesions were found. Correlation Physician impression using the mobile ODT colposcope and gold standard histopathology was performed.

Result: We screened 2050 women in a span of 9 months. Out of which 147 women were found to be screen positive by cytology, VIA or primary HPV testing. Mobile ODT EVA had a sensitivity 86.8% (75-95, specificity 81.9% (73-89), PPV 73% (60-83, NPV and diagnostic accuracy of 83.7% (77-89) when compared to gold standard of histopathology.

Conclusion: Mobile ODT EVA with is valuable for triage of screen positive women for further management.

Oral – 7

Comparison of Modified IFCPC 2011 Nomenclature V/S Swede Score in Diagnosing Premalignant Lesions of Cervix

Ira Arora, Prabha Lal, Smita Singh, Triveni
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, India

Introduction: Every year in India, 122,844 women are diagnosed with cervical cancer and 67,477 die from the disease. Cervical cancer has a long precancerous stage hence early detection is important. Modified IFCPC 2011 nomenclature reduces subjectivity and increases reproducibility between different colposcopists. Very less studies are available so we will try to validate the positive claims emanating from the sparse literature.

Objective: To compare the predictive value of colposcopic evaluation with modified IFCPC 2011 nomenclature and swede score for diagnosing premalignant lesion of cervix.

Methods: A comparative study including 50 women>21 years of age to 65 years of age with abnormal Papanicolaou test (ASCUS, LSIL, ASC-H, HSIL) was done. Colposcopic evaluation by both Swede score and Modified IFCPC 2011 Nomenclature

was done in same women and then statistical association with histological findings were analyzed.

Results: Sensitivity, specificity, positive predictive value, negative predictive value and diagnostic accuracy of swede score for predicting LSIL and HSIL were 87.50% , 41.18%, 41.18% , 87.50%,56.00% and 100.00%, 77.27%,37.50% ,100% ,80.00% respectively. Sensitivity, specificity ,positive predictive value, negative predictive value and diagnostic accuracy of Modified IFCPC 2011 nomenclature for predicting LSIL and HSIL were 87.50%, 58.82%, 50.00% ,90.91% , 68.00% and 100.00% , 100.00%, 100.00% , 100.00% ,100.00% respectively.

Conclusions: Modified IFCPC 2011 Nomenclature had better predictive value than swede score in diagnosing pre malignant lesions of cervix.

Oral – 8

Screening for Mental Health Disorders and Neurochemical Correlates in Gynecology Cancer Survivors: A Cross-Sectional Study from a Tertiary Care Center in India

Nilanchali Singh, Shalini Singh, Rizwana Qureshi, DN Sharma, Roshan Bhad, Neerja Bhatla

All India Medical Scences, New Delhi, India

Background: Mental health issues are under-evaluated and under-treated in gynaecological cancer survivors. Information on the prevalence and neurological correlates of these psychological issues, will help in planning of targeted treatment strategies for this problem. The aim of this study to screen gynaecological cancer survivors for mental health issues and to correlate it with serum neurochemical biomarkers.

Methodology: This study included gynaecological cancer survivors following up at a tertiary care center, in the age group of 18-55 years. The study subjects were assessed using the study questionnaires, which included semi-structured socio-demographic proforma, semi-structured proforma for details regarding current diagnosis, pain status, analgesic use, DASS-21 (Hindi) for depression, anxiety and stress screening, the WHO ASSISTv3.0 (Hindi) for alcohol, smoking and substance involvement screening.Disease characteristics of cancer survivors were abstracted from medical records. Serum levels of neurochemical biomarkersi.e. Brain Derived Nerve Growth Factor (BDNF), Neuropeptide Y (NPY) and peptide Substance P (SP), were analyzed.

Results: A total of 143 gynaecological cancer survivors were identified. 22.4% of the study population did feel depressed after being diagnosed with gynaecological cancer. The prevalence of depression was not associated with site (p=0.308) or stage of cancer (p=0.778). Serum BDNF level was significantly high in screen positives for depression (98.11+10.7 ng/ml vs 80.47+6.6 ng/ml; p=0.04). Serum NPY(p=0.48) and SP(p=0.68) were not significantly associated. 27.3% patients were screened positive for anxiety, which was not associated with site (p=0.166) or stage (p=0.774) of cancer. The neurochemical markers were not significantly associated with anxiety levels. 13.33% of the study population did use psychoactive substance after being diagnosed with cancer, independent of site (p=0.233)/stage (p=0.826) of disease. Though, the levels of BDNF and NPY did not correlate with psychoactive substance use, however, serum levels of substance P were significantly associated with its use (101.42pg/ml vs 81.19; p= 0.02pg/ml)

Conclusion: Mental health conditions are highly prevalent in gynaecological cancer survivors. Depression is associated with high levels of BDNF and psychoactive substance use is associated with high levels of substance P, in these subjects. Future clinical trials should focus on elucidating mental health conditions in such patients and providing targeted treatment. Utility of the neurochemical correlates needs further elucidation.

Session- 2 (Maternal and Fetal Medicine)

Oral – 1

Cerebral-placental Ratio as a predictor of perinatal outcome in Hypertensive Disorders of Pregnancy and Its Comparison with the constituent Doppler Indices

Madan Nikita, Maurya Divya, Malik Neeru, Jain Sandhya, Ranjan Rajeev

Dr. Baba Saheb Ambedkar Hospital, Rohini, Delhi, India

Introduction: The hypertensive disorders of pregnancy (HDP) complicate about 3– 10% of pregnancies and increases adverse perinatal outcomes. About 16% of all stillbirths and 10% of early neonatal deaths are accounted by HDP.

Objective: Doppler velocimetry is an established

method of antepartum fetal surveillance in pre-eclampsia. Cerebral-placental ratio detects the centralization of fatal blood flow as also insufficiency in placental circulation and is postulated to be a better marker of perinatal outcome than either vessel Doppler alone. The current study aims to assess Cerebral-placental ratio as a predictor of adverse perinatal outcomes and compare to S/D ratio of umbilical artery (UA) and middle cerebral artery (MCA).

Methods: The present prospective observational cohort study included 100 patients with hypertensive disorders of pregnancies between 32 to 37 weeks. Ultrasound with Doppler was done and these parameters were assessed: - fetal biometry, amniotic fluid index, UA and MCA pulsatility index, SD ratio of UA and MCA, and Cerebral-placental ratio was calculated. Sensitivity, specificity, positive and negative predictive value were calculated for Cerebral-placental ratio and other established methods for predicting perinatal outcome and McNemar's test was used for the comparison of sensitivity and specificity.

Results: 32 patients had abnormal Cerebral-placental ratio. Adverse perinatal outcomes such as caesarean section for fetal distress, small for gestational age, APGAR <7 at 1 and 5 minutes, NICU admission and perinatal mortality were more in the group with abnormal Cerebral-placental ratio and the difference was statistically significant-

Conclusion: The Cerebral-placental ratio is a more reliable predictor of adverse perinatal outcomes and should be routinely calculated during obstetrical Doppler for antepartum fetal surveillance in case of HDP. It suggested that the Cerebral-placental ratio might be calibrated in the software of the Doppler ultrasonography machine for routine use in high-risk pregnancies.

Oral – 2

Prenatal Diagnosis of Gene Disorders: A Prospective Observational Study

Aparna Setia[1], Prakash Mehta [2], Preetha Tilak [3], BS Ramamurthy [4], Rachita Ramamurthy[4]
[1]Department of Obstetrics and Gynecology, University College of Medical Sciences and GTB hospital
[2] Dept. of MFM, Bhagwan Mahaveer Jain Hospital, [3]Dept. of Clinical Genetics, St. John's Hospital,
[4]Sreenivasa Ultrasound Scanning centre, Delhi, India

Introduction: Genetic disorders account for 20% of the neonatal deaths and gene disorders may occur in up to 2% of new-borns. The most recent advance in prenatal genetic is next generation sequencing (NGS). The guidelines regarding when and who to offer genetic counselling and invasive prenatal testing (IPT) and which tests to offer is lacking. Objective: The aim was to understand the clinical profile of patients who fulfil the criteria for gene testing, to identify the common indications for IPT, to analyse the NGS results and correlate with pregnancy outcome and to calculate the diagnostic yield.

Methods: This study was carried out in 112 pregnant patients who had a suspicion of gene disorder at division of MFM, BMJH and BPDTA, Bangalore from December 2019 to June 2021.

Results: Forty-six /112 (41.1%) had a clinical history suspicious of gene disorder, 48/112 (42.9%) had a definitive gene disorder in the family, 13/112 (11.6%) had a sonographic abnormality in the foetus and 5/112 (4.5%) had a clinical suspicion plus sonographic abnormality. They were offered pre-test counselling and IPT. Thirty-six/46 (78.3%) with clinical, 47/ 48 (97.9%) with definitive gene disorder, 5/13 (38.5%) with sonographic abnormality and 1/5 (20%) with clinical + sonographic abnormality had a clear diagnosis. The overall diagnostic yield was 79.5%.

Conclusion: This study has shown that using a targeted approach to case selection and data interpretation, NGS techniques can yield very timely results with high diagnostic rates and this will have important implications for both ongoing and future pregnancies.

Oral – 3

Shock Index during Immediate Postpartum Period after Uncomplicated Vaginal Delivery and Caesarean Delivery

Rohini Gaonkar, Asmita M Rathore, Madhavi M Gupta
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: There is paucity of reference range of shock index in Indian literature in obstetric population. Aims and objectives: To study reference range of SI for the obstetric population and its association with demographic factors, obstetric factors and other vital parameters.

Methods: A prospective observational study conducted on patients delivered by vaginal and caesarean section with average blood loss and gestation >34wk and excluded womens with uncontrolled hypertension, thyroid disorder, sepsis,

severe anemia, heart disease, coagulopathy and blood transfusion. 550 participants were recruited. After delivery HR, SBP, DBP, SI, PP and MAP were measured at 30mins and 2-4hrs of delivery. Quantitative data were expressed in mean ± SD and normality distribution differences between two comparable groups were tested by student's t-test. Qualitative data were expressed in percentages and statistical differences between the proportions were tested by the linear regression method and Annova test.

Results: The mean age of the participants 26±4years. Almost 83% had a normal BMI of 18.5-24.9kg/m 2. The reference range of SI obtained was 0.39-0.98, HR52-116bpm, SBP 96-160mmHg, DBP 56-100mmHg, PP range 12-78mmHg and MAP71-116mmHg. SI showed a significant association with the mode of delivery, use of an aesthetic agents and hypertension (P<0.005).

Conclusion: We recommend calculating SI in all patients in immediate postpartum, to detect the patients in compensatory and early shock. SI is a better parameter to assess the risk of severe adverse outcomes in the immediate postpartum period.

Oral – 4

Immuno-Modulatory Effects of Raised Bilirubin in Pregnancy Outcomes

Minal[1], Anoushka Saxena[2], Shakun Tyagi[1], Nirupama Trehanpati[2], Y M Mala[1]
[1]Department of Obstetrics and Gynecology, Maulana Azad Medical College and Lok Nayak Hospital,
[2]Department of Molecular and Cellular Medicine, Institute of Liver and Biliary sciences, new delhi, india

Background & objectives: Deranged liver function tests are markers of hepatic damage and inflammation. Viral hepatitis, intrahepatic cholestasis of pregnancy, gallstones and pre-eclampsia are the most common causes of jaundice in pregnancy, causing significant perinatal morbidity and mortality. Therefore, we aimed to investigate the relationship between deranged liver functions, high bilirubin and immune dysfunction during pregnancy.

Materials & Methods: A prospective observational study was done at a tertiary care hospital on antenatal patients with clinical and biochemical jaundice over one year period. Peripheral immune cell subsets were analyzed with serum bilirubin >2.0 mg/dl (N=66), positive for IgM/IgG Hepatitis E virus (N=33/66) and healthy (N=7) by flow cytometry.

Results: Females with high bilirubin levels (>2 mg/dl), N=66 were screened and presented with: asymptomatic (7.5%), deranged LFT/clinical jaundice (100%), k/c/o liver disease (9%), k/c/o hepatitis E (9%), pre-eclampsia (18%) and hepatic encephalopathy (9%). Pregnant females with high bilirubin levels showed an elevated percentage of Monocytes (p=0.0012), CD4+ (p=0.0009) and CD8+ T-cells (p<0.0001) compared to healthy. However, increased expression of inhibitory markers: PD-1, CTLA 4, BTLA, SLAM1, LAG-3, TIGIT, TIM-3 all with p<0.0001 and BLIMP-1(p=0.0008), on Transitional and effector memory subset of T-cells was evident. Compared to healthy, elevated frequency of myeloid dendritic cell population and B-cell subsets (p<0.0001) was found in cases (p<0.0001) and infected with HEV (p=0.0095), indicating immune suppression. Yet, defective activation and proliferation as suggested by diminished expression of BAFF-R (p=0.04) and APRIL (p=0.02) and rise in PDL1 (p=0.0025) was determined. Pregnancy outcomes, hepatic encephalopathy, pre-eclampsia, PPH, DIC, HELLP, Sepsis/MODS, abortion and maternal mortality were noted and correlated with immune dysfunction.

Conclusion: Our results clearly indicate that pregnant females with high bilirubin, including those infected with HEV exhibit increased suppressive T and B cells with diminished BAFFR/APRIL expressing B cells.

Oral – 5

Role of Shock Index in Predicting Maternal Outcome in Postpartum Haemorrhage

Priyanka Lader, Asmita M Rathore
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India.

Introduction: Postpartum haemorrhage (PPH) is a leading cause of maternal mortality, accounting for 27% mortality worldwide. In this study role of Shock Index (SI) was studied in early detection of adverse maternal outcome due to PPH.

Objective: To establish threshold values of SI to predict adverse maternal outcome in PPH defined as need for blood or blood product transfusion ≥ 4 units, ICU admission, surgical intervention and maternal mortality.

Methods: We conducted a prospective observational study, on 274 women diagnosed with PPH. We recorded vital signs following PPH and Initial and final set of SI were calculated. Parameters such chi square test, odds ratio and ROC analysis were used in the study.

Results: The cut off value of SI for blood product

transfusion ≥ 4 unit was 0.99, for ICU admission was 1.09 and for surgical intervention was 0.95. SI had highest AUROC for blood transfusion ≥ 4 units, ICU admission and surgical intervention, and the values were 0.92 (95% CI 0.89-0.98), 0.99 (95% CI 0.96-1) and 0.79 (95% CI 0.70-0.87) respectively compared to PR, SBP, PP and MAP. There was one maternal mortality.

Conclusions: SI ≥ 0.9 is significantly associated with adverse maternal outcome. This, study proposes an SI cut of value of 0.9 for referral to tertiary care hospital for management to reduce maternal morbidity and mortality.

Oral – 6

Glycaemic Variability and 24 Hours Ambulatory Glucose Profile in Gestational Diabetes Mellitus and its Correlation with Feto-Maternal Outcome

Anamika Baghel, Aruna Nigam, Nidhi Gupta
Department of Obstetrics and Gynaecology
Hamdard Institute of Medical Sciences and Research (HIMSAR), New Delhi

Introduction: Glycaemic variability has been shown to be deranged in diabetes mellitus and has been related to endothelial dysfunction. This concept has not been adequately studied in gestational diabetic pregnancies.

Aim: To study Glycaemic variability (GV) & ambulatory glucose profile (AGP) in GDM using Flash Glucose Monitor (FGM) and its correlation with feto-maternal outcome.

Materials & Methods: It was a cross-sectional observational study. 40 Pregnant females between 19-35 years diagnosed as GDM controlled on pharmacotherapy fulfilling inclusion criteria were recruited. 20 women with singleton pregnancies with normal OGTT were recruited as control group. FGM was used to record AGP between 32-36 weeks. Total 400 days with 38,400 glucose values in the study group and 200 days with 19,200 glucose values in control group were analysed.

Results: All the parameters of 24-hour AGP were significantly high in study group who were apparently controlled on pharmacotherapy ($p<.001$). Variables of GV: MAGE and SD were significantly high in study group ($p<0.001$) Adverse maternal and fetal outcome was 20 % and 17 % in GDM women as compared to none in control group. Time in range was 44.83 % for GDM women and 79.80 % for normoglycemic pregnant women ($p<0.001$)

Conclusion: There is a significant difference in the glycaemic variability and 24-hour glycaemic profile in apparently controlled GDM women on pharmacotherapy as compared to euglycemic healthy pregnant women which can be correlated with poor fetomaternal outcomes in these women.

Oral – 7

Mode of Delivery and Pelvic Floor Disorder Symptoms in Primi-gravida Women in Postpartum Period

Prateeksha BS, Anuradha Singh, Manju Puri
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, India

Introduction: Pelvic floor disorder is a common health, physical and social problem, which affects all ages, groups and communities. One of the main reason for women not seeking medical treatment is the embarrassment and stigma attached with PFD and lack of knowledge. The aim is to study the relationship between mode of delivery and pelvic floor disorders in primiparous women in postpartum period.

Methodology: A prospective observational study was conducted in which the study population consisted of 200 primiparous women with term singleton delivery who visited postnatal OPD. The total PFDI 20 score was calculated. The women were divided into 2 groups after delivery, NVD and LSCS groups, which were compared. In addition, evaluated using validated Hindi version of PFDI20 questionnaire.

Results: The most common PFD symptom was POP in both groups with a prevalence of 52% in NVD and 51% in LSCS groups, followed by FI symptoms, and UI symptoms in both groups. The percentage prevalence of any PFD symptoms was more in LSCS 67% as compared to 63% in the NVD group. Overweight women with BMI >28, women with prolonged duration of labour>18 hours, instrumental delivery in the vaginal delivery group, and birthweight >3 kg had the highest prevalence of any PFD symptoms at 3 months postpartum. When the odds ratio was calculated for birthweight > 3kg as a risk factor it was found that, in LSCS category women who had 3kg birthweight, had 2.67times more chances of developing PFD at 3 months PP(OR-2.679,CI lower: 0.992, upper: 7.229). For birth weight>3kg OR 2.679, CI lower: 0.992, upper:7.229)

Conclusion: There was no significant difference in the prevalence and severity of PFD in the postpartum

period with respect to the mode of delivery.

Oral – 8

Pro-calcitonin Levels in Maternal Serum and Cord Blood as Marker for Diagnosis of Early-Onset Neonatal Sepsis

Puja Yadav, Anita Rani, Neha Yadav
Department Of Obstetrics & Gynaecology, Department Of Biochemistry, Department Of Dermatology, Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Early-onset neonatal sepsis (EONS) is a clinical syndrome that presents within the first 72 hours of life. It is the leading cause of morbidity and mortality in neonates. To avoid serious and life-threatening consequences, neonates with suspected sepsis must receive early diagnosis and treatment.

Objective: To assess the diagnostic accuracy of Pro-calcitonin in maternal serum and umbilical cord blood to predict EONS.

Methods: Prospective analytical cohort study conducted over a period of 18 months, on pregnant women > 34 weeks of gestation having risk factors for EONS like premature rupture of membranes, fever 2 weeks prior to delivery, and preterm delivery.

Results: In our study, maternal and cord blood PCT were statistically significant in predicting EONS with high sensitivity and high NPV and the sensitivity was similar for both maternal and cord blood PCT, whereas the specificity of maternal PCT (98.8%) was more compared to cord blood (94%). However, there was no significant difference in the diagnostic performance of maternal pro-calcitonin and cord blood pro-calcitonin.

Conclusion: Pro-calcitonin in both maternal, as well as cord blood, is a promising biomarker to detect EONS. The sensitivity and specificity of PCT in our study were quite high, so we can safely rule out infants without infections and withhold irrational antibiotics thereby preventing their deleterious effects in neonates.

Oral – 9

Substance use during Pregnancy and its Effects on Mother and Fetus

Divya Meena, Madhavi M Gupta, Ashish Jain, Asmita M Rathore
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India.

Introduction: Perinatal substance use like alcohol, tobacco and illicit drugs is a major public health problem and is associated with several deleterious maternal and fetal outcomes.

Objective: To study the prevalence and outcome of substance use amongst women delivering in tertiary care centre.

Methods: This was a cross- sectional study including 2500 (n) delivered women. Information was collected with the help of a predesigned structured proforma. The data included demographic details, antenatal history, delivery details, baby details and details of substance if consumed in any form

Results: In our study, a total of 32 women were active substance users leading to a prevalence of 1.28%. Among the substance users, 1.08% used tobacco while the 0.2% used other substances. Among tobacco users, 1.04% used smokeless tobacco while the remaining 0.04% smoked cigarettes. Previous spontaneous abortion (p value= 0.014) and low APGAR at 5 minutes (p value = < 0.001) was found to be significantly associated with different forms of exposure.

Conclusions: Prevalence of substance use during pregnancy is less in our study as compared to previous studies. Our aim should be to focus and incorporate awareness regarding substance use during pregnancy especially smokeless tobacco. In addition, any programme developed must involve the husband and the family.

Session - 3 (Benign Gynaecology)

Oral – 1

Addressing the Adenomyosis Enigma: A Clinico-Pathological Co-Relation

Pankhuri Jain, Anjali Choudhary
SGRRIM & HS, Patel Nagar Dehradun, Uttarakhand, India.

Introduction: Adenomyosis is a complex pathological entity that affects the uteri of women in their reproductive years. Characterized by the presence of active endometrial tissue in the myometrial layer of the uterus - either diffuse or focal- it can cause abnormal uterine bleeding, dysmenorrhea, dyspareunia, deep pelvic pain and backache.

Objective: To find out the occurrence of adenomyosis in hysterectomized specimens of the uteruses, and to correlate it to the severity of symptoms.

Methods: In this retrospectively study during year

April 2019-2020, we searched records of women who have undergone hysterectomies, for various indications, in the year of the study to understand the incidence of adenomyosis and correlate it to their clinical presentation.

Results: Out of 146 cases in the study period, 41.78% of patients had histopathological evidence of adenomyosis. Adenomyosis on HPE was found in 7 out of 25 women operated for prolapse uterus,12 out of 55 women operated for fibroid, and three out of 12 women operated on for endometrial causes. Only 80% of women with a preoperative diagnosis of adenomyosis showed histopathological features of adenomyosis, and 20 % had no evidence of the condition. As per histopathological elements of adenomyosis, only 21 women had a preoperative diagnosis of the condition.

Conclusion: Most of the time, the definitive diagnosis of adenomyosis is retrospective by histopathological examination of hysterectomy specimens. The presence of adenomyosis, as seen on histopathological examination of the uterus, does not always match the clinical presentation.

Oral – 2

Correlation of Obesity Indices and Inflammatory Markers with Severity of Lower Urinary Tract Symptoms in Females

Priyanka Singrore, Monika Gupta
Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

Introduction: In recent decades, there has been a dramatic increase in obesity around the world. There is growing evidence that obesity may be one of the key etiological factor of metabolic syndrome-induced inflammation and other severe health problems including lower urinary tract symptoms (LUTS).

Objective: To study the correlation between obesity indices and inflammatory biomarkers with severity of lower urinary tract symptoms in females.

Material and method: 200 women >18 years of age presenting with LUTS were enrolled in this cross sectional study after satisfying inclusion and exclusion criteria. LUTS includes storage, voiding and post micturition symptoms. Obesity indices (BMI, waist circumference and WHR) and serum inflammatory marker (CRP and IL6) were measured. ICIQ FLUTS questionnaire used to assess the severity of LUTS and subjects were divided into mild, moderate, severe and very severe according to the score obtained.

Results: Mean age of our study population was 43.65 ± 9.20 yrs. We found a strong positive correlation with hsCRP levels (rho = 0.83, p = <0.001) and moderate positive correlation with IL6 levels (rho = 0.46, p = <0.001), BMI (rho = 0.39, p = <0.001), WC (rho = 0.48, p = <0.001) and WHR (rho = 0.46, p = <0.001) and this correlation was statistically significant.

Conclusion: The obesity indices like BMI, waist circumference and WHR are positively correlated with symptom severity of LUTS in Indian population. In addition, serum inflammatory biomarkers like hsCRP and IL-6 are moderate to strongly correlated with severity of LUTS.

Oral – 3

Diagnostic Evaluation of Unexplained Infertile Women for Chronic Endometritis by Endometrial Histopathology and Immunohistochemistry

Mahua Das, Rashmi, Narendra Pal Singh
University College of Medical Sciences and Guru Teg Bahadur Hospital, New Delhi, India

Introduction: Wide variety of unexplained infertility is due to Chronic Endometritis (10- 66%). Diagnosis is based on detection of plasma cell infiltration in the endometrial stroma on histopathology. IHC staining for CD 138 improves the sensitivity.

Objective: Percentage of chronic endometritis among Indian unexplained infertility by endometrial histopathology and immunohistochemistry.

Methods: 75 study subjects were enrolled in the study. Endometrial biopsy was taken in late follicular phase. The biopsy tissue was sent for histopathological examination for detection of plasma cells, for common bacterial cultures and for GeneXpert for detection of endometrial tuberculosis. The patients diagnosed with chronic endometritis were given antibiotic treatment according to the microbial cultures.

Results: 12.2% cases (9/75) of unexplained infertility were diagnosed as chronic endometritis out of which 2 cases were diagnosed by routine histopathology and additional 7 cases were diagnosed by immunohistochemistry CD138. Detection by IHC CD138 was found to be much higher than routine HPE and the difference was statistically significant (12.2% versus 2.7%, p value = 0.008). Endometrial culture was positive in all CE patients showing growth of common organisms who received

antibiotics according to the culture. One patient was diagnosed with TB endometritis.

Conclusions: We detected chronic endometritis on endometrial biopsy in 12.2% of the unexplained infertility cases in Indian population. Immunohistochemistry for CD138 was found to be much superior to routine histopathology in diagnosing chronic endometritis. Tubercular endometritis was detected in only one case (1.3%) in our study population.

Oral – 4

Is Ovarian Reserve Associated with Body Mass Index and Obesity in Infertile Women? A Cross Sectional Study

Vidushi Gupta, Leena Wadhwa
ESI-PGIMSR, Basaidarapur, New Delhi, India

Introduction: Obesity is recognized chronic disease with increasing prevalence and almost a fourth of Indian women are overweight or obese. Various molecular and endocrinological mechanisms elaborate the interplay between obesity and reduced fertility.

Objectives: To find the correlation between BMI and ovarian reserve among infertile women.

Material and Methods: This cross-sectional study was conducted for 18 months among 202 infertile women between 21-45 years attending infertility clinic at Department of Obstetrics and Gynaecology, ESIPGIMSR, Basaidarapur, New Delhi, after excluding diagnosis of tubo-ovarian mass, PCOS, endometrioma or history of ovarian surgery. Ethical clearance was taken from institutional ethical committee. Informed written consent was obtained. Height (centimetre), weight (kilograms) was measured, BMI was calculated. For ovarian reserve estimation, bilateral ovarian volume and antral follicular count were measured using TVS and blood tests for S.FSH, S.Estradiol and S.AMH were performed on day 2-3 of menstrual cycle. The data was entered systematically into excel worksheets and appropriate statistical tests were applied.

Results: Mean age of infertile women was 30.6±4.66 years (21-39 years). Mean BMI was 23.8-±3.87 kg/m2 (15.60 - 39.67 kg/m2). 58.91% women were overweight or obese Women had low ovarian reserve according to S.FSH (10.13±9.16 IU/ml) and total AFC (7.59±3.51). Negative correlation was found between BMI, AFC and ovarian volume (r= -0.158, p=0.025), (r= -0.240, p=0.001). 73.33% underweight, 45.95% overweight and 44% obese infertile women had low ovarian reserve.

Conclusion: Infertile women have low ovarian reserve at a younger age of 30 years. Both increase and decrease in BMI has a negative impact on ovarian reserve of women

Oral – 5

Preoperative Management of HMB due to leiomyoma with Depot Leuprolide and Oral Norethisterone: A Randomized Control Trial

Geetanjali, Ratna biswas
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, India

Introduction: Medical management of uterine leiomyoma is indicated in preoperative control of heavy menstrual bleeding. The ideal treatment is one that controls symptoms and improves hemoglobin fast to attain preoperative fitness.

Objectives: To compare the number of women who attain Pictorial Blood Assessment Chart) score of ≤50 and increase in haemoglobin of 1 gm % and 2 g% and reduction in myoma volume by >15% and >25 % after 1st and 2nd treatment cycle in both groups.

Methods: 60 women with HMB and leiomyoma were randomised into two groups; Group A received depot leuprolide 3.75mg IM, Group B received oral norethisterone 5mg for 21 days. PBAC score, Hb and myoma volume were recorded at recruitment, after 1st and 2nd cycle.

Results: Percentage fall of PBAC score was significantly more in Group A ($p<0.007$) after 2 months of treatment whereas percentage increase in Hb and reduction in myoma volume was insignificant. 72.4% in Group A Vs 40% in Group B achieved PBAC score of ≤ 50 and increase in Hb of 2 gm% after 2nd treatment cycle ($p<0.002$). 65.5 % in Group A Vs 33.3 % in Group B had reduction of myoma volume ≥25 % after 2nd treatment cycle (p 0.013)

Conclusion: Injection Leuprolide is more effective in control of myoma induced heavy menstrual bleeding and can be considered as standard of care though norethisterone is also an effective alternative.

Oral – 6

Evaluation of Young Girls with Delayed Menstrual Cycles and Identifying the Population at Risk

Nutan, Singh A, Mahey R, Kachhawa G, Manchanda S, Bhatla N
All India Institute of Medical Sciences (AIIMS), New Delhi,

India

Introduction: There are significant variations seen in the menstrual cycles in adolescence and the association between obesity, hyperandrogenism and metabolic risks is evident in adolescence, which strengthens the importance of noting menstrual disorders at an early age.

Aims & Objectives: To evaluate the correlation of various hormonal and metabolic factors in girls with delayed menstruation.

Material & Methods: In a cross-sectional study, 100 consecutive girls aged 14-21 years with delayed menstrual cycles underwent hormonal and metabolic profiles. The study subjects were divided into four groups based on cycle length as ≤60, 61-90, 91-120, and >120days.

Results: The mean age of girls was 19.3±1.89 years and the mean age of menarche was 12.74 ± 1.43 years. Out of 100 girls, 3% were diagnosed with hyper-gonadotropic hypogonadism, 2% had late-onset congenital adrenal hyperplasia, 62.8% fulfilled the AES criteria for PCOS, and 36.8% had oligo-menorrhea with or without polycystic ovarian morphology. The mean arterial pressure (p=.049), BMI (p=.025), and Global acne score (p=0.020) were more in girls with >120 days cycle length, however, the waist-hip ratio (p=0.613) and the modified Ferriman-Gallwey score (p=0.580) were similar across the groups. Girls with cycle length >120 days had higher fasting blood sugar (p= .002), TSH (p=0.001), and AMH (p=0.019) while HOMA-IR and lipid profiles were similar across the groups. Serum LH (p=0.711) and FSH (p=0.741) had shown an increasing trend across the groups. At 6 months of follow-up, girls with a cycle length of 60 days increased from 46% at the start to 87% while girls with >120 days cycle length still had menstrual cycle length of >90 days.

Conclusion: Our study concluded that adolescent and young girls with cycle length ≤60 days can be managed expectantly and should be advised lifestyle modification while girls with more delayed cycle length >120 days require follow-up for long-term complications as they have a deranged metabolic and hormone profile.

Oral – 7

Uro-Gynae Evaluation in Postmenopausal with Lower Urinary Tract Symptoms (LUTS)

Neha Bharti, Monika Gupta
Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Menopause is defined as the cessation of menstrual periods for at least 12 consecutive months and not due to physiologic (e.g. lactation) or pathologic causes. LUTS is defined as the subjective indicator of a disease or change in condition perceived by the patient.

Objective: To study the prevalence of urogynaecological disorders in postmenopausal women presenting with LUTS and the correlation of pelvic floor anatomy and muscle strength with severity of LUTS.

Methods: The study was a cross sectional with sample size 179, was conducted in the Department of Obstetrics and Gynecology in collaboration with Department of Urology.

Results: Most prevalent uro-gynaecological disorder was pure wet OAB followed by mixed urinary incontinence, pure dry OAB, Pure SUI and Voiding dysfunction. There was a moderate positive correlation between Genital Hiatus and severity score of LUTS and this correlation was statistically significant. Digital evaluation of Pelvic floor muscle strength showed moderate negative correlation with severity score of LUTS and this correlation was statistically significant. As per Perineometer assessment of PFM strength, vaginal resting tone, vaginal squeeze pressure, rectal resting tone and rectal squeeze pressure showed a moderately negative correlation with severity score of LUTS and this correlation was statistically significant.

Conclusions: Since postmenopausal women are most neglected age group in terms of healthcare, urogynaecologists and practitioners need to be aware about the prevalence of various urogynaecological disorders. They should also take care that the pelvic floor anatomy and strength are thoroughly evaluated during clinical examination in patients presenting with LUTS.

Oral – 8

Association of Novel Markers with Anthropometric Parameters and Cardiovascular Risk Indicators in Women with and Without PCOS - Cross Sectional Comparative Study

Purnima Kiran Gautam, Pikee Saxena
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, India

Introduction: Fetuin a is a hepatokine and adipokine and plays a role in insulin regulation. Kisspeptin is an important mediator of gonadotropin releasing hormone secretion, the onset of puberty, sex hormone mediated feedback, and adult fertility.

Copeptin is a 39 amino acid glycopeptide and is associated with insulin resistance and diabetes mellitus.

Objective: To evaluate the relation of novel markers with anthropometric and cardiovascular parameters in women with and without polycystic ovarian syndrome.

Material and method: Cross sectional, comparative study 180 infertile women with and without PCOS (90).

Results: Fetuin a (<0.001), kisspeptin(<0.002) and copeptin(<0.001) were significantly higher in women with PCOS than controls. There were a positive correlation between serum Fetuin a and carotid intima media thickness (p<0.001), Hb1ac (p<0.027), and testosterone (p<0.001). Serum Kisspeptin was significantly higher in PCOS women and correlated positively with LH (p<0.006), testosterone (p<0.001), WHR (p<0.044) and PPBS (p<0.043). The serum Copeptin levels of PCOS subjects were higher and had positive correlation with HbA1c (p<0.027) and testosterone level (<0.001) .Carotid intima media thickness (CIMT) was significantly higher in PCOS as compared to control group. (p<0.001). Total cholesterol (<0.001), FBS (<0.001), PPBS (<0.001), insulin postprandial (<0.007) and systolic blood pressure (<0.008) were higher in PCOS groups than controls.

Conclusion: High Fetuin a, kisspeptin and copeptin in PCOS subjects has a role in glucose metabolism and energy may play a crucial role in pathogenesis of PCOS. As these novel markers play a crucial role in pathophysiology of PCOS.

Session - 4 (Maternal and Fetal Medicine)

Oral – 1

Role of NT-proBNP for Prediction of Feto-maternal Outcomes in Preeclampsia with Severe Features

Soni Kumari, Renu Arora, Anita Rani
Vardhman Mahavir Medical College & Safdurjung Hospital, New Delhi, India

Introduction: Preeclampsia with severe features complicates 3-10% of pregnancies and is major contributor of maternal morbidity and mortality. Hypertensive disorders of pregnancy accounts for nearly 30,000 maternal deaths annually. 30% of all maternal near-miss events are due to pregnancy hypertension.

Objective: To compare the serum levels of NT-proBNP in preeclampsia with severe features and normotensive pregnancy and to study its association with fetomaternal outcomes.

Methods: Case control study was conducted enrolling 90 patients, 45 constituting preeclamptic women with severe features and 45 normotensive pregnancy. Venous blood collected in EDTA vial for measurement of NT-proBNP by ELISA technique. Patients were managed according to hospital protocol. Fetomaternal outcomes were correlated with NT-proBNP levels.

Results: Cases had higher mean NT-proBNP of 1188.09±409.29 pg/ml compared to normotensive pregnancy (360.13±211.58 pg/ml). NT-proBNP correlated with fetomaternal outcomes during antepartum, intrapartum and postpartum period. Higher NT-proBNP was associated with SBP (p<0.001), DBP (p<0.001), lab parameters (SGOT, SGPT, serum creatinine, blood urea and serum potassium levels) during antepartum period. Mode of delivery (p<0.001), higher caesarean section rates (p<0.001) and intrapartum complications (p=0.019) in intrapartum and persistence of high BP (p<0.001)), need for anti-hypertensive medications to control BP post-delivery (p<0.001) and development of chronic hypertension (p=0.006) were associated with maternal serum NT-proBNP levels during antepartum period. Higher maternal NT-proBNP was associated with poorer Apgar score (p<0.005), NICU stay (p<0.001) and fetal death (p=0.006).

Conclusion: NT-proBNP can be used in preeclampsia women with severe features to predict disease severity and fetomaternal outcomes.

Oral – 2

Middle Cerebral Artery Pulsatility Index for Prediction of Successful induction of Labor in post-dated Pregnancy

Yashi Nagar, Rekha Bharti, Kajal Baleja, Amita Malik, Divya Pandey, Jyotsna Suri
Vardhman Mahavir Medical College & Safdurjung Hospital, New Delhi, India

Introduction: Uncertainty regarding outcome of induction of labor is associated with anxiety in the women planned for labor induction. Middle cerebral artery pulsatility index (MCA PI) used for prediction of fetal outcome has been found to be a good predictor of successful induction of labor (IOL), in women with postdated pregnancy. It yields a high positive likelihood ratio for vaginal delivery after IOL.

Objective: To evaluate Middle cerebral artery pulsatility index as a predictor of successful induction

of labor in postdated pregnancy

Methods: This was a prospective observational study done on 290 nulliparous women with singleton postdated pregnancy admitted in obstetric wards for IOL. After detailed history and examination, pervaginal examination for Bishops score and transabdominal ultrasound for fetal MCA Doppler was done. Women were followed for progression to active labor and mode of delivery was noted.

Results: Out of 296 women enrolled in the study, 285 women (96.28%) had successful IOL, and 98.59% women with successful IOL had vaginal delivery. Mean MCA PI was significantly lower in women with successful outcome of IOL than in women with failure of IOL, 1.23 ± 0.11 and 1.74 ± 0.05, respectively, p<0.001. At a cut off of <1.67, MCA PI for prediction of successful IOL had a sensitivity, specificity, PPV, NPV, and Diagnostic accuracy of 100%, 99%, 84.6%, 100%, and 99.3%, respectively.

Conclusions: MCA PI is a good predictor of successful induction of labor in nulliparous women with postdated pregnancy.

Oral – 3

NT-proBNP as a Novel Marker for the severity of Hypertensive Disorders in Pregnancy

Vandana N A, Shakun Tyagi, Y M Mala, Bhawna Mahajan
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Introduction: Preeclampsia has a complex pathophysiology, the primary cause being abnormal placentation leading to defective uteroplacental blood flow. Plasma levels of NT-proBNP are increased in women with hypertensive disorders and have been reported to be associated with early onset or severe disease. Therefore, the purpose of this study is to study the NT-proBNP levels in pregnant women with hypertensive disorders in pregnancy.

Objective: To correlate NT pro-BNP and urinary protein levels in women with hypertensive disorders of pregnancy and correlate its levels with maternal and fetal outcome.

Methods: Prospective study including 50 cases with hypertensive disorders and 50 controls without hypertensive disorders matched for the period of gestation were enrolled in the study. A detailed history was taken and routine clinical examination was done, preeclampsia profile was sent and NT-proBNP was determined.

Results: NT-proBNP levels were significantly higher in cases (p<0.001) and the levels were significantly high with preeclampsia with severe disease. We found positive correlation between NT pro-BNP levels and urinary protein with correlation coefficient of 0.679 which was statistically significant (p<0.001). The incidence of induction of labour, emergency cesarean section (p<0.001), preterm delivery (p<0.001), low birth weight (p<0.001), NICU admission were statistically significant in cases.

Conclusion: There was significant association of NT-proBNP levels with hypertensive disorders, as the severity of hypertension increases the levels on NT-proBNP increased. These levels can be used to predict the future adverse cardiovascular events due to strain on the heart caused by fluid overload, which occurs in hypertensive disorders in pregnancy.

Oral – 4

Evaluation of New Innovation: Continuous Glucose Monitoring v/s Self-Monitoring of Blood Glucose for Management of Pregnant Diabetic Women on Insulin

Gunjan, Pikee Saxena
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, India

Introduction: Patient satisfaction is the most important tool for determining treatment adherence in achieving normoglycemia. Self-monitoring of blood glucose is the conventional method for glycemic monitoring. This gives only a snapshot of blood glucose; hence, several episodes of hypoglycemia and hyperglycemia may be missed. Flash glucose monitoring is a new innovative method, which is being used for capturing continuous glucose profile of the patient for 14 days without any pain or inconvenience.

Objective: To compare FGM vs SMBG for achieving normoglycemia**,** patient satisfaction by using diabetes treatment satisfaction questionnaire (DTSQ) in both groups and fetomaternal outcomes in both group.

Material and method: Randomized controlled trial included 70 recruited pregnant women who were randomized into two groups of 35.

Results: There was significant improvement in average percentage of time in range (p<0.001), time in hyperglycemia (p=0.113) and time in hypoglycemia (p =0.002) in FGM group. DTSQ score were significantly higher for 7 out of 8 parameters in the FGM group (p<0.001). Fetomaternal outcomes were comparable in both group.

Conclusion: Patient satisfaction was significantly more in FGM group where women were educated and trained by graphical representation of their

glycemic status and it helps to improve time in range and avoid hypoglycemia and hyperglycemia. It could become an important tool for patient education in each trimester along with SMBG.

Oral – 5

Maternal Near Miss in a Tertiary Care Hospital: A Retrospective and Prospective Observational Study

Ankita Chonla, Sangeeta Gupta, Deepti Goswami
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Introduction: Maternal mortality has been a very important maternal health indicator although it is frequently described as "just the tip of the iceberg". Little attention has been given to the near miss obstetric events. This study attempts to analyze the MNM cases in our tertiary care hospital.

Objective: To study the prevalence and clinical profile of Maternal Near Miss in a tertiary care center and evaluate the underlying disorders, contributory factors and sociodemographic variables among maternal near miss cases.

Methods: This observational study was undertaken for a period of one year. The data for the study was collected both retrospectively and prospectively from January 2019 to December, 2021.The collected data was entered in Microsoft Excel and was analysed and statistically evaluated using SPSS-25 version. Quantitative data was expressed by mean and qualitative data was expressed in percentage.

Results: A total of 23 cases were recruited in the study. There were 7064 live births. Near miss ratio was 3.25 per 1000 live births. Near miss to mortality ratio was 0.38:1. Mortality index was 71.95%. The most common cause of near miss and mortality was haemorrhage and hypertensive disorders, respectively.

Conclusion: Lessons can be learned from near miss cases, which can serve as a useful tool in reducing maternal mortality ratio.

Oral – 6

Can SFLT-1 /PLGF Ratio Help in Triaging Patients in Second Trimester with High Risk Factors of Preeclampsia and Help Us in Improving Maternal Outcomes

Preeti Singh, Anita Kaul
Apollo Centre Fetal Medicine, Sarita Vihar, New Delhi, India

Introduction: Preeclampsia contributes to both perinatal and maternal mortality and morbidity, as well as preterm birth. It remains unclear whether a measured SFLT-1/PLGF ratio in early pregnancy and mid pregnancy, well before the onset of clinical signs of PE, is predictive of who will develop PE.

Objective: To assess whether SFLT /PLGF ratio in second trimester can predict preeclampsia early in patients with high risk factors for preeclampsia and can further help in triaging them in order to improve maternal fetal outcomes.

Methods: The database of our ultrasound laboratory was searched retrospectively for cases who had high risk factors for preeclampsia who had undergone preeclampsia screening in second trimester between 2017 and 2022. Twenty-Five patients were included. Various parameters were recorded during preeclampsia screening were clinical history, mean blood pressure, mean uterine, SFLT-1/PLGF ratio. Clinical outcomes included those who developed PE, timing of PE onset or severity and SFLT-1/PLGF ratio were correlated.

Results: Out of 25 patients, 24 had delivered and one of them is an ongoing 32 weeks pregnancy. A total of five patients had developed preeclampsia, of which four had developed preterm preeclampsia (<32weeks) and one had term preeclampsia. On correlating the SFLT /PLGF ratio among these five pregnancies it was found that SFLT /PLGF ratio value >38. It was observed that higher the value of SFLT / PLGF ratio worse was maternal and fetal outcome.

Conclusion: The SFLT-1/PLGF ratio elevated levels before 28 weeks' gestation can aid in the identification of women who will or who will not develop PE and triage them accordingly.

Oral – 7

Third Trimester Obstetric Ultrasound for Risk Stratification of Fetuses with Estimated Fetal Weight less than 40th Centile

Sakshi Nischal, Sumitra Bachani
Vardhman Mahavir Medical College & Safdurjung Hospital, New Delhi, India

Introduction: Small-for-gestational age (SGA) infant accounts for almost 46.9% of Low birth weight (LBW) infants, constitutes a major contributor to adverse perinatal outcomes. Management protocols for growth-restricted fetuses are specified however, no protocols are defined for fetuses with estimated fetal weight (EFW) between 3rd - 10th centile with

normal maternal and fetal Doppler. Studies have reported adverse perinatal outcomes in this group.

Objectives: To stratify fetuses with EFW less than 40th centile by obstetric ultrasound into low, intermediate and high risk categories and study the perinatal outcomes.

Methods: Prospective observational cohort study conducted on 280 antenatal women between 35 to 36+6 weeks gestation with singleton fetus. An ultrasound biometry and doppler was performed, estimated fetal weight (EFW), Umbilical artery and Middle cerebral artery pulsatility index calculated. Women were risk stratified based on these parameters into high (3rd -10th centile) intermediate (10th -20th centile) and low risk (20th -40thcentile) group and monitored until delivery. Labor and neonatal outcomes documented.

Results: We observed 100%, 76.8% and 13% neonates were SGA in high, intermediate and low risk group respectively and NICU admissions occurred in 32.5%, 12% and 3.8% neonates respectively. The cut-off of EFW of 2122g or lesser has a 80% sensitivity and 70% specificity to predict NICU admissions of these fetuses.

Conclusion: A single third trimester ultrasound with Doppler measurements done at 35-36 weeks is an important adjunct to identification and risk stratification of singleton foetuses. The foetuses in intermediate group comprises an important cohort, which needs timely monitoring and delivery.

Oral – 8

Innovative Technique of Amniotic Fluid Index (AFI) measurement by two pockets and establishing normal values in Level 1 (11-13+6 Weeks) Ultrasound and Correlation of AFI to Congenital Malformation

Nutan Agarwal, Priyanka Jaiswal, Kanukolanu B Shekhar, Ashutosh Gupta
Department of Obstetrics and Gynaecology, Artemis Hospital Gurgaon

Introduction: There is no simple technique to measure AFI and its normal values for level1 scan. It is documented as adequate or inadequate. Measuring by 2 pockets can be feasible at this time as uterus is small.

Objective: To measure AFI in level 1 scan by two vertical pockets of AF and find normal levels. To correlate AFI values to risk of fetal malformations.

Methods: Prospective observational study was conducted on 300 pregnant women, recruited at time of level1 scan. AFI was measured by two vertical pockets in upper and lower segments of uterus. Nuchal, Intracranial translucency (NT and IT) were noted. Parameters were correlated to occurrence of malformations.

Results: Mean AFI in level 1 Scan (11-13+6 weeks) was 5.29±0.8 (3.5-8.4). It was 5.19±0.9at11-<12, 5.27±0.8at12-<13 and 5.47±0.7at13-<14 weeks. Rise of AFI was 0.8/1mm CRL. AFI was 4.8±0.7 in higher risk (21) cases vs 5.2±0.7in low risk (p=0.2), 4.1 below 10th percentile and 7.02 above 90th. Mean IT was1.2mm, NT was 0.68. NT increased 0.02mm/1mmCRL and IT 0.01mm/1mmCRL. In high risk, NT was higher but IT was lower.

Conclusion: AFI measurement by two vertical pockets is feasible simple and reliable method at level 1 scan. AFI level value of 5 can be taken as normal at this time. Lower level of AFI and IT with higher of NT are associated with risk of developing anomalies. IT less than 50% of NT can be a predictor of chromosomal or structural abnormalities.

Abstracts of Oral Paper Presentation on 13 November, 2022

Session - 5 (Gynae Endoscopy and Miscellaneous)

Oral - 1

Comparing the Effect of Laparoscopic Salpingectomy Using Harmonic versus Bipolar Energy on Ovarian Reserve in Patients with Hydrosalpinges: A Parallel Two Arm Randomized Controlled Trial

Avir Sarkar, Rinchen Zangmo, Prof. Kallol K. Roy, Perumal Vanamail
All India Institute of Medical Sciences, New Delhi, India

Introduction: Hydrosalpinges are relatively common in women with tubal factor infertility undergoing In-Vitro Fertilization (IVF). The prevalence of hydrosalpinges is around 30%. Prophylactic salpingectomy in women with hydrosalpinges has recently been shown to be beneficial in terms of increased pregnancy and live birth rates after IVF. However, the effect of salpingectomy on ovarian function has been debated and the results

of previous published studies are not entirely in consensus. The close anatomical association of the vascular and nervous supply to the Fallopian tubes and ovaries constitutes the rationale for the risk of impaired ovarian function after surgery.

Methods: It was a Randomized Controlled Trial conducted in the division of Minimally Invasive Gynecological unit of AIIMS, New Delhi. We compared the effect of Harmonic device versus Bipolar energy source used for salpingectomy on Ovarian Reserve. A total of 66 women with infertility and hydrosalpinges were recruited. Baseline ovarian reserve was checked in all women by a Day 2-4 FSH, AMH and AFC by transvaginal ultrasound. The participants were randomized into Group 1 where salpingectomy was done with Harmonic device and Group 2 where Bipolar Energy was used. Post-salpingectomy, ovarian reserve was again checked at 6-8 weeks later.

Results: Baseline parameters were comparable between the groups. Mean duration of hospital stay was also comparable. Although decline in ovarian reserve was noted in both the groups, however Harmonic was associated with lesser decline.

Conclusion: Harmonic assisted salpingectomy is associated with lower decline in ovarian reserve compared to Bipolar Energy source (Ovarian Friendly).

Oral – 2

Efficacy of Laparoscopic Davydov's Vaginoplasty in Patients with Absent Vagina: A Follow up Study

Manasi Deoghare, Bhawna Arora, Garima Kachhawa, Reeta Mahey, Neerja Bhatla
All India Institute of Medical Sciences, New Delhi, India

Introduction: Women with primary amenorrhoea with vaginal agenesis require creation of neovagina. One of the ways to create neo-vagina is laparoscopic Davydov's vaginoplasty.

Objective: To assess outcomes of laparoscopic Davydov's vaginoplasty in patients with vaginal agenesis.

Methods: This is a case series of 18 women who underwent laparoscopic Davydov's vaginoplasty. Operating time, post-op vaginal length and sexual dysfunction in post of period were assessed.

Results: Mean age at presentation was 16.61+/- 2.38 years and the mean age at surgery was 23.94 +/1 13.44 years. Out of 18 women, 16(88.8%) patients had MRKH syndrome and 2(11.2%) had 46 XY DSD. Two patients with MRKH had single kidney while One had rudimentary uterine horn who underwent rudimentary horn excision along with vaginoplasty. Clitoroplasty and gonadectomy were done in cases with 46XY DSD as additional procedures and HRT given. The pre-operative and postoperative vaginal length were 0.69 +/- 0.76 cm and 6.72 +/- 1.32 cm respectively and operating time for vaginoplasty was 101.33 +/- 19.80 mins. The mean follow up period was 43.44 +/- 23.98 months. Out of 18 women, 13 were married and experienced satisfactory coitus with no dyspareunia. Of unmarried women, 1 had vaginal stenosis at 6 months follow up.

Conclusion: Laparoscopic Davydov's procedure is a safe and effective approach for creating neovaginas in women with vaginal agenesis.

Oral – 3

Minimally Invasive Surgical Management of Postpartum Pyoperitoneum: Our Experience

Arifa Anwar Elahi, Aruna Nigam
Hamdard Institute of Medical Sciences and Research (HIMSAR), India

Introduction: Pyo-peritoneum is one of the life-threatening conditions in the postpartum period having high maternal morbidity and mortality. Timely surgical intervention in the form of thorough peritoneal lavage along with good antibiotic cover is the mainstay of treatment in these cases. This management is usually done by laparotomy.

Case Series: We present a series of five cases of postpartum pyo-peritoneum, which have been managed laparoscopically in last 3 years with successful post-operative outcome. Out of these five cases, three developed pyo-peritoneum after vaginal delivery and two after caesarean section. All patients presented with fever, abdominal distension, pain abdomen and inability to pass flatus within 7 to 22 days of delivery. Clinical examination and investigations (USG abdomen/CT abdomen) were suggestive of ascites or loculated collection along with bowel adhesions. Laparoscopic extensive peritoneal lavage was performed by placing the one central supra-umbilical port and 2 ipsilateral and one contralateral port. Flimsy adhesion was broken in upper abdomen as well as lower abdomen and pelvis using blunt suction tip and lavage continued until the clear aspirate was obtained. All the patients drained around 1.5 to 3 litre of frank pus, which was sent for culture also. Two intraperitoneal drains were left through lower side ports i.e paracolic gutters and

POD under direct vision. Post-operative antibiotic was continued and changed according to the culture report. None of the patient needed laparotomy or had bowel injury. All recovered successfully with no post-operative complications.

Conclusion: This case series suggests that laparoscopic management is a safe procedure in the hands of expert laparoscopist with added advantage of 360-degree examination and lavage, placement of drain from the port side, avoiding laparotomy scar, reduced morbidity, hospital stay and economic burden.

Oral – 4

Total Hysterectomy with Bilateral Salpingectomy; Effect on Ovarian Reserves: A Prospective Observational Study

Tasneem Jahan, Debasis Dutta, Deepak Chawla, Kanika Jain
Sir Gangaram Hospital, New Delhi, India

Introduction: This was a prospective observational study, which was undertaken with the aim to determine the effect of laparoscopic hysterectomy with bilateral salpingectomy on ovarian reserves. The assessment of ovarian reserve parameters would help us in deciding if the retained ovaries would actually be able to maintain the hormonal balance till the natural age of menopause or, whether the patients would require additional hormone replacement therapy (HRT) after the surgery. The various outcomes that were studied were: the serum AMH levels (in ng/mL), pulsatility index (PI) & resistance index (RI) of the ovarian stromal blood flows by Transvaginal ultrasound within 15 days pre-operatively and 3 months post-operatively.

Objectives: To assess the effect of Laparoscopic Hysterectomy with Bilateral Salpingectomy on ovarian reserves in premenopausal women based on serum Anti Mullerian Hormone levels. In premenopausal women, to assess the effect of Laparoscopic Hysterectomy with Bilateral Salpingectomy on Ovarian Doppler blood flows.

Methodology: It was a prospective Observational Study. Premenopausal women between 35-50 years age undergoing TLH with bilateral salpingectomy for benign conditions with no history of ovarian pathology. In all these patients, baseline characteristics and ovarian reserve parameters were recorded within 15 days before and subsequently 3 months after surgery. On days 2 to 5 of menstrual cycle, AMH levels were measured in the serum sample and a Transvaginal ultrasound examination were performed to determine PI & RI of the ovarian stromal artery. All examinations were conducted during the follicular phase of the menstrual cycle in the afternoon. The examination were done by the same observer in order to eliminate the investigator bias. In hysterectomized women, the follicular phase was determined by the absence of both a dominant follicle and corpus luteum on ultrasound. Doppler ultrasonography of the ovarian stromal arteries was done at the follicular phase of the menstrual cycle because flow is reduced and similar in both ovaries during this period.

Results: There was no statistically significant difference noted in the pre-operative and post-operative values of AMH levels (p-value of 0.102). Similarly, no statistically significant changes could be observed in the Right ovarian blood flow [Pulsatility Index ($p = 0.884$), Resistance Index ($p = 0.180$)] and in the left ovarian blood flow [Pulsatility Index ($p = 0.484$), Resistance Index ($p = 0.465$)].

Conclusion: Prophylactic salpingectomy done for benign hysterectomies did not decrease ovarian reserves significantly as measured by serum AMH levels and ovarian stromal blood flow indices i.e. PI & RI preoperatively and postoperatively. Thus, indicating that routine salpingectomy along with preservation of ovaries should be a norm in premenopausal women.

Oral –5

Pattern of Progression of Labor in Indian Women at a Tertiary Care Centre

Lekshmi S A, Krishna Agarwal
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Introduction: The anthropometric and demographic characteristics could vary among different population groups, which could modify the labor duration of that population. Hence following Friedman's rate of cervical dilation and the WHO partograph there could be more caesarean sections. There is paucity of studies on Indian population therefore, this study was planned. Various organizations provide different recommendation on oral intake during labor. There are no clear uniform guidelines so far. This study was so taken up to assess the satisfaction of oral intake in labor with labor progression rates.

Aims: To estimate the average rate of cervical dilatation, from onset of labor until 4 to 6 cm dilatation and after 4 to 6 cm dilatation till full

dilatation of cervix and to find out the subjective perception regarding satisfaction of oral intake during labor and its effect on cervical dilation rates and duration of labor.

Methods: It was a prospective observational study including women at term gestation undergoing spontaneous vaginal delivery. The labor progression details were noted. The participants were asked about their satisfaction of oral intake during labor.

Results: The mean rate of cervical dilation was 0.59 ± 0.54 cm/hour in the latent phase and 1.53 ± 1.26 cm/hour in the active phase in the primigravidas. Only 6.7% of primigravida and 25% of multigravida were very satisfied with oral intake. Patients who were dissatisfied with oral intake in labor had slower median cervical dilation rates and prolonged duration of labor compared to the very satisfied group.

Conclusion: The labor progression rates in our study population were almost similar to American and Chinese population, faster than the Japanese population and slower than the Sweden population. Adequate oral supplementation during labor has to be address to prevent prolonged labor and dissatisfaction among patients.

Oral – 6

Tele-ANC Model in Public Sector in India: A Feasible Option to Sustain Quality Antenatal Care

Radhika Aggarwal, Kiran Guleria, Richa Aggarwal, Himsweta Srivastava
University College of Medical Sciences & Guru Teg Bahadur Hospital, New Delhi, India

Introduction: Traditional antenatal care is resource intensive with heavy footfall in public sector OPD leading to compromise in quality of care. Therefore, hybrid 'TELE-ANC model' is a feasible option to sustain quality care in limited resource setting.

Objective: Assess feasibility of 'TELE-ANC model' in reducing 'in-person visits' in terms of provider, process and recipient, determine barriers and facilitators to implementation and robustness of process in delivering the model.

Methods: Single-center prospective feasibility study composed of 50 low-risk women within 20 weeks of pregnancy. Model had five in-person and four virtual visits. During in-person visits, history, examination, investigations, ultrasounds were done, clubbed. During virtual visit, patients monitored BP, pulse, weight and fetal movements at home. Patients and provider filled Satisfaction Performa after each virtual visit; measured through Likert scale.

Results: Each patient made five physical and virtual visits (one extra than proposed 4), saved 10 hours and 700 Rupees during their ANC. Adequacy to conduct visits, decision making, technical issues faced, ease and safety of process, improvement of access to healthcare; demonstrate Provider satisfaction score of >80% overall. High patient satisfaction score of 80-90% in care received, doctor-patient rapport, knowledge about pregnancy, convenience of self-monitoring, ability to contact provider during emergencies, ability to express, continuation of visits post COVID, reduction in overall cost and time, desire in future. Minimal technological barriers identified. 'Good' in terms of robustness.

Conclusion: 'TELE-ANC model' is feasible in delivering efficient ANC with advantages of lower cost, greater doctor-patient rapport, increased patient and provider satisfaction, time management.

Oral – 7

Role of Neutrophil to Lymphocyte and Platelet to Lymphocyte Ratio as a Predictor of Preterm Premature Rupture of Membrane

Monika, Bindu Bajaj, Anjali Dabral, Rekha Bharti
Vardhman Mahavir Medical College & Safdurjung Hospital, New Delhi, India

Introduction: Preterm premature rupture of membrane (PPROM) is associated with adverse maternal and neonatal outcome. Neutrophil to lymphocyte ratio (NLR) and platelet to lymphocyte ratio (PLR) are found to predict PPROM and adverse neonatal outcome in women with PPROM.

Objectives: To find out role of neutrophil to lymphocyte ratio and platelet to lymphocyte ratios as predictor of PPROM and adverse neonatal outcome in women with PPROM.

METHODS: This was a prospective observational cohort study enrolling 250 low risk primi-gravida at 16-18 weeks gestation. NLR and PLR were done at the time of enrollment, at 30-32 weeks and at the time of admission. The women were followed till discharge from hospital. The main outcome measures were development of PPROM and adverse neonatal outcome (NICU stay, Neonatal death) in women with PPROM.

Results: NLR and PLR at the time of admission were higher in women with PPROM as compared to women without PPROM, 6.37 vs 3.88, $p<0.001$ and 156.02 vs 125.66, $p<0.001$, respectively. Sensitivity and specificity of NLR and PLR at 16-18 weeks

and 30-32 weeks for prediction of PPROM was 38.7% & 73.1%, 41.9% & 77.6% and 90.3% & 26%, 77.4% & 41.6%, respectively. For adverse neonatal outcome, cut off ≥5.9 for NLR and ≥140.5 for PLR, had sensitivity and specificity of 96.2% & 93.8 % and 100.9 % & 86.2%, respectively.

Conclusion: NLR and PLR are higher in women with PPROM. These ratios are not good predictors for PPROM but can predict adverse neonatal outcome in women with PPROM.

Oral – 8

Evaluation of Presepsin Levels in Pregnancy Associated Sepsis

Priyanka Shanker, Rachna Agarwal, Medha Mohta, Mohit Mehndiratta, Anshuja Singla
University College of medical sciences and Guru Teg Bahadur Hospital, Delhi, India

Introduction: Early recognition of obstetric sepsis is crucial for better maternal outcomes. Presepsin (sCD14-ST) has been identified as one of new biomarker to increase in early stages of Pregnancy Associated Sepsis (PAS) and correlates with severity of sepsis.

Objective: Objective of this study was to estimate Presepsin levels in cases and controls and to correlate Presepsin levels with maternal outcomes and omSofa score. Assesment of various risk factors among PAS cases was also done.

Materials and Methods: This case control study included 35 PAS cases as well as 35 controls based on exclusion and inclusion criteria. OmSofa scoring was done at time of admission. Samples were taken, centrifuged and stored at -20°C and analysed later for Presepsin levels using ELISA kit.

Results: It was found that Presepsin significantly raised in cases with median values of 2966.8 pg/ml while in controls median values were 1869.7 pg/ml (p value<.001). A significant correlation was found between presepsin levels and duration of hospital stay (correlation coefficient 0.850, p value 0.002, spearman rank correlation coefficient). Also omSofa score was found to be significantly higher among PAS cases.

Conclusion- Serum presepsin levels were significantly higher among PAS cases and along with OmSofa score it can be used as a valuable futuristic tool to guide for early and accurate diagnosis and prognostication of obstetric sepsis.

Session-6 (Miscellaneous)

Oral – 1

Comparative Study of Elective Induction of Labour at 39 versus 40 Completed Weeks in Low-Risk Pregnant Women

Saumya Rajput, Taru Gupta
ESIC PGIMSR Basaidarapur, New Delhi, India

Introduction: Optimum timing of delivery is crucial for a healthy pregnancy outcome. The decision to terminate low risk full term pregnancies, i.e. between 39 0/7 to 40 6/7 weeks, has remained controversial. Risk to benefit ratio has to be weighted with respect to induction of labour and prolongation of pregnancy.

Objective: To compare maternal and fetal outcomes between low risk pregnant women electively induced at 39 versus 40 completed weeks of gestation.

Methods: 80 low risk pregnant women carrying a live singleton fetus in cephalic presentation were randomly assigned into 2 groups- A) elective induction at 39 completed weeks (N=40), and B) elective induction at 40 completed weeks (N=40). Labour induction was performed according to standard institutional protocol. Primary outcome studied was caesarean section rates.

Results: Rate of caesarean delivery was significantly increased in women undergoing elective induction of labour (eIOL) at 40 weeks versus 39 weeks (55% vs 27.50% respectively, P value= 0.013). Instrumental delivery occurred in 7.5% women induced at 39 weeks, but in none induced at 40 weeks. A non-significant increased risk of post-partum haemorrhage occurred after eIOL at 40 weeks (2.5% in 39 weeks and 15% in 40 weeks, P value=0.108). There were no significant between-group differences with respect to adverse neonatal outcomes.

Conclusion: Elective induction of labour at 39 weeks is associated with a reduced incidence of caesarean section as compared to elective induction at 40 weeks gestation. There is no increased incidence of adverse neonatal outcomes after induction at 39 weeks.

Oral – 2

Perinatal Outcome Following Fresh and Frozen Embryo Transfer in IVF Cycle

Kajal Kesharwani, Renu Tanwar
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Introduction: Assisted reproductive techniques are a widely employed modality for the treatment of infertility. Fresh and frozen embryo transfer are done after the ovum pickup. Fresh embryo transfer are done in the same IVF cycle while frozen embryo transfer is done in hormone replacement therapy cycles.

Objective: Compare the perinatal outcomes following fresh and frozen embryo transfer in the IVF cycle.

Methods: In this study, 38 study subjects with fresh embryo transfer and 113 study subjects with frozen embryo transfer were studied regarding perinatal outcome. Perinatal outcome like multiple pregnancy, preterm birth, low birth weight, Large for gestational age (LGA), congenital anomalies and perinatal mortality were studied.

Results: In our study, twin pregnancy (0.009), preterm birth (p-value 0.9), congenital anomalies (p-value 0.577), perinatal mortality (p-value 1) were seen more in frozen embryo transfer study subjects while low birth weight was seen more in fresh embryo transfer babies in both singletons and twins.

Conclusion: Pregnancy after frozen embryo transfer was associated with improved perinatal outcome with regard to birth weight. There were more twin pregnancy in frozen embryo transfer study subjects. Further studies are needed to assess the impact of freezing and thawing procedures on implantation and development of embryo.

Oral – 3

Association of Preterm Placental Calcification with Uterine Artery Doppler Changes in Fetal Growth Restriction

Sakshi Aggarwal, Shakun Tyagi, Y M Mala, Alpana Manchanda
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Aim: This prospective case control study aimed to evaluate the association between preterm placental calcification and abnormal uterine artery Doppler changes in fetal growth restriction.

Method: A total of 70 antenatal women visiting tertiary health care hospital were enrolled, consisting of 35 patients with FGR and 35 patients without FGR between the POG 28 to 35 weeks over a period of one year. Doppler study was done on various vessels along with placental calcification grading.

Result: There was no significant association seen between uterine artery pulsatility index >95th percentile and grade 3 preterm placental calcification (PPC) (p=0.712) but was present between abnormal umbilical artery pulsatility index and grade 3 ppc (p=0.026). Adverse prenatal outcomes like low birth weight, low Apgar score, Meconium stained liquor, intrauterine fetal death were observed in FGR group with significant association with increased duration of hospital stay and NICU admission.

Conclusion: Despite no association between UtA PI and grade 3 PPC, separately they can be used in monitoring and prognostication in FGR. We recommend closer surveillance and frequent follow up in patients with above findings to improve outcome and avoidance of poor long-term sequelae.

Oral – 4

Efficacy of 7 Point Blood Glucose Profile in Initiating Management of Gestational Diabetes Mellitus in Indian Population - A Randomised Control Trial

Astha Jain
Hamdard Institute of Medical Sciences (HIMSAR), New Delhi

Introduction: Gestational diabetes mellitus has emerged as a major public health problem. It affects approximately 18 million births (14%) annually worldwide. The number of GDM cases are rising and in country like India, where the resources are limited, it is important to accurately diagnose and treat GDM.

Objective: To compare feto-maternal outcomes in patients having abnormal OGTT and normal 7-point blood glucose profile with or without intervention

Methods: It was a Randomised control trial conducted in a tertiary health centre, New Delhi over a period of 18 months. During this period, women

diagnosed with GDM using IADPSG criteria at 24-32 weeks of gestation underwent 7-point blood glucose profile. If the profile was within normal limits, women were randomised into two groups, one in which no intervention was given and the other group in which intervention was give. Both the groups were followed up until delivery every 2-week using four point home blood glucose monitoring and fetal maternal outcomes were compared and analysed.

Results: A total of 150 patients were randomised, making 75 patients in each group. Group 1 - 75 patients did not receive any intervention whereas in Group 2 - 75 patients received Medical Nutrition Therapy. Both the groups were monitored for euglycemia. Differences in maternal and fetal outcomes between the two groups were followed up and analysed and was not found to be statistically significant.

Conclusion: Euglycemia is the cornerstone in the management of GDM. Patients diagnosed as GDM with IADPSG criteria, who did not receive any treatment had similar feto-maternal outcomes as compared with patients who were given treatment.

Oral – 5

Comparison of Fetomaternal Outcome in Women with Preterm Premature Rupture of Membranes on Expectant Management versus Delivery at 34 Weeks

Shailja Jha
Vardhaman mahavir medical college and Safdarjang hospital, Delhi, India

Introduction: Preterm premature rupture of membranes (PTPROM) is breach in the amniotic membranes <37weeks of gestation affecting 3% of pregnancies and causes 30-40% of preterm births. Neonatal risks includes prematurity, sepsis, cord prolapse and pulmonary hypoplasia. Maternal risks includes chorioamnionitis and abruption. There is lack of specific guidelines regarding the best time of delivery in such cases.

Objective: To study the fetomaternal outcomes in women with PTPROM on expectant management versus delivery at 34weeks of gestation.

Methods: Prospective observational study conducted on 262 women with PTPROM from 28 -33+6weeks of gestation. Women were monitored until 37weeks unless there was any indication for termination or women delivered spontaneously. Fetomaternal outcomes were documented. Statistical analysis was done using SPSS software.

Result: Amongst women delivering at <34 weeks 45(86.5%) and seven (13.4%) while amongst women delivering >34 weeks 193(91.9%) and 17(8%) responded to expectant management and required intervention respectively. A latency of 3-4weeks was observed in 131(50%) of the study population. Chorioamnionitis developed in 13(4.9%) and 5.7% neonates developed sepsis however both had no correlation with the latency period. Neonates who developed sepsis (5.7%) were comparable in both the groups (p=1.000). Early neonatal death (END) occurred in 10 amongst which seven died because of Low birth weight (LBW), two due to sepsis and one due to respiratory distress. LBW was significantly associated with END. (p<0.001)

Conclusion: Expectant management beyond 34 weeks with close monitoring can improve the neonatal outcomes without increasing maternal morbidity in PTPROM.

Oral – 6

Hematological Markers: A New Diagnostic Modality for Intrahepatic Cholestasis of Pregnancy?

Preeti Thakur, Anshuja Singla
University College of Medical Sciences & Guru Teg Bahadur Hospital, New Delhi, India

Introduction: Intrahepatic Cholestasis of pregnancy (ICP) is the most common pregnancy specific liver disorder and is associated with adverse perinatal outcomes like preterm birth, meconium-stained liquor, fetal distress and even stillbirth. Total Bile Acid (TBA) is gold standard for its diagnosis but is expensive and time consuming.

Objective: In this study, we aimed to evaluate the role of Neutrophil to Lymphocyte ratio (NLR), Mean Platelet Volume (MPV) and Red-cell Distribution Width (RDW) in making the diagnosis of ICP, their association with severity of ICP and also their relationship with TBA levels in an effort to find an inexpensive and easy way to diagnose and prognosticate women with ICP. Material and Methods: NLR, MPV, RDW and TBA levels in the blood samples of 82 pregnant women with ICP were examined in this prospective case–control study. 60 of the patients had mild disease and 32 had severe disease; 82 healthy women in uncomplicated pregnancies served as the control group.

Results: NLR and MPV are significantly raised (p <0.05) while RDW is lowered in pregnant women with ICP.

Conclusion: MPV can serve as a good screening tool due to its high sensitivity (95.1%) while NLR can be used as a confirmatory test as it has high specificity (96.3%) to make diagnosis of ICP, although further exploration with larger multicentric studies is required.

Oral – 7

Role of Hematological Inflammatory Markers in Intrahepatic Cholestasis of Pregnancy

Manisha Patel, Abha Singh, Prof. Prabha Lal
Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital New Delhi, India

Introduction: IHCP is most common pregnancy related liver disorder occurring mainly in 3rd trimester of pregnancy with chief complain of pruritus associated with adverse maternal and fetal outcome.

Objective: To assess the hematological inflammatory markers in women with IHCP.

Material and Methods: This prospective observational study was conducted over a period of one year in a tertiary care hospital of Delhi. After institutional ethical committee clearance, 88 pregnant women with pruritus ≥ 34 week of pregnancy were recruited for study after fulfilling the inclusion criteria. These women were further subdivided into two groups - mild IHCP (TBA= 10-39 micromol/L) and severe IHCP (TBA= ≥40 micromol/L). Hematological inflammatory markers- Platelet lymphocyte ratio (PLR) and Mean platelet volume (MPV) compared between these two groups.

Result: Mean gestation at delivery in mild IHCP was 37.02+ 1.53 week and 37.56 + 1.22 week in severe IHCP. Mean TBA in mild IHCP was 22.8 micromol/L with mean PLR and MPV 132.99 and 13.15 f/L. However in severe IHCP where mean TBA was 70.5 micromol/L PLR and MPV 153.35 and 14.09f/L respectively. In mild IHCP 5.88% had IUD and 2.94% had stillbirth while in severe IHCP 10% IUD and no stillbirth was observed. Therefore, with increasing serum bile acid hematological inflammatory markers (PLR and MPV) also increase.

Conclusion: As severity of IHCP increases, the hematological inflammatory markers (PLR and MPV) also significantly increase.

Oral – 8

Implementation of Clinical Practice of Obstetrics National Early Warning Scoring (ONEWS) In the Obstetrics and Gynaecology Emergency Department (ED) of a Tertiary Care Center in North India - A Quality Improvement (QI) Initiative

Nalini Bala Pandey, Divya Prasad, Asmita M Rathore
Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Background: High-risk obstetric patients at risk of rapid deterioration can be detected at an early stage using an early warning score. Obstetrics national early warning scoring ONEWS is one of the validated tools to predicting adverse maternal outcomes in high-risk pregnant Indian women.

Objective: This QI project aimed at implementing the clinical practice of obstetrics national early warning scoring (ONEWS) in Obstetrics and Gynaecology ED of Lok Nayak Hospital from 20% to 50 % in 12 weeks from 07/06/2022 to 30/08/2022.

Methods and interventions: A QI team was formed and point of care quality improvement (QI) methodology was used. After obtaining the baseline data, problems were analyzed using the fishbone chart and multiple Plan-Do Study-Act (PDSA) cycles were run. The main change ideas were revising departmental policy, sensitizing, and training the doctors and staff, posters displaying ONEWS charts, revising SOPs, frequent reminders on WhatsApp groups, and presentations in monthly meetings.

Results: The outcome indicator was the percentage of patients with ONEWS score out of all patients admitted to the labour ward and HDU from ObGyn ED. The impact of various interventions on these indicators was followed over time with run charts. The median value of the ONEWS score percentage increased from 20% to 60% after the first PDSA cycle and Implementation of other changes in 12 weeks' time.

Conclusion: Simple steps of QI methodology can

potentially improve the acceptance of ONEWS score in our busy public healthcare ObGyn ED. However, implementation of any new practice comes with significant challenges.

Session-7 (Miscellaneous and Population Stabilization)

Oral – 1

Role of Maternal Anogenital Distance Measurement on Prediction of Perineal Tears during Vaginal Delivery

Karishma Singh, Sandhya Jain, Rachna Agarwal, Bhanu Priya
University College of Medical Sciences & GTB hospital, Delhi, India

Introduction: Almost 85% women suffer perineal trauma during vaginal birth, which can have long-term consequences. Anogenital distance AGD) is novel useful parameter for prediction of perineal tears during vaginal delivery.

Objective: To determine a) Accuracy & cut-off of AGD in predicting ≥2nd degree perineal tears b) Risk factors for perineal tears c)Pelvic Floor Distress Inventory (PFDI-20) and pelvic floor muscle strength (OXFORD grading) at 6weeks postpartum.

Method: In an observational case-control study, 160 primigravida at ≥37 weeks were recruited in early labour. Cases were subjects who suffered ≥2nd degree perineal tears during vaginal delivery and controls had intact perineum or up to 1st degree tears. Anthropometric data such as AGD ac {anustoclitorisdistance} and AGDaf{anusto fourchette distance} and labour parameters like fetal position, duration of the second stage, induction of labour, birthweight etc. were noted. ROC curves were plotted to obtain cut-off values AGDac and AGDaf for predicting ≥2nd degree perineal tears.

Result: Mean AGDac and AGDaf were lower in cases as compared to controls. AGDaf had better sensitivity for prediction of ≥2nd degree perineal tears and anal sphincter injury as compared to AGDac. Specificity ofAGDaf was better for ≥2nd degree perineal tears, while for sphincter injury, AGDac was more specific. Fetal head position and birthweight were strongest risk factors for tears. Cases had more bowel and prolapse symptoms at 6 weeks postpartum.

Conclusion: Perineal length as measured antenatally by AGD (AGDac & AGDaf) is useful in predicting occurrence of perineal tears during vaginal delivery. If found short, the obstetrician can be more cautious while conducting delivery. This can reduce the occurrence of anal sphincter injuries and their long-term consequences.

Oral – 2

Comparison of DIPSI and WHO Criteria for Diagnosis of Gestational Diabetes by Assessment of Feto-Maternal Outcomes

Mansvi Raghav, Jyotsna Suri, Anita Rani, Pradeep Debata
Vardhaman mahavir medical college and Safdarjang hospital, Delhi, India

Introduction: GDM is carbohydrate intolerance of variable degree with onset or recognition during pregnancy. Based on the HAPO study, IADPSG has recommended their own criteria for GDM. IADPSG criteria is the only one, which is based on adverse feto-maternal outcomes. DIPSI is based on WHO 1999 criteria which has now been replaced by WHO 2013 (based on IADPSG).

OBJECTIVE: To diagnose GDM using DIPSI and WHO 2013 criteria and to evaluate feto-maternal outcomes in women who are normoglycemic by DIPSI but are GDM by WHO criteria versus those who are normoglycemic by WHO criteria.

Materials and methods: It was a prospective cohort, blinded study. 550 participants tested negative by DIPSI test underwent WHO 2013 OGTT test after 72 hours. All 550 participants were followed for adverse feto-maternal outcomes until delivery. Out of 550 participants, 492 had normal WHO OGTT while 58 had abnormal WHO OGTT value. Participants with normal DIPSI test and normal WHO 2013 OGTT were labelled as group 1. Participants with normal DIPSI test but abnormal WHO 2013 OGTT were labelled as group 2. Feto-maternal outcomes were compared between these two groups.

Results: The occurrence of GDM by DIPSI was 5.1% and by WHO 2013 it was 10.5%. We found a statistically significant association between poor feto-maternal outcome and GDM by WHO 2013 test (with normal DIPSI test).

Conclusion: We conclude that DIPSI test miss

patients with GDM who can have adverse fetomaternal outcomes. Missed patients have fasting hyperglycemia. These patients were diagnosed by WHO 2013 criteria.

Oral – 3

Cervical Funneling for Prediction of Vaginal Delivery in Term Nulliparous Women Undergoing Induction of Labor

Kajal Baleja
Vardhaman mahavir medical college and Safdarjang hospital, Delhi, India

Introduction: The success of induction of labor (IOL) depends on the readiness of cervix. Although Bishop Score is gold standard, it has high interobserver variability. Presence of cervical funneling (CF) on ultrasonography reliably predicts IOL outcome.

Objectives: To find out the predictive value of cervical funneling for successful vaginal delivery in term nulliparous women undergoing labor induction.

Methods: An observational cohort study was conducted on 310 nulliparous women with term singleton pregnancy and intact membranes planned for IOL. A transvaginal ultrasonography was performed to find out presence of CF, measure cervical funnel length (CFL) & width (CFW), and calculate cervical funneling index (CFI). This was followed by pelvic examination to calculate the Bishop score. Women with Bishop score >5 were excluded from the study. Cervical priming was done using intracervical dinoprostone gel followed by induction of labor with oxytocin. Women were followed for labor outcome. Predictive value of cervical funneling for successful vaginal delivery was calculated.

Results: Out of 310 women, 100 had CF and the odds ratio of cervical funneling for successful vaginal delivery was 3.85 (95% CI; 1.31-11.26). CFL, CFW, and CFI had low sensitivity and low diagnostic accuracy (<40%), although specificity was around 90%. CFI ≤0.07 ±0.11 was associated with significantly shorter induction to active phase and induction to delivery interval, p<0.001.

Conclusion: Presence of cervical funneling increases the odds of vaginal birth. CFL and CFW are weak predictors of vaginal delivery in nulliparous women undergoing IOL but lower CFI is associated with shorter induction delivery interval.

Oral –4

To Determine the Factors Influencing Access to Emergency Services by Obstetric Patients during Covid 19 Pandemic

Triveni GS, Aishwarya Kapur, Manju Puri, Noopur Chawla, Prateeksha
Lady Hardinge Medical College India

Introduction: COVID has caused drastic changes in policies and there has been nationwide lockdowns resulting in increased stress and helplessness among pregnant women and their families. An insight into factors causing delay in seeking emergency care will help us in policy making and planning for safe, accessible and equitable maternity services.

Objective: To study the various factors causing delay in accessing emergency services by obstetric patients.

Methods: This study was Prospective, Observational study done during lockdown period from 1.5.2021 to 31.5.2021. The obstetric patients admitted from Gyne Casualty at LHMC and SSKH were included in this study.

Results: The total of 666 patients participated in this study. The major cause of delay was found to be Level 1. Among Level I delay, about 45.8% had delay due to unawareness of danger signs, 30.93% had delay due to lockdown, 17.40% had delay due to fear of catching COVID infection, 7.35% had no accompanying attendant. Among Level 2 Delay, about 13.96% had delay due to lack of transportation, 13.21 % had financial constraints, 21.3% due to care declined at previous center. Level 3 delay was seen in 6.9% of participants due to non-availability of bed and 4.65% due to overcrowding.

Conclusion: The unawareness of the danger signs and symptoms is the most common cause for delay in seeking emergency care by pregnant women and her family. Hence counseling and communication during antenatal period is very essential for improving the decision making capacity of the pregnant women and her family.

Oral – 5

Study of Acceptance of Contraception in Post-abortal period in Tertiary Care Hospital

Ishita Gupta, Neeru Malik, Anupa Singhal, Sandhya Jain
Dr Baba Saheb Ambedkar Hospital, Rohini West, Delhi, India

Introduction: India accounts for 8% of total maternal mortalities due to unsafe abortions. Women coming for abortion services to the hospital are unlikely to return for contraception later. As fertility resumed in the first cycle after abortion, post-abortal contraception can help in preventing these unintended pregnancies.

Objective: The study was done with an objective to know the acceptance rate of post-abortal contraception. Also, to study the method of contraception accepted.

Methods: It was a retrospective observational study from 2019 to 2021 done in Dr BSA Hospital, Delhi. A total of 2538 patients were enrolled in the study. Data was collected from records of family welfare department. Inclusion criteria were women who report for spontaneous, missed or induced abortion to the hospital. Exclusion criteria were molar pregnancy, ectopic pregnancy.

Results: A total of 2538 patients were included in the study. Various methods of contraception were accepted by 1755 patients whereas 783 patients did not opt for any method of contraception. 601 patients accepted post-abortal IUCD. 552 patients accepted DMPA. 144 patients accepted post-abortal tubal ligation. 77 patients accepted MALA-N. 24 patients accepted Chhaya.

Conclusions: Acceptance of post - abortal contraception was good. Post-abortion period is one which is important to prevent subsequent abortions and family planning services after abortion need to be strengthened.

Oral – 6

Knowledge Attitude and Practices of Contraception among Married Women of Reproductive Age

Anuradha Sharma, Y.M. MALA
Lok Nayak hospital, New Delhi, India

Introduction: India is the second most populous country in the world

Aim: Assess knowledge, attitude & practice of contraception among married women of reproductive age.

Methodology: A cross-sectional study was conducted in department of OBGY, LNH. Study group includes 100 women of reproductive age group attending OPD.

Results: 94 % women knew about at least any of contraceptive method. 94.9% knew about condoms, IUCD (90.8%) & vasectomy (69.4%). Main source of information were husband and relatives (40.5%), followed by ASHA worker (39.2%). 75 women were using contraception while 25 were not. Maximum women (61.3%) preferred condoms, followed by IUDs (22.7%) and natural methods (8%). Reasons for not using contraceptive - prevalence of myths and misconceptions. 33% women thought that Cu-T cause perforation. 29% women did not prefer condom due to risk of rupture. Major cause of refusing tubectomy was religious 28.1%. Attitude & practice 94% of women had knowledge of contraception but only 75% women were using it. 12% were not using mainly due to misconceptions associated with contraceptives like risk of perforation with CuT, religious causes with tubectomy. 80% of women were able to discuss family planning with their husbands. Choice of method to gain knowledge about contraception 62% wants the awareness to be done by ASHA worker either in dispensary or home to home counselling.

Conclusion: It is evident that there are many myths and misconceptions regarding contraceptive methods. Fear of side effects was one of the main reasons for poor compliance. ASHA workers can be trained to spread knowledge among women.

Oral – 7

Acceptance And Continuation of Contraceptive Methods following second Trimester Abortion: 6 Months Follow Up

Mohit Singh Mann, Sumitra Bachani, Yamini Sarwal
Vardhaman mahavir medical college and Safdarjang hospital, Delhi, India

Introduction: Safe and effective contraception can be provided with abortion procedures when otherwise medically appropriate for a woman. It can help individuals achieve their desired reproductive outcomes and minimize the burden of multiple appointments. Contraceptive counselling and basket should be made available to all women undergoing abortion, and her right to decline or postpone this care should be respected while recognizing that each woman has a unique unmet need of contraception.

Aims and objectives: To compare acceptance of contraceptive methods and continuation till 6 months after second trimester abortion.

Materials and methods: A retrospective study

conducted at a tertiary care hospital in which women who underwent second trimester abortion over a period of one year were telephonically interviewed regarding their acceptance and continuation of the contraceptive method till 6 months post abortion.

Results: A total of 142 women, 67 were Primigravida and 75 were multigravida, underwent second trimester abortion amongst which 122 accepted a contraceptive method. Acceptance of injection Depot Medroxy progesterone acetate(DMPA) was highest (48.36%), followed by Male condom Nirodh (33.60%), Minilap Ligation(9.8%),Tab Chhaya (4.09%,) Tab Mala N (3.2%), Laparoscopic ligation (1.6%) and CuT (0%).Women who accepted DMPA and Chhaya had low continuation due to concerns of irregular bleeding and amenorrhoea. Continuation of Mala N and Nirodh was higher due to regularity of menstrual cycle and ease of use. All women who opted for ligation had 100% satisfactory continuation.

Conclusion: Injection DMPA was most acceptable method of contraception after second trimester abortion followed by male condom however continued usage of progesterone-based methods was low. Women were most satisfied with permanent methods. CuT acceptance was lowest due to myth of association with irregular vaginal bleeding and abdominal pain.

Oral – 8

Acceptance of Contraception after Second Trimester Abortion

Surbhi, Rachna Sharma, Shakun Tyagi, Y.M.Mala
Maulana Azad Medical College and associated LNH New Delhi, India

Introduction: Unsafe abortions contribute to about 8% of maternal deaths in India. Promoting contraception not only for spacing but also to prevent unintended pregnancies is important measure to reduce MMR.

Aim: To study the acceptance of methods of contraception and impact of amendment on indications of second trimester abortion.

Methods: This was a retrospective case record study and inclusion criteria was women seeking second trimester abortion at Department of ObGyn, MAMC and LNH Delhi. All case records were studied, the data was entered in predesigned proforma and analyzed. As per hospital protocol, Women were provided comprehensive abortion care. Contraceptive counselling is done in Family Planning OPD before admission and reinforced at the time of abortion procedure. The contraceptive options discussed included sterilisation [male and female], Copper T, Inj DMPA, Centchroman, COC, Condom available free of cost in hospital.

Results: Total of 451 patients attending Family Planning OPD were enrolled in the study. Contraceptive acceptance rate was - 79.23%. The contraception chosen by study participants included IUCD-28.66% [commonest], COC-14.83%, Centchromane-10.02%, Inj. DMPA-12.19% and Minilap sterilisation13.53%. The proportion of women not accepting any contraception was-20.77%. After new MTP amendment in Oct 2021, congenital anomalies were the commonest indication for second trimester abortions.

Conclusion: Study shows- The contraceptive acceptance after second Trimester abortion in our hospital is 79% with IUCD being the most common method.

Poster Presentation

Abstracts of Poster Presentation (Hall A) on 12th November, 2022

Session 1 A (Obstetrics)

P-1A/OP-1

Bilateral Retinal Detachment in Pre-Eclampsia - A Case Report

Duha Gari, Anjum Malik, Aiyleen
Department Of Obstetrics & Gynaecology; SKIMS MCH, Srinagar, Kashmir

Introduction: Pre-eclampsia affects about 4.6% of pregnancies globally of which bilateral, serous, non-rhegmatogenous retinal detachment is a rare complication. Its pathogenesis is related with choroidal ischemia secondary to an intense arteriolar vasospasm. The management of retinal detachment as a complication in pre-eclampsia is conservative and the prognosis is usually good.

Case: Herein, we report a case of a 33 years old female with precious pregnancy (G3A2) who was hospitalized at 28 weeks of gestational age with severe pre-eclampsia and developed bilateral exudative retinal detachment. An emergency caesarean section was performed for maternal benefit and a live baby was delivered. A few weeks after delivery there was resorption of subretinal fluid, regression of macular edema with improvement in visual acuity. There was resolution of exudative retinal detachment after 6 weeks.

Conclusion: Pregnancies complicated by preeclampsia are associated with a worse prognosis for mother and child. A multidisciplinary approach is needed to handle the various complications that may arise. Most patients with pregnancy induced hypertension and retinal detachment have full spontaneous resolution within a few weeks without any long-term sequelae.

P-1A/OP-2

Case of Jaundice in Pregnancy: A Diagnostic Dilemma

Aparna Setia[1], Prakash K. Mehta[2], Taniya Khanum[2]
University College of Medical Sciences and GTB hospital[1], Bhagwan Mahavir Jain Hospital[2] Delhi, India

Introduction: The incidence of jaundice in pregnancy in India is 0.4to 0.9/1000 deliveries with varied etiology including pre-existing liver disease, pregnancy associated conditions or coincidental liver disease. The diagnosis is crucial as the management depends on it, which if not made, we have to rely on clinical and laboratory parameters.

Case: 26 years woman, G5P3L3A1 at 34+2 weeks was referred I/v/o jaundice with disseminated intravascular coagulation (DIC) of undetermined etiology in active labor. Post-delivery she developed atonic and traumatic postpartum haemorrhage. Investigations: Bilirubin 22mg/dl, INR 4.4, TLC 38000/ mm3, PC 60000/ mm3. Uterine artery embolisation with uterovaginal packing was done, she was shifted to ICU and managed conservatively because of DIC. She had persistent bleeding causing hypovolemic shock. She received multiple blood product transfusions and improved gradually. She received total 94 blood product transfusions (34 FFP, 19 PRBC, 22 RDP, 2 SDP, 16 Cryoprecipitate, 1 prothrombin concentrate). Patient was borderline HAV-IgM positive, rest viral markers were negative. But, HAV in pregnancy is very rarely a cause of fulminant hepatitis. As per Swansea criteria, a clinical diagnosis of Acute fatty liver of pregnancy (AFLP) was made. Thus, we conclude that though a final diagnosis could not be made but with multidisciplinary care and timely interventions we could save the life of both mother and baby.

P-1A/OP-3

Study of Maternal and Fetal Outcomes in Obese Women

Mansi Kumar
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Obesity in Indian women had increased from 10.6% to 14.8% in India. Mothers who are overweight or obese during pregnancy and childbirth cause significant antenatal, intrapartum, postpartum and also neonatal complications.

Objective: The present study aimed to explore various maternal and fetal outcomes influenced by maternal obesity. The objective was to find the effect of obesity on maternal and perinatal outcome among obese pregnant women compared to those of normal weight.

Methods: A prospective observational study was conducted out in a tertiary care referral hospital for a period of 6 months. A standardized questionnaire was used and details of medical history, clinical examination, maternal history during antenatal, natal and postpartum period were collected. Body Mass Index (BMI) assessed prior to 20 weeks of gestation and patients with BMI more than 30kg/ m2 were included in the study. Results recorded in simple percentages.

Results: Eighteen percent cases developed gestational diabetes mellitus during their antenatal period and 15% developed gestational hypertension. 44% patients underwent lower segment caesarean

section. The need for induction of labour and caesarean section was found to be higher. Increased NICU admissions for stabilization of the new-born among cases was higher. Conclusion: It was clearly evident from the present study that maternal obesity had adverse maternal and fetal outcomes. Maternal obesity was strongly associated with antenatal complications like gestational diabetes mellitus, gestational hypertension, preeclampsia and increase in need for induction of labour and operative interference.

P-1A/OP-4

Association of Lipid Profile of Infertile Men with Abnormal Semen Parameters

Lovely Singh, Bindu Bajaj, Anjali Dabral,Rekha Bharti
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Male's inability to result in pregnancy in a fertile female is referred as male factor infertility. Various comorbidities that negatively affect health of male partner can be associated with impaired reproductive functioning. Cholesterol is the main substrate for steroid synthesis and affects spermatogenesis, highlighting the role of serum lipids in male fecundity.

Objective: To evaluate correlation of lipid profile of male partners with abnormal semen parameters in infertile couples.

Methodology: This was a cross sectional study carried out in the infertility clinic of a tertiary care hospital over a period of 18 months. A total of 151 infertile men with abnormal semen parameters were enrolled. Lipid profile was done after 10-12 hours of fasting and its correlation with abnormal semen parameters was analysed.

Results: The most common abnormal parameter in the semen analysis of male partners of infertile couples was decreased progressive motility, seen in 85.5% men. Most of the men (90%) had normal total cholesterol and high-density lipoprotein, whereas, low-density lipoproteins and triglycerides were found to be deranged in 73% and 57% men, respectively. LDL and Triglyceride levels showed significant positive correlation with sperm concentration and total sperm count. However, sperm motility and total motile sperm count showed significant negative correlation with Triglyceride.

Conclusion: Higher serum triglyceride levels are the common lipid derangements seen in the male partner of infertile couples and have significant negative impact on sperm motility.

P-1A/OP-5

Knowledge Attitude and Practice Towards Breastfeeding Among Postnatal Mothers in Tertiary Care Centre

Vijaita, Y M Mala
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction:Breastfeeding is the cornerstone of child development, survival and nutrition. Infants who are not exclusively breastfed are more likely to develop serious morbidity like gastro intestinal infections and other long-term adverse health outcomes.

Objective:To assess knowledge, attitude and practice of breastfeeding among post-natal women.

Methods:This was a cross- sectional study including 100 delivered women. Information was collected with the help of a predesigned structured proforma. The data included socio-demographic details, breastfeeding knowledge, attitude and practices.

Results:Twenty two percent (22%) of the mothers did not start breastfeeding within 1 hour of birth and 7% of mothers discard colostrum. Pre-lacteal feed was given in 10% of baby. Fifty nine percent (59%) of woman knew correct technique of initiating breast-feeding. Ninety two percent (92%) of women practice burping after feeding. Only 53% of study participants were aware of the fact that Breast feeding has long term benefit on cardiovascular system of baby. Only 35% women considered breast-feeding should be continued during diarrheal episodes.

Conclusions:Maternal knowledge, maternal level of education and age of childbirth may play an important in promoting the practice of EBF during antenatal visits. Imparting knowledge about breast-feeding should be started in antenatal period. Strengthening of prenatal and postnatal interventions to improve breastfeeding practices is recommended.

P-1A/OP-6

Facilitators And Barriers in Acceptance of Covid 19 Vaccine Among Pregnant Women in India: A Cross-Sectional Study

Tanya Singhal, Kanika Chopra, Swati Aggarwal, Reena Yadav
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Pregnant women are vulnerable to get COVID-19 disease leading to increased morbidity and mortality of mother-baby dyad. Vaccination

against COVID-19 is considered to be most effective method of preventing this. However, there is a paucity of studies on COVID vaccination coverage among pregnant women in India. This study was undertaken to determine this and also the factors leading to acceptance or denial of the vaccine.

Methodology: A cross-sectional study was conducted at Department of Obstetrics and Gynaecology, LHMC, which included 250 consenting antenatal women who were interviewed by the author using a pre-validated questionnaire. Details regarding demographic profile, obstetric history, medical or obstetric disorders, status of COVID-19 vaccination (two plus booster doses), encouraging factors and barriers to vaccination were enquired.

Results: Out of 250 women, only 4 (1.6%) had full vaccination coverage and 183 (73.2%) women had taken 2 doses of vaccine. 54 women had taken only 1 dose (21.6%) and 9 women were not vaccinated (3.6%). The facilitators were widespread source of information regarding the need of vaccination including media (38.3%), relatives (35.5%), health professionals (12.9%) and friends (12.5%). The barriers to vaccination were concerns about safety issues of vaccination during pregnancy (63.2%), risk benefit ratio of the vaccine (9.6%), lack of awareness (13.4%) and resistance from family (4.9%).

Conclusion: Complete vaccine coverage among pregnant women is very less mainly due to the concerns of mothers regarding the safety of vaccine on the fetus. Obstetricians hold prime responsibility of educating mothers about this and simultaneously allaying their apprehensions.

P-1A/OP-7

Rising Trend in Ectopic Pregnancy: A Clinical Study at a Tertiary Care Hospital

Duha Qari[1], Anjum Malik[1], Yousha Gillani[2]
Sher-i- Kashmir Institute of Medical Sciences Medical College Hospital, Bemina[1], Government Medical College, Srinagar[2], India

Introduction: Ectopic pregnancy is the major cause of maternal mortality during the first trimester of pregnancy accounting for 10-15% of all maternal deaths. This retrospective analysis was done to determine the incidence, age, risk factors, clinical features, modalities of treatment, morbidity and mortality associated with ectopic pregnancy in a tertiary care hospital.

Objective: To determine the age group, parity, risk factors, clinical presentation, treatment employed and outcome of ectopic pregnancy.

Methods: This retrospective study was conducted from 1st June 2021 to 30th June 2022 during which 80 cases were reported with ectopic pregnancy. Information was collected in a structured proforma, tabulated and descriptive analysis was carried out. The case sheets of these patients were traced through hospital records mainly labour room and operation theatre registers.

Results: Total number of deliveries conducted during study, either vaginally or through caesarean section, were 3809 of which 80 (2.1%) were diagnosed as ectopic pregnancy. The mean age for this study was 27.5 ± 5. The incidence of tubal ectopic was maximum (96.25) with ampulla being the most common site of ectopic implantation (73.75%). Majority of the cases were ruptured ectopic pregnancies (78.20%) with salpingectomy being the most common intervention (82.5%). Previous abdominopelvic surgeries were the commonest risk factor (21.25%).

Conclusion: A high index of suspicion is needed in the diagnosis of ectopic pregnancy at an early stage, purpose should be directed towards overcoming the crisis with minimal invasive procedure to help in reducing morbidity, mortality and preserving fertility for those who desire it.

P-1A/OP-8

Postpartum Maternal Collapse: A Case Report.

Aditi Rathi, Shivani Mane, Niharika Dhiman, Deepti Goswami
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Maternal respiratory compromise in immediate postpartum period poses diagnostic challenges.

Case report: A 22-year-old unbooked, Primigravida 33week 1day period of gestation presented in early labor. One day before, she was diagnosed as gestational hypertension and was started on tablet labetalol 200mg BD. On examination, she had mild pedal oedema, her BMI was 30kg/m2, pulse rate was 84/min, blood pressure was 130/90mmhg. Patient delivered vaginally. Immediately after delivery, she complained of difficulty in breathing. Her respiratory rate was 27/min, SPO2 dropped to 70%, pulse rate was 100/min, and blood pressure was 140/90mmhg. Bilateral crepts were detected on chest auscultation. ABG indicated respiratory acidosis. Uterus was well contracted and no postpartum haemorrhage detected. Patient was intubated and shifted to intensive care unit. Chest x-ray was suggestive of pulmonary oedema. Her NT-proBNP levels were markedly increased to 12800ng/L. Patient's vitals

improved on treatment with injection lasix and low molecular weight heparin. Patient responded to treatment and was extubated. Echocardiography indicated peripartum cardiomyopathy, left ventricular systolic dysfunction with 25% ejection fraction.

Conclusion: Cardiomyopathy can cause sudden onset respiratory compromise and should be considered among the differential diagnosis of postpartum maternal collapse.

P-1A/OP-9

Right Interstitial Ectopic Pregnancy in A 27-Year-Old Female: A Case Report

Supriya Singh, Shivani Agarwal
Kasturba Hospital, New Delhi, India

Introduction: Interstitial pregnancy is a rare variant of tubal ectopic pregnancy that carries a risk of life-threatening haemorrhage.

Objective: To manage a case of unruptured interstitial ectopic pregnancy that converted to ruptured interstitial pregnancy.

Case report: 27yr old female G4P1L1A2 presented in emergency with complaint of amenorrhea from 3 months and pain lower abdomen since last 2 days. On examination patient had pallor but hemodynamically stable. On per-vaginal examination right sided adnexal fullness ad tenderness present. Her serum beta-HCG was 4548. Ultrasound showed G-sac of size 18mm in right adnexa with cardiac activity present with fetal pole and minimal fluid in pouch of Douglas (POD). Injection methotrexate given and repeat beta-HCG was done on day4 that was found to be 3055. But patient started complaining of severe abdominal pain after 5 days. Repeat TVS showed moderate fluid collection in POD. Diagnosis of ruptured interstitial pregnancy made and patient was taken up for emergency laparotomy with wedge resection of cornua and reconstruction of uterine wall was done.

Result: Histopathological examination confirmed that she had right sided interstitial ectopic pregnancy.

Conclusions: Early diagnosis is a key element in appropriate management. Medical and conservative surgical methods are safe and effective. Selection of treatment option must be individualized and based upon clinical presentation, hemodynamic status, future pregnancy desire and surgeon's expertise.

P-1A/OP-10

Conservative Management of Caesarean Scar Pregnancy: A Case Presentation

Pankhuri Jain, Anjali Choudhary
Shri Mahant Indresh Hospital, Patel Nagar, Dehradun, India

Introduction: With the increasing caesarean section rates a new challenging evil of Caesarean scar pregnancy has emerged. As a variant of ectopic pregnancy caesarean scar pregnancy is the rarest of all. The estimated incidence ranges from 1 in 1800 to about 1 in 2216 of all caesarean deliveries. Implantation and growth of a conceptus in the niche of a previous caesarean scar often leads scar pregnancy and is associated with significant maternal morbidity and mortality as a result of torrential obstetric haemorrhage, need for hysterectomy and massive blood transfusions.

Objective: Conservative management of a 29-year-old G3P2L2 woman, with previous 2 caesarean section presented in the gynae OPD at 7weeks 6 days amenorrhea and spotting for 2 days was diagnosed with caesarean scar ectopic pregnancy on TV-USG caesarean scar pregnancy with precautions for haemorrhage control.

Methods: Patient was managed successfully with Intra-sac Methotrexate under ultrasound guidance with a catheter at the scar site for tamponade. Patient was followed up with serial Beta HCG.

Results: The treatment led to complete resolution of scar pregnancy with no complications followed by serial beta HCG.

Conclusion: Management of caesarean scar pregnancy can be challenging. Trans-abdominal intra-sac Methotrexate injection offers feasible mode of treatment with minimal complication and high success rate.

Session 2 A (OBSTETRICS)

P-2A/OP-1

Study Of Association of Cerebroplacental Ratio with Adverse Perinatal Outcome in Term Appropriate for Gestational Age Fetuses

Aparajita Soni, Jaya Chawla, Alka Goel
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: FGR arises when foetuses in-utero fail to reach their growth potential.70-80% FGRS are late onset (>32 weeks) in which diagnosing the condition is the challenge which leads to high incidence of sudden fetal compromise. In this study, cerebroplacental ratio (CPR) was studied to screen those at-risk foetuses of late onset FGR that have failed to reach their growth potential but appear to be appropriate for gestational age (AGA).

Aims: To evaluate CPR in term AGA foetuses and to find its association with perinatal outcome.

Methodology: A prospective observational study was conducted in 270 women with singleton term AGA foetuses admitted under Dept of OBG, RML Hospital from January 2021 to May 2022 who underwent doppler for CPR (MCAPI: UAPI) either at onset of labour or pre-induction. Women with normal and abnormal CPR were compared in terms of incidence of intrapartum fetal distress, MSL, neonatal outcomes were compared such as birth weight, mode of delivery, APGAR at 1 and 5 minutes, NICU admission and perinatal morbidity andmortality.

Results and Conclusions: In the study 12(4.4%) foetuses were found to have abnormal CPR. The APGAR at 5 minutes of life and birth weight was found to be lower in the abnormal CPR group however no significant difference was found in the incidence of fetal distress, MSL, APGAR at 1 minutes, LSCS, NICU admission, perinatal morbidity and mortality. Findings strongly suggested that evaluation of CPR, as a measure of risk assessment is inappropriate as of now.

P-2A/OP-2

To Find an Association Between Hypothyroidism and Gestational DiabetesMellitus

Apoorva Singh, Bangali Majhi
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Aims and Objectives: To find whether hypothyroid antenatal patient are high risk for developing gestational diabetes mellitus.

Materials & Methods: A prospective observational study was done in a tertiary care hospital in New Delhi, India where in antenatal patients attending OPD were screened for hypothyroidism before 22 weeks of pregnancy. Thyroid function test was performed including T3, T4, TSH and anti-TPO antibody at the first antenatal visit and segregated into 2 groups based on their TSH value that is group A and B, with 210 patients in each group and followed up till 24 weeks of gestation after which oral glucose tolerance test by DIPSI criteria was performed and the diagnosis of gestational diabetes mellitus in these patients was made accordingly.

Results: Prevalence of GDM was in hypothyroid group was 15.7% compared to 5.7% in euthyroid group. The relative risk for developing GDM was 1.98 (95% CI: 1.20-3.24). The result was statistically significant ($p<0.0001$). Additionally, the mean T3 and T4 level were significantly lower in GDM patients (1.89±0.81 & 0.54±0.30 respectively) compared to patients without GDM (2.27±0.90 & 0.65±0.27 respectively).

Conclusion: It was observed that a significant association exist between high TSH concentration and diabetes mellitus in antenatal patients. Furthermore, the study highlights the needs for vigilance in early gestation in obese and older hypothyroid patients for development of gestational diabetes mellitus in pregnancy.

P-2A/OP-3

Effect Of Fever on Maternal and Fetal Outcome in Pregnant Women Beyond 28 Weeks of Gestation

Nupur Sagar, Dr. Sangeeta Gupta
ESI-PGIMSR Hospital, Basaidarapur, Delhi, India

Introduction: In pregnancy, fever is a common clinical issue worldwide. Infection and fever substantially increase the risk to mother and fetus.

Objective: To study the maternal and fetal outcomes in pregnant women suffering from fever beyond 28 weeks of gestation.

Methods: This prospective cohort study was conducted in the department of Obstetrics and Gynaecology in collaboration with the department of MEDICINE from December 2020 to April 2022. 100 pregnant women having fever and 100 pregnant women not having fever were enrolled in the study. After correlating the clinical findings and investigations, the diagnosis was established. Maternal and fetal outcomes were studied.

Results: The common causes of fever were Upper respiratory tract infection (URTI)- COVID Negative (35%), URTI COVID Positive (28%), Typhoid (18%), TB (3%), Malaria (6%), UTI (3%), Hepatitis (2 %), Dengue (3%) and unexplained (2%). Adverse fetal outcomes were preterm (36%), low birth weight (52%), low APGAR (<7) at 5 min of birth (38%), IUGR (20%), and IUD (1%). Adverse maternal antenatal complications were preterm (27.9%), oligohydramnios (4.7%), IUGR (20%), PIH (8%), postdates (4%), PROM (12%), fetal distress (36%), previous LSCS with scar tenderness (0.8%).

Conclusion: We found that fever had a definitive adverse impact on outcomes during pregnancy. The maternal outcomes were related to the etiology of the fever whereas fetal outcomes were similar regardless of the cause. Hence it is suggested that to have a better maternal and fetal outcome, fever during pregnancy should be investigated and treated promptly

P-2A/OP-4

Prevalence of Gestational Diabetes Mellitus (GDM) in Intrahepatic Cholestasis of Pregnancy (IHCP)

Umaira Fathima, Garima Kapoor
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Incidence of IHCP in Indian population is 0.02%-2.4% and that of GDM is 3.8% - 17.9%. Frequent co-existence of both has raised the question of any association. There exist only few studies to prove or disprove any association.

Objectives: Primary Objective: To determine the prevalence of GDM in women with IHCP. Secondary Objective: To compare the feto-maternal outcome in women with GDM with or without IHCP.

Methods: The study was conducted in the Department of Obstetrics and Gynaecology, VMMC and SJH, New Delhi in 514 women with singleton pregnancy ≥28wks, divided into two groups, Women with IHCP and Women without IHCP. The Diagnosis of IHCP was made according to the RCOG Guidelines. OGTT with 75 mg glucose was done to make the diagnosis of GDM. Management was as per obstetrics protocol and feto-maternal outcomes recorded till delivery.

Results: No statistically significant difference in the prevalence of GDM observed in both groups (5.4% in women with IHCP and 8.2% in women without IHCP, p=0.220). Significantly higher number of preterm deliveries (21%, p<0.001), induced labour (53.6%, p<0.001), women undergoing LSCS (46.3%, p<0.001) in women with IHCP. No association of FGR, MSL, Fetal maturity, labour onset, mode of delivery, stillbirth, low APGAR score, NICU admission, or PPH in women with GDM with or without IHCP.

Conclusion: The prevalence of GDM is not higher in women with IHCP but significantly higher incidence of preterm delivery, induced labour, and caesarean sections in women with IHCP. No significant difference between women with GDM with or without IHCP.

P-2A/OP-5

Role of Folic Acid & B12 in Pregnancy and Abortion

Preeti Gahlawat Jakhar, S. Nanda
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Vitamin B12 maintains normal folate metabolism during pregnancy. Maternal folate deficiency has been associated with adverse pregnancy outcomes.

Objective: To predict the risk of abortion in pregnancy by studying the relation between folate and B12 levels. Methods: This prospective observational study was carried out on 100 pregnant women with singleton pregnancy of 6 to 12 weeks gestation. Females were divided into three groups: Group 1: 30 pregnant women without history of abortion; Group 2: 35 pregnant females with history of abortion; and Group 3: 35 pregnant women with complaint of bleeding per vaginum. Serum folate and B12 levels were estimated. Data obtained were computed as mean with standard deviation and SPSS/ANOVA was applied.

Results: Serum folate and B12 levels were comparable in all groups. Mean difference was statistically significant. 26.66%, 37.13%, and 31.42%

patients had folate deficiency, of which 3,33%, 5.71% and 5.71% aborted in Groups 1, 2 and 3 respectively. Patients with B12 deficiency were 73.33%, 82.85% and 37.13%; of which 3.33%, 8.57% and 2.85% had abortion in group 1, 2 and 3 respectively.Thus, folate and B12 deficiency were not found to be associated with abortion.

Conclusion: A positive correlation was seen between serum folate and B12 levels. All females planning for conception should be given folate and B12 supplementation

P-2A/OP-6

Knowledge Attitude and Practices of Antenatal Care Among Women Attending Lok Nayak Hospital

Mallary Chandravadia, Nidhi Garg, Shikha Sharma, Latika Sahu
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Improving maternal health is one of the eight-millennium development goals. Health knowledge is an important element to enable women to be aware and emphasise importance of appropriate antenatal care. Very few studies were carried out in India about this aspect of maternal health and hence data in this regard is scarcely available.

Aim and objective: The purpose of this study is to assess knowledge, attitude, and practices related to antenatal care among women attending Lok Nayak hospital, Delhi.

Materials and method: A cross-sectional questionnaire-based study was conducted among 203 women attending Lok Nayak hospital between 20th September to 20th October 2022.

Results: Majority of the respondents (99%) agreed that antenatal check-up is necessary for pregnant women, however only 81% were self-motivated to come for antenatal check-up. Iron and folic acid supplementation are good for mother and foetus according to 97% women but only 88% were taking them. Majority of the patients (94%) agreed that blood pressure should be checked during pregnancy but only 66% knew that increased blood pressure can affect fetal growth. Almost all 99% women agreed that hospital delivery is better than home delivery but only 97 out of the 112 multipara patients had delivered previous baby at the hospital.

Conclusion: With an upsurge in educational levels of women knowledge regarding antenatal care has been observed to be increased. Still, a lot of work needs to be done to reflect this knowledge into practices, to overcome barriers and reduce maternal morbidity and mortality.

P-2A/OP-7

Invasive Prenatal Diagnostic Procedures: A Single Centre Experience

Rapaka G[1], Rana A[1], Bhatla N[1],Gupta N[2], Kacchawa G[1], Mahey R[1], Sharma JB[1], Madhumita RC[2], Shukla R[2], Singh A[2], Mishra P[2], Kabra M[2]
[1]Department of Obstetrics and Gynaecology,
[2]Department of Paediatrics and Division of Genetics,
AllIndia Institute of Medical Sciences, New Delhi

Introduction: Invasive prenatal diagnostic procedures aid in determining the genetic condition of the fetus and management of the pregnancy. The utility of these procedures has widened with the amendment in the MTP (medical termination of pregnancy) law as MTP can now be offered at an advanced gestational age also, minimizing the agony to the couple. Objective: To study the indications and outcomes of various invasive prenatal diagnostic procedures in a tertiary referral fetal medicine centre.

Methods: This retrospective study included 175 pregnant women between 12-31 weeks of gestation who underwent various invasive diagnostic procedures between March 2021 to August 2022. The gestational age, indications, procedure related complications and results of the procedures were evaluated.

Results: A total of 187 procedures including 98 (52.41%) amniocentesis, 81 (43.31%) chorionic villus sampling and 8 (4.27%) cordocentesis were performed during this period. The most common indication was genetic disorders in the family or previous child 53/175 (30.28%).The other indications were ultrasound features of abnormality in which soft markers were seen in 47/175 (26.85%) and gross anomalies in 43/175 (24.57%). Positive screening for aneuploidy prompted testing in 35/175 (20%) of patients. 147 (84%) patients had normal reports, 26 patients (14.85%) had abnormal reports and 2 (1.14%) had culture failure. 41/175 (23.43%) women opted for MTP based on abnormal result (15/41; 36.58%) or gross anomalies (26/41; 63.41%). 6/175 (3.42%) women had gestational age more than 24 weeks. Procedure related loss was seen in 2 (1.1%) patients within 1 week of procedure.

Conclusion: Invasive testing is a safe and feasible option for diagnosis of various prenatal conditions. It should be offered to all patients who have history of genetic disorder in family, ultrasound abnormality in fetus or screen positive for aneuploidy.

P-2A/OP-8

Whether BMI Calculated from Data Collection of Height and Weight Parameters Affect the Various Outcomes of Assisted Reproduction?

Shubhadeep Bhattacharjee
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Objective: Obesity is a worldwide concern with detrimental health effects including decreased fecundity. However, obesity's impact on in vitro fertilization (IVF) is inconclusive and there is little data concerning poor ovarian responders (POR). This study explored the effects of overweight and obesity on IVF outcomes.

Design: We retrospectively evaluated 75 women undergoing IVF cycles and divided into three groups based on BMI.

Materials and Methods: Patients were categorized into three groups. Group 1 was normal weight POR (18.5–24.9 kg/m2, n = 25); Group 2 was overweight POR (25.0–29.9 kg/m2, n = 25); and Group 3 was obese POR (≥30.0 kg/m2, n = 25). Main measured outcomes included IVF outcomes.

Results: Fertilization rates of obese subjects were significantly lower than normal and overweight subjects (p = 0.04). Obese women's clinical pregnancy rates were (15%) than normal weight women (33.3%). Total dose of gonadotropin consumed was significantly higher in the obese group 3 as compared to group 1 and 2.

Conclusions: Despite similar counts of recruited mature oocytes, obese POR women had decreased fertilization and clinical pregnancy rates. They had greater consumption of gonadotropins to produce equivalent number of oocytes or embryos. Obesity rather than overweight significantly decreased IVF outcomes.

P-2A/OP-9

SLE During Pregnancy Maternal and Perinatal Outcome in Tertiary Hospital

Nayana DH, Meenakshi Karan
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: SLE is an autoimmune disease most frequently found in women of child bearing age. Its multisystem involvement and therapeutic interventions pose a high risk for both the mother and the foetus. Disease flares in pregnancy pose challenges with respect to distinguishing physiologic changes related to pregnancy from disease related manifestations.

Objective: The present study analyses the feto-maternal outcome of pregnant women with SLE.

Methods: Analysis of feto-maternal outcome of pregnant women with SLE during April 2021 to May 2022 at a tertiary hospital.

Results: During the period from 1 year, 3773 deliveries were conducted. Eleven pregnant women with SLE were followed up, giving an incidence of 0.29/1000 deliveries. A high rate of lupus flare during pregnancy was found in current study. Even among women in remission for more than six months before pregnancy, the rate of lupus flare was not low (27%). Also, other complications seen were pre-eclampsia 54.54%, HELLP syndrome in 9.09%, PPH in 50%, polyserositis seen in 9.09% and one maternal death was seen (9.09%). No neonate suffered from heart block, however there was 75 % NICU admissions among live borns.

Conclusions: Advancing technology and better understanding of the maternal-foetal relationship in lupus have improved outcomes in lupus pregnancies over the last decade. The multisystem nature of the disease, the severity of the organ involvement needs to be assessed and a multidisciplinary approach is required for its diagnosis and successful management.

P-2A/OP-10

Covid 19 Vaccination in Pregnancy: Attitude Practice and Concerns

Sumedha Sharma, Nidhi Gupta
Hamdard Institute of Medical Sciences and Research (HIMSAR), New Delhi, India

Objective: The study is aimed to evaluate the knowledge regarding COVID vaccine, their attitude towards taking vaccine during pregnancy and to

know the factors which lead to non-acceptance of vaccine.

Materials & methods:This was an observational cross-sectional study done in department of Obstetrics and Gynaecology, Hamdard Institute of Medical Sciences & Research, New Delhi over a period of 6 months. A google form-based questionnaire was prepared with Cronbach's alpha value of 0.795. A pretested and validated questionnaire was used on pregnant women coming to antenatal OPD of HAHC hospital. It consisted of demographic characteristics, knowledge, and attitude about COVID-19 vaccination in pregnancy. For knowledge and attitude questions, a 5-point Likert scale was used ranging from 1 to 5. Appropriate statistical analysis was done with p values < 0.05 were considered as significant.

Results:The study included 451 pregnant females. Vaccine acceptance rate in pregnancy was 7.3% while anticipated vaccine acceptance rate was 41% and vaccine hesitancy was 59%. Most common reason for not taking the vaccine was the concern for effect on pregnancy. As the education level increased, agreement was on the fact that COVID infection may occur after vaccination and also the need of vaccination after COVID infection.

Conclusion: In view of low vaccine acceptance rate, health education programmes and mass media coverage are needed for reducing the gap of knowledge among pregnant women.

Session 3 A (Obstetrics)

P-3A/OP-1

Risk Stratification Scores in Predicting Adverse Cardiac Outcomes in Pregnant Women with Congenital Heart Disease

Divya Prasad, Shakun Tyagi, Nalini Bala Pandey, Asmita M Ratore
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Objective: To assess performance of risk stratification scores in predicting adverse cardiac outcomes in pregnant women with congenital heart disease.

Methodology: Single-centre retrospective study conducted was conducted at a Tertiary care academic hospital. Existing risk stratification scores used in predicting adverse cardiac outcomes in pregnant women with congenital heart disease were studied. Women ≥ 18 years with International Classification of Diseases, Ninth Revision, Clinical Modification codes indicating congenital heart disease who delivered in the months of June to October 2022 were included in the study. CARPREG I and ZAHARA risk scores, modified World Health Organization (WHO) and ACHD-AP criteria were applied to each woman. The primary outcome was defined by ≥1 of the following: arrhythmia, heart failure/pulmonary edema, transient ischemic attack, stroke, dissection, myocardial infarction, cardiac arrest, death during gestation and up to 6 months post-partum.

Results: Amongst the various scoring criterias, ACHD- AP criteria is the latest scoring criteria which has been assessed in non-pregnant population but has not been validated in pregnant population. Among the ten pregnant women who were admitted and subsequently delivered, various scores had different prognostic value.

Conclusions: Pregnancy in a patient with congenital heart disease is a rare event. Further studies are required to validate the latest scoring scheme used for predicting adverse pregnancy outcome in these pregnant women.

P-3A/OP-4

Oxytocin Alone Versus Dinoprostone Insert Followed by Oxytocin for Inducing Labour in Term Prelabour Rupture of Membranes (Term Prom)

Divith Khagraj, Anjali Dabral, P K Debata, Rekha Bharti
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Immediate induction in Term Prelabour rupture of membranes (PROM) decreases infectious morbidity in mother and baby. Induction of labour in Term PROM with unfavorable cervix can be done directly with oxytocin or by first priming the cervix with prostaglandins followed by oxytocin augmentation if needed. Direct oxytocin induction leads to shorter induction to delivery interval but increases caesarean delivery.

Objective: To compare the induction to delivery interval and feto-maternal outcome in women with Term PROM and unfavorable cervix induced with Oxytocin versus Dinoprostone (PGE2) Vaginal insert followed by oxytocin.

Methods: This was a randomized comparative study including 150 low risk pregnant women with term PROM and poor bishops score, done over a period of 18 months, women were randomized into two

groups of 75 each after obtaining informed consent. Women in-group A were induced with Oxytocin directly while Group-B were first primed with dinoprostone vaginal insert followed by oxytocin induction/augmentation if needed. All women were followed for induction to delivery interval and feto-maternal infectious morbidity.

Results: Induction to delivery interval and hospital stay was significantly shorter in group A as compared to group B, 11.4 hours & 18.3 hours, p <0.001 and 75.12 hours & 90.48 hours, p <0.001 respectively. The caesarean rate was similar in both groups, p=0.546. There was no feto-maternal infectious morbidity in the study population.

Conclusion: Direct oxytocin induction in term PROM results in shorter induction delivery interval and shorter duration of hospital stay without increasing caesarean rate.

P-3A/OP-5

To Compare Feto-Maternal Outcomes of Pregnancies Complicated by Superimposed Preeclampsia on Chronic Hypertension Vs Preeclampsia

Aishwarya Yadav, Kiran Aggarwal, Sanghamita R, Prabha Lal, Anuradha Singh, Kavita Badhal
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Objective: To compare feto-maternal outcomes of pregnancies complicated by Superimposed Preeclampsia on Chronic Hypertension vs Preeclampsia.

Study design: Prospective analytical study of pregnancies complicated by chronic hypertension with superimposed preeclampsia (Group A, n=40) and preeclampsia (Group B, n=40) beyond 20 weeks of gestation managed in LHMC from January 2021 to June 2022. The primary outcomes were compared in terms of preterm deliveries < 34 and 37 weeks of gestation and secondary outcomes were compared in terms of maternal and neonatal complications between the two groups.

Results: Women of Group A vs Group B were older (Mean age:31.8±6.15 vs 26.52±3.9 years; p:0.001) and had higher BMI (28.6±3.1 kg/m2 vs 23.7±2.7 kg/m2; p:1.41). They were multigravidas (70% vs 30%; p:<0.001), and had family history of hypertension (60% vs 25%; p:0.001). Mean BP at presentation (SBP:167.5 ± 19.4 mmHg vs 155.4 ± 10.8 mmHg; p:0.002, DBP:105.2 ± 7.9 mmHg vs 100.5 ± 10.8 mmHg; p :0.02) and over the antepartum period (SBP: 154.3±13.7 mmHg vs 145.3± 15.5 mmHg; p:0.001, DBP: 100.8±8.2 mmHg vs 94.8±8.9 mmHg; p:0.03) was higher in group A. The need for more than one oral (25%vs10%; p:0.07) and injectable antihypertensive (45%vs 22%; p:0.04) was higher in Group A. Immediate termination when presented at <34 weeks (32.5%vs 7.5%) and rate of early preterm deliveries (62.5% vs 35%; p:0.01) was higher in Group A.

Conclusion: Women of Group A have increased percentage of preterm deliveries. Caesarean Section rates were equivalent in both groups but operative complications were higher in group A. Coagulation related disorders, Renal function derangements, Dyslipidemia were higher and newborns were more likely to be preterm, have fetal growth restriction and increased NICU admissions in Group A.

P-3A/OP-6

Treating Severe Hypertension in Pregnancy

Nalini H, Ana Fatima, Renu Arora
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Hypertensive disorders of pregnancy accounts for 5-10% of all pregnancies. Treatment of severe hypertension in pregnancy is a great challenge. Most guidelines recommend labetalol, hydralazine and nifedipine as first line drugs. Labetalol and nifedipine have fast emerged as drugs of choice.

Objective: To compare the efficacy and side effects of oral nifedipine with intravenous labetalol for control of severe hypertension.

Methods: Double-blinded randomized comparative study done in 120 antenatal women of gestational age >20 weeks with severe hypertension in pregnancy. Labetalol group received 20mg followed by escalating doses of 40mg, 80mg, 80mg (4 doses) every 20min to a maximum of 220mg. Nifedipine group received 10mg followed by repeated doses of 10mg every 20min (total 5 doses) to a maximum of 50mg. The time taken, number of doses required to achieve the target blood pressure (≤150/100 mmHg), side effects were recorded. Results: 60 women were randomised to each group. None of the patients in nifedipine group required labetalol, whereas 3 patients in labetalol group achieved target BP only after nifedipine was administered after maximum dose of labetalol. The mean time taken to achieve target BP in the labetalol group was 30mins and in

the nifedipine group was 27mins p=0.25. The mean number of doses to achieve target BP in nifedipine group was 1.35 and 1.50 in labetalol group.

Conclusion: Both intravenous labetalol and oral nifedipine were effective in controlling severe hypertension. Nifedipine reduced BP more rapidly than labetalol. Nifedipine can be a better alternative due to ease of oral administration.

P-3A/OP-7

Case Report of Atypical Eclampsia with Status Epilepticus

Anjali Sinha, Shivani Agarwal
Kasturba hospital, New Delhi, India

Objective: To diagnose and manage a case of atypical eclampsia.

Case report: 19 yrs. old female primigravida at 37 weeks 4 days of gestation presented to casualty in early labour with 2-3 cm dilated and early effaced cervix. Examination showed normal BP, no history of proteinuria, edema or raised BP. After 2 hours, status epilepticus occurred which was managed with Inj. Midazolam and Pritchard regimen of MgSO4was started. After stabilisation with concurrent fetal monitoring, caesarean section was done under GA. 2 more episodes of generalised tonic clonic seizures (GTCS) occurred in immediate post operative period with raised BP of 160/110 mm of hg with urine dipstick of 2+ in postictal phase. After 8 hours post op, patient was stable with normal BP and no proteinuria. CT brain showed no focal changes. There was no complain of blurring of vision. Patient was discharged on day 8 after total stitch removal and followed up in OPD for postpartum period which was uneventful.

Result: Clinical findings and blood reports ruled out other hypertensive disorders of pregnancy and thus diagnosis of atypical eclampsia with status epilepticus was made.

Conclusion: Diagnosis and timely management of patient with atypical eclampsia is very important as its course is unpredictable. The sudden onset of GTCS without predisposing findings contribute to maternal and fetal morbidity and mortality

P-3A/OP-8

A Retrospective Study of The Comparison of Maternal Outcomes in In-Vitro-Fertilization Pregnancy Versus Spontaneous Conception

Reena, **Kanika Chopra**, Aditi
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Infertility has become one of the serious global disabilities. In vitro fertilization (IVF) has brought along with its adverse maternal outcomes, that have not been studied so far, especially in India.

Objective: This study was planned with the aim to compare maternal near miss and mortality in pregnancies conceived with IVF as compared to those conceived spontaneously, at a tertiary level hospital, New Delhi.

Methods: It was a retrospective cohort study conducted in our hospital from 2018-2020. The details of all IVF conceived women who delivered in our hospital were taken from medical record section and a preformed proforma was filled. The demographic, obstetrics, significant past history, presence of obstetric related morbidity, mode of delivery, maternal near miss and mortality and their reasons were included. Similar data from spontaneous conceptions were compiled. Data was statistically analysed. The quantitative variables were expressed as Mean ± SD and qualitative variables as percentages. Comparison of maternal characteristics in terms of obstetrics history and intra and postpartum events was tested using chi-square test, p value < 0.05 was considered as significant.

Results: Mean age of women in the study group was 33.16±5.58 years and in controls was 26.16±4.28 years. The risk of multiple pregnancy (58.5% versus 2%, p< 0.0001), pre-eclampsia (62.8% versus 17.1%, p< 0.0001), gestational diabetes mellitus (23.5% versus 14.2%, p- 0.0493), intrahepatic cholestasis of pregnancy (32.8% versus 10%, p<0.0001), antepartum haemorrhage (12.1% versus 2.85%, p-0.0066) and preterm deliveries (66.4% versus 5.7%, < 0.0001) were much higher in study group as compared to control group and was statistically significant. Maternal near miss among the study group was significantly higher than the control group (12.8% versus 0.7%, OR 20.50, 95% CI - 2.6979 to 155.8916) and p = 0.0035. The odds of maternal mortality were 4.0882, 95% CI 0.4512 to 37.0465, p = 0.2105 in the study group as compared to control group.

Conclusion: IVF conceived pregnancies are at an increased risk for potentially life-threatening complications to mother. There is a need to counsel the couples wanting to conceive via IVF about not just the procedure and success rates, but also the

potential after pregnancy complications.

P-3A/OP-9

To Evaluate Disability and Functioning of Women with Low-Risk Pregnancy Using World Health Organisation (WHO) Disability Assessment Schedule 2.0 (WHODAS 2.0)

Nausheen Anis, Nupur Gupta
ESI-PGIMSR Basaidarapur, New Delhi, India

Introduction: Low risk pregnancy is gestation without any additional high-risk factors that affect maternal and fetal wellbeing. WHO developed questionnaire to quantify the level of disability and functioning called World Health Organization Disability Assessment Schedule 2.0 having six domains namely cognition, mobility, selfcare, getting along, life activities and participation with variable number of questions and score from 1 to 5 for progressively increasing level of disability that is none, mild, moderate, severe and extreme. Urinary incontinence is involuntary loss of urine during increased intrabdominal pressure or reaching the loo or mixed.

Objective: The objective of study was to evaluate disability and functioning in low-risk pregnancy using WHODAS 2.0, 36 item score in late second and third trimesters. The study also individually assessed the complaint of urinary incontinence and degree of pain during the two interviews.

Methods: The study was prospective observational cohort study on women with low-risk singleton pregnancy in late second and third trimester using WHODAS 2.0,36 item score and question on pain and urinary incontinence.

Results: On comparing individual and total scores of both trimesters statistically significant results were obtained; p value < 0.001. The first domain cognition had significant decrease in scores while the other five domains had an increase in disability in third trimester and no statistically significant change in urinary incontinence and pain on comparing both trimesters.

Conclusion: Our study concluded that low risk pregnancy has a significant reduction in functioning and increased disability than what is normally perceived in our system. Pregnancy is dynamic and fast changing state however both at the level of woman and society we need a better understanding and improved care in pregnancy.

Session 4 A (Obstetrics)

P-4A/OP-1

Caesarean Scar Ectopic Continues to Be a Challenge

Aditi Goyal, Reena Yadav, Manisha Kumar, Nishtha Jaiswal, Kanika Chopra, Lalitha Palaparthi
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Caesarean Scar Ectopic Pregnancy is implantation in the myometrial defect in the previous uterine incision. The prevalence is 1 in 2,000 pregnancies. The diagnostic and therapeutic challenge posed by the condition and its life-threatening nature continue to push our limits and upgrade our skills.

Case: A 35-year-old lady gravida 5 para 2 live 2 abortion 2 at 10-week gestation with previous 2 LSCS presented with spotting for 5 days. Ultrasound was suggestive of intrauterine pregnancy following which she was given mifepristone and misoprostol. There was no response and ultrasound showed presence of cardiac activity therefore patient was administered intracardiac KCl and intraamniotic methotrexate. After waiting 48 hours for spontaneous expulsion, the patient was planned for suction and evacuation in Operation Theatre. After attempting suction and evacuation the patient started bleeding profusely and therefore the decision for emergency laparotomy was taken followed by total abdominal hysterectomy with bilateral salpingectomy. She had a blood loss of 2.3 litres and received multiple blood transfusions. The post-operative period was uneventful and the patient was discharged on postoperative day 6. This shows an unusual presentation of a scar site ectopic which resorted to surgical management only. The cases of scar site ectopic have been rising and we need upgradation of our skills on how to effectively diagnose and manage the condition with minimal morbidity to the patient. Also, since the underlying cause is the increasing number of caesarean sections, there is a dire need to audit our caesarean section rates at all healthcare system levels.

P-4A/OP-2

Ambient Air Pollution-A New Intrauterine Environmental Toxin for Preterm Birth and Low Birth Weight

Neha Bhardwaj, Aruna Nigam, Arpita De
Hamdard Institute of Medical Sciences and Research

(HIMSAR), New Delhi, India

Introduction: Urbanisation and industrialisation in developing and developed countries have led to rise of intrauterine environmental toxins ~ PM2.5, PM10, NO2 and Ozone. No study has been published till date from Northern India which investigates association between ambient air pollution exposure and pregnancy outcome.

Objective: To determine association of ambient air pollution exposure (PM2.5, PM10, Ozone, NO2) with pregnancy outcomes (Pre-term delivery, Low birth weight)

Methods - The study is a retrospective cohort study done from January 2021 till June 2022 in a tertiary care hospital, New Delhi. Purposive sampling was done and a pre-designed proforma was filled of all the patients delivered. For each patient, exposure of PM 2.5, PM10, Ozone, NO2 was recorded from the government recording stations nearest to her residence and pregnancy outcome correlated with same. Maternal age between 21 and 35 years with singleton live pregnancy and residing in Delhi during current pregnancy were included. Indoor air pollution, IVF pregnancies, Multiple gestation, Occupational hazards, Co-morbidities like Chronic hypertension, Diabetes mellitus, renal disease, were excluded.

Results -Total 1155 patients were recruited. In this study, incidence of preterm (< 0.05) between PM2.5, NO2,Ozone and pre term birth during first and second trimester of pregnancy. Our study also established significant association ($p < 0.05$) between PM2.5, PM10 exposure and low birth weight during first trimester of pregnancy.

Conclusion -The study reveals direct relationship between ambient air pollution exposure and pregnancy outcomes (preterm birth and low birth weight).

P-4A/OP-3

Critical Appraisal of Causes Interventions and Outcome of Maternal Near Miss in A Tertiary Care Hospital

Poonam Jakhar, Ratna Biswas
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Maternal near miss as defined by WHO refers to "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy. The review of these cases helps in the assessment of maternal health services and identify the gaps. It forms the framework for future research, based on which policy makers can take decisions.

Objectives: To study the aetiological and contributory factors responsible for MNM and To study the key interventions undertaken and outcome of MNM events

Methods: It was a prospective observational study conducted from January 2021 to March 2022. Women identified as MMN by the Operational Guidelines, MOHFW were recruited in the study.

Results: There were 99 MNM cases and 37 maternal deaths. The maternal near miss ratio and severe maternal outcome ratio were 9.3 and 12.7 per 1000 live births respectively. 75 cases were recruited for the study. Obstetric haemorrhage was the leading cause in 60%, followed by hypertensive disorders of pregnancy in 9.3% and obstetric sepsis 6.7%. Anemia was the commonest contributory cause (44%) followed by previous caesarean section in 36% and lack of blood products (12 %)

Conclusion: Haemorrhage was the primary cause and anemia was the major contributory cause of MNM. Strengthening anemia prevention programs and establishing blood bank services in peripheries will be instrumental in reducing maternal near miss events.

P-4A/OP-4

Fetal cardiac rhabdomyoma: ultrasound, autopsy, histopathology and genetic analysis

Jyoti Chugh, Rajneesh Juneja, Gaurav Garg, Deepa Khurana, Seema Thakur
Satyam Medical Centre,

Background: Diagnosis, management and fetal counselling of cardiac rhabdomyoma is challenging on in utero diagnosis.

Methods: We discuss a case of fetal rhabdomyoma detected antenatally at 23-24 weeks and discuss autopsy, histopathology and molecular findings.

Results: Antenatal ultrasound at 23-24 weeks showed an echogenic mass, size 7 mmx5 mm in the cardiac septum near apex. Fetal echo confirmed a cardiac mass. Fetal autopsy after termination confirmed rhabdomyoma near the apex and the tumor was distorting the shape of the ventricle. Internally a small mass was seen on septum. Histopathogy confirmed this mass as cardiac rhabdomyoma. Molecular analysis on fetal tissue showed a heterozygous variant in TSC2 gene. c.65del (p.Gly22GlufsTer24 . This is a frame shift mutation and reported as PATHOGENIC.

Conclusions: Fetal cardiac rhabdomyomas are often benign and have a tendency to regress, but their prognosis is guarded due to very strong association with tuberous sclerosis. During prenatal counseling, parents should be counselled regarding association with Tuberous sclerosis in 70-90% cases. Tuberous sclerosis is caused by mutation in two genes: TSC1(26% and TSC2 (69%). About two third cases of TSC are denovo. Parental testing for known variant is essential for genetic counselling. If one of the parents is carrying the same variant then the recurrence risk is 50%. However if the parents do not harbour the same variant, the risk to siblings of being affected is low (~1%-2%) because of germline mosaicism.

P-4A/OP-6

A Study of Pattern and Distribution of Congenital Malformations and Birth Defects with Antenatal Associations

Apoorva Hans, Sangeeta Gupta, Ashish Jain
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Globally, the highest contributors to neonatal deaths were preterm births (34.7%), intrapartum complications (19.6%), pneumonia (16.3%) and neonatal sepsis (15%). Congenital anomalies constitute the fifth largest cause, being responsible for an estimated 9% of neonatal deaths in the year 2010 (1).

Aims and Objectives: To study the pattern and distribution of congenital malformations and birth defects in a tertiary care centre in Delhi.

Methods: A both retrospective and prospective descriptive study enrolled all birth defects from January 2019 to December 2021. The birth defects were analysed for prevalence and an association of the pattern of anomalies with the antenatal maternal factors was also studied.

Results: A prevalence of 4.2% was calculated for congenital malformations and birth defects in our centre. Commonest prevalence was of musculoskeletal malformations, followed by nervous system anomalies with 25.7% and 22.8% respectively. In babies with malformation, 2.5% mothers had diabetes mellitus and 2.6% of women had epilepsy, of which 77.78% of the women were on anti-epileptics. About 23% patients with malformations in the fetuses had no antenatal care and consanguinity was identified in 29% of the cases.

Conclusion: Understanding the association of different antenatal maternal risk factors in causation of these malformations helps in planning contextual policies and strategies for counting, and caring for neonates and mothers and preventing congenital malformations.

Abstracts of Poster Presentation (Hall B) on 12th November, 2022

Session 1 B (Gynaecology)

P-1B/GP-1

Early Diagnosis and Appropriate Management of Atypical Mullerian Malformations: Need of the Hour

Neha Varun, Reeta Mahey, Shalini V Singh, Tanya Satija, Garima Kachhawa, J B Sharma, Neerja Bhatla
All India Institute of Medical Sciences, New Delhi, India

Introduction: Mullerian congenital anomalies are a result of defect in the normal process of embryonic formation of organs. Obstructed hemi-vagina ipsilateral renal agenesis (OHVIRA) is a rare anomaly of the urogenital system. Robert's uterus is another rare type of congenital uterine anomaly where septum divides the uterine cavity asymmetrically resulting in the formation of a non communicating hemi uterus. Both these malformations are the causes of progressive dysmenorrhoea among adolescent girls. We here present two cases of such rare atypical Mullerian malformations, which were managed successfully.

Case 1: 19-year female, came with the history of pain abdomen and progressive dysmenorrhea since menarche. Imaging made a likely diagnosis of septate uterus. Previously, there was a history of laparo-hysetroscopy along with the drainage of hematometra at some other center. Pt underwent laparoscopy and hysteroscopy, diagnosis of type 3 Robert's uterus made and hysteroscopicmetroplastyis done.

Case 2: 14-year female, presented with progressive dysmenorrhea since menarche. On examination vague mass approximately 10x5 cm felt on right side of abdomen. Imaging made a likely diagnosis of didelphys uterus with hematometra and hematosalpinx. There was a previous history of ultrasound guided hematometra drainage. Patient underwent lapro-hysteroscopy and diagnosis of OHVIRA syndrome was made. Vaginal septal resection along with pyo-salpinx drainage was done and Mallecot catheter was inserted. Patient again presented with high-grade fever and hematosalpinx

(20*10 cm) and underwent laparotomy followed by right salpingo-oophorectomy and right hemi-hysterectomy.

Conclusion: These cases emphasize the need of awareness and understanding of these atypical or rare obstructive Mullerian malformations. Misdiagnosis, late diagnosis and repeated incomplete surgical interventions lead to inappropriate surgical and future reproductive outcome.

P-1B/GP-2

Obstructed Hemivagina and Ipsilateral Renal Agenesis (OHVIRA) Syndrome in An Adolescent Girl: A Case Report

Tanya Singhal, Reena Yadav
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Obstructed Hemivagina with Ipsilateral Renal Agenesis (OHVIRA), also known as Herlyn-Werner-Wunderlich syndrome is a rare Mullerian Duct anomaly. Patients with this syndrome frequently present with hematocolpos, hematometra or even hematosalpinx. Here, we present a case of an adolescent girl with this syndrome.

Case: A 13-year-old girl presented to us with worsening dysmenorrhea with continuous left pelvic pain for 2 months. On examination, patient had tenderness in left iliac fossa. On Per rectal examination- a large, cystic, tender mass was felt on the left side. MRI revealed a hemorrhagic collection of 7x14cm in the cervix with a communicating uterine horn on the left side having a similar collection of 3x1.5cm. Another rudimentary horn was noted on the right side. The left renal fossa was empty. Per-operatively, a communicating left sided horn was seen having hematometra and early features of endometriosis. Vaginal septum resection was done relieving the obstruction. Consequently, hematocolpos and hematometra were drained.

Discussion: In this girl, by surgically relieving the obstruction, we have ameliorated her symptoms and given a normal menstrual cycle. Normal sexual activity and conception, as has been seen in other cases of OHVIRA syndrome, is also being expected in our patient.

Conclusion:OHVIRA syndrome is an uncommon congenital anomaly with clinical significance and simple surgical management. Imaging, particularly an MRI plays a major role in diagnosis. An early surgical intervention for relieving obstruction can relieve symptoms and prevent long-standing complications of endometriosis.

P-1B/GP-3

Is Liverpool Normogram of Uroflow Patterns Applicable to Indian Women?

Bhawna Arora, Renu Arora
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Aim: Liverpool normogram of uroflow patterns applied to Indian females.

Introduction: Uroflowmetry is the first and simplest urodynamic test for voiding dysfunction. It measures flow of urine over period of time. Liverpool normogram is most widely universally accepted normogram which was composed using Caucasians. There is difference in pelvic floor dysfunction among different ethnic groups. Hence, there is need of individual normograms for different ethnic populations.

Objectives: Uroflowmetry parameters (maximum flow rate - Qmax and average flow rate - Qavg) of asymptomatic Indian women were plotted on Liverpool normogram.

Methods: The study was conducted in the department of OBGY, VMMC and Safdarjung hospital, New Delhi. Uroflowmetry was performed after taking consent. 30 out of 384 study subjects who were asymptomatic for any urinary complaint were plotted on Liverpool normogram. Also, flow rates of 384 subjects were calculated and a separate normogram was made for Indian population.

Results: Mean age in Halen BT and our study was 32 vs 33 years. Sample size in Halen BT and our study was 249 vs 384. Qmax in Halen BT vs our study was 22.36 ml/sec vs 21.72 ml/sec. Qavg in Halen BT vs our study was 12.58 ml/sec vs 11.64 ml/sec. Only voided volume was different 171 ml vs 252 ml. So, Indian women have more voiding volume. The uroflow parameters when plotted on Liverpool normograms fell between 10th to 25th centile for Qmax and between 10th to 50th centile for Qavg. Liverpool normograms are not applicable to Indian women.

Conclusion: Liverpool normograms cannot be used universally.

P-1B/GP-4

Abdominal Wall Endometriosis: Experience at A Tertiary Care Centre

Namita Jain, Shaily Hanumantaiya, Alka Kriplani
Paras Hospitals, Gurugram, India

Introduction: Abdominal wall endometriosis is characterized by the presence of endometriosis

between the parietal peritoneum and the skin and generally develops within or adjacent to a surgical scar, resulting from pelvic surgeries such as cesarean delivery or hysterectomy. It is often misdiagnosed as hernia, abscess and malignancy. Despite a gynaecologic condition, patient often present to a surgeon.

Aims & Objective: To share the demographics, risk factors, role of imaging and management approach used for patients with abdominal wall endometriosis at our centre.

Methods: This is a prospective observational study. 13 women with abdominal wall endometriosis were managed at Paras Hospital, Gurugram over a period of 4 years (2018-2022). Clinical data, imaging, treatment and the outcome of above-mentioned patients were recorded. Technical skills to reduce recurrence during surgery are also discussed.

Results: Total 13 patients with abdominal wall endometriosis (AWE) were managed over a period of 4 years. Majority of women had one live issue by caesarean section. History of caesarean was common in all the women. 3 women had history of preterm caesarean and 1 had history of hysterotomy. Size of endometrioma varied between 1-3.5 cm. One patient had an associated track connecting uterine cavity with abdominal wall endometrioma. All patients required surgical excision of AWE and one patient additionally required uterine repair. None of the patient required mesh insertion. All 100% patients were asymptomatic on follow-up. One patient with uterine connection was given suppressive therapy for preventing recurrence for 2 months.

Conclusion: Understanding of AWE is relevant as its on rise with increase in cesarean rates and affects quality of life. Surgical excision is considered the criterion standard for treatment of AWE. Surgical excision with 1-cm margins on all sides of the endometrioma is optimal. Standardized protocols with multi-disciplinary team involvement are the key in the management of such cases. Diligent pre-operative planning and competent surgical skill can help mitigate its recurrence.

P-1B/GP-5

Effect of Music on Anxiety in Women Undergoing Colposcopy: A Randomized Controlled Trial

Ashima Gupta, Swati Agrawal, Manju Puri, Anuradha Singh
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Colposcopy has been shown to be associated with high levels of anxiety. This can have adverse consequences, including pain and discomfort during the procedure and high rates of default. Music therapy during colposcopy has been found to reduce the levels of anxiety experienced by women undergoing colposcopy examination. We conducted a hospital based open label Randomized Controlled Trial to study the effect of music on anxiety levels in women undergoing colposcopy.

Methods: The study was conducted at the colposcopy clinic of LHMC & SSKH from January 2021 to June 2022. Women between age group of 25-45 years undergoing colposcopy were randomized to study and control groups. The baseline anxiety of all women was calculated using a VAS anxiety score. In addition, baseline heart rate (HR) and blood pressure (BP) was measured for all the women. The women in the study group received Indian Instrumental music played through earphones starting 5 minutes before the entry to colposcopy room. The women in the control group underwent routine colposcopic assessment.

After the colposcopic assessment a repeat VAS anxiety score, Heart rate, Blood pressure as well as post procedure VAS pain score was recorded. The data was subjected to statistical analysis.

Observations: The median VAS anxiety in the study group was 3 which decreased to 2 after the procedure and the median VAS anxiety was 2 in the control group which increased to 3 after the procedure and the difference was found to be statistically significant. ($p<0.05$). It was found that the average blood pressure decreased in 80% of women in the study group as compared to only 25% of the women in the control group. It was also seen that the heart rate was increased in only 20% of the women in the study group as compare to 75% of women in the control group. Post-procedure pain scores calculated for both groups using the VAS pain score, were found to be comparable in both the groups suggesting that music had no impact on post-procedure pain. (p value =0.062).

Conclusion: This study showed a positive effect of music on patient's level of anxiety during the colposcopy procedure. Additionally, the women in the study group had a decrease in the post-procedure vital parameters which were physiological measures of anxiety. Based on these results, the authors conclude that music is a simple, inexpensive, user friendly and efficient technique for easing anxiety related to colposcopy and maybe used routinely for colposcopic as well as other day care procedures.

P-1B/GP-6

Impact of menopausal symptoms on quality of life and health care seeking behaviour in postmenopausal women

Arpita Joshi, Latika Sahu
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Menopause is defined by WHO as 12 months of amenorrhea around the menopausal age (45-54year). Post-menopausal symptoms occur after menopause which is vasomotor symptoms, psychosocial symptoms, physical symptoms, sexual symptoms.

Methods: A prospective cross section survey was conducted by approaching 433 menopausal women in Delhi, India. Inclusion criteria were any women having attained menopause naturally and post-menopausal women with at least 1 year of amenorrhea. Study populations were postmenopausal women age of group 44 to 64years.

Result: In this study mean age was 53.02±5.66 years, illiterate was 81.1% (n=351), mean age at attaining of menopausal women were 45.6±4.32 years. The prevalence of postmenopausal symptoms was found to be 71.4%. In this study prevalence of physical symptoms, sexual symptoms, vasomotor symptoms, psychosocial symptoms were 68.4% 35.8%, 12.2%, 10.6% respectively. In this study most of women had experienced not bothered symptoms while bothered symptoms were less commonly seen. Lower educational status was associated with more sexual symptoms in menopausal women after multivariate analysis [adjusted odds ratio –2.17 (95% CI: 1.20-3.42)]. Coping domain has been analysed. In general, acceptance is most used strategy while second most common emotional support used strategy.

Conclusion: Our goal to decrease menopausal symptoms and increase quality of life of postmenopausal women. Health care provider and education programme both will help in increase awareness of postmenopausal symptoms and its consequences.

P-1B/GP-7

Effect of Yoga on Clinical, Biochemical and Doppler Parameters in Infertile Women with Polycystic Ovarian Syndrome

Kumari Jyoti, Bindu Bajaj
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: PCOS is one of the common endocrine disorders in women with a prevalence range of 2.2% to 26% in India. PCOS is thought to have a complex aetiology involving gonadotrophic dysregulation, genetic predisposition and environmental variables. They can present with varying symptoms such as infertility, menstrual irregularities, hirsutism, acne, polycystic appearing ovaries, and insulin resistance. Lifestyle intervention is the first line treatment. There is role of Yoga on the various parameters in infertile women with PCOS.

Aim: To determine the effect of Yoga on clinical, biochemical and doppler parameters in infertile women with polycystic ovarian syndrome.

Methods: A Randomised Comparative study conducted over a period of 3 months in IVF center at Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi. All infertile patients reporting or presenting at Infertility Clinic of VMMC and Safdarjung hospital who were fulfilling Rotterdam Criteria of PCOS were enrolled. The infertile couple underwent routine infertility investigations as per standard hospital protocol. This included semen analysis for male partner. The tubal factor as a cause of infertility in the women was ruled out. Written informed consent was obtained from all the participants of the study. These enrolled patients were divided into two groups group A (lifestyle, dietary changes, exercises) and group B (lifestyle, dietary changes, Yoga). A well-structured Yoga session of 45 minutes daily including Asanas (yoga poses), Pranayama (proper breathing), Shavasana, and Meditation was performed. After 3 months reevaluation was done by repeating biochemical investigations, hormonal levels, doppler parameters were measured by transvaginal ultrasound.

Results: There was significant difference in BMI, FBS, OGTT, S.TSH, D2-FSH, D2-LH after 3 months of Yoga in Group B. There was significant difference in uterine artery RI, PI after 3 months of Yoga in Group B.

Conclusion: The effect of Yoga on human body is gradual and subtle and takes a long time to reflect in biochemical parameters. Hence, we need to study a large cohort over a longer time preferably over a year to observe changes in the blood flow parameters. In addition, there is need to study Doppler parameters in individual phenotypes of PCOS. Due to the time constraint, we could not do the same.

P-1B/GP-8

An Audit on Factors Delaying Time to Chemotherapy in Stage

IIB-IV Ovarian Cancer Patients

Megha Mittal
Max hospital, Saket, India

Aims and objectives: To identify risk factors associated with delay in adjuvant chemotherapy in ovarian cancer patients Materials and methods: This is single institute retrospective study. all patients of high-grade epithelial ovarian, fallopian tube, and primary peritoneal carcinoma, FIGO Stage II to IV, who underwent PDS at our institution from January 2018 to December 2019 were included. Patients were excluded if they had non-epithelial ovarian histology, borderline tumours, or if they were declared unresectable or R-2 (> 2cm residual tumour) resection at the end of surgery, synchronous tumours or if they received chemotherapy from outside our institution. The demographic data, biochemical parameters and surgical complexity score was recorded and analysed statistically.

Results: We identified a total of 102 patients who met the inclusion criteria with a mean age of 60.1 years, SD 11.4. Of these, 22 patients (21.6%) experienced a delay in chemotherapy and 80 patients (78.4%) started chemotherapy without any delay. Our study highlighted that age >65 years and low albumin preoperatively was significantly associated with delay in chemotherapy.

Conclusion: This study enables the oncologist to form a predictive model in customizing the treatment for patients for better outcomes, target the delay group for high compliance and low case fatality rates.

P-1B/GP-9

Evaluation of Vulvar Disorders Using Vulvoscopy Index And N-S-P Scheme Using Three Rings Vulvoscopy (TRIV)

Anjali Sarkar, Sruthi Bhaskaran
University College of Medical Sciences and GTB hospital, Delhi, India

Background and Objective: TRIV is a new and promising technique based on fact that Vulva can be divided into three circular zones based on anatomy, embryology and histology- Outer, Middle and Inner ring. Vulvoscopy Index and N-S-P scheme are objective tools to improve the systematization of vulvoscopy findings and to simplify information management using TRIV.

Methods: 100 women with vulvar complaints (Cases) and 100 asymptomatic women (Controls) underwent TRIV and findings were documented as per N-S-P Scheme and Vulvoscopy Index. Biopsy was taken from specific lesions. Vulvar disorders were categorized into five categories based on histology and clinical findings- Vulvodynia, Impaired vulvar skin, Vulvar dermatosis, premalignant lesions of vulva and others.

Results: According to N-S-P, scheme most common formula were- N-N-N for Normal vulva, P-P-P for vulvar dermatoses and premalignant lesions and N-S-N for Impaired Vulvar skin. The mean Vulvoscopy index was 4.33 ± 0.52 for impaired vulvar skin, 6.11 ± 2.87 for vulvodynia, 24 ± 6.04 for pre-malignant lesions of vulva and 25.17 ± 4.31 for vulvar dermatosis. The sensitivity, specificity and diagnostic accuracy of Vulvoscopy Index for detecting vulvar disorders were 100%, 96.51% and 98.50% respectively. The positive and negative predictive values were 0.97 and 1.00 respectively.

Conclusion: Vulvoscopy Index is a significant predictor for vulvar disorders. N-S-P scheme helps in objective and systematic documentation of TRIV findings, which allows monitoring of the vulvar changes. TRIV can be used for preventing early stages of vulvar dermatosis, which is a risk factor for vulvar malignancy.

P-1B/GP-10

Correlation Of Endometrial Thickness by Transvaginal Sonography with Histopathology on Endometrial Biopsy in The Postmenopausal Women with Postmenopausal Bleeding

Mona Rani, BS Meena
[1]Lady Hardinge Medical College and SSKH Hospital, New Delhi, India, [2]SMSMedical College Jaipur, India

Aims & Objectives: To correlate the endometrial thickness as measured by TVS with histopathology of endometrium obtained at endometrial biopsy. To look for sensitivity of TVS in predicting endometrial pathology.

Methods: This is a descriptive type of observational study conducted among women with postmenopausal bleeding who attended the gynaecology OPD SMS medical college Jaipur. 60 Postmenopausal women were included in this study after applying the inclusion and exclusion criteria and their detailed history and clinical examination & investigations and workup, transvaginal sonography and the endometrial biopsy and their

histopathological report were followed.

Results: On the basis of histopathological examination most of the patients was having atrophic endometrium followed by simple endometrial hyperplasia. Majority of patients had atrophic endometrium I.e 38.3 % cases, followed by endometrial hyperplasia was detected in 14 patients i.e 23.3 %cases out of which 11 had simple endometrial hyperplasia while 3 patients had atypical endometrial hyperplasia. Endometrial cancer was detected 8 patients i.e 13.3 %cases. Out of 8 patients one case was confirmed as adenocarcinoma on histopathology after polypectomy through hysteroscope. Histopathological evaluation is mandatory for ruling out malignancy in all cases of postmenopausal bleeding by hysteroscope.

Conclusions: The statistical probability of one of those postmenopausal bleeding episodes being due to gynaecologic cancer is extremely low. Most of the patients was having atrophic endometrium, but Histopathological evaluation is mandatory for ruling out malignancy in all cases of postmenopausal bleeding.

Session 2 B (Obstetrics)

P-2B/OP-1

An Audit on Success Rate of Medical Management of Ectopic Pregnancy in a Tertiary Care Center, New Delhi

Shivani Mane, Deepti Goswami
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Ectopic pregnancy is a common life-threatening obstetrical emergency. Selected cases can be managed medically with methotrexate.

Aims and objectives: This audit aims to study the success rate of medical management for ectopic pregnancy.

Methods: This was an observational study of 150 women with ectopic pregnancy. Data retrieved from case files was analyzed.

Results: 20/150 (13.3%) subjects were managed medically with injection methotrexate. Patients who were managed medically, 5/20 patients received injection methotrexate in recommendeddose based on their body surface area (BSA, 50mg/m2). These 5 patients had median ß-hCG of 2883mIU/L and mean ectopic mass size of 2.32 cm.15/20 patients received a fixed dose of injection methotrexate (50mg).The median ß-hCG in these subjects was 2069 mIU/L and a mean ectopic mass size of 2.59 cm.The medical management failed in 5/20 cases (25%). These five patients had received a fixed dose of methotrexate which was not according to BSA. One patient among these five also didn't fulfill the criteria of medical management (ß-hCG value of 7459 mIU/L and adnexal mass of 8cm). All patients who received the dose of methotrexate based on their BSA resolved uneventfully (100 %success rate). The success rate was only 66.67 % in women who received fixed dose of methotrexate (50 mg).

Conclusions: A proper case selection meeting the criteria for medical management and use of proper dose of methotrexate calculated based on BSA are essential prerequisites to ensure successful medical management of ectopic pregnancy.

P-2B/OP-2

In Vitro Fertilization Pregnancy Outcome in Levothyroxine Treated Women with Hypothyroidism Compared to Women Without Having Thyroid Dysfunction Disorders

Meenakshi Karan, Deepti Goswami, Nayana DH
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Hypothyroidism has been associated with menstrual disorders and infertility. Treatment of hypothyroidism restores a normal menstrual pattern, reverses hormonal alterations, and improves fertility. However, some women with treated hypothyroidism still fail to conceive and seek infertility treatment, including controlled ovarian hyperstimulation (COH) and IVF.

Objective: To assess whether in vitro fertilization (IVF) pregnancy rates differ in levothyroxine treated women with hypothyroidism compared to women without thyroid dysfunction/disorders.

Methods: It is a retrospective study where treated hypothyroid and euthyroid women undergoing IVF at IVF and Reproductive Biology Centre, Department of Obstetrics and Gynaecology, Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi were studied. Women with hypothyroidism were treated with levothyroxine 0.025– 0.15 mg/day for at least 3 months to maintain baseline thyrotropin (TSH) levels of 0.35–2.5 IU/mL prior to commencing IVF treatment. Causes of infertility were similar in both groups. The main outcomes studied were implantation rate, clinical pregnancy rate, clinical miscarriage rate, and live birth rate.

Results: We reviewed the first IVF retrieval cycle performed on 240 women aged 37 years or less during the period January 2015 to October 2022. Women with treated hypothyroidism had significantly less implantation, clinical pregnancy, and live birth rates than euthyroid women. We conclude that, despite levothyroxine treatment, women with hypothyroidism have a significantly decreased chance of achieving a pregnancy following IVF compared to euthyroid. A larger prospective study is necessary to confirm these findings, and determine the optimal level of TSH priorto and during COH for IVF.

P-2B/OP-3

Maternal Resuscitation and Post Cardiopulmonary Resuscitation Survival of Mother

Megha Gupta, RenuTanwar, Nalini Bala Pandey, Mangala Sharma, Shalini Shakarwal, Dr Madhavi M Gupta
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Cardiac arrest during pregnancy is a rare event.The initiation of quick resuscitation response is critical to the outcome of both the mother and the fetus. Cardiac arrest requires high-quality medical care consisting of timely identification, initiation of CPR, and expedited delivery of infant to achieve optimal outcomes for mother and infant.

Case: A 34 years woman, admitted as G2A1, 30+5 weeks of POG with moderate MR, gestational hypertension with superimposed preeclampsia, acute congestive heart failure (MWHO risk class IV), not in labor. Patient was admitted and stabilised in ICU. Review echo revealed CAD, RWMA in RCA, moderate LVSD; moderate MR. Patient developed acute heart failure again after 10 days. Patient got intubated in view of deteriorating vitals and was taken for emergency LSCS in view of decompensating maternal hemodynamic status. Intraoperatively patient underwent cardiac arrest, revived after CPR and defibrillatory shock (pulseless ventricular tachycardia). Patient developed cardiac arrest again immediate postoperatively, sinus rhythm achieved after CPR, defibrillator shock and amiodarone (ventricular tachycardia). Patient became hemodynamically stable and got successfully extubated on POD2. Postoperative echo reported severe MR, LVSD, AMV prolapse. Post-operatively period remained uneventful for the mother.

Conclusion: Early aggressive resuscitation and timely decision for termination of pregnancy by well-trained health care providers improve the chances of successful outcomes for both the patient and her fetus.

P-2B/OP-4

Feto-Maternal Outcomes in Twin Pregnancy

Yashvi Dagar, Deepti Goswami, Sangeeta Gupta, Ajay Kumar
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Twin pregnancy is inherently different from singleton pregnancy and both mother and fetuses are at a higher risk.

Objective: To study the clinical profile and feto-maternal outcomes in women with pregnancy.

Methodology: This was an observational study of 96 women with twin gestation delivering at Lok Nayak Hospital. Data were recorded from case files. These women were contacted telephonically to enquire about the neonatal status, breastfeeding and contraception practices.

Results: Dichorionic diamniotic (71.8%) were the most common type of twins. Nearly half of the women developed antenatal complications; premature rupture of membranes (PROM) (32.3%), hypertensive disorder of pregnancy (21.9%), anaemia (15.6%) and PPH (8.3%). 52.1% required Caesarean section for delivery; malpresentation of first twin (42%) being the most common indication. Discordant fatal growth was observed in 19.8% women and 7.3% women had intrauterine fetal demise. Preterm delivery (69.8%) was the most common fetal complication, median gestational age at delivery being 35weeks 4 days. 75% of both twins were low birth weight (<2.5kg). 44.2% of new-borns required NICU admission. Neonatal death was seen in 9 new-borns. Contraception was adopted by 57.3% women; PPIUCD (39.6%) was the most widely accepted method. 66.7% women exclusively breastfed for atleast 6 months.

Conclusions 48.4% women developed antenatal complications; PROM was the most common maternal complication. Preterm birth and low birth weight were major neonatal complications. Nearly half of the new-borns required NICU admission. A well-developed NICU is essential for improving fetal outcome in these pregnancies. More than half of women adopted contraception and nearly two third women exclusively breastfed for 6 months.

P-2B/OP-5

Contraceptive Practices and Reproductive Outcomes in Women Managed for Ectopic Pregnancy

Shivani Mane, Deepti Goswami
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Ectopic pregnancy has a bearing on reproductive outcome of the affected women due to the underlying cause or surgical treatment.

Aims and objectives: To study the reproductive outcomes in women following management of an ectopic pregnancy (EP).

Method: This was an observational study of 150 women managed for EP. Patient were contacted telephonically following discharge from our facility for their contraceptive practices and subsequent pregnancy details. The average duration of follow-up was 2 years.

Results: 50/150 women had undergone tubal sterilization or had lost both fallopian tubes. Among remaining 100 women, 64 didn't use any contraception after discharge, 25 of them achieved subsequent pregnancy. 32/100 women used barrier method of contraception, 6 of them conceived. 2/100 patients opted for injectable progesterone, one patient chose oral contraception and one opted for an intrauterine device. None of these 4 patients conceived during our follow up. An analysis of these findings was done according to treatment modality for EP in patients who didn't use any contraception or used barrier contraception (n=96). 69/96 patients were managed surgically with salpingectomy. 15/96 patients were managed medically with methotrexate. 12/96 patients underwent expectant management. Overall pregnancy rate was 31% within 2 year. The pregnancy rate was 26% (18/69) after surgical management, 46.7% (7/15) after medical management and 50 % (6/12) after expectant management. There were 3 cases of recurrent EP, 1 was after surgical management and 2 after expectant management.

Conclusions: There is a fair chance of conceiving after management for EP in patients with atleast one intact tube. The pregnancy rate is higher following medical and expectant management as compared to surgical management.

P-2B/OP-6

Maternal Near Miss

Kiran Dhawan, Jaya Chawla, Kamna Datta, Preeti Sania, Ashok Kumar
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Objectives: To study the maternal near miss obstetric cases in a tertiary care hospital from Jan 2021 to March 2022.

Introduction: Women who develop severe acute complications during pregnancy share many pathological and circumstantial factors. By evaluating these cases for "near-miss", much can be learnt about the processes in place (or lack of them) for the care of pregnant women. METHODS- We studied patients who developed various complications that occurred intrapartum, intraoperatively and post-partum. The WHO near-miss approach was implemented in three steps in a cyclical manner: (1) baseline assessment (or reassessment); (2) situation analysis; and (3) interventions for improving health care. Their ICU stay was studied along with the sepsis markers and ICU management.

Results: Out of these six patients, one presented with atonic postpartum haemorrhage, one with pre-ecalmpsia with pulmonary edema, two presented with antepartum eclampsia, one came with postpartum shock and one with acute kidney injury and shock. All six patients required ICU admission and multispeciality treatment. Four patients required intubation out of which two were also given ionotrope support. One patient required hemodialysis.

Conclusion: It was found that early ICU admission and intervention, screening the patients for sepsis markers, and involving multidisciplinary approach was crucial in the management of maternal near miss obstetric cases.

P-2B/OP-7

First Trimester Mean Arterial Pressure for Prediction of Pre-Eclampsia

Anjali Chandra, Rekha Bharti,Pratima Mittal, Nita Bhandari
Vardhman Mahaveer Medical College and Safdarjung Hospital, Society of Applied Science, New Delhi, India

Introduction: First trimester mean arterial pressure (MAP) is an easy, non invasive, cost effective, easily available test that can be used for early prediction of Preeclampsia (PE).

Objective: Role of first trimester MAP for early prediction of Preeclampsia.

Methods: This retrospective study was done at a tertiary care center of Delhi. Women coming for antenatal registration from a specified region of South Delhi between August 2020 and February 2021 were enrolled. Women with high risk of developing G. HTN/PE were excluded. MAP was measured from first trimester blood pressure of all enrolled patients.

Outcome: The main outcome measure was development of PE. The records of all women were retrieved from electronic data base and transferred

to excel sheet for statistical analysis. Multivariate Poisson regression with robust variance was used to analyse the effect of MAP on outcome. ROC curve was used to find out cut off of MAP to predict PE, G. HTN and Eclampsia. Sensitivity, specificity and PPV and NPV were calculated. Results First trimester MAP ≥85 mmHg had sensitivity, specificity, negative predictive value (NPV) & diagnostic accuracy of 90.90%, 54%, 99.7%, & 54.69 % respectively for prediction of PE and sensitivity, specificity, NPV& diagnostic accuracy of 33.3%, 93.3%, 100% & 93.16% respectively for eclampsia. The risk of developing PE increased with each incremental rise in MAP.

Conclusion: MAP is simple test with a good diagnostic accuracy for prediction of PE in first trimester.

P-2B/OP-8

To Study the Effect of Umbilical Cord Length on Perinatal Outcome

Ashika Happy, Madhavi M Gupta, Anjali Tempe
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: The umbilical cord is a conduit between the fetus and the placenta and indeed the lifeline of the fetus. Cord length at term has a variation with extremes ranging from no cords to length up to 300 cm. Extremes of cord length and diameter associated with poor fetal and maternal outcomes.

Aims and Objectives: To study the umbilical cord length after delivery of baby and compare umbilical cord length with fetal outcome and mode of delivery.

Method: It was prospective observational study conducted on 300 singleton pregnant women. Mode of delivery, sex, amniotic fluid color, number of loops around new born, weight, Apgar score at 1 and 5 min were noted cord length measured from new born as well as from the placental side.

Results: The normal cord length ranges from 46 to 78 cm, mean cord length was 59.6 cm, ≤46 consider as short cord, ≥78cm consider as long cord, male had significantly longer cord length, long cord had high incidence of meconium stained liquor and cesarean rate while in short cord birth asphyxia, NICU admission, ventilatory support, parenteral nutrition, low 1 minute Apgar score and early neonatal death were significantly more common and no correlation found between the age, parity, number of loops around neck, weight of the newborn and presentation of the fetus with umbilical cord length.

Conclusion: Male had longer cord length and extremes of cord length had poor maternal and fetal outcomes. Longer cord had high incidence of LSCS while in short cord birth asphyxia event and NICU admission is more common.

P-2B/OP-9

Impact of Who Labour Care Guide on Mode of Delivery in Low-Risk Nulliparous Females in Spontaneous Labour

Sanskriti Garg, Divya Pandey
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: WHO in 2018 redefined stage of labour and gave new recommendation for intrapartum care. New partograph WHO LCG was released in 2020 for its application.

Objective: To determine the effect of WHO LCG in low risk nulliparous females in spontaneous labour on mode of delivery.

Method: This was randomised comparative study done on 300 low risk nulliparous females in spontaneous labour delivering at a tertiary teaching institute over 6 months duration. After informed consent, those meeting the eligibility criteria were enrolled and randomised into study and control group. Labour monitoring was done as per WHO LCG in study group and WHO modified partograph in control group respectively primary outcome was mode of delivery. clinicodemographic data with relevant labour details were noted and subjected to statistical analysis. P value <0.05 was considered significant. Result- Study and control group comprised of 150 women each. The two groups were matching in terms of clinico-demographic parameters. There was significantly higher vaginal delivery rate in study group (p >0.05).

Conclusion: LCG has potential to achieve successful vaginal delivery.

P-2B/OP-10

Correlation between Ultrasound Doppler Placental Histopathology and Perinatal Outcome in Pregnancies with Small for Gestational Age

Shruti Kumari, Rajni Mittal
Hindu Rao Hospital, Delhi, India

Introduction: SGA refers to weight below the 10th percentile for gestational age or 2 standard deviations below the mean. Worldwide prevalence of SGA births is approximately 8.6%–9.6%. Objective

of this study is to analyze the correlation between ultrasound doppler, placental histopathology and perinatal outcome in pregnancies with small for gestational age

Methods: This is a prospective observational cohort study carried out in department of OBGY, Hindu Rao Hospital, for a period of 2 year. A total of 65 antenatal cases with pregnancies complicated by SGA were identified and usg doppler was done to assess uterine artery, umbilical artery and ductus venosus After delivery placenta was weighed and sent to the department of pathology for histopathological examination. Details of labour, neonatal outcome baby sex, weight ,APGAR score was recorded.

Results: Almost half of the cases of SGA have no risk factors for SGA. Almost half of the babies had mild SGA and almost 1/3rd had severe SGA. Placental histopathological abnormalities are present in almost 80% cases with SGA. Ultrasound doppler can be normal in almost 85% of cases with SGA.

Conclusion: Doppler study remains normal despite presence of histopathological abnormality in placenta in 81-82% cases. Hence abnormal doppler is a late manifestation and is seen in only 18.18% of SGA cases. More than 90% cases with abnormal doppler have abnormal placental histopathology.

Session 3 B (Obstetrics)

P-3B/OP-1

Risk Factors Associated with Surgical Site Infections (SSI in Caesarean Section in a Tertiary Level Hospital)

Ayushi Hada, Renuka Malik
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: SSI is defined by the CDC criteria as an infection occurring within 30 days after a surgical procedure involving skin, subcutaneous tissue, soft tissue, or any other part of anatomy as being with incisional or organ space. It is classified into superficial, deep incisional and organ/space SSI.

Aim: To determine risk factors associated with SSI following CS in a tertiary level hospital.

Methodology: 920 consecutive patients undergoing CS were studied in this non-interventional prospective study from 1 January 2021 to 31st may 2022. 13 risk factors namely age, diabetes in pregnancy, anemia, pre-pregnancy BMI, indication of CS, number of previous caesareans, PROM>24 hours, prolonged labor>12 hours, type of skin incision, MSL, intra-operative blood loss, type of skin closure and type of skin suture material used were evaluated for their association with SSI and classified according to the CDC criteria.

Results: Out of the 920 who underwent CS, 54 (5.9%), women developed SSI. Diabetes in pregnancy, anemia, PROM>24 hours, pre pregnancy BMI, type of skin incision, intraoperative blood loss and prolonged labor were found to be significant risk factors ($p<0.05$) for developing SSI following CS. E coli (25.9%) was found to be the commonest organism followed by 20.4% normal flora of skin, 18.5% Klebsiella, 9.3% MRSA.

Conclusion: Development of SSI after CS is multifactorial. Diabetes in pregnancy, anemia, PROM>24 hours, pre pregnancy BMI, type of skin incision, intraoperative blood loss and prolonged labor were found to be significant risk factors for developing SSI following CS. Their modification may help in reduction of SSI rates.

P-3B/OP-2

Iron Prophylaxis in Nonanemic Pregnant Women: Boon or Bane?

Gaganpreet Kaur, Divya Kumari, Manju Puri
Lady Hardinge Medical College and SSKH Hospital, New Delhi, India

Introduction: Anemia is a serious global public health problem. In India, socioeconomic status and diet consumed contribute to iron deficiency. Hence, iron and folate prophylaxis is essential to meet the increased demands during pregnancy. WHO recommends daily oral iron supplementation to prevent maternal anemia. Despite that, the prevalence of anemia is high. There are various barriers to effective supplementation; the most pivotal is poor compliance.

Objective: To study the effectiveness of routine oral iron supplementation in non-anemic pregnant women

Methodology: This observational study was conducted on women attending the ANC OPD for one year. 200 pregnant women with singleton pregnancy in the second trimester with hemoglobin ≥ 11 gm% were enrolled. Women with thalassemia, chronic renal disease, chronic infection and multiple pregnancies were excluded. Subjects were prescribed iron as per ANC protocol. They were enquired about any specific side effects at follow up. After 100 days, hemoglobin and ferritin were done and results were evaluated.

Results: At the end of the study, 57% women were compliant and 43% were non-compliant. Hemoglobin and ferritin increased in 52% and 57% women and decreased in 48% and 43%

respectively. Side effects were in the non-compliant group suggesting that non-compliance could be consequent to side effects.

Conclusion: Intermittent oral iron supplementation may be considered as a viable option as it leads to fewer side effects and is effective in preventing anemia in non-anemic pregnant women.

P-3B/OP-4

Seizure episode in Pregnancy: A Diagnostic Dilemma

Nalini Bala Pandey, Uma, Surbhi Sharma, Shakun Tyagi, Poonam Sachdeva, Y M Mala
Maulana Azad Medical College & Lok Nayak Hospital, New Delhi, India

Introduction: Seizures in pregnancy usually result from eclampsia, epilepsy or central nervous system disorders. Other differential diagnosis including tubercular Meningitis although rare, is an important cause of first-time convulsions in pregnancy.

Case: A 25-year-old Primigravida with 6 months of amenorrhoea presented in ED with history of seizures off and on for 2 days. On examination, she was in post-ictal phase, RR-28, SPO2- 60 % room air, right basal crepts, PR – 134/min, BP – 130/90 mm HG Urine Albumin 1+, GCS – E2V2M3, Dextrose-134mg %. She was resuscitated with NRBM @15 litres, IV bolus of 200 cc and ABG showed decompensated metabolic acidosis with lactates – 9 mmol/litre. Differential diagnosis kept was Eclampsia or seizure disorder due to Infection? Organic cause? Loading dose of Injection levetiracetam 1 gram given and patient intubated by anaesthetist and shifted to ICU. NCCT head showed normal study. History of fever episode off and on for 7 days with family history of Tuberculosis in father revealed later on. Lumbar puncture done and CSF finding suggestive of tubercular meningitis with raised ADA levels. Patient started on anti-tubercular therapy (ATT), Levetiracetam, antithrombotic prophylaxis and antibiotics. Multidisciplinary treatment continued and she was extubated on Day 8. She was managed successfully with ATT and discharged in stable condition at day 20, with advice to follow regularly with LFTs in ANC OPD. Later she had a normal vaginal delivery of male baby of 2.4 kg and both of them discharged in stable condition.

Conclusion: Though eclampsia is considered as a common cause of seizures, tubercular meningitis should be considered in the differential diagnosis of pregnancy with seizures. Prompt and appropriate diagnosis and team based multidisciplinary approach is the key of successful outcome.

P-3B/OP-6

Mifepristone-Misoprostol Combination versus Misoprostol Alone for Termination of Pregnancy with Intrauterine Fetal Demise

Hansika Anuragi
Vardhman Mahaveer Medical College and Safdarjung Hospital, Society of Applied Science, New Delhi, India

Introduction: The safety and efficacy of mifepristone and misoprostol for termination of pregnancies up to 24weeks has been in literature. However, their usage in induction of labour in cases of late IUFDs is restricted to observational and non-randomized controlled comparative trials. Aim of this study was to evaluate the efficacy of mifepristone-misoprostol combination regimen for termination of early and late IUFDs in comparison to misoprostol only regimen.

Objectives: To compare induction-delivery interval between group receiving Mifepristone Misoprostol combination regimen versus group receiving Misoprostol alone and the adverse effects.

Methods: This Randomized Comparative Study was conducted in the Department of Obstetrics and Gynaecology, Vardhman Mahavir Medical College and Safdarjung Hospital over a period of 18 months. Seventy patients were enrolled and randomized and categorized into group A and group B using Block Randomization. Group A was induced by Mifepristone-MisoprostolCombination regimen whereas Group B was induced by Misoprostol only.

Conclusion: The mean IDI was more in group A than in group B. The mean number of doses of misoprostol required was significantly less in patients treated prior with a stat dose of mifepristone. Majority of patients in both groups had no adverse effects from the drugs administered. All patients enrolled in the study delivered within 72 hours except one from the group that followed misoprostol only regimen. The patient was managed as per department protocol.

P-3B/OP-7

Case of Hydrocephalus and Congenital Heart Disease- Prenatal Diagnosis and Post-Natal Course

Ana Fatima, Nalini, Renu Arora
Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi, India

Introduction: VACTERL with hydrocephalus (VACTERL-H) is a rare genetic disorder that affects multiple anatomical systems. Clinically at least

three of the eight anatomical components of the disorderare considered necessary for diagnosis. The combination varies in different affected individuals.

Objective: VACTERL-H is sporadic, autosomal recessive or X-linked inheritance. With early pre nataldiagnosis and prompt post-natal treatment, can be managed. Still, the affected individuals often experience a number of medical complications. Thus highlighting the case is important.

Methods: Prenatal ultrasound of a 25yr old primigravida at 19week gestation, depicted bilateral ventriculomegaly, small inlet VSD, bilateral club foot, and unilateral absent kidney. These findings were confirmed by fetal ECHO at 24 weeks and fetal MRI at 28wks. The couple was counseled regarding prognosis of each condition, pedigree was drawn and suspicion of genetic association was made. Coupleopted for genetic testing. Amniotic fluid sample was sent for QFPCR and microarray. Report came out tobe normal and they refused testing for whole exam sequence.

Results: She delivered female baby of 2.1 kg at 36 weeks POG. Baby had 21 days of NICU stay.Postnatal follow up for CTEV was done in orthopedics and MRI was done depicting aqueduct stenosis for which she was planned for VP shunt placement. For small inlet VSD she was put on conservativemanagement. Baby has small delay in achieving milestones.

Conclusions: A multidisciplinary approach is essential for optimal treatment given the complexity of anomalies and complications associated.

P-3B/OP-8

Amenorrhea With Raised Beta-HCG: Can It Be a Predicament for Obstetrician???

Saloni Kamboj, Vidushi Kulshrestha, Shekhar Swaroop,Seema Singhal,Neena Malhotra
All India Institute of Medical Scienced, New Delhi, India

Introduction: Elevated beta HCG is found in pregnancy (either intrauterine or extrauterine) or pregnancy related conditions such as gestational trophoblastic disease, ovarian or peripheral germ cell tumor. However, it can be a diagnostic challenge when no such pregnancy or pregnancy related cause is found.

Case: We describe a case of 32-year-old female P2L2 who presented with a history of amenorrhea with positive urine pregnancy test with unstable vitals. On evaluation, no intrauterine or extrauterine gestational sac was found. Beta HCG was found to be raised (32000 IU/ML). Patient required multiple blood transfusions and a diagnosis of Pregnancy of Unknown Location was made. On further imaging studies, patient was found to have a space occupying lesion in liver without any notable lesion in pelvis. Patient also had a history of on and off melena, for which an upper GI endoscopy & colonoscopy was done, biopsy was taken from polypoidal lesions in duodenum and a diagnosis of duodenal adenocarcinoma was made. Patient was also found to have multiple metastasis to lungs, liver, left adrenal gland that explained elevated beta HCG as para-neoplastic syndrome.

Conclusion: Hunting for causes of elevated beta HCG in a patient with no gestational sac can be mind boggling. An understanding of the differential diagnosis and awareness of available diagnostic modalities are crucial for accurate diagnosis.

P-3B/OP-9

Successful Antenatal Management of Fetal CCAM in Twin Pregnancy: A Case Report

Chittala KS, Asmita MR, Krishna A
Maulana Azad Medical College & Lok Nayak Hospital, New Delhi, India

Introduction: Multiple pregnancies with discordant anomalies are more prone to preterm delivery. There are dilemmas about the management of these cases.

Case: 20yr, Primigravida, POG - 24 weeks with DCDA twin with USG shows CCAM in twin 1. 2D USG - Twin 1 right lung showed echogenic area 28x21mm with few anechoic cystic spaces within with levocardia, f/s/o CCAM. No evidence of hydrops or abnormality identified. Twin 2– no gross anomaly seen. Fetal MRI done at 26weeks – multicystic heterogeneously T2 hyperintense lesion seen involving the right lung of twin 1 1.7x1.5x1.7cm peripheral in location s/o CCAM type 1. CCAM lung volume 2.34cc and CCAM- HC ratio CVR measures 0.10 which is favourable prognostic sign. No obvious mass effect or mediastinal shift seen. No hydrops seen. Couple counselled that isolated CCAM doesn't carry risk of chromosomal anomalies or other genetic syndromes; there is chance of developing hydrops in 10% cases. They opted for expectant management. At 32 weeks, spontaneous labour received steroids. APGAR 9, 9, 9. Birth weight 1495 and 1480gm. Twin 1 with CCAM required O2 support in first 24hr, stable at room air on day 2 onwards. CXR: Right lung hyperintense lesion.

Conclusion: Twins with nonlethal discordant anomaly may not need selective termination. Expectant management with regular ultrasound follow-up may results in good outcome.

Session 4 B (Obstetrics)

P-4B/OP-1

Analysis of Caesarean Sections among Primigravida-Changing Trends in Indications in Our Setup

Azmat Jahan Mantoo, Zohra Younis, Mehbooba Beigh
SKIMS MCH Bemina, Srinagar, Jammu & Kashmir, India

Background: High caesarean birth rate especially among primigravidas is an international public health concern which makes it utmost essential to be reanalyzed and to study the changing trends in indications. The present study is a hospital based study analyzing the indications of primary caesarean section in our setup.

Methods: This is a retrospective hospital record based study done from 1st January-2019 to 30th June-2022.

Results: During the study period total numbers of deliveries conducted were 13041of which total number of caesarean section deliveries were 5305 and primary caesarean sections were 2391.The caesarean section rate was 40.68% of which primary caesarean section rate was 45.07%.Commonest indication for primary caesarean section was non progression of labour-23.17% followed by fetal distress -20.85%, Obstetrical reasons-17.65%, Cephalopelvic disproportion-15.76%, Others-14.57%, breech-8%. The rate of primary caesarean section was higher in the age group of 20-30 years with BMI more than 23.

Conclusion: There is a significant increase in the total caesarean section rate with primary caesarean section accounting for a significant increase.

Recommendations: Use of precise interpretation of fetal heart rate tracing, practice of evidence based obstetrics, implementation of Robson classification, optimal management in labor, operative vaginal deliveries, trail of labor in case of nulliparous breech & use of confirmatory tests where fetal compromise is suspected.

P-4B/OP-2

Successful Outcome of Heterotopic Pregnancy

Azmat Jahan Mantoo, Mehbooba Beigh
SKIMS MCH Bemina Srinagar Jammu & Kashmir, India

Introduction: Heterotopic gestation is defined as the coexistence of intrauterine and extrauterine gestation commonly in the fallopian tube and uncommonly in the cervix or ovary.Spontaneous heterotopic pregnancy is quite rare and the estimated incidence is 1 in 30,000 in spontaneous pregnancies, in general population a fair estimate was 1 in 7000 pregnancies. However, with assisted reproduction techniques, this incidence increases to 1 in 100 pregnancies. Risk factors for heterotopic pregnancy include previous tubal damage, ectopic pregnancy and assisted reproduction technique like in vitro fertilization, gamete intrafallopian transfer, also reported with pharmacological ovulation.

Case: In this case report, the ectopic component was in right fallopian tube-7weeks2days Gsac with 9.5X11cm hematoma which was managed with immediate laparotomy & resuscitation. The intrauterine component was a viable fetus of 11 weeks 2 days gestation which was allowed to continue normally. The intrauterine pregnancy was uneventful with successful outcome. Mode of delivery was Caesarean section.

Conclusion: Heterotopic pregnancy though extremely rare should be kept in mind even if an intrauterine pregnancy is diagnosed. High index of suspicion is needed to ensure early & timely diagnosis & management & timely intervention can result in a successful outcome of intrauterine pregnancy 8& prevent tubal rupture &haemorrhagic shock which can be fatal.

P-4B/OP-3

Impact of OSA in Hypertensive Disorders of Pregnancy and Its Feto-maternal Outcome

Pooja Paswan, Vinita Sarbhai
Kasturba Hospital, New Delhi, India

Introduction: Sleep Disordered Breathing (SDB) is a spectrum of respiratory abnormalities due to the partial or complete collapse of the upper airway during sleep, leading to intermittent hypoxia and fragmentation of sleep. Obstructive Sleep Apnea (OSA) Syndrome is the most common amongst the myriads of forms of SDB.Recent studies have reported that SDB is seen more commonly in women with preeclampsia. Recent studies have reported that SDB is seen more commonly in women with preeclampsia, if left untreated, upper airway flow limitation during pregnancy may lead to dire maternal and fetal health consequences.

Objective: To study impact of OSA among pregnant women with and without hypertension and its fetomaternal outcome by questionnaire based assessment.

Methods: This hospital based case-control study was conducted in the Department of Obstetrics and Gynecology, Kasturba Hospital, New Delhi, India, during a period of 1 year January 2021 to December 2021.

Results: During study 200 subjects were enrolled.

100 In each group of cases (pregnant women with hypertension) and Control (pregnant women without hypertension).40% of cases were in age group of 26-30 years. osa was present in 45% of cases and in 8% of controls.27% women in cases had undergone LSCS while 9% in control. Cases had higher APH which was 6% than control as none of them had APH.

Conclusions: Sleep Disordered breathing like snoring, can complicate pregnancy given the risk factors of weight gain, upper displacement of the diaphragm, and hormonal-induced hyperaemia of the nasopharyngeal passages. The recognition and treatment of OSA during pregnancy may lead to improved outcomes.

P-4B/OP-4

Determinants and Incidence of Perinatal Asphyxia in Full Term Live Births in a Tertiary care Center

Madan Nikita, Malik Neeru, Kumar Amit, Chaudhary Sanjay
Dr. Baba Saheb Ambedkar Hospital, Sector-6, Delhi, India

Introduction: Perinatal asphyxia is a leading cause of neonatal morbidity and mortality globally, and the central cause of diseases like cerebral palsy, mental retardation and epilepsy. Understanding associated factors of perinatal asphyxia will help identify vulnerable groups and improve care during the perinatal period.

Objective: The present study is taken up to evaluate risk factors associated with birth asphyxia among term babies delivered at a tertiary care hospital in an endeavour to prevent birth asphyxia. By avoiding birth asphyxia, the financial burden of care of affected neonates in resource restricted settings like India will be reduced.

Methods: This is a case control study conducted on 2000 consecutively born term new born infants delivered over a one-year period. The dependent variable was perinatal asphyxia, whereas the independent variables were antepartum factors (previous obstetric history, ANC visits, obstetric and medical complications), intrapartum factors (membrane rupture, duration of labour, meconium-stained liquor, malpresentation, mode of delivery), and foetal factors (birth weight, sex of the new born). Data was collected on structured forms after taking consent. Multivariate logistic regression model was performed to identify risk factors.

Results: Risk factors with statistically significant contribution to birth asphyxia in term new-borns are maternal age.

P-4B/OP-5

Early Diagnosis of Placenta Accreta in Case of Mid-trimester Post-abortal Haemorrhage with Previous 3 Cesarean Sections

Arti Gautam, Neeru Malik, Sandhya Jain, Charvi
Dr. Baba Saheb Ambedkar hospital New Delhi, India

Introduction: Placenta accreta is potentially life-threatening complication of pregnancy. Placenta accreta usually manifests with vaginal bleeding during difficult placental removal at delivery in the third trimester of pregnancy, very rarely mid trimester pregnancy termination, may lead to profuse postabortal haemorrhage.

Objectives: To know the risk and management of post-abortal haemorrhage in patients with previous cesarean delivery to prevent maternal mortality.

Methods: A 36 years old female P3L3A1 with previous 3 LSCS with retained placenta with profuse bleeding per vaginum with history of expulsion of foetus (18 week) on the way to hospital, presented to labor room. Patient was unbooked and uninvestigated. Initial resuscitation done along with oxytocic given but no sign of placental separation was there and bleeding was continued. On the basis of torrential bleeding and history of previous three caesarean deliveries, patient is immediately shifted to operation theatre for exploration laparotomy in view or provisional diagnosis morbidly adherent placenta with torrential haemorrhage. On laparotomy, the anterior surface of lower uterine segment of uterus fully covered with engorged blood vessel. Bladder was spared. Decision of subtotal laparotomy taken in view of morbid adherent placenta .Subtotal hysterectomy was done, haemostasis achieved.2 unit PCV transfused intraoperatively and patient shifted to ICU postoperatively. Her post-operative period was uneventful; she was discharged on post-operative day 6 under satisfactory condition. The specimen was sent for histopathological examination.

Result: Histopathological examination was suggestive of Pregnancy related Changes in Uterus with placenta accreta. Vigilant monitoring and timely intervention in obstetric emergency can avoid maternal mortality.

Conclusion: The postabortal haemorrhage can be potential life-threatening condition associated with maternal mortality and morbidity. Hysterectomy remains common procedure for placenta accreta spectrum but early identification and quick decision and timely intervention can save a life.

Abstracts of Poster Presentation (Hall A) on 13th November, 2022

Session 5 A (Obstetrics)

P-5A/OP-1

Maternal And Fetal Outcome in Pregnancy with History of Arteriovenous Malformation (AVM)

Anuradha Sharma, Jyotsna Suri, Suchandana Das Gupta
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: AVM results from the failure of differentiation of embryonic vascular plexus into a mature capillary bed. Blood flows directly from the arterial system to venous system without passing through a capillary system. In most of the cases it presents with hemorrhage.

Objective: To evaluate the maternal and fetal outcome in patient with history of brain AVM.

Methods: 30-year-old G2P1L1 lady was booked at 24 weeks of gestation with a past episodic history of a black out three years back. It was followed by severe giddiness, headache, repeated vomiting and weakness. The CT head was suggestive of right cerebellar hemorrhage and the exact diagnosis of right cerebellar AVM was confirmed by a DSA. It was being fed by right superior cerebellar artery with an intramidal aneurysm. Gamma knife surgery was done in 2019. At 36 weeks of gestation, she was admitted in ward for safe confinement in view of high-risk pregnancy. At this time, she was not on any medication. Repeat CT scan was done during hospital stay and neurosurgery referral done for the mode of delivery. She was advised for an elective caesarean section.

Result: Elective LSCS was done at 37 weeks of gestation under combined CSE. A healthy baby girl weighing 2744 gm was delivered, LSCS was uneventful. On post op day seven the patient was discharged.

Conclusion: Multidisciplinary approach is necessary to manage a high-risk pregnancy following AVM surgery. Elective LSCS helps in optimum outcome of the mother in such cases.

P-5A/OP-2

A Nightmare in Obstetricians Practice

Shweta Prasad, Meenakshi Singh
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: Maternal mortality is a global issue of concern and puerperal infection is one of its major causes. Wound infection is observed more in cases of cesarean section than in vaginal delivery. Necrotising fascitis is an uncommon complication observed in pregnancy and can cause life threatening mobidity to the patient. It is an aggressive infection involving superficial fascia and subcutaneous tissue ultimately leading to systemic toxicity.

Case: Here we report a 22 years old female who presented to us on day 11 of normal vaginal delivery with episiotomy with extensive ulcerations on the thigh extending upto perineum involving the episiotomy thigh. Patient was managed by anemia correction, extensive antibiotics, surgical debridement followed by split skin grafting and Singapore flap cover. Flap division was done after 4 weeks. After undergoing 4 surgeries, patient was discharged in satisfactory condition. A physician must be vigilant in considering NF as a probable diagnosis in any local signs of infection especially when associated with systemic signs.

Conclusion: This case report calls attention to the risk of necrotising fascitis in undernourished and anemic women in low- and middle-income countries during postpartum period and also highlights the importance of correction of anemia in successful management of NF apart from surgical debridement.

P-5A/OP-3

Isolated Fetal Ventriculomegaly: Antenatal Evaluation and Postnatal Follow Up (Case Series)

Rashi Saini, Sumitra Bachani
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Fetal Ventriculomegaly one of the commonest pathologies (2/1000 live births) is categorized as mild (10-12 mm), moderate (13-15 mm) or severe (≥16 mm) according to trans-ventricular diameter. Commonest Aneuploidy associated with this condition is Trisomy 21.

Case series: We report series of 10 women in the age group of 24 to 35 years with singleton fetus

without co-morbidity. Six cases were diagnosed in second trimester (4 mild, 2 moderate) and four in third trimester. Four fetuses had unilateral (two mild, one moderate, one severe) and six had bilateral ventriculomegaly. Karyotyping following amniocentesis was done in seven women and all were normal. Infection screening done in seven women was negative. MRI was done in eight women amongst which one fetus was diagnosed with partial genesis of corpus callosum. Two moderate cases progressed to severe ventriculomegaly. Fetus with partial agenesis of corpus callosum was diagnosed with cleft palate and PDA at birth and had an early neonatal death. One baby with mild ventriculomegaly and mild periventricular flare on post-natal ultrasound, was doing well at one year follow up. Another baby with antenatally diagnosed moderate ventriculomegaly had basal ganglia calcification raising suspicion of cytomegalovirus (CMV) infection. At 15 months the baby had global developmental delay with hearing and vision impairment. All other babies had a normal neurological outcome and were doing well at one year follow up.

Conclusion: Mild isolated ventriculomegaly carries the most favorable prognosis. All cases should be investigated for aneuploidy, infection and structural defects.

P-5A/OP-4

Peripartum Pubic Diastasis with Bladder Injury: A Rare Case Report

Soni Kumari, Arita Singh
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Pubic diastasis is abnormal widening of pubic bones at the symphysis pubis. It is an uncommon condition with a reported incidence of 1 in 600-30000 in the peripartum period. The incidence is found to be gradually increasing. During pregnancy, under the influence of hormones like estrogen and relaxin, resulting in relaxation of structures of symphysis pubis.

Case: A 33- year- old women P3L2 presented in gynae emergency 6 days after home delivery with complains of inability to pass urine and rectal incontinence since delivery. On examination, her vitals were stable. Urethral opening, labia majora and anterior vaginal wall were completely torn. X ray pelvis AP view showed pubic diastasis of 5 cm. She underwent laparotomy in which repair of bladder neck and posterior bladder wall was done followed by complete exteriorization of ureters and diversion colostomy.

Discussion: Pubic diastasis could be total separation or instability of the symphysis without breaking the pubic bones. Nulliparity, multiple pregnancy, prolonged second stage, instrumental delivery, contracted pelvis and cephalopelvic disproportion are considered to be the risk factors. Treatment options include conservative and surgical management.

Conclusions: Pubic symphysis diastasis is a rare condition that should be kept in mind when, peripartum women with excruciating pain in pubic symphysis present after traumatic delivery. These cases can be successfully managed conservatively avoiding the need for surgery in many cases.

P-5A/OP-5

Hyperemesis Gravidarum: A Case Report

Bhawna, Renu Arora, Sarita Singh
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Hyperemesis gravidarum is characterized by severe nausea and intractable vomiting sufficient to interfere with maternal nutrition and causes weight loss, dehydration, acidosis and electrolyte imbalance. It is diagnosis by exclusion. It usually begins at 4 to 6 weeks, peaks at 8 to 12 weeks and resolve by 20 weeks of gestation.

Case: A 29-year-old primigravida presented to us with hyperemesis gravidarum at 8 weeks of gestation. The presenting complaints were intractable vomiting 10 to 12 times per day, unable to accept orally and weakness. She had signs of dehydration on general physical examination. On investigating her further we found that she had ketonuria 3+ along with deranged serum electrolytes (Na+ 123, K+ 2.3 mEq/L). Patient was put on IVF NS at 75 ml/hr. salt capsules and syp potklor advised. IV pantoprazole and perminom was given BD. Also, MVI were given to her. Patient resolved soon and was sent home on tab DoxinateG 25mg TDS. But she presented with same complaints multiple times even after 20 weeks of gestation. Her LFT was- S.bil was normal, SGOT and SGPT were raised in range of 200 to 300. Patient was diagnosed as IHCP and put on T.Udiliv 300 mg TDS. KFT was normal. Serum electrolytes came normal within few days. Viral markers including HAV and HEV were negative. USG W/A and Upper GI endoscopy didn't reveal any findings. Gastro referral was also done.

Conclusion: Hyperemesis Gravidarum can occur anytime during pregnancy and may not resolve throughout pregnancy.

P-5A/OP-6

Shock Index as A Predictor of Maternal Outcome in Postpartum Period

Jaladarshini N, Rupali Dewan
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Aim: To study the role of Shock Index in immediate postpartum period as an indicator of maternal outcome.

Objectives: Primary objective is to determine the normal range of Shock Index among postpartum women at 1 hour of delivery and to determine the threshold points and predictive value of SI for adverse maternal outcome. Secondary objective is to find the association between the maternal characteristics and SI at 1 hour of delivery.

Materials and Methodology: A prospective cohort study was carried out in the department of OBGY, SJH for 18 months. A total of 2000 women were recruited in the study. The study cohort were postpartum women who delivered in labor room between 9am and 4pm. SI was calculated at one hour of delivery. All these postpartum women were managed according to the hospital protocol and followed till their discharge.

Results: The study determined reference range of SI at 1 hour of delivery i.e., 0.672-0.875. The SI threshold of > 0.87 indicated increased risk of adverse outcomes. SI was higher in women with post-delivery complications. The mean SI of atonic PPH was 1.04±0.16, traumatic PPH was 0.88±0.12 and with obstetric hysterectomy 1.045±0.10 In women with ICU admission SI was 1.13±0.14, in maternal mortality 1.217±0.144, in women with need of Blood transfusion>4 unit 1.055±0.138, in women with Emergency hysterectomy 1.045±0.098 and in women with any adverse maternal outcome 1.103±0.153. Maternal characteristics had minimal effect on SI.

Conclusion: Shock Index is a better predictor of adverse outcome as compared to Heart Rate and Systolic BP alone.

P-5A/OP-7

Dyssegmental Dysplasia Silverman Handmaker Type: Variant of Unknown Significance or Likely Pathogenic Variant?

Harshiba, Ranjana Mishra, Asmita M Rathore, Kiran Sri Chittala
Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi, India

Introduction: Dyssegmental dysplasia, Silverman-Handmaker type (DDSH), is a lethal autosomal recessive form of dwarfism with characteristic anisospondylic (marked difference in size and shape of the vertebral bodies) micromelia (abnormally short limbs). Other features include flat face, micrognathia, cleft palate and reduced joint mobility. DDSH is caused by homozygous or compound heterozygous mutation in the gene encoding perlecan (HSPG2) on chromosome 1p36.

Case: 24-year-old primigravida presented to us at 24 weeks with a grossly anomalous fetus on ultrasound showing short long bones, femur to foot ratio falling in lethal parameters, hand and spinal deformity and polyhydramnios. Patient was counselled regarding the possibility of lethal skeletal dysplasia and was offered amniocentesis for whole exome sequencing. Due to advanced gestational age decision for continuation of pregnancy was taken. The WES report revealed 2 variants of unknown significance (VOUS) After genetic consultation, patient was counselled regarding the possibility of DSSH, but due to insufficient evidence postnatal review was advised. Female fresh stillbirth born at 38 weeks had striking similarity to DDSH having exophthalmos, flat facial profile, micrognathia, short neck, short limbs and a small thorax. Infantogram revealed bowed, short long bones and unequally shaped vertebrae.

Conclusion: The clinical presentation and infantogram matched with the diagnosis of Dyssegmental dysplasia Silverman handmaker type previously reported. The parents were offered whole exome sequencing for segregation analysis to prove pathogenicity but they declined. This case may help in further reclassifying this variant as pathogenic or likely pathogenic according to the American Medical Genetics Criteria.

P-5A/OP-8

Intrauterine Transfusion: Our Experience at Tertiary Care Hospital

Poornima Sharma, Harsha Gaikwad, Sumitra Bachani, Suchandana Dasgupta, Shreya Singh Kushwaha
Division of Fetal Medicine & Genetic Clinic, Department of Obstetrics & Gynaecology
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Intrauterine transfusion (IUT) of the severely anaemic fetus improves perinatal outcomes with overall survival being ≥95percent with transfusions performed for alloimmunization

but varies with center, experience, and gestational age at development of hydrops fetalis.

Objective: We aim to study the gestational and neonatal outcomes, role of the decline in haemoglobin as a guide for scheduling subsequent transfusions after first IUT.

Methods: A retrospective study conducted at the Fetal Medicine division of Safdarjung Hospital and included all women with Rh-isoimmunised pregnancy who underwent IUT procedures in last 6 months.

Results: A total of 25 IUT procedures for 10 women with singleton Rh-isoimmunised pregnancy were performed. The mean gestational age at first IUT procedure was 28 weeks. Subsequent IUT was planned according to the post IUT fetal haematocrit. Average interval between first and second transfusion was 10 days while between second and third transfusion was 17 days. The rate of fall of haematocrit decreased with each IUT, interval between subsequent procedures increased. Signs of hydrops were present in five fetuses with ascites being most common. Cesarean delivery was performed in eight women with mean gestational age of 34 weeks and two had spontaneous early preterm vaginal delivery after single transfusion and resulted in early neonatal death. Only two neonates needed exchange transfusion.

Conclusion: The presence of hydrops due to severe anaemia is the main prognostic factor affecting survival after IUT. According to the decline in haematocrit, time for subsequent procedure can be decided where MCA PSV is less reliable.

P-5A/OP-9

Case Report- Pregnancy with Multicystic Dysplastic Kidney Disease

Soni Kumari, Ana Fatima
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: MCDK is cystic renal disease in which normal tissue is replaced by various sized cysts surrounded by abnormally functioning renal parenchyma. Incidence is 1:4000 if unilateral, and 1:12000 live births if bilateral. It is associated with genetic syndromes like VATER, VACTERAL, Meckel-Gruber Syndrome, Zellweger syndrome and Joubert syndrome related disorders.

Case: A 29 yrs. primigravida came with USG level 2 scan showing SLIUF, breech with bilateral pelvicalyceal system dilatation with multiple cysts (L>R) with VSD and unilateral suspicious CTEV. Couple counselled about the risks of associated chromosomal anomalies and the prognosis was explained. They decided to discontinue the pregnancy and opted for amniocentesis and microarray testing. Chromosomal microarray analysis revealed, heterozygous deletion on short arm of chromosome 11 from cytoband 11q24.3 to cytoband 11q25 and on chromosome 7, there was duplication on short arm of chromosome 7 with gain from cytoband 7q36.1 to cytoband 7q36.3. These deletions are found to be overlapping with Jacobson syndrome, thrombocytopenia, atrial septal defect, patent ductus arteriosus, hypoplastic left heart and sepsis, developmental delay and multiple congenital anomalies. Patient was admitted and pregnancy was discontinued. She delivered a male fetus. Autopsy was done after informed consent which revealed presence of multiple cysts in both kidneys. HPE report confirmed the diagnosis.

Conclusion: USG screening, confirmation and timely diagnosis by amniocentesis prevented couple to have a syndromic baby with multiple co-morbidities.

P-5A/OP-10

Reducing Anaemia at Childbirth in Booked Pregnant Women: A Quality Improvement Initiative

Shilpi Nain, Manju Puri, Gaganpreet Kaur, Neeraj Jindal, Milo Suka, Triveni GS
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: Anaemia in pregnancy is associated with increased morbidity and mortality. Despite an increase in access to antenatal care and initiation of targeted government programmes, 52.2% of pregnant women are still anaemic. Early detection and treatment of anaemia in pregnant women is integral to antenatal care.

Objective: We aimed to reduce the prevalence of anaemia in booked pregnant women admitted in labour from baseline to 32% within 4 months.

Methods: We adopted the Point of care quality improvement methodology. The process measure was to implement standard guidelines for screening for anaemia at the first visit, 28 weeks and 36-week gestation as well as management of anaemia by appropriate haematinics (oral and intravenous), deworming and diet counselling. The outcome measure was to assess the prevalence of anaemia in booked parturients. The data was plotted on

time series run chart. Variations were analysed and interventions were done using multiple plan-do-study-act cycles.

Result: There was a gradual reduction in the number of anaemic women at delivery (median shift from 46.2% to 24.75%) with a significant fall in the percentage of moderately anaemic women (42.8% to 22.2%).

Conclusion: We incorporated standard clinical pathways for screening of anaemia. Appropriate counselling, tailored laboratory requisitions and iron prescriptions helped in the reduction of the prevalence of anaemia in women during childbirth. The measures are simple to implement and can be adapted to serve other populations with a high burden of iron deficiency anaemia.

Session 6 A (Obstetrics)

P-6A/OP-1

Antenatal Detection and Prognostication of Congenital Diaphragmatic Hernia: A Case Series

Shreya Singh Kushwaha, Sumitra Bachani, Upma Saxena, Renu Arora
Division of Fetal Medicine & Genetic Clinic, Department of Obstetrics & Gynaecology
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Congenital diaphragmatic hernia (CDH) occurs in 1 in 3300 live births, a congenital defect in the diaphragm that allows herniation of abdominal viscera into the thorax. This leads to pulmonary hypoplasia and hypertension, which are the primary determinants of morbidity and mortality. Ultrasonography based observed Lung Heart ratio (LHR) helps in antenatal prognostication and defining postnatal management plan. We present four cases of CDH.

Case: All women were monitored with LHR and counselled regarding prognosis, risk of aneuploidies and paediatric surgeons were consulted. Mrs A presented at 36 weeks with observed LHR=1.32 and observed/expected LHR=45.52%. She delivered at 40 weeks and baby had early neonatal death on day 2 due to severe respiratory morbidity. Mrs B presented at 29+6 weeks with oLHR=1.2 and o/eLHR=28.23%. She delivered at 40 weeks and baby was operated but expired on post-operative day 14 due to post-operative complications. Mrs C, at 31+3 weeks had left CDH with oLHR=1.1 and o/eLHR=27.07%. On follow-up after 2 weeks oLHR=0.79 and o/eLHR= 17.45% and she is still antenatal. Mrs D presented at 32+3 weeks with an ultrasound report at 24+3 weeks of left CDH with o/eLHR=27.1%. At 35+3, oLHR and o/eLHR were 0.6 and 18.8% respectively and is still under antenatal follow-up.

Conclusion: Antenatal diagnosis and risk prognostication will help identify infants with severe CDH and allows multidisciplinary team management and delivery at tertiary centre with the proper facilities to optimize the outcome.

P-6A/OP-2

A Pregnant Woman's or Deal with Cerebellar Hemangioblastoma: A Case Report

Roohat Parveen, Garima Kapoor
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Cerebellar hemangioblastoma in pregnancy is a relatively rare benign vascular tumor. 75-80% of these tumors are sporadic while one-fourth can be associated with Von-Hippel Lindau syndrome. During pregnancy, these tumors may increase in size. Symptoms are due to raised intracranial pressure because of obstructive hydrocephalus and/or edema due to direct brain stem compression. Diagnosis in pregnancy is often delayed due to overlapping symptoms of tumor and pregnancy.

Case: A 29 years female at 27 weeks of pregnancy came to emergency with complaint of severe headache associated with on and off vomiting and vertigo since last 1.5 months. Headache intensity had increased over last one month and now she developed photophobia and deceased vision in both eyes since last one day. After neurological consultation, she was provisionally diagnosed with migraine and started on antimigraine medications. Patient threw 4-5 seizure episodes. Inj. Levera was started but seizure episodes recurred. MRI brain done which suggested posterior fossa hemangioblastoma with mass effect and obstructive hydrocephalus. Patient underwent ventriculo-peritoneal shunting under general anaesthesia. She was symptomatically relieved and was discharged after 2 days. Definitive treatment was planned after delivery.

Discussion: Management of hemangioblastoma during pregnancy is a challenging task and depends on gestational age and severity of maternal symptoms. Options include observation, CSF diversion or tumor resection. However, neurological

deterioration may occur after CSF diversion which may necessitate surgical excision of tumor.

Conclusion: Detailed neurological examination is of utmost importance in these patients. Overall, direct surgery is a better option if patients present in early pregnancy.

P-6A/OP-3

Psoriasis in Pregnancy-A Case Report

Pragya Saini, Y M Mala, Poonam Sachdeva, Shalini Shakarwal, Shakun Tyagi
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Psoriasis is an immune-mediated disease affected by environmental and genetic factors. Its pathogenesis involves both the innate and the adaptive immune compartment, with overproduction of several cytokines.

Case: Here we report a rare case of 24-year lady, G5P1L1A3 at 31 weeks with gestational diabetes mellitus admitted in view of uncontrolled sugars with new onset pustular psoriasis. She was medically managed and her lesions healed. She was taken for emergency caesarean section and was off the anti-psoriatic drugs for 3 days. During this period her lesions flared up and her dose of anti-psoriatic drugs was increased and her lesions healed. The pre and post treatment images of the lesions will also be depicted.

Review of literature: There is limited data available about the impact of pregnancy on psoriasis. Data reviewed from retrospective study in 91 pregnancies of psoriatic women, show improvement in 56% of cases, worsening in 26.4%, and no variation in clinical course in 17.6%. An exception may be represented by generalized pustular psoriasis. This article aims to review the impact of psoriasis and its management during pregnancy.

Conclusion: During pregnancy, there may be a higher risk of a rare condition called pustular psoriasis of pregnancy (PPP) in women which can be managed medically.

P-6A/OP-4

Study of Clinical and Biochemical Variables in Maternal Near Miss in Women with Hypertensive Disorders of Pregnancy

Janithya P, Kiran Aggarwal, Vidhi Chaudhary, Amrita Mishra
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: Hypertensive disorders of pregnancy complicate 10% of all pregnancies. This study is done to analyse clinical and biochemical variables in maternal near miss with hypertensive disorders of pregnancy. It is important to study these variables for timely referral, intervention, termination of pregnancy to improve feto-maternal outcome.

Objective: To study the clinical and biochemical variables associated with maternal near miss in hypertensive disorders of pregnancy.

Methods: This was analytical descriptive study. 50 women with hypertensive disorders of pregnancy who had maternal near miss as per WHO criteria were included. Detailed history, examination and investigations were done. The hospital course and maternal and perinatal outcome was observed. The causes responsible for maternal near miss and evaluation of avoidable factors which led to maternal near miss morbidity were studied.

Results: The mean age of near miss cases was 26.02+_5.3 years. 78% of patients did not have minimum antenatal care. The mean gestational age was 34.73+_3.28 weeks. 52% had eclampsia, 22% had pulmonary edema, 12% had PRES Syndrome, 8% had HELLP syndrome and 6% had acute kidney injury. 8% of the cases had severe anaemia. 46% of patients had elevated liver enzymes. 60% of the patients had decreased total protein and serum albumin. On univariate analysis hypoproteinaemia, severe anaemia, lack of antenatal care, young age and low education were risk factors for hypertensive women to develop near miss.

CONCLUSION: We conclude poor socioeconomic status, lack of education, poor antenatal care, anaemia, hypoproteinaemia, poor nutrition was important to determine near miss. Near miss can be prevented if antenatal care, awareness and management in the hospital improved.

P-6A/OP-5

Macrosomia with Intrauterine Demise: Management Dilemma

Drishti Malhotra, Alka Maurya, Niharika Dhiman, Deepti Goswami
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Fetus with Intrauterine demise (IUD) is preferably delivered vaginally. A dilemma arises when such a baby is Macrosomic.

Case: Unbooked patient Mrs. X, Gravida 2 Para 1 live 1 with 39+3 weeks gestation with uncontrolled gestational diabetes (GDM) was admitted in labor room at Lok Nayak Hospital with complains of decreased fetal movements for 1 day. At admission, her blood sugars were 270-320mg/dl with no ketonuria and insulin was started. Ultrasound showed absent cardiac activity with diffuse subcutaneous edema. Her previous pregnancy was complicated by GDM and shoulder dystocia during delivery which resulted in a permanent brachial plexus injury in her baby (birthweight 4.5 kg). Her BMI was 30.2 and clinically estimated baby weight was 4 kg. She reached second stage within 7 hours spontaneously. During delivery, the anterior shoulder could not be delivered with usual traction. Suprapubic pressure along with McRoberts manoeuvre was performed to disimpact the anterior shoulder. Woods corkscrew manoeuvre was then performed by rotating the posterior shoulder to anterior position. After 35 minutes, a macerated still born male fetus weighing 4880 g was delivered vaginally. No trauma to maternal genital tract was noted and the episiotomy was repaired.

Conclusion: When dealing with a Macrosomic baby with IUD, careful decision-making regarding mode of delivery is needed to balance possibility of maternal injury with vaginal delivery vis-à-vis caesarean scar for an IUD baby. This case exemplifies that in carefully selected patients and with skilled obstetric care, it is worth trying for vaginal delivery in such case

P-6A/OP-6

Factor XI Deficiency in Pregnancy: One in A Million Case

Nikita Sharma, K. Gujral, Renuka Brijwal
Sir Gangaram Hospital, New Delhi, India

Introduction: Factor XI deficiency is a rare autosomal disease with a variable propensity for bleeding. Pregnancy outcomes of this condition during antepartum, intrapartum and postpartum period ranges from no bleeding complications to severe bleeding diasthesis. We present this case of factor XI deficiency diagnosed incidentally during pregnancy and its outcomes and management.

Case: A 33-year-old Primigravida presented at 31+2 weeks at outside hospital with oligohydramnios and was admitted for steroid cover on routine investigations APTT levels reported prolonged. Mixing studies were done next and were reported normal. Then. she was evaluated for clotting factors and was diagnosed with factor XI deficiency. She was referred to our hospital for further management. She gave no history of any abnormal bleeding diasthesis. No history of excessive trauma related bleeding, easy bruising ,epistaxis, menorrhagia. Management: She presented at 35 weeks with PTPROM. In tranexamic acid 1gm and in vitamin K was administered prophylactically. Labour was induced and she delivered vaginally. Mild PPH was encountered which was managed with uterotonics. Two units FFP was given.

Discussion: Factor XI deficiency may or may not cause excessive obstetrical bleed making planning for clinical management challenging. A multidisciplinary approach with inputs from anaesthesia and haematology team are required for management of pregnant factor XI deficient patient. Antifibrinolytic therapy is often used with or without bleeding to enhance haemostasis. Factor XI replacement is mainstay of prophylaxis at induction of labour or preoperatively in these patients especially with severe deficiency.

P-6A/OP-7

Scar Ectopic: Report of A Rare Case

Sunita Yadav, Poonam Sachdeva, Y M Mala, Shakun Tyagi, Anju Garg
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Caesarean scar pregnancy is the rarest form of ectopic pregnancy which has been reported in only 0.15% of pregnant women with a history of caesarean delivery. 1 Its incidence is rising with the increasing rate of caesarean sections and early detection with the widespread use of ultrasonography. It is associated with life-threatening complications like abnormal placentation, haemorrhage, uterine rupture, shock leading to maternal death if not managed properly.

Case: A 35-year-old female, G5P1L1E2 with 11+2 wk POG came to OPD with complaints of bleeding per vaginum. On General physical examination, BP= 112/84 mmHg, PR=92/min, RR= 18/m, no pallor/ icterus/cyanosis seen P/A P/S P/V Tr scar+ Soft No G/T/R Os close Minimal bleeding seen Uterus 8-week Anteverted B/L fornices free On USG – scar ectopic pregnancy diagnosed of size of 6cm with vascularity seen on colour doppler. Beta HCG = 6033mIU/ml Patient has given Inj. Methotrexate 5omg intramuscular, vital monitoring don Beta HCG repeated on day 4 = 4499 mIU/ml Beta HCG on day

7 = 2930 mIU/ml Patient followed up with weekly beta HCG. In 6 weeks, beta HCG came out to non-pregnant levels.

Discussion: Caesarean scar pregnancy should be diagnosed at earliest to avoid severe complications. Most cases are diagnosed early in first trimester, due to widespread usage of ultrasound. It can be managed by medical methods or surgical methods depending on gestation age and size, clinical stability, desire for future fertility. However, several type of conservative treatment can be used like methotrexate, selective UAE

Conclusion: Caesarean scar pregnancy can have very fatal and poor outcomes, include massive bleeding, shock, uterine rupture. To avoid maternal morbidity and spare fertility in patients, methotrexate therapy can be tried.

P-6A/OP-8

Intra Parenchymal Haemorrhage in Pregnancy: A Diagnostic Dilemma

Akansha Yadav, Samina Naaz, Nalini Bala Pandey, Sangeeta Bhasin, Asmita M Rathore
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Intraparenchymal hemorrhage is a rare entity in pregnancy with incidence of 0.2% only. The risk of which is maximum in the last trimester and post-partum. It has been seen that hemorrhage is a more common over ischemia as a cause of stroke in pregnancy. The cause of these hemorrhages can be Arteriovenous malformation (AVM) rupture, preeclampsia/eclampsia, coagulopathies, cerebral venous thrombosis.

Case: This is a case of a 26-year-old female, with 32 weeks of pregnancy, who presented with the complaints of headache, vomiting, two episodes of seizures, raised BP values, and radiologically proven haemorrhage where MRI head was suggestive of intraparenchymal haemorrhage with site of bleed being bilateral Basal ganglia. All these clinical signs and symptoms and radiological evidence but with no signs and symptoms of weakness or unilateral/bilateral paralysis or paresis or localising signs of stroke. Investigations also revealed deranged Liver function tests and deranged PT INR. Patient was managed conservatively for raised BP and intraparenchymal hemorrhage and later termination of pregnancy was done via lower segment caesarean section in view of eclampsia with intra parenchymal hemorrhage. Post-delivery patient's blood pressure normalised and she was relieved of her presenting complaints.

Conclusion: Patients who present with no localising signs of stroke or limb/facial paralysis or paresis can prove as a diagnostic dilemma in patients of eclampsia until MRI or CT head is done.

P-6A/OP-9

Heterotopic Pregnancy: Often an Overlooked Obstetric Condition

Tanya Mudgal, Triveni GS, Kiran Aggarwal, Prabha Lal, Anuradha Singh
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: A heterotopic pregnancy is a condition where implantation occurs both inside and outside the uterus simultaneously. The incidence of heterotopic pregnancy is <1/30,000. It is more common with assisted reproductive techniques (ART). This condition can be life threatening if the diagnosis is missed.

Material and Methods: A 35 years old female G3P1L1A1 presented to gynaecology emergency at 8weeks amenorrhoea with chief complaints of acute abdominal pain and dizziness. Her urine pregnancy test came out to be positive. On physical examination, tenderness was present in left lower abdomen. Transvaginal Scan (TVS) revealed an intrauterine gestational sac with complex left adenexal mass with moderate free fluid in pouch of douglas. Provisional diagnosis of heterotopic pregnancy with ruptured left sided ectopic pregnancy was made. Patient was taken up for emergency laparotomy. Per op, left sided ruptured ectopic with 200cc hemoperitoneum and left sided salpingectomy done along with Dilatation and evacuation of intra uterine pregnancy as opted by patient.

Discussion: Spontaneous heterotopic pregnancy is quite rare in occurrence. However, with ART, this incidence is increasing. High-resolution TVS with color doppler is helpful in making diagnosis. Management is laparoscopy or laparotomy in case of tubal pregnancy. **Conclusion:** A heterotopic pregnancy, though extremely rare, should be kept in mind even if an intrauterine pregnancy is diagnosed. The high index of suspicion should be there to ensure early diagnosis and timely intervention that can result in successful outcome of intrauterine pregnancy and prevent fatal tubal rupture and haemorrhagic shock.

P-6A/OP-10

Dress Syndrome in Pregnancy

Ankati Majumder, Shubham Bhiduri, K Usha Rani
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Drug reaction with eosinophilia and systemic symptoms (DRESS) is a severe adverse drug reaction characterized by an extensive skin rash in association with visceral organ involvement, lymphadenopathy, eosinophilia and atypical lymphocytosis. Although DRESS Syndrome is rare, physicians should be careful in case of pregnant patients with comorbidities and identify risk factors present for timely diagnosis and treatment.

Case: I report a case of a 36-year-old G2P1L1 female at 32weeks Period of gestation with leaking PV for 3 hours, with a history of jaundice 2 months back with K/c/o hypothyroidism on treatment. On admission, patient was kept on conservative management, investigations, cultures were sent. Dexa cover and Triple IV antibiotics were started. After few hours, she went into spontaneous labor, and delivered uneventfully in a few hours. She was asymptomatic in the initial 2 postnatal days, after which on PND3 she complained of generalized swelling all over the whole body, beneath the eyes, itching, papular lesions and wheal on the whole body. Derma referral provisionally diagnosed it as Cholinergic urticaria, and she was started on antiallergics, antihistaminics and ointments. However even with those medications, when there was no relief, she was reviewed and was diagnosed as Dress Syndrome. She was put on steroids for 2 months, after which to be tapered gradually, with liver and renal function monitoring. Skin Biopsy was advised. Her viral markers were HepC IgM positive, wheras rest, along with HIV negative. Chest Xray was also normal. Her LFT gradually improved over the days, and she was continued on steroids, and gradually improving, with skin biopsy been done.

Conclusion: DRESS Syndrome is a rare dermatological disorder with a multiorgan involvement, which is even rarer in pregnancy. Clinicians should keep the condition in mind in seeing pregnant patients with risk factors, for timely diagnosis and complete recovery.

Session 7 A (Obstetrics)

P-7A/OP-1

Anti-Kell Antibody in Pregnancy

Sreeba Balakrishnan KV, Jaya Chawla, Kamna Datta, Preeti Sania, Ashok Kumar
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: The incidence of RhD alloimmunization in pregnancy has been significantly reduced, with the almost universal clinical practice of routine antenatal anti D prophylaxis (RAADP). Next to anti-D, anti-K and anti-c are the most common antibodies implicated in severe hydropic disease of fetus and new-born (HDFN). The management of non-Rh alloimmunized pregnancy is an arduous task since clear guidelines for the same do not exist.

Case: A 27-year-old lady, G4P2L1A1, Rhesus negative pregnancy with Rheumatic heart disease, post Mitral valve replacement, over the course of evaluation of a positive indirect Coomb's test (ICT), was found to be negative for anti-D but positive for anti-Kell antibodies in significant titres (1:8). Her partner as well as her previous baby were negative for Kell antigen / antibody. She received routine antenatal anti D prophylaxis and was monitored with non-invasive serial fetal middle cerebral artery peak systolic velocity measurements to rule out fetal anemia. The patient delivered alive and healthy baby at full term vaginally without any complications.

Discussion: The finer nuances of management of concomitant rhesus negative blood group with Kell isoimmunisation should be kept in mind.

P-7A/OP-2

Case Report of a Rare Presentation of Tubercular Meningitis in Postpartum Female

Dhruthi S, Shakun Tyagi, Y M Mala, Poonam Sachdeva, Shalini Shakarwal
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Tuberculosis (TB) - common infection in developing countries. Central nervous system (CNS) TB, most devastating form of tuberculosis, noted in 5-10% of extrapulmonary TB, approximately 1% of all TB cases. CNS TB with pregnancy - a rare entity. Reporting a case of TB Meningitis in a previously healthy woman, symptoms developed immediately after delivery, initially attributed to postpartum depression and psychosis, but diagnosis was made timely and managed appropriately in our institute and had a favourable outcome- highlighting importance of early diagnosis and treatment.

Case: A 35 years old, P3L2 Lady, undergone uneventful vaginal delivery, delivered healthy baby. Six hours post-delivery, patient started developing

abnormal behaviour started with slurring of speech, not responding to attender's commands, not communicating with her attenders, not feeding her baby, later even progressed to agitated behaviour with abnormal repetitive voluntary hand movements, was even intubated since had strained respiratory efforts with agitated behaviour. Her routine lab parameters were all within normal limits. Timely CSF analysis & brain imaging (CT&MRI) helped in making a constructive diagnosis of Tubercular meningitis and ruling out other differentials. Starting Antitubercular drugs brought a drastic improvement of her condition.

Discussion: During pregnancy immune system is suppressed to prevent fetal rejection. Gets reconstituted postpartum. During this reconstitution phase, reactivation of TB may occur, making it essential to test peripartum females for latent TB, especially those belonging to endemic regions.

Conclusion: CNS TB having most dreaded manifestations, increased morbidity & mortality-timely diagnosis and treatment, proven to have favorable outcome.

P-7A/OP-3

SLE and HIV: A Deadly Duo for The Foetus

Mansi Garg, Shilpi Nain, Soni, Manju Puri
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: Hydrops fetalis (HF) is a serious fetal condition defined as an abnormal fluid accumulation in fetal extravascular compartments and body cavities caused by either immune or non-immune conditions. Systemic Lupus Erythematosus (SLE) is a rare cause of immune hydrops. Flare up of the disease in an immunocompromised woman causes placental edema which may lead to inadequate placental perfusion causing stillbirth.

Case: A 28-year Primigravida affected with human immunodeficiency virus (HIV) on Anti-Retroviral therapy (ART) developed extensive skin rashes all over body at 29 weeks gestation and was diagnosed as a case of systemic lupus erythematosus (SLE). She developed hypertension and fetus became hydropic (despite a normal level II ultrasound). Investigations revealed no impact on her CNS or kidneys. She was started on Hydroxychloroquine (HCQs) followed by oral steroids but the acute cutaneous symptoms persisted. IGRA was found to be positive and patient was started Isoniazid and pyridoxine followed by resolution of symptoms. Unfortunately, she had intrauterine fetal demise at 33-week gestation.

Discussion: This is a rare case where acute SLE caused Stillbirth. Low immunity in an ART receiving PLHA may result in acute flare of autoimmune diseases and which may further get complicated by tuberculosis.

P-7A/OP-4

Pregnancy in Uncorrected Tetralogy of Fallot (TOF): A Case Report

Reena kumari Meena, Vaishali, Divya Pandey, Jyotsana Suri, Sumitra Bachani, Monika Gupta
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Tetralogy of Fallot (TOF) is the most common congenital cyanotic heart disorder but only 3% of patients achieve pregnancy. The pregnancy in uncorrected TOF poses serious perinatal risks with upto 15 % mortality. We, hereby present pregnancy outcome in a 26 yr old female with uncorrected TOF.

Objective: To study presentation of TOF in pregnancy Methods-An unbooked 26-year-old primigravidae presented in Gynae casualty at 31week of period of gestation in established preterm labor with history of NYHA grade II dyspnea with history of cyanotic spells since childhood. Clinical diagnosis of Cyanotic Heart disease was made on history and clinical examination. Meticulous monitoring was done and patient delivered preterm baby. The patient was started on cardiac drugs after cardiology consultation. Both mother and baby are in satisfactory condition at present. Careful history and examination can diagnose cyanotic heart disease thereby enabling correct management.

Conclusion: Uncorrected TOF can lead to adverse perinatal outcome, hence correct and timely diagnosis and subsequent multidisciplinary management can help in achieving favourable outcome.

P-7A/OP-5

Spontaneous Hemoperitoneum in Pregnancy with Abruption: A Case Report

Renu Sehgal, **Nidhi Jain**, Neha Bansal
Artemis Health Sciences, Gurgaon, Haryana, India

Objective: To evaluate a case of spontaneous hemoperitoneum in pregnancy with abruptio placenta, with IUD.

Methods: A second gravida, came to Artemis emergency as a case of 36 weeks pregnancy with loss of fetal movements, with pain abdomen, bleeding per vagina, with suspected abruptio placenta. IUD was confirmed on USG, with no significant retroplacental collection, but there was evidence of moderate hemoperitoneum, with oligohydroamnios. She was severely anemic with tachycardia (pulse rate 140/min), and hypotension with BP 80/70mmhg. Necessary investigations were sent, and she was immediately taken up for emergency LSCS, in view of poor Bishop's score. Perop she was found to have 500ml blood in peritoneal cavity, with 800ml retroplacental clots with a fresh IUD. Uterus was Couvelaire with uterine surface showing multiple endometriotic spots, with large fragile venous lakes.

Results: She recovered well postop, received 2units LDPRC and 4 FFP. She was kept in ICU for monitoring, she was discharged on 5th postop day.

Conclusion: Spontaneous hemoperitoneum in pregnancy can be due to bleeding from endometriotic spots, which may need immediate intervention.

P-7A/OP-6

Pregnancy With Neurosurgical Emergency: A Team Effort

Yashi Nagar, Rekha Bharti, Dipanker Singh Mankotia
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Pregnancy increases the risk of haemorrhage in cerebral arteriovenous malformation (AVM). There have been few reports of bleeding cerebral AVMs presenting during pregnancy. But there is no consensus regarding the best course of treatment for cerebral AVM diagnosed during pregnancy.

Case: A 27-year-old primigravida with 4-month amenorrhoea presented to the obstetric emergency with sudden onset headache and loss of consciousness. Patient was intubated and emergency CT scan was done, which demonstrated a large frontal hematoma. Further investigations revealed an AVM in the frontal region with feeders from anterior cerebral artery and large venous pouch. Patient was shifted to neurosurgery OT, a large frontal craniotomy was made and after removing hematoma, AVM was identified. All feeders were coagulated and large venous pouch was excised. In postoperative period, patient remained stable and was extubated on post-operative day 2. She was discharged on day 8 and followed in neurosurgery and antenatal outpatient departments. At 39 weeks she went into spontaneous labour and had a full term normal vaginal delivery of 3 kg baby with Apgar score of 7, 9. Both mother and baby were discharged in good condition on postnatal day 2.

Conclusion: Cerebral AVM during pregnancy are rare. The management of unruptured cerebral AVM is planned after weighing risk of surgery with potential cerebral haemorrhage due to increased risk of rupture of AVM in pregnancy. However, pregnant women with ruptured cerebral AVMs should undergo prompt intervention.

P-7A/OP-7

A Rare Manifestation of Dengue Haemorrhagic Shock in Reproductive Age Group Woman

Kajal Baleja, Jyotsna Suri, Rekha Bharti
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Dengue fever can be complicated with dengue haemorrhagic fever, or dengue shock syndrome. Haemorrhage is a life-threatening complication of dengue fever. We came across a case of dengue haemorrhagic fever presenting as ectopic pregnancy.

Case: A 24-year G3P2L1 female presented to the emergency at 1.5 months of amenorrhoea with complaints of abdominal pain and vomiting for one day. Urine pregnancy test was positive. On examination PR=110/ min, BP=90/56 mm Hg, RR=21/ min and the shock index was 1.3. Abdomen was tender with guarding and rigidity. On per vaginum examination revealed normal size uterus with fullness and tenderness in left fornix. Ultrasound showed mixed echogenic mass 7.5X4.6 cm anterior and left to uterus and another 3.3X3 cm cystic lesion with internal septation adjacent to mass with gross free fluid in peritoneum suggestive of ruptured ectopic pregnancy. Her haemoglobin was 4.4g% and platelet count were 19000/cumm. The patient was taken up for emergency laparotomy with adequate packed cells, platelets and fresh frozen plasma. Three litres hemoperitoneum was drained, left ovary showed a ruptured cyst-like structure without gestational sac. Patient had two spikes of fever on postoperative day one. Her dengue IgM was positive. Histopathology of tissue showed ovarian cyst with blood clots without evidence of trophoblastic cells. Her serum beta HCG did not show doubling in 48 hours.

Conclusion: Hemoperitoneum with ruptured ovarian cyst is a rare manifestation of dengue haemorrhagic fever presenting as ectopic pregnancy.

P-7A/OP-8

Rare Case of Tubo-Ovarian Mass with Torsion in Pregnancy

Gaurav Wadhwa, Priyanka Singh, Neelam Rajpurohit
ESI-PGIMSR Basaidarapur, New Delhi, India

Introduction: Tumour in pregnancy is a rare finding with prevalence of 1:1000 pregnancies. Usually, they are benign. Most common mass in pregnancy is functional ovarian cyst and luteomas. Whenever malignancy is suspected it is either borderline epithelial ovarian tumour or germ cell tumour. The most common complication is torsion of ovary which can be caused due to long pedicle or moderate size mass. The prevalence of torsion is 1:5000 pregnancies. Patients usually present with complains of vague lower abdominal pain or acute colicky pain and vomiting. Ovarian torsion is an acute emergency which needs surgical intervention. The timely treatment can reduce the chances of oophorectomy if the tissue seems viable.

Case report: Here we are presenting case of patient A 20 yrs. old G2P1L1 with Period of gestation 20 week came to gynae casualty with complain of pain abdomen for 3 days which was insidious and gradually progressive and associated with vomiting and nausea. On MRI it was suggestive of benign serous cystadenoma of left ovary. On USG, the torsion couldn't be ruled out. And patient was put on conservative management. Pt was managed on analgesics and antiemetics and was advised to be NPO. The patient again complained of pain and was not resolved on analgesics. On Examination- Pallor was absent and pulse rate was 110/min with BP of 108/70 mmHg. On per abdominal examination: Uterus was of 20-week size. No mass felt separately. There was tenderness in left lumbar region and left iliac region. Routine Investigations: WNL Hb= 12-gram percent Patient was taken up for Emergency Exploratory Laparotomy. Intra operatively there was Uterus was of approx. 20-week size, ovarian torsion with three twists and haemorrhagic mass of approx. 22 cmx 22 cm was found. The specimen was sent for histopathology. Summary A 20 years old G2P1L1 at 20-week period of gestation with lower abdominal pain for three days. The initial approach was conservative management with analgesics and antiemetics with IVF fluids but left oophorectomy was done as the ovarian mass had torsion with three twists with haemorrhagic and gangrenous changes.

Conclusion: Early diagnosis and prompt treatment with high suspicion is the only way to preserve the ovary. Delaying surgery may be life threatening for both mother and foetus and may cause serious infections.

P-7A/OP-9

Diagnostic Dilemma Between Occipital Encephalocele and Cystic Hygroma

Penzy Goyal, Alpana Singh
University College of Medical Sciences and GTB hospital, Delhi, India

Introduction: Encephalocele is a neural tube defect with incidence of 1 in 10000 out of which 75 percent are occipital encephalocele. Cystic hygroma are congenital malformations of lymphatic tract and manifests as fluid filled cavity in neck region. Both the anomalies look very similar on USG, cystic hygroma will present as a well-defined anechoic thin-walled cyst with multiple septations and a characteristic midline septum representing the nuchal ligament, whereas occipital encephalocele will appear as a well-defined anechoic area with no septations and is seen in direct continuity with a defect in the calvaria.

Case: A 21-year-old G2A1 presented to antenatal OPD at 40 weeks 5 days for routine antenatal check-up. She had level II USG which was suggestive of cystic hygroma. A review USG was done and diagnosis of cystic hygroma was made. Poor prognosis of baby was explained and patient was planned for normal vaginal delivery. A 2.7 kg female baby with large occipital encephalocele was delivered. Baby was shifted to NICU, CT scan was done, diagnosis of ruptured encephalocele was made and baby was planned for surgery. Baby had seizures in the preoperative period and expired.

Conclusion: Since both the anomalies have different prognosis but look very similar, accurate diagnosis may be missed. Hence fetal MRI must be done whenever there is a large swelling in head or neck region so that accurate diagnosis can be made and LSCS can be planned timely.

P-7A/OP-10

Maternal Resuscitation and Post Cardiopulmonary Resuscitation Survival of Mother

Megha Gupta, Mangala Sharma, Nalini Bala Pandey, Renu Tanwar, Shalini Shakarwal, Madhavi M Gupta
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Cardiac arrest during pregnancy is a rare event.The initiation of quick resuscitation response is critical to the outcome of both the mother and the fetus. Cardiac arrest requires high-quality medical care consisting of timely identification, initiation of CPR, and expedited delivery of infant to achieve optimal outcomes for mother and infant.

Case: A 34 years woman, admitted as G2A1, 30+5 weeks of POG with moderate MR, gestational hypertension with superimposed preeclampsia, acute congestive heart failure (MWHO risk class IV), not in labor. Patient was admitted and stabilised in ICU. Review echo revealed CAD, RWMA in RCA, moderate LVSD, moderate MR. Patient developed acute heart failure again after 10 days. Patient got intubated in view of deteriorating vitals and was taken for emergency LSCS in view of decompensating maternal hemodynamic status. Intraoperatively patient underwent cardiac arrest, revived after CPR and defibrillator shock (pulseless ventricular tachycardia). Patient developed cardiac arrest again immediate postoperatively, sinus rhythm achieved after CPR, defibrillator shock and amiodarone (ventricular tachycardia). Patient became hemodynamically stable and got successfully extubated on POD2. Postoperative echo reported severe MR, LVSD, AMV prolapse. Postop period remained uneventful for the mother.

Conclusion: Early aggressive resuscitation and timely decision for termination of pregnancy by well-trained health care providers improve the chances of successful outcomes for both the patient and her fetus.

Abstracts of Poster Presentation (Hall B) on 13th November, 2022

Session 5 B (Gynaecology)

P-5B/GP-1

A Rare Presentation of Uterine Leiomyoma: Pseudo-Meig's Syndrome

Maninder Kaur Ghotra, Jyoti Meena, Rajesh Kumari, Swati Mittal, Radha Rani Seelam, Vatsla Dadhwal.
All India Institute of Medical Sciences, New Delhi, India

Introduction: Pseudo-Meigs' syndrome is a distinct pathological entity which is defined as secondary accumulation of ascites and hydrothorax associated with a pelvic tumor other than benign ovarian tumors such as fibroma, which usually resolve after surgical removal of the tumor. Uterine leiomyoma is commonly reported in cases of pseudo- Meigs' syndrome. Leiomyomas are rarely found in association with ascites and hydrothorax. Elevation in CA-125, in addition to the pseudoMeigs' syndrome is also a rare finding.

Objective: Pseudo-Meigs' syndrome is one of the rare clinical entities among the differential diagnosis of triad of pelvic mass, ascites with elevated CA-125 levels. It also poses a great diagnostic challenge for gynaecologists. Through this case we want to emphasize on the fact that, although above triad often suggests malignancy, Pseudo-Meigs' syndrome should be considered in differential diagnosis with surgery being the main stay of treatment.

Method: This report narrates our experience with a case of 46-year-old female who presented with abdominal distension of 3 months duration. Imaging demonstrated a 15 cm abdominopelvic mass abutting uterus and ileal loops with ascites, peritoneal and omental thickening with elevation of CA125.Surgical resection was performed with subsequent resolution of symptoms. Histopathology report identified uterine leiomyoma, confirming the diagnosis of Pseudo-Meig's syndrome.

Conclusion: Although this is a fairly rare syndrome, it should be considered in women presenting with unexplained hydrothorax and ascites. Suspicion of this syndrome allows for prompt diagnosis by ultrasound and subsequent tissue diagnosis.

P-5B/GP-2

Osseous Metaplasia of Endometrium: A Case Report

Kaavya Sreedhar
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: Osseous metaplasia is a rare pathological transformation of the endometrial mesenchymal layer to form bone tissue. Limited literature about this benign condition suggests that it occurs due to transformation of endometrial stromal cells to osteoblastic cells usually preceeding anti-inflammatory trigger most commonly being history of abortion followed by currettage. The most widely reported presentation of osseous metaplasia is secondary infertility.

Case: This is a case of 36yr female who presented to Dr RML Hospital, New Delhi with dysmenorrhoea and chronic unresolved discharge PV, both since 10yrs, with secondary infertility. The patient had obstetric history of second trimester abortion 18yr ago which

was followed by D&C. Patient thereafter experienced infertility for which she was investigated an gave history of Endometrial biopsy wherein she was told to have bone spicules in her uterus and was denied IVF conception. The patient did not pursue the same thereafter. Transvaginal ultrasonography for her present complaint showed incidental finding of multiple linear echogenic foci in endocervical region. Patient underwent hysteroscopy and was found to have osseous metaplasia in the form of multiple bony spicules in endometrial cavity which were removed and sent for histopathological examination, which showed osseous cellular morphology.

Conclusion: The minimal case reporting of osseous metaplasia makes it a unique and rare case of infertility and hysteroscopic removal of bone tissue has been found to reverse the same and bring about conception.

P-5B/GP-3

Perrault Syndrome: A Case Report

Divya Meena, Madhavi M Gupta
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Perrault syndrome, first described by Perrault in 1951, is an inherited autosomal recessive congenital disorder that is characterized by sensorineural hearing loss in both genders and female gonadal dysgenesis.

Case report: A 15-year-old girl presented to the outpatient department with a complaint of primary amenorrhea. History and examination revealed that she is deaf and mute since birth and has sensorineural hearing loss (SNHL) with a 60% hearing deficit. Her family history was significant that her parents had a consanguineous marriage, her elder sister and younger brother had similar complains of hearing loss and also her sister had a similar complaint of primary amenorrhea. On examination external genitalia was normal, and the breast showed tanner stage 1. There was no pubic or axillary hair. Lab investigation reported raised LH, FSH, decreased estrogen, and normal TSH and prolactin. Ultrasound was done where the uterus was found to be hypoplastic and both ovaries were present. She underwent karyotype, which was 46XX, and was diagnosed with hypergonadotropic hypogonadism with hearing loss, which is consistent with Perrault syndrome, gonadal dysgenesis XX type. She was started on the tablet Premarin for puberty induction and is on regular follow-up. Due to the cost of testing, she has not yet had her specific molecular diagnosis made.

Conclusion: Perrault syndrome may not be rare as some cases might have been unrecognized or not reported. We report this case for its rarity as approximately 100 cases have been reported so far in the literature.

P-5B/GP-4

A Young Nulliparous Infertile Female: An Unusual Adnexal Mass

Nidhi Gupta, Aruna Nigam, Sumedha Sharma
Hamdard Institute of Medical Science & Research & HAHC hospital, New Delhi, India

Introduction: Adnexal masses are common and are having varied gynecological and nongynecological causes.

Case: A 26-year-old infertile, nulliparous presented with vague pain in the abdomen and an abdominal lump for the last one and half years. There were no menstrual complaints. She underwent staging laparotomy 4 years back for a complex adnexal mass at tertiary care medical center in Delhi which was reported to be a serous cystadenoma with granulomatous salpingitis. For which patient was given ATT for 6 months. She also underwent laparo-hysteroscopy one year back in view of primary infertility with a complex adnexal mass. But the procedure was abandoned because of the frozen pelvis. On per-abdomen, a midline scar along with 3 small scars and a vague mass (10 X 12 cm) was palpable in the right iliac and lumbar fossa with firm consistency & restricted mobility. On vaginal examination, the uterus was normal with the same mass felt. Imaging showed a thick wall complex lesion (8.2x9.1x9.7 cm) in the right adnexa having cystic and eccentric solid components with few thin internal septa. On laparoscopy, a huge 15*10cm mass adherent to the anterior abdominal wall above and intestines below was visualized. On adhesiolysis, large gauze was visualized inside the mass and small pieces of gauze were visualized embedded in the capsule. All were removed. Diagnosis of GOSSYPIBOMA was made. The patient was discharged in satisfactory condition.

Conclusion: Safe working culture, open communication, teamwork, and accurate sponge counting and accounting, remain our best defence.

P-5B/GP-5

Synchronous Endometrial and Ovarian Cancer

Naseema A, Nidhi Garg, Shikha Sharma, Latika Sahu
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: It is defined as simultaneous presence of endometrial and ovarian cancers at the time of diagnosis. It has been reported in 3-10% of ovarian cancers and 3-5% of endometrial cancers. It accounts for 50-70% of all synchronous female genital tract tumours. Due to different management and favorable prognosis of SEOC's it is important to separate it from metastatic disease.

Case: A 42yr old P2L2A2 presented with chief complaint of pain in lower abdomen for 2months and lower abdominal heaviness for 2 months USG is suggested of left ovarian mass (14*9*12cm). MRI confirmed left malignant epithelial tumor with intramural fibroid in posterior myometrium with cervicitis. CA-125 was 82.7IU/ml Endometrial aspirate showed endometriod adenocarcinoma. Patient was taken for staging laparotomy with TAH+BSO and pelvic & paraaortic lymphadenectomy. Left ovarian cyst of 12*10cm multiloculated with vascular surface, solid areas and thick septae. Uterus was bulky cut section showed hyper plastic endometrial lining. Histopathology showed uterus-well differentiated endometriod adenocarcinoma (Gr1; <1/2 myometrial invasion)-St 1A and left ovary endometriod adenocarcinoma with focal area of capsular involvement (Stage 1B) with no LVSI. Post operatively, patient was started on chemotherapy-paclitaxel and carboplatin.

Discussion: Young women with endometrial cancer have high risk of synchronous ovarian cancers. Thus, in young women with Endometrial cancer bilateral salpingoopherectomy or careful histological assessment of both ovaries are recommended in order to rule out SEOC. HNPCC testing should be offered to all women.

Conclusion: OEC patients have a high proportion of simultaneous endometrial lesions. OEC with simultaneous endometrial lesions are younger than patients with pure OEC. Synchronous endometrial lesions do not affect the prognosis of patients with OEC.

P-5B/GP-6

Recurrent Ovarian Torsion in An Adolescent

Ayushi, Renuka Malik
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: Ovarian torsion is a surgical emergency that can affect future fertility. Oophoropexy can be done to prevent recurrent torsion. This article presents a case of a recurrent ovarian torsion that presented following oophoropexy.

Case report: A 17-year-old unmarried female presented to the emergency with complaints of severe pain abdomen with vomiting for one day. There was history of similar episode of pain two years back when the patient underwent right sided salpingoophorectomy for large necrotic ovary along with oophoropexy of the contralateral side. Patient had history of irregular cycles. On examination, patient was found to have tachycardia and tenderness in left lower quadrant with guarding. USG report showed enlarged left ovary with stromal edema and small peripheral cyst and absent flow on color doppler. Diagnosis of left ovarian torsion was made and patient was taken for laparotomy where left ovary was detorted and oophoropexy was done using the hot dog in bun technique. Patient was followed up post-operatively and reported to have regular cycles. Repeat USG was done 2 months post-operatively which showed normal left ovary with normal color flow on doppler and normal S. AMH levels.

Conclusion: Recurrence of torsion can occur even after Oophoropexy so strong suspicion of ovarian torsion should be kept in mind for adolescent presenting with acute abdomen. Timely intervention is a must to preserve ovarian function and future fertility.

P-5B/GP-7

Laparoscopic Assisted Removal of Giant Cervical Fibroid by Exsection: A Surgeon's Plight (Video Presentation)

Anshul Kulshreshtha, K K Roy, Jyoti Meena, Rinchen Zangmo, Maninder Kaur Ghotra, Priyanka Das
All India Institute of Medical Sciences, New Delhi, India

Introduction: With rise in age limits of marriage and child bearing, there is a surge in number of unmarried and nulligravida females seeking treatment for fibroids. Uterus preservation and cosmesis are major solicitude in them. Incidence of cervical fibroids is only 1-2 % but their removal is a technical challenge due to the distorted anatomy, possibility of injuries to surrounding structures and difficulty in restoring the anatomy between cervix and lower uterine segment leading to chances of landing up into hysterectomy.

Objective: Removal of large cervical fibroids in infertile patient is a surgeon's nightmare and a surgical challenge. Laparoscopic myomectomy, being a minimally invasive approach, appreciably tackles the cosmetic concerns but remains a

technically challenging procedure. Correct knowledge of altered anatomy and continual upgrading of operative technique is a key to success in such cases.

Method: This report narrates our experience with a case of an unmarried female presented with a huge cervical myoma (a 36 weeks gestation sized), who successfully underwent laparoscopic assisted myomectomy. After ruling out possibility of sarcoma using clinical, biochemical and imaging modalities, we performed a novel approach of minilap assisted laparoscopic myomectomy (i.e., Hybrid technique) under general anaesthesia. Fibroid retrieved out using manual morcellation, thus avoiding power morcellation. Histopathology report confirmed 30*25*5.5 cm morcellated pieces with features s/o Leiomyoma, weighing 4 kgs.

Conclusion: Hybrid technique overcomes the inherent technical challenges associated with laparoscopic myomectomy and also addresses both cosmetic and fertility concerns esp. in nulliparous and unmarried patients.

P-5B/GP-8

Ruptured Corpus Luteal Cyst in Women on Anticoagulant Therapy-A Case Series

Shalini Parashar, Krishna Agarwal, Lekshmi, Niharika Dhiman, Asmita M. Rathore
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Incidence of ruptured corpus luteal cyst among women receiving anticoagulants is 1%. Ruptured corpus luteal cyst is commonly seen in women of the reproductive age, but hemoperitoneum in case of ruptured corpus luteal cyst in women on anticoagulant is a rare complication. Corpus luteal cyst rupture may occur spontaneously or often triggered by trauma, coitus, exercise, on anticoagulant therapy, or vaginal examination.

Case Series: Here we are presenting three cases of ruptured corpus luteal cyst with hemoperitoneum who had history of heart valve replacement and were on oral anticoagulants presented as acute abdomen and were managed conservatively by dose adjustment of anticoagulants.

Conclusion: Hemoperitoneum due to ruptured corpus luteal cyst may be confused with ectopic pregnancy. If ectopic pregnancy ruled out then such cases can be safely managed conservatively.

P-5B/GP-9

Labial Agglutination in A Pubertal Girl-A Case Report

Smriti Thakur, Krishna Agarwal, Lekshmi, Asmita M. Rathore
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Labial agglutination is common in prepubertal girls, predominantly amongst 3 months to 5 years old and rarely seen in post-menopausal females.

Case: Here we present a case of labial agglutination with urinary retention in a young girl which is relatively a rare condition. A 16-year-old girl presented with acute urinary retention and pain abdomen for 2 days with normal menstrual history. Per abdominal examination was normal. On local examination, pin point opening seen at the introitus with complete agglutination of labia minora and majora. Foleys catheter introduced through the opening; clear urine drained. Ultrasound revealed distended bladder and fluid in vagina, catheter bulb also seen. Examination under anaesthesia was planned. Both labia minora were fused, vertical incision given on the fused labia. Once labia separated, normal urethral opening seen. Labial repair done with interval sutures.

Conclusion: Labial agglutination is often a misdiagnosed condition. Clinical suspicion and meticulous examination need to be re-enforced to prevent unnecessary investigation in the paediatric age group.

P-5B/GP-10

Haemato-Myeloid Malignancies Masquerading as Gynaecological Masses: A Rare Yet Existing Entity

Seema Singhal[1], Neena Malhotra[1], Swati Tomar[1], Ekta Dhamija[2], Sandeep Mathur[3], Neerja Bhatla[1]
[1]Department of Obstetrics and Gynaecology, [2]Department of Radiodiagnosis, [3]Department of Pathology, All India Institute of Medical Sciences, New Delhi, India

Introduction: Hematological malignancies mimicking gynaecological neoplasia is a rare entity. We present three unusual cases where patients presented with genital tract manifestations pointing to benign gynecological disorders but turned out to be haematopoietic cancers.

Case Series: Three cases were included with age ranging 30-44 years. The clinical presentation was abnormal bleeding per vaginum. One patient

presented with secondary PPH, and other two presented with AUBL. Examination revealed presence of abdominopelvic mass. The clinical presentation was mis-leading and led to a delay of 4-14 months. The atypical imaging led to suspicion and biopsy was confirmatory. The final diagnosis was Mantle cell lymphoma, non-Hodgkin's lymphoma, and Acute Myeloid leukemia. One patient succumbed to illness despite therapy. One patient was kept under observation; and chemotherapy followed by salvage surgery led to remission for one case.

Discussion: In women with abdominopelvic mass and or vaginal bleeding, placing differential diagnosis of hematological malignancy is rarely considered. Only 6/9500 lymphomas in women present with gynecological manifestations. Myeloid sarcoma of the ovary as a manifestation of underlying AML is extremely rare with only 10 cases reported in literature. In none of our cases, initial blood picture pointed towards a hematological malignancy. However, atypical clinical findings not correlating with imaging raised suspicion of something unusual and histopathology with IHC was confirmatory.

Conclusion: The OBGyn specialists should always be alert of unusual disease when encountering atypical history and clinical signs on examination. Collaboration with multidisciplinary team facilitates prompt diagnosis and timely initiation of appropriate therapy.

Session 6 B (Gynaecology)

P-6B/GP-1

Uterine Prolapse in Pregnancy

Amanat Kullar, Jharna Behura
Kasturba Hospital, New Delhi, India

Introduction: Uterine prolapse is the descent of uterus and cervix down the vaginal canal towards the introitus. Uterine prolapse in pregnancy is a rare condition. It can cause antepartum, intrapartum and puerperal complications in pregnancy and is associated with adverse outcomes such as vaginal infection, cervical ulceration and preterm delivery.

Objective: To present the case of uterine prolapse in pregnancy.

Methods: A 30-year-old female, G2P1L1 presented with mass coming out of vagina during third trimester of pregnancy at 38 weeks gestation with complaint of pain abdomen. On local examination third degree uterine prolapse seen. On PV examination cervical os 5cm dilated with vertex presenting part at -2 station and bag of membranes. As the edema tour and thick trapped cervix was not reducible, the labour was obstructed. CTG showed decelerations in FHS for which artificial rupture of membranes was done. The liquor was Grade 3 meconium stained. The caesarean delivery was decided in view of fetal distress.

Results: The prolapsed uterus recovered spontaneously following cesarean section. On Postoperative day 1 the local examination showed no mass coming out of vagina.

Conclusion: Genital prolapse concurrent with pregnancy is a seldom condition occurring during pregnancy. Management of uterine prolapse in pregnancy and labour should be individualised depending on the severity of the prolapse, gestational age and parity. Many cases benefit from conservative management.

P-6B/GP-2

A Large Para Ovarian Cyst with Torsion

Asmita Anand, Niharika Dhiman, Deepti Goswami
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Para ovarian cyst is a fluid filled sac found near ovaries also called as Para tubal cyst or hydatid cyst of Morgagni. It represents about 10% of all adnexal mass. Risk of torsion in Para ovarian cyst is 2.1 to 16%. They are generally benign.

Case: A 16-year unmarried girl presented with complain of pain abdomen associated with vomiting on and off. On general physical examination, Heart rate-100, BP-100/60, afebrile. On per abdominal examination-tenderness present in hypogastrium and a 10 x 10 cm mass palpable whose lower margin was not reached. Preoperative diagnosis was right ovarian cyst with torsion. An exploratory laparotomy was performed which revealed a large para ovarian cyst of size 15x10cm over the right ovarian ligament displacing the ovary lateral to the mass. Cyst was rotated 3-14th of a circle along horizontal axis over the right ovarian ligament causing mechanical obstruction of the blood supply to ovary. Fallopian tube stretched out and fimbriae seen in the mesothelium. Cyst wall separated using blunt dissection and was cut, clamped, and ligated. Mesothelium reconstruction was performed. Postoperative course was uneventful.

Conclusion: Para ovarian cyst often occur in adolescence and can induce fallopian torsion when it is of bigger size. Main clinical manifestation is acute abdominal pain. Associated symptoms are variable

but vomiting is the most associated symptom. Detorsion and cystectomy is the main modality of treatment.

P-6B/GP-3

Radiological and Surgical Correlation of Peritoneal Carcinomatosis Index for Epithelial Ovarian Cancers

Shubham Pandey, Megha Mittal, Manash Biswas, Kanika Batra Modi, Harit Chaturvedi
Max Hospital Saket, Delhi, India

Aims and objectives: The study aims to identify the accuracy of computed tomography (CT) in preoperative Prediction and staging of ovarian cancer using peritoneal carcinomatosis index (PCI) score and compare it with the PCI determined at the time of surgery.

Materials and Methods: This study was prospective observational study over 3 months including all patients with primary peritoneal cancer or epithelial ovarian cancer with stage II B or more. Sugar baker's PCI score was used to objectively assess the site, size and tumour load preoperatively by CECT and intraoperatively during exploratory laparotomy. Statistical analysis was done comparing the two PCI. Results Total of 15 patient were included in the study. There was a statistically significant correlation between the intra-operative and radiological observations which showed Pearson's correlation coefficient of 0.733 The correlation was more in the middle and lower abdominopelvic regions. There was underestimation of PCI by CT in cases but was not statistically significant.

Conclusion -Radiological PCI has a good correlation with surgical PCI and, hence, is useful in predicting patients with potentially unresectable disease.

P-6B/GP-4

Large Twisted Sub-serosal Fibroid with Acute Intestinal Obstruction

Anshul Bhartiyam, Sangeeta Bhasin, Nalini Bala Pandey, Sameena Naz, Krishna Agarwal, Asmita M Rathore
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Twisted sub-serosal fibroid presenting as an acute abdominal pain is a rare event and impose diagnostic dilemma.

Case: This case report of a women, 26 years old, presenting with abdominal mass, acute abdominal pain and vomiting in emergency. The physical examination pointed towards an abdominal mass. USG revealed fibroid with query degenerative changes and X-ray abdomen erect and supine showed intestinal obstruction. Patient underwent laparotomy. On opening the abdomen, twisted large solid pedunculated fibroid was found for which myomectomy was done and resection and anastomosis for the stricture in intestine done. Histological examination confirmed the diagnosis of leiomyoma. There were no post op complications and the patient was discharged.

In this paper, a literature review of diagnosis and treatment of this rare presentation of fibroid, based on current data is given.

P-6B/GP-5

A Rare Case of Exceedingly Huge Round Ligament Leiomyoma Presenting as Ovarian Neoplasm.

Rashmi Saxena[1], Vinita Jaggi[2], Manisha Sharma[1]
Hindu Rao Hospital, Delhi State Cancer Institute, Delhi, India

Introduction: Leiomyoma of uterus is common but leiomyoma of round ligament of uterus is rare. Huge Leiomyoma of the round ligament presenting as ovarian carcinoma is not reported till date. It arises from smooth muscle of round ligament. It is difficult to diagnose preoperatively, despite advanced imaging, as it mimics ovarian neoplasm.

Objective: To address a massive tumor in abdomen does not always ovarian mass and to emphasise: surgery with high-risk consent and chance of aborted surgery is the only option.

Methods: Exploratory Laparotomy done under general anesthesia. Intra-operatively,uterus along with both tubes and ovaries were normal and the tumor was arising from round ligament on right side. The mass entirety, was delivered out of incision by pressing from all sides of abdomen,and sent for histopathological examination.

Results: The HPE revealed -Right sided round ligament mass: 50 x40x30 cm, well encapsulated. On cutting majority solid having homogenous gray whitish fleshy cut surface, leiomyoma mass 50x40x30cm with hyaline change and cystic degeneration. No coagulative necrosis / atypia / malignancy seen.

Conclusions: Round ligament leiomyoma is a rare condition which can mimic carcinoma ovary. CT scan can differentiate but surgical exploration can

provide relief to the patient and diagnose exact nature of the swelling. This case presents an unusual example of huge round ligament leiomyoma. This unique case suggests that the round ligament leiomyoma in very rare cases may be so huge which mimics ovarian cancer, in my best knowledge this is first case worldwide with 25 kg round ligament leiomyoma.

P-6B/GP-6

Yolk Sac Tumor in A 22-Year Female

Peuly Das, Y.M. Mala
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Yolk sac tumor most frequently arises from gonads as a type of Germ cell tumor. It is highly malignant tumor and metastasized rapidly. AFP is tumor marker, as it is elevated in > 90% of cases. The treatment generally involves debulking surgery of tumor followed by systemic chemotherapy.

Case report: This is a case about a female in reproductive age group, presenting with high grade fever and pain abdomen with abdominal pelvic mass in puerperal period solid cystic, well-defined (11.5 X 10 X 15 cm) mass found in left side pelvis. She underwent exploratory laparotomy with right salphingoophrectomy in view of puerperal sepsis. On opening abdomen, turbid peritoneal fluid with pus deposit over omentum seen and large ovarian mass (20 X 15 X 12 cm) on right side, lobulated in appearance, with solid to cystic in consistency, with evidence of capsule rupture seen. On HPE, the diagnosis of Yolk sac tumor is confirmed. Serum AFP is 6600. On CECT, peritoneal mets with retro peritoneal lymph nodes mets are there. After a smooth post-operative course, the patient was started on chemotherapy (BEP regimen).

Conclusion: In our case illustrates, even at late-stage positive treatment results can be achieved through prompt treatment with debulking surgery and chemotherapy and symptoms like pain abdomen, multiple episodes of high-grade fever should not be neglected because these might be critical sign of YST.

P-6B/GP-7

Experience At One Stop Centre

Nirupama Gupta
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: This article discusses the nature and incidence of the sexual abuse and invites detailed research on the socio-cultural and familial risk factors involved in sexual abuse.

Objectives: The objective of the study is to evaluate the spectrum of women requiring 'One Stop Centre' care by analysing the number of survivors of abuse reported under medicolegal system in a tertiary care centre.

Methods: All cases reported in a span of one year, at one stop centre in districts under Dr RMLH Hospital, New Delhi.

Result: There were a total of 300 medicolegal cases from 01-09-2021 to 30-09-2022 reported under medicolegal cases under the department of obstetrics and gynaecology. The total cases reported as sexual assault were 31.66%, Of these, 22.1 % consented for safe kit examination. Twelve patients (4%) patients were admitted. The age group ranged from 2 years to 55 years of age. Maximum (48%) survivors fell in the age group of 13-18 years, with 83% cases reported as abscond secondary to mental and physical assault, 17 % cases as sexual assault. Seven percent survivors fell under age group of 13 years. Out of them 52% cases were of sexual assault. Around 40% survivors were in the age group of 19-55 years. All the survivors were offered counselling, and was provided in 96.6% cases.

Conclusion: The study highlights the type of assaults women are facing in the national capital and, the requirement towards the need of awareness and education regarding sexual assault reporting.

P-6B/GP-8

A Rare Presentation of Structural Abnormalities of Uterus in Young Girls

Sangeeta kumari, Kamna Datta, Jaya Chawla, Preeti Sania, Ashok Kumar
Atal Bihari Vajpayee Institute of Medical Sciences & Dr Ram Manohar Lohia Hospital, New Delhi, India

Introduction: Accessory and cavitated uterine masses (ACUM) is a rare, newly recognized mullerian anomaly. It is an accessory cavity lined by functional endometrium within an otherwise normal uterine cavity, in contrast to other Mullerian anomalies where uterus is malformed. In most cases, surgical treatment is recommended due to severe dysmenorrhea.

Cases: We have studied cases of two unmarried female with severe dysmenorrhea and not relieved

with any form of medical treatment. **Case 1** – 23-year-old unmarried female with complaints of pain abdomen referred with radiological imaging suggesting obstructed non communicating horn of bicornuate uterus. On detailed evaluation and intraoperatively assessment, it was found to have Accessory and Cavitated Uterine Mass. **Case 2** – 15-year-old unmarried female with complaints of severe dysmenorrhea, not relieved on medication, on evaluating was found to have rudimentary horn. Outcome - Symptoms of both patents relieved after surgical treatment.

Conclusion - Different types of mullerian anomalies can present with similar presentation. High index of suspicion with good imaging may help us clinch the diagnosis and initiate correct management.

P-6B/GP-9

Utero-cutaneous Fistula: A Rare Complication of Adenomyosis Surgery

Niharika Sharma
Hamdard institute of medical science and research, Delhi, India

Introduction: Uterocutaneous fistula (UCF) is a rare entity which is an abnormal communication between epithelial surface of uterus and skin. Most UCF occurs as a result of post operative complication

Case: A 35 year old female with primary infertility with adenomyosis and grade 4 endometriosis had been operated for adenomyoma laparoscopically f/b mini laparotomy for removal of adenomyoma and repair.An area of 2 cm over stitch line didn't heal post operatively. after 1.5 months patient had blood mixed discharge from wound. She was initially treated conservatively (on antibiotics) f/b resuturing. Subcutaneous drain inserted while doing resuturing i/v/o excessive oozing. As the drain had 50 cc of blood mixed discharge in post operative period for 7 days, MRI was done which showed large gap in uterine myometrium. Endometrial cavity was connected with the wound. She was put on high dose progesterone which gradually stopped the bleeding and healing of wound in 2 months Progesterone was continued for 3 months and then tapered. MRI was done which showed healing.

Discussion: UCF are rare and difficult to treat when connected to external wounds.It will lead to non-healing of wound and blood discharge. Progesterone/Leuprolide are needed to produce amenorrhoea along with excision of tract for complete healing.

P-6B/GP-10

Unusual Case of Ovarian Torsion with Multiple Dermoid

Vishwani Khurana, Nidhi Gupta
Hamdard institute of medical science and research, Delhi, India

Introduction: Ovarian tumors are a common form of neoplasm in women. Mature cystic teratoma is the most common type, with a bilateral incidence of 8-15%. However, few cases are reported as bilateral and multiple.

Objective: Present a case of Left sided ovarian torsion with multiple dermoid cysts present bilaterally.

Case: A rare case of left ovarian torsion (5 times torsion) with bilateral multiple dermoid cysts in a 30-year-old female patient, who presented with severe abdominal pain of 5-days duration. She had a medical history of pulmonary koch's 10 years ago, for which she had received DOTS therapy. Surgical history of 1 LSCS 1 year ago. She had a regular menstrual history. Emergency laparotomy with dermoid cystectomy with bilateral ovarian reconstruction was performed. Per op: Right side-ovarian mass ~ 8*8cm (+), 5 dermoid cyst present; dermoid reconstruction done. Left side: 14*14cm ovarian mass (+), 5 times ovarian torsion (+), 7 dermoid cysts present (largest ~ 6*6cm); dermoid cystectomy done alog with ovarian reconstruction. Post op ovaries: Right- 3*3cm, left: 4*4cm

Conclusion: Dermoid cysts are innocent tumors but epidermoid carcinoma occurs in 1.7% cases. Differential Diagnosis for complex/solid adnexal masses are: ectopic pregnancy, Corpus luteal cyst, Endometrioma, Hydrosalpinx, Pedunculated fibroid.

Session 7 B (Gynaecology)

P-7B/GP-1

Carcinoma Endometrium with Solitary Vulvo Vaginal Metastasis: A Rare Presentation

Soni, Sharda Patra, Manju Puri
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Background: Endometrial cancer metastases that are implanted in the vulvar region are quite

uncommon. The fact that vulvar metastasis (VM) is anecdotal is likely due to the different regional lymphatic drainage from the corpus uteri.

Case: Here we are presenting a case of endometrial carcinoma FIGO Stage IIIB that metastasized to the vulva and extended to the lower part of vagina. Her histopathology from endometrium and from vulvar lesion was suggestive of common origin from the endometrial cancer poorly differentiated adenocarcinoma based on IHC markers. After consultation in the tumor board team and in view of non-operability of vaginal metastasis, the patient was subjected to 4 cycles of neoadjuvant chemotherapy with Carboplatin and paclitaxel. The response to Neoadjuvant chemotherapy was seen with disappearance of the vulvovaginal mets. Hence the patient underwent interval debulking surgery followed by further 2 more cycles of adjuvant chemotherapy. Patient is now planned for Chemoradiation.

Conclusion: This case is one of the few reported cases in the literature where carcinoma endometrium is diagnosed with solitary vulvovaginal metastasis. The cervix and upper vagina remain uninvolved by the tumour. In this case report we also explore the literature discussing the different mechanisms of vulvar metastasis pathogenesis and also the management options in these cases.

P-7B/GP-2

Monomanual Monodigital Examination for Diagnosis of Pelvic Floor Myofascial Spasm

Monika, Rekha Bharti
Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi, India

Introduction: Chronic pelvic pain (CPP) diagnosed as non-cyclic pelvic pain perceived to originate from pelvic organs lasting of more than 6 months, affects 5.7% to 26.6% women. The evaluation and management of CPP can be facilitated by differentiating it into visceral, neuromusculoskeletal and psychosocial origin.

Case: A 44-years-old P2L2 presented to Gynaecology OPD with complaint of pain lower abdomen and perineum radiating to left buttock for 2 years. Pain was noncyclic, sharp and stabbing, 7/10 score in nature, with no history of diurnal variation or dyspareunia, and not associated with urinary or bowel symptoms. She had visited multiple government and private gynaecologists and orthopedic surgeons. She had received multiple courses of antibiotics, took dinogestrone 2 mg once a day for 3 months, and received physiotherapist for pain in neck and upper back. Patient was anxious looking with normal chest, CVS and abdominal examination. She had 5 trigger points in the paraspinal region around neck and upper back. A gentle monomanual monodigital pervaginal examination revealed one trigger point on upper border of left levator ani muscle. She was started on NSAIDS & duloxitine 20 mg for 2 weeks. She was given trigger point injection and continued on duloxitine 20 mg and referred to ortho OPD for neck and back pain. Now, 6 weeks after trigger point injection patient is free of pelvic pain.

Conclusion: Careful and gentle monomanual monodigital pervaginal examination is important part of examination in women with pelvic pain.

P-7B/GP-3

Paraovarian Cyst with Tubal Torsion: A Rare Cause of Acute Abdomen

Nikita Saxena, Ratna Biswas, Reena, Vidhi Chaudhary
Lady Hardinge Medical College and Smt S K Hospital, New Delhi, India

Introduction: Para-ovarian cysts are present in approximately 10% of all adnexal masses. They arise from epoophores, which are located in the broad ligament. They are usually asymptomatic but can sometimes cause tubal torsion.

Objective: To emphasize that normal ovarian blood flow doesn't rule out torsion especially tubal torsion.

Case: A 19-year-old unmarried girl presented with acute abdominal pain and vomiting. Pelvic ultrasound showed a left paraovarian cyst of size 6.7cm X 5 cm long with a left ovarian endometriotic cyst of 3 cm with preserved ovarian blood flow. Her urine microscopy and ultrasound KUB were normal. She was started on analgesics but pain was not relieved hence decision to do diagnostic laparoscopy and proceed was taken. On PAC, T wave inversion in lead II, III, AVF was noted and it was advised to convert to laparotomy. Intraoperatively a paraovarian cyst of 5 X 6cm was lying in the POD with the left tube having undergone 2 and half twists. The tube was long congested and edematous. The left ovary was bulky 4 X4 cm with a hemorrhagic cyst 3X3 cm with a long ovarian ligament. Detorsion of the tube was done along with enucleation of paraovarian cyst followed by plication of ovarian ligament. Post operative period was uneventful and she was discharged on the 3rd postoperative day

Conclusion: When torsion is strongly suspected

clinically despite normal doppler study, a paraovarian cyst with tubal torsion is an important differential diagnosis and early diagnostic laparoscopy and tubal preservation is strongly advocated,

P-7B/GP-4

Magic Needle - Port Closure Needle

Mamta Tyagi
Perfect Tyagi Hospital

Magic needle – port closure needle port size more than 10 mm in adult and more than 5 mm in childern should be closed. large size port used for laparoscopic and robotic procedures will require appropriate closure to reduce the trocar site complication including hernia and hematoma. Port closure needle made nowadays is having very sharp tip to enter in abdomen under vision and is very helpful in taking out the thread from abdomen easily, we use this needle for ovarian suspension, uterine suspension, management of bleeding from inferior epigastric artery, additionally after myomectomy for uterine haemostasis.

We used port closure needle in 11 cases for different purposes besides port closure. Our objective of study was to maximise the use of very economical and easily accessible instrument for life saving purposes. Our motive is to encourage every endoscopic surgeon to think widely i,e out of the box. our study included 11 cases among them we used port closure needle except port closure. One case of bleeding from inferior epigastric artery, in this case free thread introduced via working port in to the abdomen and ends of thread taken out from abdomen and were tied below the point of haemorrhage i,e near origin . in four cases we used this needle for ovarian suspension after removal of endometriotic cyst to avoid adhesion formation. in two case we suspended the uterus to anterior abdominal wall after myomectomy by taking out the end of suture and securing to the anterior abdominal wall. it ensured better haemostasis and it may also decrease the chances of adhesion formation posteriorly .in three cases we suspended round ligament to prevent adhesion formation after adhesiolysis. In one case we use this needle for cornual pregnancy management. use of port closure needle in laparoscopy is very promising and it may be called as magic needle .it is very easy to use and time saving. in our cases it proved lifesaving many times. Laparoscopy instruments in general are very costly, t lift devices are single use, but using port closure needle is very cheap, time saving and effective method.

P-7B/GP-5

Unusual Bilateral Ovarian Metastasis from Primary in Gastrointestinal Tract

Jaspreet Kaur, Mangla, Renu Tanwar, Nalini Bala Pandey, Madhavi M Gupta
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Secondary ovarian involvement by an adenocarcinum of gastric, pancreatic or biliary tract origin is, by definition evidence of advance tumour stage (pM1) and carries a poor prognosis. The rate of secondary (metastatic) ovarian malignancy varies from 6- 22%.

Case: 45-year-old female P3L3 presented to gynae OPD with abdominal distension associated with decreased appetite for 3 months with severe anaemia. Last menstrual period was 8 months back. Previous menstrual cycles were regular. On examination her abdomen was tense, 24wks size mass palpable with hard irregular surface and restricted mobility lower margin not reached. On per vaginum examination uterus not felt separately, mass occupying B/L fornices. Blood transfusion done. Anaemia corrected. CECT abdomen pelvis shows Bilateral epithelial ovarian neoplasm likely mucinous cystadenocarcinoma with Thrombosis of main portal vein and right branch with resultant segmental areas of infarct involving right lobe of liver with border line splenomegaly Ascitc tapping done. ICD drain inserted in left chest in view of massive pleural effusion. Upper GI endoscopy normal. Patient taken up for surgery under moderate to high risk. Staging laparotomy with hysterectomy with suprocolic omentectomy and B/L ovarian mass remoral done. Ovarian mass with uterus and cervix sent for histopathological examination. HPE report suggestive of mucin secreting adenocarcinoma - on IHC tumour cells are positive for CDX2, negative for CD56 and Inhibin.

Conclusion: There is significant overlap of clinical, radiological and pathologic features between primary and metastatic ovarian adenocarcinoma. In the work up of a mucinous ovarian neoplasm a secondary malignancy should always be excluded pathologically or clinically. In case of gastric carcinoma, an ovarian mass is usually the presenting sign and 70-75% of patents have no primary identified at time of diagnosis.

P-7B/GP-6

Venous Thromboembolism in Ovarian Cancer

K. Rini, Deepti Goswami, Niharika Dhiman
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Case: A 38yr old lady, para 1 live 1 presented with complaints of menstrual irregularities for one year. She had complaints of prolonged cyclical bleeding lasting for 10-12 day. She was being conservatively managed for the same in another hospital. Around four months back, patient received blood transfusion in view of severe anaemia after which she developed unilateral swelling of right lower limb. She was admitted to hospital and diagnosis of right lower limb deep vein thrombosis (DVT) with cellulitis with sepsis with right ventricular clot was made. It was managed conservatively on antibiotics and anticoagulants and discharged on same. She had another episode of abdominal pain which was diagnosed as common iliac vein thrombosis with right lower limb DVT with pulmonary embolism. She had an IVC filter placement after this episode. She was thoroughly investigated with echo, ultrasonography, CECT Chest and abdomen. On CECT Abdomen, complex solid cystic left adnexal lesion of size 6x4.3 cm with thick nodular septae and solid component showing vascularity with no visualization of left ovary separately. USG guided FNAC was done from the same and features were suggestive of Adenocarcinoma with areas of necrosis. Currently being managed with neoadjuvant chemotherapy.

Conclusion: The incidence of VTE is high in ovarian cancer. Because a large pelvic tumour or massive ascites may compress the intrapelvic veins, women with ovarian cancer are at high risk for VTE. VTE adversely affects survival in ovarian cancer. Obesity, high grade and stage of cancer, subtype and high CA 125 level should be incorporated into protocols of VTE prophylaxis in women with ovarian cancer.

P-7B/GP-7

Endometrial Stromal Sarcoma Masquerading as Rectovaginal Endometriosis

Akanksha Gupta, Seema Singhal, Sachin Khurana, Jyoti Meena, Ekta Dhamija, Sunesh Kumar
All India Institute of Medical Sciences, New Delhi, India

Introduction: Low grade Endometrial stromal sarcoma (LG-ESS) is primarily a uterine mesenchymal neoplasm but may also occur in extra uterine sites. Rectovaginal involvement is still rarer. The diagnosis may be masked by the co existent endometriosis because of non-specific symptoms. We present a rare case of low grade ESS presenting as rectovaginal (RV) endometriosis.

Case: A 38-year-old P2L2 presented with complaints of dyspareunia, dysmenorrhea and painful defecation since last one year with blood mixed purulent discharge from vagina for past three months. On examination a hard, tender mass was felt in the posterior fornix with irregular nodularity in vaginal mucosa. MRI pelvis showed ill-defined planes posteriorly with rectum. With a biopsy proven diagnosis of rectovaginal endometriosis, progesterone treatment was given. Patient was relieved symptomatically and her lesions regressed. However, after 1 year, she had exacerbation of all the symptoms. A hard fixed mass was felt posteriorly extending to recto vaginal septum. A biopsy from necrotic growth in posterior fornix was suggestive of low grade endometrial stromal sarcoma. Patient was taken up for laparotomy. Intra operatively pouch of Douglas was found to be obliterated and a 7x8 cm mass was seen in the RV septum infiltrating the rectum. Left sided ureter was encased within the mass. Complete cytoreduction with retrograde hysterectomy along with removal of involved portion of sigmoid colon and rectum was done. Diagnosis of LG-ESS stage III A was confirmed and patient was started on Tab Anastrozole 1 mg daily. Patient is under follow up and disease free after 64 months of follow up.

Conclusion: This case emphasizes that gynaecologist should keep in mind the probability of developing malignant transformation of extra gonadal endometriosis particularly if they are given hormonal treatment for long duration

P-7B/GP-8

Primary Bilateral Ovarian Burkitt Lymphoma; A Rare Case in Gynaecologic Oncology

Anushka Gupta, Mangla Sharma, Renu Tanwar, Madhavi M. Gupta
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: Primary bilateral non-Hodgkin's lymphoma of the ovary is a rare occurrence. An ovarian involvement by non-Hodgkin lymphoma (NHL) may include one of the four subtypes of lymphoma: diffuse large B-cell lymphoma, Burkitt's lymphoma (BL), lymphoblastic lymphoma or anaplastic large cell lymphoma. Burkitt's lymphoma is a rare entity with a specific poorly differentiated

pattern.

Case: We report a case of a primary ovarian Burkitt's lymphoma with bilateral involvement in a 20-year-old patient. She firstly presented with weight loss, pain abdomen, fever and abdominal distension. The purpose of this presentation to draw the attention of the health care provider to the possibility of ovarian Burkitt lymphoma which should be kept in the differential diagnosis of ovarian tumour. The diagnosis of malignant Burkitt lymphoma was established after bilateral salphingo-oopherectomy and histological study of excised tissue.

Conclusion: Although bilateral Burkitt Lymphoma is a rare primary ovarian neoplasm due to absence of lymphatic tissue with in the ovaries. Most of the patients suffering from ovarian Burkitt Lymphoma underwent surgery after the ovarian tumour had been detected, surgical treatment is not the treatment of choice in patients with ovarian lymphoma. The mainstay of therapy is chemotherapy without further surgery. The prognosis is better if the chemotherapy protocol is more aggressive which improves the survival rate.

P-7B/OP-9

Synchronous Endometrial Carcinoma and Ovarian Neuroendocrine Tumour: A Rare Case Report

Vaishnavi Jayaram, Madhavi M Gupta, Renu Tanwar, Mangla Sharma,
Maulana Azad Medical College & Lok Nayak Hospital

Introduction: Synchronous endometrial and ovarian cancer (SEOC) is defined as the simultaneous presence of these two cancers at the time of diagnosis.

Case: A 55-year-old P6L5 postmenopausal lady presented with postmenopausal bleeding and abdominal distention for 6-7 months. She was a known diabetic and hypertensive on treatment for last 5 years and had class-1 obesity. There was no family history of cancer. Clinical examination revealed enlarged uterus with right parametrial thickening. Abdominal ultrasound showed enlarged uterus with a 10.1x7.5 cm complex predominantly cystic lesion in the right adnexa. On MRI, an irregular hypo enhancing mass lesion 4.2x5.5x3 cm was seen centred within the endometrial cavity with >50% myometrial invasion and prolapsing into the proximal endocervical canal. There was no obvious uterine serosa or cervical stromal invasion. A large well defined complex solid-cystic abdominopelvic mass 12.7x15.5x7.5cm was also noted. CA-125 was 283 (N < 35u/ML) rest tumour marker panel was normal. The patient was posted for staging laparotomy with frozen section of the ovarian mass which showed nuclear overlapping, pleomorphism and atypical mitosis, suggesting malignant neoplasm. The patient then underwent total abdominal hysterectomy, bilateral salpingooophorectomy, bilateral pelvic lymphadenectomy and infracolic omentectomy. Histopathological findings revealed Endometrioid type grade1 endometrial carcinoma with <50% myometrial invasion and High-grade Neuroendocrine tumour of the ovary, positive for NSE, CD-56 and EMA. Peritoneal cytological washings and lymph nodes were negative for malignant cells. The patient has been planned for adjuvant chemo-radiation.

Discussion: According to various studies, 10% of women with ovarian and 5% with endometrial cancer are diagnosed with SEOC. The histological subtype of both primary tumours is endometrioid in 50-70% of all cases. Ovarian NETs are uncommon, accounting for only 1-2% of malignant ovarian tumours. On extremely rare occasions, they can coexist with another malignancy, usually adenocarcinoma.

P-7B/GP-10

Presentation of Benign Epithelial Neoplasm with Recurrence of Abdominal Lump in Early Post Op Period

Akanksha Pandey, Madhvi M Gupta, Renu Tanwar
Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India

Introduction: A 25-year-old nulliparous woman was detected with recurrence of abdominal lump 2 months following laparotomy done for a large ovarian cyst. Initially the patient had presented with a 5-month history of abdominal distension and pain, for which imaging revealed a giant cystic lesion along with plentiful ascites. Our patient was worked up on the lines of a malignant ovarian neoplasm, considering the acute presentation and massive ascites. Patient underwent exploratory laparotomy+ left salpingo-oophorectomy and on frozen section analysis the mass was found to be benign mucinous neoplasm. Intra operatively 9 litres of mucinous ascites were drained. Patient recovered well and the final histopathology report also suggested benign mucinous neoplasm. Patient again presented to OPD with complains of severe pain abdomen after 2 months and on examination was found to

have a cystic mass in the left adnexa measuring around 8x8 cm. On doing laparotomy, an encysted collection of thick mucus was found abutting the uterus posteriorly. Fibrous tissue on all sides was organized in the form of a pseudo cyst wall. Rest of the peritoneal cavity was found to be thickened, right tube and ovary was found to be normal.

Conclusion: Reactionary changes of the peritoneal lining led to persistent secretions which formed this collection before the fibrosis set in, hence the peritoneum was also found to be thickened. In these kinds of cases the recurrence of adnexal mass can raise strong suspicion of a malignancy, but the probability of an encysted collection should also be considered in the decision making.

P-7B/OP-11

Population Stabilization: Challenges Ahead for Delhi

Supriya Singh, Jyoti Sachdeva
Department of Family Welfare, GNCTD, India

Introduction: Family Planning program for past seven decades shifted the focus from population control to population stabilization.

These investments however must be differentially planned **keeping in mind the principle of equitability**.

The NFHS-V data for Delhi reveals the progress made in family planning as also the persisting gaps. The poster on one hand shows the **status of some important indicators** while also hinting towards **targeted interventions**. It is for program implementers to **use the survey data effectively and usefully** so that gaps, challenges and **priority areas** are identified and addressed.

Methodology: Analytical study of the recent NFHS data set was done on family planning measures. Trends were observed on the same to find out the priority areas.

Objective:

- To analyse progress and gaps by studying trends in not only the **total percentage coverage** of eligible couples with different family planning methods but also to **analyse disaggregated data**
- Based on the observational trend analysis, to identify the **targeted interventions** that may be contribute to greater dividends with similar investments.

Result:

- The trend analysis of NFHS- 4 and NFHS-5 data indicates that family planning measures have peculiar and pocketed challenges.
- The disaggregated data of spacing and limiting needs points towards some scope in popularizing permanent methods especially male sterilization.
- If we base planning of the program on these Targeted interventions, it can help achieve uniform progress throughout the reproductive lifespan and across wealth quintiles.

P-7B/GP-12

Robert Uterus: Causing Intractable Dysmenorrhea and Chronic Pelvic Pain

Tanya Grover, Aruna Nigam, Sumedha Sharma
Hamdard Institute of Medical Sciences and Research, HAHC

Introduction: Mullerian duct anomalies result from the defective fusion of Mullerian ducts. Robert's uterus is a rare type of complete septate uterus and it is also known as asymmetrical septate uterus (Class V(a) of the American Society of Reproductive Medicine). Prevalence of septate uterus in the general population is 2.3%, the incidence of Robert's uterus is very rare.

Case: A 30yearold nulliparous married woman presented with severe abdominal pain, dysmenorrhea, dyspareunia. On abdominal examination - tenderness in hypogastrium and right iliac fossa with vague suprapubic mass of 14 weeks deviated to right side. On per speculum - healthy cervix and vagina. On per vaginum examination - tender 14 weeks size uterus deviated to right side with restricted mobility. MRI reported a 4.8 x4.2 cm noncommunicating cavitated cystic uterine mass with haemorrhagic contents with deviated uterine cavity. A hysterolaparoscopy was planned. On laparoscopy, dense adhesions were seen between the uterus, anterior abdominal wall, bowel and omentum. Decision for laparotomy taken. On laparotomy: Oblique septum of 5 cm from the fundus of the uterus toward the right side of the cavity dividing the uterine cavity with no communication with the rest of the uterine cavity nor with the cervical canal suggestive of Robert uterus. Adhesiolysis followed by resection of right hemiuterus was done.

Conclusion: Robert's uterus is a rare anomaly and young women with Mullerian anomalies with intractable dysmenorrhea should be evaluated carefully to achieve a good reproductive outcome.

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Call for Nominations

AOGD President & Vice President Election (2023-24)
Call for nominations

Nominations are invited from eligible AOGD members for the following posts

- President (2023-24)
- Vice President (2023-24)

Last date for submission of nominations is 18th November 2022

- Applications by desirous candidates should be submitted on the prescribed form available on AOGD website (www.aogd.org) / bulletin / office, with due entry in the office register.
- The nomination shall be proposed by one regular member and seconded by two regular AOGD members.
- The candidate, his/her proposer and seconder should have cleared all their dues towards the membership subscription in full. Non compliance with this condition shall render the nomination invalid.
- Nominations as per the eligibility criteria should reach AOGD secretariat: Room no. OG -14, 1st Floor, PNW-1, department of Obst. & Gynae, Maulana Azad Medical College & Lok Nayak Hospital, New Delhi- 110002 (Phone no. 9211656757) by 18th November 2022.

Accepted nomination(s) will be displayed on AOGD website by 1st December 2022.

NOTE:

- The new members joining AOGD after the date of call for nominations willl not be eligible for voting.
- Associate members are not eligible to vote.

Dr. Deepti Goswami
(Secretary AOGD
9968604348)

Eligibility Criteria for PRESIDENT AOGD

1. He/she shall be a senior and active member of faculty in a multidisciplinary hospital of Delhi in the public or the private sector, with such hospital having clinical and para-clinical departments and having post graduate courses, duly recognized by the National Medical Commission and/or the National Board of Examination.
2. He/she must have held the post of professor/ senior consultant/an equivalent there of with such hospital for more than 10 years.
3. He/she must have the experience of having completed at least one tenure as the chairperson of a sub-committee of the AOGD or the experience of having completed at least one tenure as Vice President or Secretary or member of the Executive Committee of the AOGD.
4. He/she must be a life member of the AOGD with more than twenty years of experience after post graduation in the specialty of obstetrics and gynaecology.
5. He/she should have experience of conducting academic conferences, seminars or workshops.
6. A person who has held the post of President of the AOGD in the past shall be ineligible to hold the post of President of the AOGD again.
7. Faculty from the institution that fields the President shall be ineligible to apply for election to the post of President for a period of five years from the date of start of the tenure of that President.

Eligibility Criteria for VICE PRESIDENT AOGD

1. He/she shall be a senior member of faculty in a multidisciplinary hospital of Delhi in the public or the private sector, with such hospital having clinical and para-clinical departments and having post graduate courses, duly recognized by the National Medical Council / National Board of Examination.
2. He/she must have held the post of professor / senior consultant / or an equivalent thereof with such hospital for more than seven years.
3. He/she must have the experience of having completed at least one tenure as the chairperson of a sub-committee of the AOGD or the experience of having completed at least one tenure as Secretary or Treasurer or Editor or member of the Executive Committee of the AOGD having attended at least 75% of the meetings of the Executive Committee during his/her tenure as member of the Executive Committee
4. He/she must be a life member of the AOGD with more than fifteen years of experience after post graduation in the specialty of obstetrics and gynaecology.
5. He/she should preferably, have experience of conducting academic conferences, seminars or workshops.
6. A person who has held the post of Vice-President of the AOGD in the past shall be ineligible to hold the post of Vice- President of the AOGD again.

AOGD Subcommittees Chairperson Election (2023-25)
Call for nominations

Nominations are invited from eligible AOGD members for the post of chairperson of following subcommittees:

1. Endometriosis Sub-Committee
2. QI Obst & Gynae Practice Sub-Committee
3. Oncology Sub-Committee
4. Urogynaecology Sub-Committee
5. Adolescent Health Sub-Committee
6. Fetal Medicine & Genetics Sub-Committee
7. Endoscopy Sub-Committee

Last date for submission of nominations is 18th November 2022

Nominations as per the eligibility criteria should reach AOGD secretariat: Room no. OG -14, 1st Floor, PNW-1, department of Obst. & Gynae, Maulana Azad Medical College & Lok Nayak Hospital, New Delhi- 110002 (Phone no. 9211656757) by 18th November 2022.

Dr. Deepti Goswami
(Secretary AOGD)

Eligibility Criteria for AOGD Sub-committee chairperson

1. The chairperson of a sub-committee should have been a member of the sub-committee in question for at least one term, with one term being equivalent to two years, prior to his/her appointment as chairperson of that sub-committee.
2. He/she should have been a member of the AOGD for fifteen years.
3. He/she should have experience in the field related to the subcommittee.
4. He/she should have completed at least fifteen years from the date of his/her registration as a medical practitioner. Further, he/she should have held a senior / faculty position for not less than that of associate professor, senior consultant or an equivalent there of in his/her respective organization, for a period of at least five years .
5. No person should hold chairperson ship of the same subcommittee for two consecutive terms with each term comprising of two years. Further, a person who has been chairperson of one subcommittee cannot be nominated as chairperson of another subcommittee unless separated by a duration equivalent to two terms of the subcommittee.
6. The Executive Committee may lay down additional criteria for the eligibility and pre-requisites for appointment as chairperson of each sub-committee from time to time.
7. An eligible member must send an application for nomination as chairperson of a sub-committee stating therein his/her previous experience in the field related to the sub-committee and future vision for furthering the goals of the AOGD through such sub-committee. One person shall not apply for chairpersonship of more than one sub- committee at a time. The application shall be scrutinized by the Executive Committee of AOGD for nomination as chairperson.
8. In the event of more than one application being received for appointment as chairperson of a subcommittee, and in the absence of unanimous decision of the Executive committee in this regard, the Executive Committee shall decide the nomination by cast of secret ballot.
9. The tenure of the chairperson of subcommittee shall be for a period of two years.

The Association of Obstetricians & Gynaecologists of Delhi

Nomination Form

Name:_____

Designation:_____

AOGD Membership no:_____

Official Address:_____

Residential Address:_____

Phone:_____Email:_____

Bio Sketch (250words)

Post Applied for

President 2023-24 ☐ **Vice President** 2023-24 ☐ **Chairperson** 2023-2025 ☐

Name of Subcommittee

Proposed by – Name **AOGD Membership no.** **Signature**

1.

Seconded by

1.

2.

Nominations should reach at AOGD Office
For any Query please call Mrs. Sarita : 9211656757

AOGD Risk Management Support [ARMS] Group

One of the ways to ensure the stress-free work environment and optimal patient care is mutual support among professional colleagues. We propose to form an advisory group of senior AOGD members that can be contacted if one of us is caught in a complex clinical dilemma / dealing with aggressive clients or is apprehensive about how to document or effectively troubleshoot a potential problem. This group will provide the timely advice and will be led by-

Convener- **Dr. Vijay Zutshi** - 9818319110

Co convener- **Dr. Aruna Nigam** - 9868656051

We invite suggestions from all members regarding functioning of this cell which will guide us forming the SOPs. Any member interested in being part of Advisory group may contact the convener.

Pl mail to aogdmamc2022@gmail.com

Calendar of Virtual Monthly Clinical Meetings 2022-23

12th & 13th November, 2022	**44th Annual AOGD Conference (Physical)**
25th November, 2022	VMMC & Safdarjung Hospital
30th December, 2022	Sir Ganga Ram Hospital
27th January, 2023	ABVIMS & Dr Ram Manohar Lohia Hospital
24th February, 2023	UCMS & Guru Teg Bahadur Hospital
31st March, 2023	MAMC & Lok Nayak Hospital
28th April, 2023	LHMC & Smt. Sucheta Kriplani Hospital
26th May, 2023	Sitaram Bhartia Hospital

Proceedings of the AOGD monthly clinical meeting at ESI Hospital on 28.10.2022

Success Story of Myomectomy

Anupma[1], Taru Gupta[2], Sangeeta Gupta[3]
[1]Assistant Professor, [2]Professor & Head, [3]Senior Consultant

Case 1- A female with primary infertility of 5 years presented with abnormal uterine bleeding since 1 year. On investigation she was diagnosed with multiple (30) uterine fibroids, both submucosal and intramural component

Case 2- A female with seven recurrent pregnancy losses and single large fibroid (16x18x16 cm) with uterus of around 26 weeks gravid uterus size presented with abnormal uterine bleeding and pressure symptoms.

Both of the patients underwent abdominal myomectomy, conceived successfully and case one carried till term, underwent caesarean section and had a full term live baby while case 2 is in her second trimester and has crossed her crucial period of previous abortions.

Discussion- The aim of myomectomy in cases of infertility is to not only remove the fibroids but also to reconstruct the functional uterus for purpose of childbearing. Previously the contraindications of myomectomy like very large fibroid or multiple fibroids distorting the uterine anatomy have now become indications with the help of intramyometrial vasopressin and improved surgical expertise, the mode could be open, laparoscopic, hysteroscopic or robotic surgery. There appears to be enough evidence that non cavity distorting (NCD) fibroid affects fertility. Type 3 fibroids may have a higher risk of poor pregnancy outcome compared to type 4 fibroids, disruption of the JZ appears to be an important cause of subfertility due to abnormal uterine peristalsis.

Result- It can be concluded that submucosal fibroids should always be removed, intramural fibroids associated with subfertility should be considered for removal while subserosal fibroids need not to be removed for subfertility unless have other symptoms.

Placenta Accreta Spectrum and Pelvic Packing

Deepshikha Jaiswal, Nausheen, Pratiksha Gupta, Nupur Gupta

Objective: A case report on placenta accreta spectrum managed by pelvic packing after Emergency peripartum hysterectomy and DIC.

Case report: A 22 years old female, G2P1L0 at 36+5 weeks POG with previous LSCS (5 yrs back) with breech presentation with placenta previa (complete), & placenta accreta spectrum with moderate anemia was referred to us.

Patient landed in emergency cesarean with consent for obstetric hysterectomy as she went into labour. Intra operatively previous caesarean scar was found ruptured with approximately1lit. hemoperitoneum, but foetal sac was intact which was then ruptured. Baby presented and extracted as breech through placenta, cried at birth.

Decision for intra-abdominal packing taken by surgeons as patient went in DIC & bleeding could not be controlled despite all best possible measures including obstetric hysterectomy. Haemostatic packing with 8 intra-abdominal packs done. Patient was intubated and put on noradrenaline infusion started and shifted to ICU, monitored vigorously with a CVP line. Investigations were suggestive of DIC with haemoglobin of 4.7g%, PT/INR-22.1/1.78D dimer/FDP -1.49/22.4. Multiple blood products were transfused.

Re-laparotomy for removal of intra-abdominal pack was done and an abdominal drain was placed on day 2. Around 2 to 2.5 litres of intraperitoneal collection was removed. Patient was shifted & monitored in ICU and extubated on day 7 of Obstetric hysterectomy.

Discussion: Bleeding after Emergency peripartum hysterectomy (EPH) can occur in settings of acquired Coagulopathyor from raw surfaces, venous plexuses or inaccessible areas. This type of bleeding resistant to clipping, ligation, suturing could be successfully

controlled with pelvic packing. So pelvic packing should not be seen as a bail out for less skilled obstetrician.
Packing techniques can be divided into 2 types: Pads or roller gauze (sterile pads bound by suture threads or wrapped in a sterile bag) and Balloon pack (Foley catheter or Bakri balloon).

Most common complication is sepsis(53%) followed by shock, Acute pulmonary oedema, Acute respiratory distress syndrome, multiple organ failure, deep vein thrombophlebitis, pulmonary embolism, acute renal failure, pelvic hematoma , bowel infarction, occlusive syndrome, pelvic organ laceration.

Packing can increase risk of abdominal compartment syndrome when the pressure applied is too high. Intra-abdominal pressures greater than 20 mm Hg have been associated with onset of organ failure requiring abdominal decompression however no cases have been reported following packing after PPH.

The small bowel can temporarily adhere to the packs which can be prevented by using a bowel bag or other non-adherent material creating a barrier between the packed pelvis and the small bowel. The pseudo-adhesions' if formed can be freed by hydro-dissection.

Conclusion: Pelvic packing is a valuable method with a high success rate in the control of hemorrhage after an EPH. This procedure is particularly useful in developing countries where more advanced technologies such as selective arterial embolization are not always available. The morbidity associated with pelvic packing is acceptable. The experience of the obstetrician is essential in order to make the proper decision as to the right indication and optimal timing to proceed with pelvic packing.

Rare Complication of Ovarian Torsion After Ovarian Stimulation in IVF Cycle

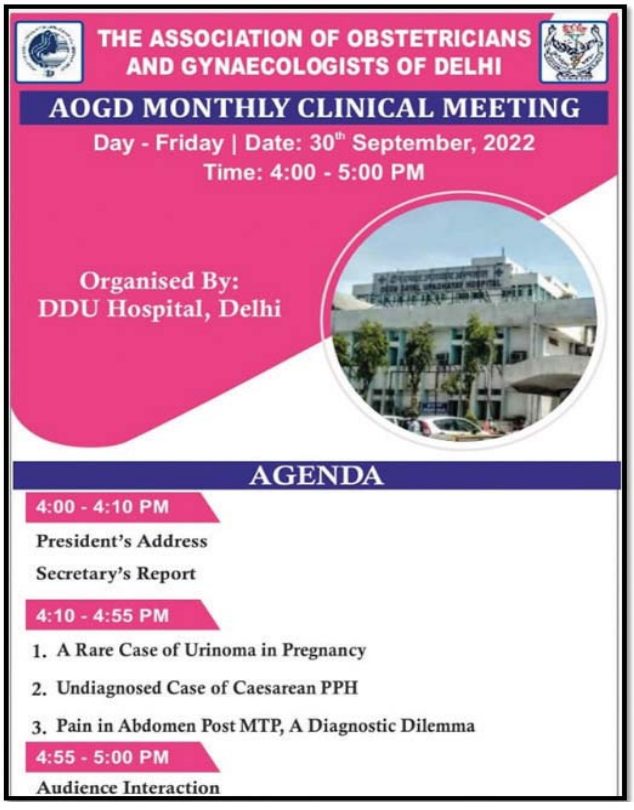
Leena Wadhwa, Pooja Singh, Priyanka Singh, Chithira, Kamta prasad

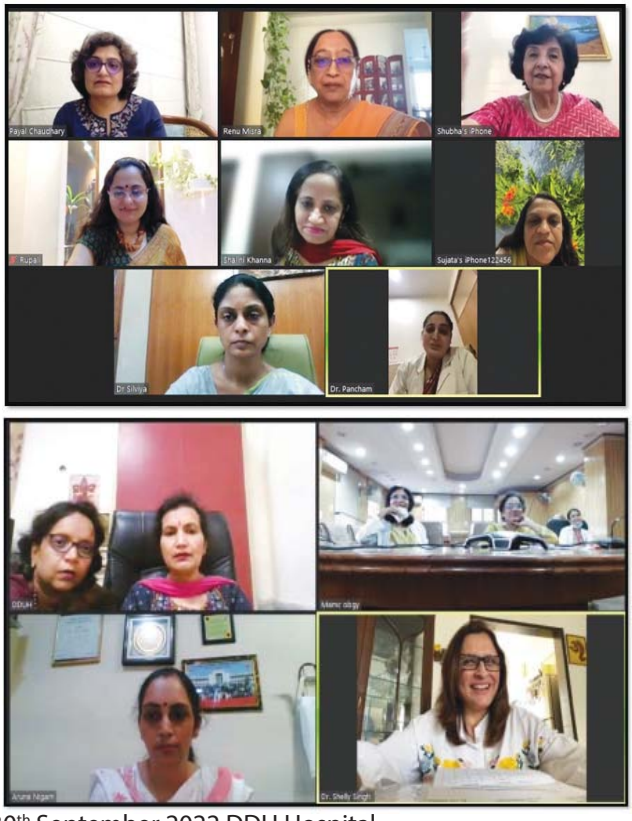
Introduction: Ovarian torsion is a rare complication (0.2%) in women submitted to ovarian stimulation with gonadotrophin for IVF.

Presentation of case: 26 year female with primary infertility with PCOM with male factor infertility (Oligoasthenoteratozoospermia) planned for IVF/ICSI was started on low dose Gonadotrophins cycle with Antagonist protocol. On D2 of cycle, COS started with Recombinant FSH 150 IU. From D6 Onward inj HMG 75 IU was added. On D8 of cycle she was admitted in emergency with sudden onset colicky pain lower abdomen. Routine blood and urine investigation reports were WNL(Hb-12.2 mg%). On TVS-RO-13 follicles (11-19 mm), LO-10 follicles (11-20 MM), ET-8.3 mm Triple layer, No free fluid. On USG abdominopelvis there was no evidence of OHSS or ovarian torsion however left ureteric calculus was suspected. Conservative management given after surgical consultation. On D9, colicky pain abdomen increased, Gonadotropins (FSH+HMG) withheld in the morning. Decision for OPU taken. Agonist trigger given at 11 pm. S. E2 level was >3000.On D10 Pain abdomen persisted, Hb sequentially dropped from 11.5 to 9g/dl but vitals were stable. On repeat USG there was no intraabdominal and pelvic collection; no evidence of torsion. On next day of ovum pickup, Hb reported was 6.7g/dl. During OPU- collection in POD seen on USG. On aspiration, bloody aspirate came out. Decision for Laparoscopy taken. On laparoscopy, uterus normal, right fallopian tube normal, right ovary enlarged and friable, left tube congested and stretched over ovary, left ovary congested (brownish black in colour), left ovarian ligament twisted three times. Clots present in POD. Decision for laparotomy taken. Clots and blood evacuated, detorsion with left ovarian reconstruction done. Follicles retrieved from other ovary. During post op patient was kept in ICU, developed pulmonary oedema which was managed. Patient received Inj. Cetrorelix (0.25mg sc daily for 7 days) and Tab Cabergoline (0.5mg HS for 10 days) in post op period. Discharged in satisfactory condition. Planned for FET.

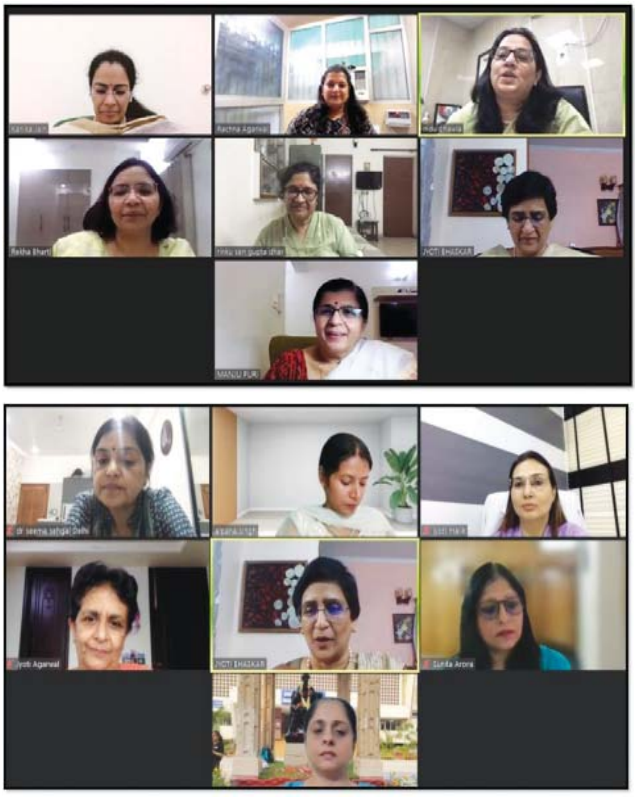
Conclusion: Ovarian torsion is an acute abdomen requiring immediate intervention. High index of suspicion for patient with risk of hyperstiulationin in In-vitro fertilization (IVF) cycles. Multidisciplinary approach for management of complication should be kept in mind.

Events Held in October 2022

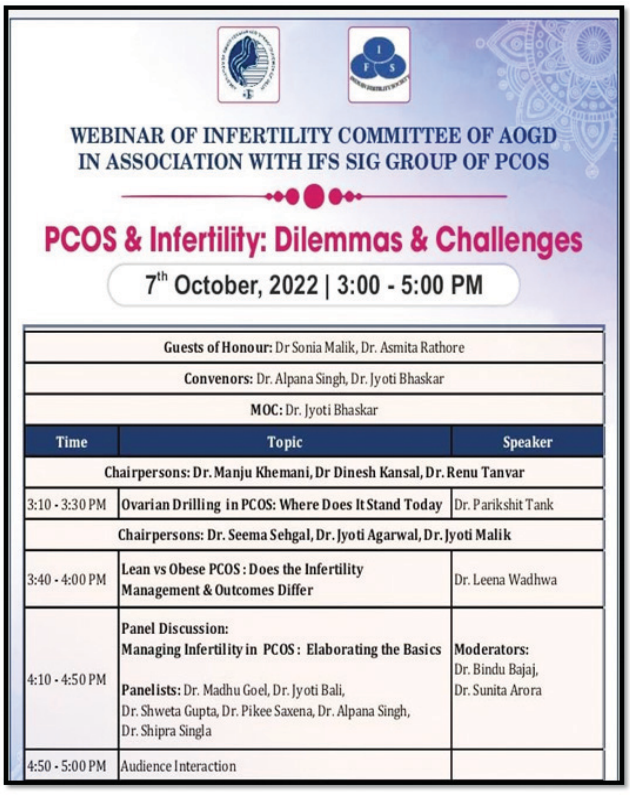




AOGD Monthly Clinical Meeting on 30th September 2022 DDU Hospital



Webinar on "Paradigm Shift in management of Ectopic Pregnancy" on 6th October Endoscopy Subcommittee



Webinar on "PCOS & Infertility: Dilemmas & Challenges" on 7th October Infertility Subcommittee

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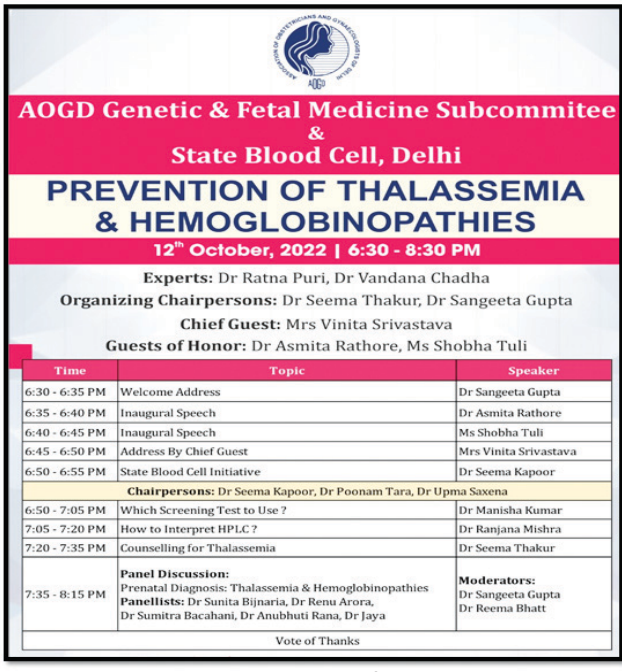

Webinar on "Prevention of Thalassemia & Hemoglobinopathies " on 12th October Genetic & Fetal Medicine Subcommittee & State Blood Cell, Delhi

PG forum on Postmenopausal bleeding on 17th October ABVIMS & RML Hospital

Physical CME on AUB on 15th October Under aegis of AOGD

Forthcoming Events

S. No.	Date	Events
1	09.11.2022 to 11.11.2022	AOGD Preconference Workshops
2	**12.11.2022 to 13.11.2022**	**44th AOGD Annual conference**
3	19.11.2022	CME by Oncology subcommittee
4	21.11.2022	PG Forum on "AUB Reproductive age"
5	24.11.2022	CME by Endoscopy committee

AOGD Sub-Committee Chairpersons 2022-2024

Committee	Chairperson	Contact No	Email.id
Breast and Cervical Cancer Awareness, Screening & Prevention Sub-Committee	Dr Mrinalini Mani	9811835888	drmrinal5@gmail.com
Infertility Sub-Committee	Dr Manju Khemani	9810611598	dr.manjukhemani@gmail.com
Rural Health Sub-Committee	Dr Shivani Agarwal	9868249464	dragarwal.shivani@gmail.com
Multidisciplinary Sub- Committee	Dr Kiran Guleria	9811142329	kiranguleria@yahoo.co.in

AOGD Sub-Committee Chairpersons 2021-2023

Committee	Chairperson & Co- Chairperson	Contact No	Email.id
Endometriosis Sub-Committee	Dr. Anjila Aneja	9810059519	anjilaaneja1966@gmail.com
QI Obst & Gynae Practice Sub-Committee	Dr K Aparna Sharma, Chairperson	9711824415	kaparnsharma@gmail.com
	Dr Jyoti Bhaskar, Co-Chairperson	9711191648	jytbhaskar@yahoo.com
Oncology Sub-Committee	Dr Sunita Malik	9818914579	svmalik@yahoo.com
Urogynaecology Sub-Committee	Dr Geeta Mediratta, Chairperson	9810126985	gmediratta@yahoo.com
Adolescent Health Sub-Committee	Dr Anita Rajouria, Chairperson	9711177891	anitarajorhia716@gmail.com
	Dr Sujata Das, Co- Chairperson	9971946064	drdas_sujata2110@yahoo.co.in
Reproductive Endocrinology Sub-Committee	Dr Surveen Ghumman, Chairperson	9810475476	surveen12@gmail.com
	Dr Deepti Goswami, Co-Chairperason	9968604348	drdeeptigoswami@hotmail.com
Safe Motherhood Sub-Committee	Dr Manju Puri	9313496933	drmanjupuri@gmail.com
Fetal Medicine & Genetics Sub-Committee	Dr Seema Thakur, Chairperson	9818387430	Seematranjan@gmail.com
	Dr Sangeeta Gupta, Co- Chairperson	9968604349	drsangeetamamc@gmail.com
Endoscopy Sub-Committee	Dr Kanika Jain	9811022255	dr.kanika@gmail.com

Association of Obstetricians & Gynaecologists of Delhi

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Encl.: Attach Two Photocopies of All Degrees, DMC Certificate and Two Photographs (Self attested)
***-Annual Membership is for the calendar year January to December.**
+ - In case of renewal, mention old membership number.
Note: 18% GST will be applicable as FOGSI requires it.

Send Complete Membership Form Along With Cheque / DD and Photocopy of required documents.

AOGD SECRETARIAT

Room No. OG-14, Department of Obstetrics & Gynaecology
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SOURCE : *Ford HB,Schust DJ.Recurrent pregnancy loss:etiology,diagnosis,and therapy.Rev Obstet Gynecol 2009;2: 76-83
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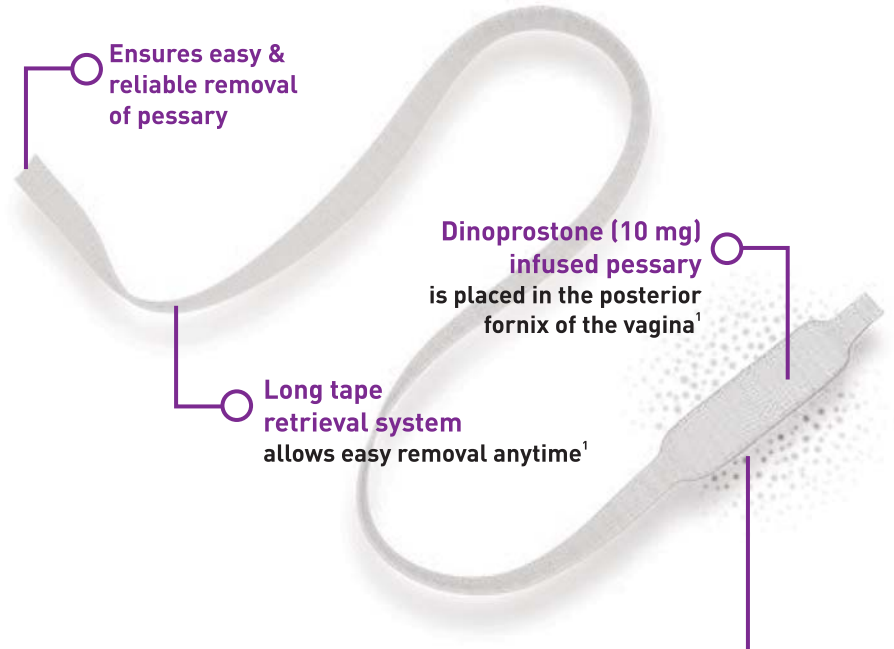

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Abbreviated Prescribing Information
Composition: Each controlled release vaginal pessary contains: Dinoprostone (PGE$_2$) 10mg **Indication:** PROPESS® is indicated for initiation and/or continuation of cervical ripening in patients at or near term in whom there is a medical or obstetrical indication for the induction of labour. **Dosage and administration:** One pessary (vaginal delivery system) is administered high into the posterior vaginal fornix. If there has been insufficient cervical ripening in 24 hours, the pessary (vaginal delivery system) should be removed. A dosing interval of at least 30 minutes is recommended for the subsequent use of oxytocin following the removal of PROPESS® (vaginal delivery system). Small amounts of water soluble lubricants should be used to aid insertion of PROPESS®. The patient should be recumbent for 20 minutes to 30 minutes after insertion. As dinoprostone will be released continuously over a period of 24 hours, it is important to monitor uterine contractions and fetal condition at frequent regular intervals. Removal: To terminate drug administration, the pessary (vaginal delivery system) can be removed quickly and easily by gentle traction on the retrieval tape. PROPESS® pessary must be removed when cervical ripening is judged to be complete or for any of the reasons listed: 1. Onset of labour. 2. Spontaneous rupture of membranes or amniotomy. 3. Any suggestion of uterine hyperstimulation or hypertonic uterine contractions. 4. Evidence of fetal distress. 5. Evidence of maternal systemic adverse dinoprostone effects such as nausea, vomiting, hypotension or tachycardia. 6. At least 30 minutes prior to starting an intravenous infusion of oxytocin. The vaginal delivery system should never be removed from the retrieval device. **Contraindications:** PROPESS® should not be used or left in place: 1. When labour has started. 2. When oxytocic drugs are being given. 3. When strong prolonged uterine contractions would be inappropriate. 4. When there is current pelvic inflammatory disease, unless adequate prior treatment has been instituted. 5. When there is hypersensitivity to Prostaglandin E, or to any of the excipients. 6. When there is placenta previa or unexplained vaginal bleeding during the pregnancy. **Warnings and precautions:** The condition of the cervix should be assessed carefully before PROPESS® is used. After insertion, uterine activity and fetal condition must be monitored regularly. The pessary should be removed from the vagina, if there is any suggestion of maternal or fetal complications, or if adverse effects occur, or uterine contractions are prolonged or excessive, or there is a possibility of uterine hypertony or rupture. PROPESS® should be used with caution in patients with ruptured membranes, a previous history of uterine hypertonus, glaucoma, asthma, multiple pregnancy and who are at a risk of disseminated intravascular coagulation (DIC). Medications like non-steroidal anti-inflammatory drugs, including acetyl salicylic acid, should be stopped before administration of PROPESS®. PROPESS® should not be administered to patients with a history of previous caesarean section or uterine surgery given the potential risk for uterine rupture and associated obstetrical complications. It is not recommended in patients with diseases which could affect the metabolism or excretion of dinoprostone, e.g. lung, liver or renal disease. A second dose of PROPESS® is not recommended. **Interactions:** Prostaglandins potentiates the uterotonic effect of oxytocic drugs. Therefore PROPESS® should not be used concurrently with oxytocic drugs. Pregnancy and **Lactation:** PROPESS® should be used for the initiation of cervical ripening in pregnant patients at term only where labour induction is indicated. PROPESS® is not indicated for use during early or other phases of pregnancy or during lactation. **Undesirable Effects:** CTG changes and unspecified fetal distress have been reported during and after administration of intravaginal dinoprostone. Increased uterine activity with hypertonic contractions with or without fetal distress has been reported. There is a much greater risk of hyperstimulation if the dinoprostone source is not removed before administration of oxytocin because prostaglandins are known to potentiate the uterotonic effects of oxytocic drugs. Common (≥1/100, <1/10): Abnormal labour affecting fetus, Fetal heart rate disorder, Fetal distress syndrome, Uterine hypertonus. **Overdose:** Overdosage or hypersensitivity may lead to hyperstimulation of the uterine muscle or fetal distress. The PROPESS® pessary (vaginal delivery system) should be removed immediately. **List of excipients:** Crosslinked polyethylene glycol (hydrogel); Polyester yarn **Shelf Life:** Do not use the product after the expiry date which is mentioned on the carton and foil. **Special precautions for storage:** Store in a freezer between -10°C and -25°C. Store in the original container in order to protect from moisture. Keep out of reach of children. **Presentation and Pack Size:** One Pessary is presented in individual, sealed aluminium/polyethylene laminate sachet.
SCHEDULE H PRESCRIPTION DRUG - CAUTION
Not to be sold by retail without the prescription of a Registered Medical Practitioner.
Manufactured by: Ferring Controlled Therapeutics Limited, United Kingdom.
Imported and Marketed by: Ferring Pharmaceuticals Pvt. Ltd., Thane – 421302, India.
For additional information on prescribing information, kindly refer to the package insert.
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1. Propess [Dinoprostone Pessary 10 mg] prescribing information

FERRING PHARMACEUTICALS
Ferring Pharmaceuticals Pvt Ltd., The Capital, Unit 509 / 510, A wing, 5th floor, Bandra Kurla Complex, Bandra (E), Mumbai 400051, India

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