AOGD-FOGSICON 2023

Annual Conference of AOGD
FOGSI PG Conference

Organised by Association of Obstetricians & Gynaecologists of Delhi
UCMS & GTB Hospital, New Delhi

Enhancing Knowledge Upscaling Skills

Souvenir & Book of Abstracts

18th to 20th August 2023

The Leela Ambience Hotel & Residences
Gurugram, Delhi NCR

Conference Secretariat

7th floor, MCH Block, UCMS & GTB Hospital, Shahdara, Delhi -110095
Contact +91 9717392924, Email: aogd.ucmsgtbh2023@gmail.com

www.aogdfogsicon2023.com

Team AOGD-FOGSICON 2023

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Dr Seema Prakash

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Dr Richa Sharma

Dr Poonam Goyal

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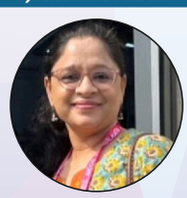


Dr Anshuja Singla

Dr Anita Sabharwal

AOGD Office Bearers

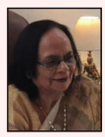

Dr Neera Aggarwal


Dr Kamal Buckshee


Dr Urmil Sharma


Dr SN Mukherjee

Patrons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Dr Sharda Jain


Dr Alka Kriplani

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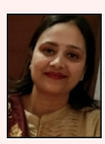
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Dr Anjila Aneja					Dr Sujata Agarwal		
Dr Seema Singal							
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Dr Abha Sood	Dr Harpreet Singh	Dr Nikita Trehan	Dr Seema Singhal
Dr Achla Batra	Dr Harsha Gaikwad	Dr Nilanchali Singh	Dr Seema Thakur
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Dr Garima Kapoor	Dr Neerja Bhatla	Dr Sangeeta Gupta	

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Dr Hrishikesh Pai	Dr Pooja Sikka	Dr Sadhana Gupta	
Dr Mitra Saxena	Dr Pushpa Choudhary	Dr Vanita Suri	

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Dr Sabaratnam Arulkumaran

प्रो.(डॉ.) अतुल गोयल
Prof. (Dr.) ATUL GOEL
MD (Med.)
स्वास्थ्य सेवा महानिदेशक
DIRECTOR GENERAL OF HEALTH SERVICES

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
स्वास्थ्य सेवा महानिदेशालय
Government of India
Ministry of Health & Family Welfare
Directorate General of Health Services

MESSAGE

I am pleased to know that Department of Obstetrics and Gynecology, UCMS & GTB Hospital is organizing the 45th Annual Conference of Association of Obstetricians and Gynecologists of Delhi (AOGD) and Federation of Obstetricians and Gynecologists of India (FOGSI) PG conference from 18-20th August, 2023 as a collaborative event of AOGD & FOGSI on the theme of **'Enhancing Knowledge & Upgrading Skills'.**

I am aware that the AOGD which is a member society of FOGSI is devoted to increasing the knowledge, awareness, and skills in obstetrics & gynecology and allied fields. It also promotes preventive and therapeutic practices to improve maternal and neonatal health.

In addition to covering every aspect of women's health, AOGD-FOGSICON 2023 has sessions dedicated to the mental and physical health of caregivers as well. A total of 12 pre-conference workshops are scheduled on 18th August, followed by important scientific sessions on 19th and 20th August, 2023.

The scientific programme even though cramped seems to be well planned and should enlighten participants on recent advances in Obstetrics and Gynecology. Postgraduates from all over the country will get an opportunity to enhance their skills and present their research work. I hope that the exchange of knowledge, and experiences, between distinguished faculty and delegates will help improve the quality of care of patients.

My best wishes for a successful event.

(Atul Goel)

Room No. 446-A, Nirman Bhawan, New Delhi-110108
Tel. No.: 011-23061063, 23061438, Fax No.: 011-23061924, email: dghs@nic.in

FOGSI President Address

Dear Friends,

Greetings!

With great pleasure, I invite you all to the 45th Annual conference of Association of Obstetricians and Gynecologist of Delhi (AOGD) to be held between 18th to 20th August 2023 in the capital city of India. The theme of the conference is - "Enhancing Knowledge Upscaling Skills" is very close to my heart as it reverberates my theme for the year too.

The conference has extensive academic program covering wide range of topics in obstetrics, gynecology, 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 magnificient city.

This year my FOGSI slogan is Swasthya 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 18thof every month.

My best wishes are with 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. Asmita M Rathore
Medical Director &
Director Professor (ObGy)

Guru Teg Bahadur Hospital & assoc.
University College of Medical Sciences
Government of NCT of Delhi
Delhi – 110095
Tel: (O) 011-22581730 Email: msgtbh@nic.in

Message

It is a great pleasure to know that 45th annual conference of Association of Obstetricians and Gynecologists of Delhi (AOGD) and Federation of Obstetricians and Gynaecologists of India (FOGSI) PG conference is being organized as a collaborative event by AOGD & FOGSI on the very relevant theme of 'Enhancing Knowledge & Upgrading Skills' from 18 – 20th August 2023. I am delighted to note that the AOGD which has its secretariat at Department of Obstetricians and Gynecologists, University College of Medical Sciences & Guru Teg Bahadur Hospital is playing pivotal role in organising this event.

It was Kofi Annan who once said, "Knowledge is power, Information is liberation, education is the premise of progress in every society and in every family". There is no better example of the thought than this conference.

Several important topics in obstetrics and gynaecology are covered in the scientific program. Distinguished speakers have been invited to deliver the keynote addresses & prestigious orations. I am sure the delegates will gain important insights from esteemed teachers on current topics and will enjoy and appreciate the high standards of scientific discussions, debates and the quiz.

All the best wishes for a successful conference.

asmita

(Dr. Asmita M Rathore)

Dr. Piyush Gupta
MD, FNNF, FIAP, FAMS
Professor, Department of Pediatrics
PRINCIPAL

UNIVERSITY COLLEGE OF MEDICAL SCIENCES
(UNIVERSITY OF DELHI)
AND GURU TEG BAHADUR HOSPITAL
DILSHAD GARDEN, OELHI-J1O 095

MESSAGE

I am delighted to know that the Department of Obstetrics & Gynaecologist, UCMS & GTB Hospital, the present office bearer of the Association of Obstetricians and Gynaecologists of Delhi (AOGD) is organising the 45th Annual AOGD & FOGSI PGConference with the theme 'Enhancing Knowledge & Upgrading Skills'on 18 —20th August 2023.

I profoundly acknowledge the effort organisers have put in and brought experts on a common platform. We welcome all the delegates on being part of this great academic bonanza and it is certain that the deliberations and proceedings of the Conference will help the budding Obstetricians and Gynaecologists to develop in depth clinical insights including the practical aspects. The exchange of knowledge, experiences and in sights amongst faculty and delegates at this congregation will aid quality patient care which will further help to improve the maternal health in the country.

I wish the conference great success and best wishes to the entire team of AOGD-FOGSICON 2023.

(Dr Piyush Gupta)

Message from AOGD- FOGSICON OFFICE

Organizing Chairpersons

Dr Neerja Bhatla

Dr Amita Suneja

Co Chaipersons

Dr Kiran Guleria

Dr Abha Sharma

Dr JB Sharma

Organizing Secretaries

Dr AG Radhika

Dr Kiran Agarwal

Dr Richa Sharma

Dr Poonam Goyal

Dear friends Greetings from AOGD Secretariat!

You are cordially invited to attend the 45th annual conference of the Association of Obstetricians and Gynecologists of Delhi (AOGD) and Federation of Obstetricians and Gynecologists of India (FOGSI) PG conference on the topic 'Enhancing Knowledge & Upgrading Skills' at Hotel Leela Ambience, Gurugram on August 18 - 20th 2023.

This conference will provide us with an excellent opportunity to upgrade our knowledge and share experiences with the national & international experts and faculty. The thoughtfully crafted scientific program includes 12 pre-congress workshops to cover the recent updates on important contextual topics including holistic approach to health followed by a rich collection of orations, keynote lectures, panels, and debates on the next two days of scientific sessions.

Very popular and not to be missed experiences specially for the young residents at AOGD Conferences are the competition papers and quiz. The topic for quiz this year is Surgical skills in Obstetrics & Gynaecology.

Our memories of the event will surely be kept alive by the E souvenir and abstract book.

The team AOGD-FOGSICON is eagerly awaiting your arrival at one of the largest academic events for knowledge exchange.

With best wishes

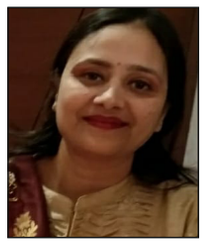
Team AOGD- FOGSICON 2023

Message from Souvenir Team


Dr Sandhya Jain


Dr Bindiya Gupta


Dr Bhanu Priya


Dr Anupama


Dr Anjila Aneja


Dr Pikee Saxena


Dr Seema Singhal


Dr Swati Agrawal

Dear Seniors & Friends

Greetings from the Souvenir Team as we welcome you all to the scientific feast of 'AOGD FOGSICON 2023' conference. With the blessings of Ma Saraswati who bestows upon us all knowledge and wisdom, the editorial team presents to you this E- Souvenir cum abstract book of 45th Annual AOGD- FOGSICON conference.

This year we got a bit early in the conference mood and it is enjoyable to see so much activity in Obs and Gynae groups in and around Delhi. Souvenir is the heart of editorial work as it is a compilation of best research from the experts and up to date writeups.

Taking out this manuscript has been an exciting journey with learning along the way. We thank our guest speakers for taking out their time and sending their write ups timely for us to be able to publish the souvenir. We are overwhelmed by the exciting response of young members to participate, present and share their studies and clinical experiences in the papers and poster section.

Along with all the conference proceedings, there is a poem written by a senior gynaecologist about her experience through journey of life.

We dedicate this legacy of AOGD souvenir to our readers and to AOGD itself. Happy reading to all of you! Best wishes for a successful conference!

ॐ

असतो मा सद्गमय।
तमसो मा ज्योतिर्गमय।
मृत्योर्मामृतं गमय।।

With Love and Regards
Souvenir Team

Scientific Programme

Pre-Conference Workshops - 18th August, 2023

Pre-Lunch Workshops (9:00 AM - 1:00 PM)

1. MEDICOLEGAL CHALLENGES IN OBGY: LEARNING TO AVOID BURNING
2. HOLISTIC CARE OF WOMEN WELLNESS
3. INTEGRATING ESSENTIALS OF FETAL MEDICINE IN DAY TO DAY OBSTETRIC PRACTICE
4. MENOPAUSAL HEALTH
5. HANDS ON WORKSHOP ON MVA & IMPLANON
6. ENSURING QUALITY IN FERTILITY ENHANCING ENDOSCOPIC SURGERIES

Post-Lunch Workshops (1:30 PM - 5:30 PM)

7. IVF (LEARN STEP BY STEP FROM BASICS TO ADVANCED)
8. WHO WORKSHOP ON RESPECTFUL MATERNITY CARE
9. UROGYNAECOLOGICAL SURGERIES: BASICS REVISITED
10. BASIC PROCEDURES IN GYNAE ONCOSURGERY- VIDEO WORKSHOP
11. ADOLESCENT HEALTH: CHALLENGES & CONTROVERSIES
12. WORKSHOP ON PREVENTIVE ONCOLOGY: FROM PRINCIPLES TO PRACTICE

Scientific Program-19th August, 2023

Cedar Hall 9:00 AM-5:00 PM-Free Communication

19th August,2023 |Day1| Royal Hall

Time	Topic	Speaker
8:30-9:00AM	**Registration**	
Session1-Adolescent Gynaecology		
Chairpersons: Dr Sunita Malik, Dr Anita Rajhoria, Dr Sandhya Jain		
9:00 - 9:15 AM	Expert's advice to young adolescent PCOS	Dr Vinita Sarbhai
9:15 - 9:30 AM	Precocious puberty - Case based scenarios	Dr Rashmi
9:30 - 9:45 AM	Ambiguous genitalia in young girls - a management Dilemma	Dr Pratap Kumar
Session2-Benign Gynaecological Conditions of Reproductive Age Group		
Chairpersons: Dr Sangeeta Gupta, Dr Dolly chawla, Dr Kanika Jain		
9:45 - 10:00 AM	Safety of Adherent Bladder : Tips & tricks	Dr Sonal Batla
10:00 - 10:15 AM	Primary ovarian insufficiency: an enigma	Dr Deepti Goswami
10:15 - 10:30AM	Asymptomatic fibroid on sonography report: how to react?	Dr Kiran Aggarwal
10:30 -10:45 AM	Audience Interaction	
10:45 - 11:15 AM	**TeaBreak**	
Session 3-Key Note Address		
Chairpersons: Dr Suneeta Mittal, Dr Chitra Raghunandan, Dr Ranjana Sharma, Dr Anjali Tempe		
11:15 - 11:35 AM	Interventions in high order multiple pregnacy	Dr Narendra Malhotra
11:35 - 12:00 Noon	Cervical Cancer Mukt Bharat - HPV Vaccination	Dr Neerja Bhatla
Session 4-FOGSI President Oration		
Chairpersons: Dr Kamal Buckshee, Dr V.L. Bhargava, Dr Sudha Prasad, Dr Amita Suneja		
12:00 - 12:30 PM	Reproductive Genetics	Dr Hrishikesh Pai
12:30 - 1:15 PM	**Inauguration**	
1:15 - 2:00 PM	**Lunch**	
Session 5- International Guest Lecture		
Chairpersons: Dr Hrishikesh Pai, Dr Sadhna Gupta, Dr Achla Batra, Dr Anita Sabharwal		
2:00 - 2:30 PM	Intrapartum Fetal Surveillance	Dr Sabaratnam Arulkumaran
Session 6 - Post Partum Hemorrhage Panel & Invited Guest Lecture		
2:30 - 3:15 PM	**PanelDiscussion:** PPH Prevention & Treatment: Recent Advances **Panelists:** Dr Mitra Saxena, Dr Ragini Agarwal, Dr Abha Sood, Dr AG Radhika, Dr Poonam Kashyap, Dr Rekha Bharthi	**Moderators:** Dr Kanwal Gujral Dr Kiran Guleria
3:15 - 3:30 PM	WHO recommendations on PPH Care	Dr Pushpa Choudhary
Session 7-Video Session (Mixed Bag)		
Chairpersons: Dr Rama Joshi, Dr Sabhyata Gupta, Dr Alka Sinha		
3:30 - 3:40 PM	HIPEC Therapy	Dr Seema Singhal
3:40 - 3:50 PM	Ovarian transposition for fertility preservation	Dr Kanika Batra
3:50 - 4:00 PM	Radical Trachelectomy	Dr Sunesh Kumar

Session 8-Tug of War		
Chairpersons: Dr Kiran Chhabra, Dr Bindu Bajaj, Dr Monika Suri		
4:00 - 4:15 PM	Detorsion for all ovarian torsions despite age?	Dr Jyoti Meena (for)/ Dr Shilpi Nain(against)
4:15 - 4:30 PM	Induction of labour in previous cesarean – Yea or NaY	Dr Astha Srivastava (for)/ Raka Guleria(against)
4:30 - 4:45 PM	Aesthetics of Genital Tract : Is there a limit?	Dr Sonia Nayak (for)/ Dr Anshuja (against)
4:45 - 5:00 PM	Fothergill operation for POP in young women – is it still relevant	Dr Vandna Gupta (for)/ Dr Sruthi Bhaskar (against)

19th August, 2023 |Day1| Ebony Hall

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
Session1-Peri-ConceptionCare		
Chairpersons: Dr Sangeeta Gupta, Dr Sushma Sinha, Dr Bindiya Gupta		
9:00 - 9:15 AM	First trimester USG	Dr Chanchal
9:15 - 9:30 AM	Abnormal aneuploidy screening report : How to deal?	Dr Reema Bhatt
9:30 - 9:45 AM	Risk assessment for PE, FGR & GDM	Dr Aparna K Sharma
Session 2 - Fetal Medicine		
Chairpersons: Dr Nirmala Agarwal, Dr Sangeeta Gupta, Dr Seema Thakur		
9:45 - 10:00 AM	Positive TORCHes report: Facts & myths	Dr Manisha Kumar
10:00 - 10:15 AM	Rh-isoimmunized pregnancy- how to deal second trimester onwards	Dr Vatsala Dadwal
10:15 - 10:30AM	Antepartum fetal surveillance: what's new?	Dr Jaya Chawla
10:30 - 10:45 AM	Audience Interaction	
10:45 - 11:15 AM	**Tea Break**	
Session 3 - Key Note Address		
Chairpersons: Dr Suneeta Mittal, Dr Chitra Raghunandan, Dr Ranjana Sharma, Dr Anjali Tempe		
11:15 - 11:35 AM	Interventions in high order multiple pregnacy	Dr Narendra Malhotra
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Session 4 - FOGSI President Oration		
Chairpersons: Dr Kamal Buckshee, Dr V.L. Bhargava, Dr Sudha Prasad, Dr Amita Suneja		
12:00 - 12:30 PM	Reproductive Genetics	Dr Hrishikesh Pai
12:30 - 1:15 PM	**Inauguration**	
1:15 - 2:00 PM	**Lunch**	
Session 5 - International Guest Lecture		
Chairpersons: Dr Hrishikesh Pai, Dr Sadhna Gupta, Dr Achla Batra, Dr Anita Sabharwal		
2:00 - 2:30 PM	Intrapartum Fetal Surveillance	Dr Sabaratnam Arulkumaran
Session 6 - Post Partum Hemorrhage Panel & Invited Guest Lecture		
2:30 - 3:15 PM	**PanelDiscussion:** PPH Prevention & Treatment: Recent Advances **Panelists:** Dr Mitra Saxena, Dr Ragini Agarwal, Dr Abha Sood, Dr AG Radhika, Dr Poonam Kashyap, Dr Rekha Bharthi	**Moderators:** Dr Kanwal Gujral Dr Kiran Guleria
3:15 - 3:30 PM	WHO recommendations on PPH Care	Dr Pushpa Choudhary

Session 7 - Panel Discussion		
3:30 - 4:15 PM	**Meeting contraceptive needs of medically challenged cases & special situations** **Panelists:** Dr Rachna Sharma, Dr Maruti Sinha, Dr Rashmi Gupta, Dr Pooja Sikka, Dr Shakuntla Kumar, Dr Kavita Aggarwal	**Moderators:** Dr Ashok Kumar Dr Garima Kapoor
Session 8 - Quiz		
4:15 - 5:00 PM	Quiz: Surgical skills in Obstetrics & Gynaecology	Dr Rachna Agarwal (Quiz Master) Dr Surveen Ghumman, Dr Upasna Verma, Dr Niharika Sethi

19th August, 2023 |Day1| Emerald Hall

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
Session 1 - Symposia - Mixed Bag		
Chairpersons: Dr Harsha Khullar, Dr Kalpana Kumar, Dr Harsha Gaikwad		
9:00 - 9:15 AM	Abnormal Thyroid report - when to Act?	Dr Reena Yadav
9:15 - 9:30 AM	Judicious use of Tocolysis in PTL	Dr Atul Seth
9:30 - 9:45 AM	Epilepsy: what all obstetricians should know?	Dr Ashima Taneja
9:45 - 10:00 AM	Audience interaction	
Session 2 - Panel Discussion		
10:00 - 10:45 AM	**Sugar Coated Pregnancy** **Panelists**: Dr Ritu Sharma, Dr Anupma Bahadur, Dr Archana Mehta, Dr Muntaha, Dr Archana Kumari, Dr Shalini Chawla	**Moderators:** Dr Pikee Saxena Dr Himshweta Srivastava
10:45 - 11:15 AM	**Tea Break**	
Session 3 - Key Note Address		
Chairpersons: Dr Suneeta Mittal, Dr Chitra Raghunandan, Dr Ranjana Sharma, Dr Anjali Tempe		
11:15 - 11:35 AM	Interventions in high order multiple pregnacy	Dr Narendra Malhotra
11:35 - 12:00 Noon	Cervical Cancer Mukt Bharat – HPV Vaccination	Dr Neerja Bhatla
Session 4 - FOGSI President Oration		
Chairpersons: Dr Kamal Buckshee, Dr V.L. Bhargava, Dr Sudha Prasad, Dr Amita Suneja		
12:00 - 12:30 PM	Reproductive Genetics	Dr Hrishikesh Pai
12:30 - 1:15 PM	**Inauguration**	
1:15 - 2:00 PM	**Lunch**	
Session 5 - International Guest Lecture		
Chairpersons: Dr Hrishikesh Pai, Dr Sadhna Gupta, Dr Achla Batra, Dr Anita Sabharwal		
2:00 - 2:30 PM	Intrapartum Fetal Surveillance	Dr Sabaratnam Arulkumaran
Session 6 - Post Partum Hemorrhage Panel & Invited Guest Lecture		
2:30 - 3:15 PM	**PanelDiscussion:** PPH Prevention & Treatment: Recent Advances **Panelists:** Dr Mitra Saxena, Dr Ragini Agarwal, Dr Abha Sood, Dr AG Radhika, Dr Poonam Kashyap, Dr Rekha Bharthi	**Moderators:** Dr Kanwal Gujral Dr Kiran Guleria
3:15 - 3:30 PM	WHO recommendations on PPH Care	Dr Pushpa Choudhary
Session 7: Potpourri		
	Chairpersons Dr Pancham Preet Kaur, Dr Kavita Bhatti	
3:45 - 4:00 PM	Black box of Endometrium	Dr Murugan
4:00 - 4:15 PM	Antenatal & Delivery Room Interventions to Improve Outcome of Premature Baby	Dr Naveen Prakash Gupta
4:15 - 4:30 PM	New Treatment option for severe PPH - Recombinant Factor VII A	Dr Niti Kautish
4:30 - 4:45 PM	Steroids Profiling in PCOD	Dr Nimmi Kansal

Scientific Program - 20th August, 2023

Cedar Hall 9:00 AM - 4:00 PM - Free Communication

20th August, 2023 |Day2| Royal Hall

Time	Topic	Speaker
8:30-9:00AM	**Registration**	
Session 1-Mixed Bag		
Chairpersons: Dr Anjali Dabral, Dr Sharda Patra, Dr Rashmi Shreya		
9:00 - 9:15 AM	Decreased ovarian reserve: poor responder	Dr Tanya B Rohatgi
9:15 - 9:30 AM	Complications of Hysteroscopy - case scenarios	Dr Richa Sharma
9:30 - 9:45 AM	Recent update on management of GTN	Dr Vijay Zutshi
9:45 - 10:00 AM	Ambulatory Gynecology	Dr Rohit Arora
Session 2 - Panel Discussion		
10:00 - 10:45 AM	**Preserve theuterus in AUB** **Panelists:** Dr Anjila Aneja, Dr Geeta Mediratta, Dr Madhavi Gupta Dr Indu Chawla Chugh, Dr Ila Gupta, Dr Manjit Kaur	**Moderators:** Dr Madhuri Patel Dr Laxmi Shrikhande
10:45 - 11:15 AM	**Tea Break**	
Session 3-Key Note Address		
Chairpersons: Dr Reva Tripathi, Dr S N Basu, Dr Pratima Mittal, Dr Krishna Gopal		
11:15 - 11:35 AM	Doppler in diagnosis & management of FGR	Dr Ashok Khurana
11:35 - 12:00 Noon	Congenital malformations of genital tract- diagnosis to intervention	Dr Alka Kriplani
Session 4 - Brigadier Khanna Oration		
Chairpersons: Dr Shaktibhan Khanna, Dr Neera Aggarwal, Dr Malvika Sabharwal, Dr Abha Sharma		
12:00 - 12:30 PM	Brigadier Khanna Oration BREAST CANCER - Every pink ribbon makes a difference	Dr Ramesh Sarin
Session 5 - Past President Oration		
Chairpersons: Dr Swaraj Batra, Dr Uma Rai, Dr Sonia Malik, Dr Abha Singh		
12:30 - 1:00 PM	LSCS for Fetal distress - What's the right time?	Dr Asmita Rathore
1:00 - 1:45 PM	**Lunch**	
Session 6- Oncology Update		
Chairpersons: Dr Gauri Gandhi, Dr Kanika Gupta, Dr Urvashi Miglani		
1:45 - 2:00 PM	Fertility preservation in endometrial cancer	Dr Vanita Suri
2:00 - 2:15 PM	Role of MIS in gynecological cancers - the current perspective	Dr Rupinder Sekhon
2:15 - 2:30 PM	Targeted therapy for ovarian cancer in the era of precision Medicine	Dr Sachin Khurana
2:30 - 2:45 PM	VIN - whom & when to treat	Dr Archana Mishra
Session 7 - Video Session		
Chairpersons: Dr Raksha Arora, Dr Neeta Singh		
2:45 - 3:00 PM	MIS in DIE	Dr BB Dash
3:00 - 3:15 PM	High Uterosacral fixation	Dr Uma Swain
3:15 - 3:30 PM	Advances in treatment of SUI	Dr J B Sharma
3:30 - 3:45 PM	Laparoscopic Adenomyomectomy	Dr Bijoy Naik

Session 8 - Controversies & Dilemmas		
Chairpersons: Dr Neena Malhotra, Dr Tarini Taneja, Dr Poonam Khera		
3:45 - 4:00 PM	Ovarian rejuvenation/ovarian tissue freezing	Dr Kuldeep Jain
4:00 - 4:15 PM	PRP- A panacea for all ailments	Dr Divya Pandey
4:15 - 4:30 PM	Antepartum choice of Parenteral Iron Therapy	Dr Leena Sridhar
Session 9		
Chairpersons: Dr Anita Rajhoria, Dr Nazia Parveen		
4:30 - 4:45 PM	Antiadhesive Barrier	Dr Renu Raina Sehgal
4:45 - 5:00 PM	HPV Point of Care Testing	Dr Priyanka Mathe
5:00 - 5:30 PM	**Valedictory Function**	

20th August, 2023 |Day2| Ebony Hall

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
Session 1 - An Epidemic of Caesarean Deliveries: A Matter of Concern		
Chairpersons: Dr Susheela Gupta, Dr Upma Saxena, Dr Vidushi Kulsreshtha		
9:00 - 9:15 AM	Scar ectopic: update in management options	Dr Sandhya jain
9:15 - 9:30 AM	Early risk categorization to optimize caesarean delivery	Dr Garima Kachawa
9:30 - 9:45 AM	Induction protocols for safe V.B.A.C.: a need of the hour	Dr Taru Gupta
9:45 - 10:00 AM	Audience interaction	
Session 2 - Panel Discussion		
10:00 - 10:45 AM	Medical Disorders (Obesity, AFLP, Thrombocytopenia) **Panelists:** Dr Balkesh Kumari, Dr Poonam Goyal, Dr Kishore Rajurkar, Dr Sumita Mehta, Dr Niharika Dhiman, Chandra Mansukhani, Dr Sudesh Agarwal	**Moderators:** Dr Jyotsna Suri, Dr Ratna Biswas
10:45 - 11:15 AM	**Tea Break**	
Session 3-Key Note Address		
Chairpersons: Dr Reva Tripathi, Dr S N Basu, Dr Neerja Goel, Dr Krishan Gopal		
11:15 - 11:35 AM	Doppler in diagnosis & management of FGR	Dr Ashok Khurana
11:35 - 12:00 Noon	Congenital malformations of genital tract- diagnosis to intervention	Dr Alka Kriplani
Session 4- Brigadier Khanna Oration		
Chairpersons: Dr Shaktibhan Khanna, Dr Neera Aggarwal, Dr Malvika Sabharwal, Dr Abha Sharma		
12:00 - 12:30 PM	Brigadier Khanna Oration BREAST CANCER - Every pink ribbon makes a difference	Dr Ramesh Sarin
Session 5 - Past President Oration		
Chairpersons: Dr Swaraj Batra, Dr Sharda Jain, Dr Sonia Malik, Dr Abha Singh		
12:30 - 1:00 PM	LSCS for Fetal distress - What's the right time?	Dr Asmita Rathore
1:00 - 1:45 PM	**Lunch**	
Session 6 - Competition Papers		
1:45 - 3:00 PM	Competition Papers	**Judges** Dr NB Vaid, Dr Nutan Agarwal Dr Manju Khemani, Dr Mala Srivastava

Session 7- New Frontiers in Women's Wellness - Mixed Obs Gynae		
Chairpersons: Dr Meenakshi Ahuja, Dr Suman Mehndiratta, Dr Anjali Chaudhary		
3:00 - 3:15 PM	Scope of impact of AI in Gynecology	Dr Harpreet Singh
3:15 - 3:30 PM	Aesthetics in gynaecology - Vaginal rejuvenation	Dr Navneet Magon
3:30 - 3:45 PM	Holistic approach to improving bone health: adding life to years	Dr Maninder Ahuja
Session 8- Video Session in Obstetrics		
Chairpersons: Dr Dinesh Kansal, Dr Anita Bansal, Dr Krishna Aggarwal		
3:45 - 3:55 PM	Laparoscopic abdominal cervical encirclage	Dr Nikita Trihan
3:55 - 4:05 PM	Inrtra-uterine fetal therapy	Dr Akshatha Prabhu
4:05 - 4:15 PM	Use of tourniquet to decrease blood loss in Placenta Accreta a novel method	Dr Archana Chaudhary
Session 9- Controversies in Obstetrics		
Chairpersons: Dr Prachi Rinjen, Dr Leena Wadhwa, Dr Mamta Tyagi		
4:15 - 4:30 PM	Unexplained RPL – What next ?	Dr Renu Mishra
4:30 - 4:45 PM	Role of intercurrent magnesium sulphate therapy in severe pre-eclampsia	Dr Sumitra Bachani
4:45 - 5:00 PM	PPROM : When to terminate?	Dr Richa Aggarwal
5:00 - 5:30 PM	**Valedictory Function**	

20th August, 2023 |Day2| Emerald Hall (ICOGCME)

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
Session 1 - Skills & Drills: Thrills for PG's		
Chairpersons: Dr Jyoti Bhaskar, Dr Preeti Arora Dhameja , Dr Sujata Agarwal		
9:00 - 9:30 AM	Breech Delivery: Managing Tactfully	Dr Aruna Nigam, Dr Sumedha, Dr Zeba Khanam, Dr Supriya Chaubey, Dr Asma Khanday
9:30 - 10:00 AM	Shoulder Dystocia: Obstetrician caught unaware	Dr Mamta Dagar & Team
Session 2- Panel Discussion		
10:00 - 10:45 AM	AWaRe: Rationale use of Antimicrobials in obs. & gynae **Panelists:** Dr Sruthi, Dr Arifa Anwar, Dr Archana Pathak, Dr Rachna, Dr Chitra Setiya, Dr Poonam Sachdeva, Dr Sonal	**Moderators:** Dr Manju Puri Dr Poonam Joon
10:45 - 11:15 AM	**Tea Break**	
Session 3-Key Note Address		
Chairpersons: Dr Reva Tripathi, Dr S N Basu, Dr Neerja Goel, Dr Krishan Gopal		
11:15 - 11:35 AM	Doppler in diagnosis & management of FGR	Dr Ashok Khurana
11:35 - 12:00 Noon	Congenital malformations of genital tract- diagnosis to intervention	Dr Alka Kriplani
Session 4 - Brigadier Khanna Oration		
Chairpersons: Dr Shaktibhan Khanna, Dr Neera Aggarwal, Dr Malvika Sabharwal, Dr Abha Sharma		
12:00 - 12:30 PM	Brigadier Khanna Oration BREAST CANCER - Every pink ribbon makes a difference	Dr Ramesh Sarin
Session 5- Past President Oration		
Chairpersons: Dr Swaraj Batra, Dr Sharda Jain, Dr Sonia Malik, Dr Abha Singh		
12:30 - 1:00 PM	LSCS for Fetal distress - What's the right time?	Dr Asmita Rathore
1:00 - 1:45 PM	**Lunch**	
Session 6		
1:45 - 2:15 PM	Eclampsia Drill: Learning methodically	Dr Seema Prakash, Dr Bhanu
2:15 - 2:45 PM	Maternal collapse: A shiver down the spine	Dr Rashmi Salhotra
Session 7 - PPH Handson Station		
2:45 - 4:00 PM	PPH Hands on Station	Dr S Kabra, Dr Shakun Tyagi
Session 8		
Chairpersons Dr Sarika Gupta, Dr Seema Prakash		
4:15 - 4:30 PM	Role of antenatal Anti-D in Rh negative mother	Dr Rajesh Kumari
4:30 - 4:45 PM	Atosiban : Current Perspectives	Dr Seema Rawat
5:00 - 5:30 PM	**Valedictory Function**	

AOGD-FOGSICON 2023

Annual Conference of AOGD FOGSI PG Conference

Organised by Association of Obstetricians & Gynaecologists of Delhi UCMS & GTB Hospital, New Delhi

Enhancing Knowledge Upscaling Skills

18th to 20th August 2023 | The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

BLK-MAX Super Speciality Hospital

Medico legal Challenges In Obgy: Learning To Avoid Burning

18th August, 2023 | 9:00 AM - 1:00 PM

Convenor

Dr Nidhi Khera
Director And Head
Obstetrics & High Risk Pregnancy
BLK-Max Super Speaciality Hospital Delhi

Dr Ashok Kumar
Director Professor & Head,
Department Of Obgyn
ABVIMS & RML Hospital Delhi
Secretary Icog

PROGRAM

Time	Topic	Speaker
8:00 - 8:10 AM	**Registration**	
8:10 - 8:45 AM	Introduction & Welcome	Dr Ashok Kumar, Dr Nidhi Khera
8:45 - 9:45 AM	Consent Taking - Handling Challenges **Panelists:** Dr Manju Puri, Dr Sangeeta Gupta, Dr Geeta Mediratta, Dr Aradhna Singh, Dr Pinky Yadav, Dr Laxmi Mantri	**Moderators:** Dr Ashok Kumar, Dr Nidhi Khera **Experts:** Dr Reva Tripathi, Dr Arti Tandon
Chairpersons: Dr Rashmi Vyas, Dr Rekha Mehra, Dr Kamna Datta		
9:45 - 10:00 AM	Documentation - Rules Of Safe Practice And Where Do We Go Wrong	Dr Girish Tyagi
Chairpersons: Dr Dinesh Kansal, Dr Sonam Garg, Dr Manisha Arora		
10:00 - 10:30 AM	Avoiding Litigation In Obs And Gynae Practice - Practical Tips From DMC President	Dr Arun Gupta
10:30 - 10:45 AM	**Inauguration**	

Chairpersons: Dr Narender Kaur,Dr Mala Srivastav, Dr Keerti Khaitan		
10:45 - 11:00 AM	Notice Served: What Next?	Dr Geetendra Sharma
Chairpersons: Dr S.M. Kantikar, Dr Poonam Khera, Dr Neeru Kiran, Dr Alka Sinha		
11:00 - 12:00 Noon	**Understanding Legal Processes & Doctors Liability**	
	Criminal Liability: Justice Mukta Gupta	
	Civil Liability: Senior Advocate Shweta Bharti	
12:00 - 1:00 PM	Reverse Panel - Day To Day Situations - Obgyn Specialist Guilty of Negligence - Yes or No ? **Panelists:** Dr Leena Sreedhar, Dr Tapas Koley, Dr Reena Yadav, Dr Sonal Bathla, Dr Tripti Sharan, Dr Poonam Yadav	**Moderators:** Dr M C Patel, Dr Gaurav Aggarwal **Experts:** Dr Ragini Aggarwal, Dr Vijay Zutshi, DCP Joy Tirkey

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heartfulness advancing with compassion

Pre-Conference Workshop
Physician - Heal Thyself
Holistic Care of Women Wellness

18th August, 2023 | 9:00 AM - 1:00 PM

Conveners

Dr Kiran Guleria
Director - Professor & Unit Head
Dept. of Obstetrics &
Gynecology, UCMS & GTB Hospital, Delhi

Dr Rahul Mehrotra
Chief- Clinical &
Non-Invasive Cardiology,
Artemis Hospitals, Gurugram

Dr Snehal Deshpande
Developmental Therapist &
Wellness Coach HOD, Pediatric Rehab,
Dr L H Hiranandani Hospital, Mumbai

Co-Convener

Dr Linoo Koul
Family physician &
Consultant Fellowship in Mother
& Child care

Special Guests: Dr NB Vaid, Dr Raksha Arora, DrAchla Batra,Dr Anita Sabharwal
MOC: Dr Seema Rawat, Dr Niharika

PROGRAM

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
9:00 - 9:05 AM	Saraswati Vandana & Welcome Address	
9:05 - 9:15 AM	Introduction & Orientation: Physician Heal Thyself: OBGYN-BURNOUT	Dr Kiran Guleria
9:15 - 9:30 AM	Activity	Dr Snehal Deshpande
Chairpersons: Dr Kiran Aggarwal, Dr Leena Sreedhar, Dr Raka Guleria		
9:30 - 10:15 AM	Swasthya - The way from DISEASE TO EASE	Dr Snehal Deshpande
10:15 - 10:30 AM	Activity	Dr Linoo Koul
Chairpersons: Dr Prachi Renjhen, Dr Jaya Chawla, Dr Nalini Bala Pandey		
10:30 - 11:15 AM	Burn out to Joy: Resilience-Don't break bend your way through	Dr Linoo Koul
11:15 - 11:30 AM	**Break**	
11:30 - 11:45 AM	Activity	Dr Rahul Mehrotra
Chairpersons: Dr Sangeeta Bhasin, Dr Anita Matai, Dr AG Radhika		
11:45 - 12:30 PM	At the He(art) of Communication-Universal connection	Dr Rahul Mehrotra
12:30 - 1:00 PM	**View Point of Special Guests & Discussion**	

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Enhancing Knowledge Upscaling Skills

18th to 20th August 2023 | The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

Integrating Essentials of Fetal Medicine in Day to Day Obstetric Practice

18th August, 2023 | 9:00 AM - 1:00 PM

Patron	Convener	Co-convener
		
Dr Asmita Rathore	Dr Sangeeta Gupta	Dr Sumitra Bachani

PROGRAM

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
9:00 - 9:10 AM	Essentials of Fetal Medicine in Obstetric Practice	Dr Sangeeta Gupta
9:15 AM - 12:30 PM	**6 Stations** (25 Minutes Each with 15 Mins Break at 11:15 - 11:30 AM) Delegates will be Divided into 6 Groups A to F & will be Rotated on each Station for 25 Mins	
	1. Screening PE + aneuploidy: Pick them early	Dr Poonam Thakur, Dr Akshatha Sharma, Dr Shakun Tyagi
	2. Genetics in Obstetrics: What I need to know	Dr Seema Thakur, Dr Rachna Gupta, Dr Neha Varun
	3. Growth monitoring and FGR: Identify the smalls	Dr Chanchal Singh, Dr Reena Rani, Dr Shyama Devadasan
	4. Multiple Pregnancy: Two to Juggle	Dr Vandana Chaddha, Dr Jaya Chawla, Dr Anubhuti Rana
	5. Stillbirth Audit: Deciphering the Jigsaw Puzzle	Dr Manisha Kumar, Dr Richa Agarwal, Dr Krishna Agarwal
	6. Soft markers: Not too hard to handle	Dr Sumitra Bachani, Dr Renu Arora, Dr Veronica Arora

Chairpersons: Dr Dipika Deka, Dr Kanwal Gujral, Dr Asmita Rathore		
12:30 - 12:45 PM	Genetics and Genomics of Fetal Medicine	Dr Sheetal Sharda
12:45 - 1:00 PM	Videos on Invasive Procedures	Dr Vatsala Dhadwal

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Menopausal Health

Organisedby

Institute of Obstetrics & Gynaecology, Sir Ganga Ram Hospital

18th August, 2023 | 9:00 AM - 1:00 PM

Convenor	Co-Convener	MOC
		
Dr Mala Srivastav	Dr Geeta Mediratta	Dr Ila Sharma

PROGRAM

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
9:00 - 9:15 AM	Inauguration	
Session1		
9:15 - 9:30 AM	Menopausal Transition: Physiology & Symptoms	
9:30 - 10:30 AM	Panel - Case Based Scenarios **Panelist:** Dr Kiranjeet, Dr Priti Dhamija, Dr Leena Sridhar, Dr Susheela Gupta, Dr Vandana Gupta, Dr Yukti, Dr Suyesha	**Moderator:** Dr Meenakshi Ahuja Dr Jyoti Bhaskar
10:35-10:45AM	**Tea Break**	
Session2		
Chairpersons: Dr Kanwal Gujral,Dr Harsha Khullar, Dr Nisha Bhatnagar		
10:45 - 10:55 AM	Premature Ovarian Insufficiency - The New Epidemic	Dr Pakhee Agarwal
10:55 - 11:05 AM	Ovarian Tissue & Oocycte Cryo Preservation Prior to Iatrogenic Premature Ovarian Insufficiency	Dr Sweta Gupta
11:05 - 11:15 AM	Surgical Menopause	Dr Madanjit Pasricha
11:15 - 11:20 AM	Discussion	

Session 3		
Chairpersons: Dr Sunita Kumar, Dr Ramnik Sabhrwal, Dr Debasis Dutta, Dr Anchal Aggarwal		
11:20 - 11:30 AM	Bone + Heart Health in Menopause	Dr Kiran Aggarwal
11:30 - 11:40 AM	HRT - Current Recommendations	Dr Pikee Saxena
11:40 - 11:50 AM	Cognition & Mental Health in Menopause	Dr Anita Mahajan
11:50 - 12:00 Noon	MHT. Migraine & Thromboembolism	Dr Rajiv Renjan
12:00 - 12:05 PM	Discussion	
Session 4		
Chairperson: Dr Kanika Jain, Dr Renu Raina, Dr Rahul Modi		
12:05 - 12:15 PM	Use of Menopausal Hormonal Therapy After Cancers	Dr Mala Srivastava
12:15 - 12:25 PM	Emerging Treatment for Menopausal Symptoms	Dr Geeta Mediratta
12:25 - 12:35 PM	Alternative & Non Hormonal Treatment for Symptoms of Menopause	Dr Ragini Aggarwal
12:35 - 12:40 PM	Discussion	
12:45 PM	Vote of Thanks	
Lunch		

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Enhancing Knowledge Upscaling Skills

18th to 20th August 2023 | The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

Pre-Conference Workshop

HANDS ON TRAINING WORKSHOP MVA & IMPLANON NXT

Organised by
FOGSIMTP Committee &
Directorate of Family Welfare, Govt. of NCT of Delhi

18th August, 2023 | 9:00 AM - 1:00 PM

Conveners

Dr Richa Sharma
Professor OBGy
UCMS & GTB Hospital Delhi
FOGSI - MTP Committee Chairperson

Dr Jyoti Sachdeva
State Program Officer
Maternal Health & Family Planning,
Directorate of Family Welfare,
Govt of NCT of Delhi

PROGRAM

Time	Topic	Speaker
8:30 - 9:00 AM	**Registration**	
9:00 - 9:05 AM	Welcome Address	Dr Richa Sharma
9:05 - 9:10 AM	**LampLighting** Dr Geetendra Sharma (FOGSI VP Incharge), Dr Vandana Bagga (Director DFW), Dr Amita Suneja (President AOGD), Dr Ashok Kumar (President Elect. AOGD), Dr Anita Sabharwal (Advisor MTP Committee)	
9:10 - 9:20 AM	**Pretest***	
Session 1- Manual Vacuum Aspiration		
Chairpersons: Dr Ashok Kumar, Dr Jyoti Sachdeva, Dr Kiran Chandana		
9:20 - 9:35 AM	MVA Use in Modern Era	Dr Sumita Mehta
9:35 - 9:50 AM	Structure & working of MVA	Dr Sangeeta Batra
9:50 - 10:00 AM	**Audience Interaction**	

Session 2-Implanon NXT		
Chairpersons: Dr Vandana Bagga, Dr Anita Sabharwal, Dr Himsweta Srivastava, Dr Alpna Kansal		
10:00 - 10:15 AM	Implanon NXT - Anatomy & Physiology	Dr Ashish Kale
10:15 - 10:30 AM	Eligibility Criteria, Screening Checklist, Counselling	Dr Shakuntala Kumar
10:30 - 10:45 AM	Insertion & Removal	Dr Richa Sharma
10:45 - 10:50 AM	Follow up & Complication Management	Dr Meenakshi Ahuja
10:50 - 11:00 AM	**AudienceInteraction**	
Session 3-Handson Training		
11:00 - 12:45 PM	Simulation Model Training - Manual Vacuum Aspiration	Dr Sangeeta Batra, Dr Chhaya Tiwari, Sameek Khan
	Implanon NXT - Training on Dummy Arms	Dr Meenakshi Ahuja, Dr Shakuntala Kumar, Dr Poonam Goyal, Dr Ashish Kale
12:45 - 12:55 PM	**PostTest***	
12:55 - 1:00 PM	Vote of Thanks	
Certificate of Training will be Provided to the Delegates Attending both Pretest & Post-Test		

AOGD-FOGSICON 2023

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Enhancing Knowledge Upscaling Skills

18th to 20th August 2023 | The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

Ensuring Quality In Fertility
Enhancing Endoscopic Surgeries

Organized By
Endoscopy, Endometriosis & QI Committee of AOGD

18th August, 2023 | 9:00 AM - 1:00 PM

Conveners

Dr Reena

Dr Swati Agrawal

Co-Conveners

Dr Vidhi Chaudhary

Dr Kanika Chopra

PROGRAM

Time	Video Session	Speaker
8:30 - 9:00 AM	**Registration**	
9:00 - 9:10 AM	Welcome Address	Dr Reena
Chairpersons: Dr Chitra Raghunandan, Dr Garima Kapoor, Dr Ritu Sharma, Dr Neha Varun		
9:15 - 9:35 AM	Step by Step Diagnostic Laparo- Hysteroscopy for Evaluation of Infertility	Dr Swati Agrawal
9:40 - 10:00 AM	Laparoscopic Tuboplasty/tubal Recanalization	Dr Kanika Jain
Chairpersons: Dr Reena, Dr Richa Sharma, Dr Vidhi Chaudhary, Dr Puja Sharma		
10:10 - 10:30 AM	Laparoscopic Myomectomy/ Adenomyomectomy	Dr Shivani Sabharwal
10:35 - 10:55 AM	Laparoscopic Management of Endometriosis	Dr Anjila Aneja

Chairpersons: Dr Kiran Aggarwal, Dr Neena Singh, Dr Aruna Nigam, Dr Kanika Chopra		
11:05 - 11:25 AM	Hysteroscopic Myomectomy	Dr Farendra Bhardwaj
11:30 - 11:50 AM	Hysteroscopic Septal Resection	Dr Subash Mallaya
Chairpersons: Dr Malvika Sabharwal, Dr Madhu Goel, Dr Garima Kachchawa, Dr Pakhee Aggarwal		
12:00 - 12:20 PM	Hysteroscopic Adhesiolysis for Asherman Syndrome	Dr Milind Telang
12:25 - 12:45 PM	Hysteroscopic Tubal Cannulation	Dr Indu Chawla
12:50 PM Onwards	**Quiz for Audience with Attractive Prizes**	
Hands-on Training on Endotrainers Endotrainers will be Available throughout the Workshop		

AOGD-FOGSICON 2023

Annual Conference of AOGD FOGSI PG Conference

Organised by Association of Obstetricians & Gynaecologists of Delhi UCMS & GTB Hospital, New Delhi

Enhancing Knowledge Upscaling Skills

18th to 20th August 2023 | The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

IVF
(Learn Step by Step from Basics to Advanced)

18th August, 2023 | 1:30 PM - 5:30 PM

Conveners

Dr Manju Khemani

Dr Sunita Arora

Co-Conveners

Dr Bindu Bajaj

Dr Madhu Goel

PROGRAM

Time	Topic	Speaker
1:00 - 1:30 PM	**Registration**	
Chairpersons: Dr Seema Parkash, Dr Manju Khemani, Dr Madhu Goel, Dr Tarini Taneja, Dr Rashmi Malik		
1:30 - 1:45 PM	The first Interaction (Indications of IVF & Counselling)	Dr Renu Mishra
1:45 - 2:00 PM	Investigation & Optimisation of Couple before IVF	Dr Bindu Bajaj
Chairpersons: Dr Sonia Malik, Dr Seema Sehgal, Dr Jyoti Malik, Dr Pikee Saxena, Dr Anjali Chawdhary		
2:05 - 2:25 PM	IVF Protocol (AGONST/ANTAGONIST) How to choose/How to start	Dr Abha Majumdar
2:25 - 2:45 PM	Individualised Controlled Ovarian Stimulation (ICOS)	Dr M Gauri Devi
2:45 - 3:00 PM	From Day 2 to trigger day (Monitoring & Modulating the doses)	Dr Reeta Mahey
3:00 - 3:15 PM	Trigger Which one & When	Dr Neena Malhotra
3:15 - 3:25 PM	**Tea Break**	

Chairpersons: Dr Poonam Goel, Dr Susheela Gupta, Dr Renu Tanwar, Brig R K Sharma, Dr Sweta Gupta		
3:25 - 3:40 PM	Tips & Tricks of Ovum pick up & Embryo Transfer (Video Presentation)	Dr Sunita Arora
3:40 - 3:55 PM	OHSS Prevention & Management	Dr Shivani Sachdev Gaur
3:55 - 4:10 PM	Preparation for FET Cycle (Natural Cycle/Stimulated Cycle/HRT Cycle)	Dr K D Nayar
4:10 - 4:25 PM	luteal Phase Support (Fresh/frozen ET Cycle)	Dr Surveen Ghuman
Chairpersons: Dr Tanya Buckshee, Dr Shalini Chawla Khanna, Dr Aastha Gupta, Dr Puneet Arora, Dr Leena Wadhwa		
4:25 - 4:40 PM	What goes on Inside an IVF Lab	Dr Sarabpreet Singh
4:40 - 4:55 PM	ART Law 2022- Implications for Level 2 Clinic	Dr Kundan Ingale
5:10 PM Onwards	Instruments & Disposables in IVF OT & Lab	Ms Sapna Gill/ Ms Nimisha Mishra Ms Anju Baghel

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Workshop on Respectful Maternity Care

In association with

WHO, India, AOGDQI Committee & NARCHI - Delhi

18th August, 2023 | 1:00 PM - 4:00 PM

Convener

Dr Manju Puri

Co-Conveners

Dr K Aparna Sharma

Dr Shakun Tyagi

Dr Kanika Chopra

PROGRAM

Time	Topic	Speaker
1:00 - 1:10 PM	Inaugural Session	Dr Pushpa Chaudhary, WHO India Dr Amita Suneja, President, AOGD Dr Manju Puri, Dir Professor, LHMC Dr Jyoti Sachdeva, SPO, Maternal Health, New Delhi Dr Kiran Agarwal, Chairperson, QI Committee
1:10 - 1:20 PM	Welcome Address & Objectives of the Workshop	Dr K Aparna Sharma
1:20 - 1:50 PM	Birth Needs Activity	Dr Shakun Tyagi Dr Rohini Sehgal
Chairpersons: Dr Achla Batra, Dr Kiran Agarwal		
1:50 - 2:10 PM	Concept & need for RMC	Dr Manju Puri
2:10 - 2:20 PM	Voices of Women	Ms Kala Vivekanand
2:20 - 2:30 PM	Discussion	

2:30 - 2:45 PM	Team building and Communication (Communication Matching Questions)	Dr Kanika Chopra
2:45 - 3:05 PM	Paper Chain Activity	Dr Anupama Dr Leena Bhatnagar
3:05 - 3:20 PM	**Tea Break**	
3:20 - 3:30 PM	Introduction to Simulation	Dr Aparna Sharma
3:30 - 4:00 PM	Simulation Demo	Dr Manju Puri Dr Achla Batra
Open House Way forward		

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Urogynaecological Surgeries: Basics Revisited Video Workshop

Organized by: AOGD Urogynaecology Committee
In Association with
FOGSI Urogynaecology Committee &
Society of Vaginal Surgeon Delhi (SOVSD)

18th August, 2023 | 1:30 PM - 5:30 PM

Convener

Dr Monika Gupta
Chairperson,
AOGD Urogynaecology Committee

Co-Convener

Dr Karishma Thariani
Academic Secretary,
AOGD Urogynaecology Committee

PROGRAM

Time	Topic	Speaker
1:00 - 1:30 PM	**Registrations**	
1:30 - 1:40 PM	Inauguration & Introduction to Workshop	Dr Monika Gupta
Session1: Pelvic Organ Prolapse		
Chairpersons: Dr Kishore Rajurkar, Dr Sonal Bathla, Dr Sandhya Jain, Dr Rajesh Kumari		
1:40 - 2:00 PM	Pelvic Anatomy	Dr Ranjana Sharma
2:05 - 2:25 PM	Vaginal Hysterectomy: Simplified	Dr Geeta Mediratta
2:30 - 3:00 PM	Vault Suspension Techniques	Dr Uma Rani Swain
3:05 - 3:30 PM	Lefort Colpocliesis: Revisited	Dr Achla Batra

Session 2: Stress Urinary Incontinence		
Chairpersons: Dr Amita Suneja, Dr Anuradha, Dr Priti Dhamija, Dr Jyoti Chugh		
3:40 - 3:55 PM	Pathophysiological basis of Urinary Incontinence	Dr Monika Gupta
4:00 - 4:20 PM	Burch Colposuspension	Dr J.B Sharma
4:25 - 4:45 PM	Synthetic Midurethral Sling	Dr Aparna Hegde
4:50 - 5:10 PM	Autologous Fascial Sling	Dr Karishma Thariani
5:10 - 5:25 PM	Intravesical Botox	Dr Amita Jain
5:25 - 5:30 PM	Vote of Thanks	

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Basic Procedures In Gynae Oncosurgery Video Workshop

18th August, 2023 | 1:30 PM - 5:30 PM

Convener

Dr Saritha Shamsunder

Co-Convener

Dr Bindiya Gupta

PROGRAM

MasterofCeremony: Dr Bindiya Gupta		
Time	**Topic**	**Speaker**
Welcome Address		Dr Saritha Shamsunder
Session 1-Basics of Oncosurgery		
1:30 - 1:45 PM	Surgical Anatomy of Pelvis and Anterior Abdominal Wall	Dr Satinder Kaur
1:45 - 2:00 PM	Energy Sources in Surgery	Sponsored Session
Session 2-Ovarian Malignancy		
Expert: Dr Rama Joshi **Chairpersons:** Dr Sunita Malik, Dr Sarika Gupta, Dr Sharda Patra		
2:00 - 2:15 PM	Staging & Types of Surgeries for Malignant Ovarian Tumours	Dr Kanika Batra
2:15 - 2:30 PM	Fertility Sparing Surgery for a Malignant Ovarian Tumour	Dr Neha Kumar
2:30 - 2:45 PM	Cytoreductive Surgery and HIPEC	Dr SVS Deo
2:45 - 2:55 PM	Q & A	

Session 3- Endometrial Cancer		
Expert: Dr Kanika Gupta **Chairpersons:** Dr Urvashi Miglani, Dr Jasmine Chawla, Dr Shruti Bhatia		
2:55 - 3:10 PM	Staging & Management of Endometrial Cancer	Dr Amita Suneja
3:10 - 3:25 PM	Hysterectomy & Lymphadenectomy In Endometrial Cancer: Open Approach	Dr Bindiya Gupta
3:25 - 3:40 PM	Sentinel Node In Endometrial Cancer	Dr R Rajgopalan
3:40 - 3:50 PM	Q & A	
Session 4- Cancer Cervix		
Expert: Dr Manash Biswas **Chairpersons:** Dr Mala Srivastava, Dr Sweta Balani, Dr Vinita Jaggi		
3:50 - 4:10 PM	Current concepts in Staging and Management of Cancer Cervix	Dr Neerja Bhatla
4:10 - 4:25 PM	Nerve Sparing Radical Hysterectomy + PLND	Dr KVN Raju
4:25 - 4:40 PM	Anterior Pelvic Exenteration	Dr Rupinder Sekhon
4:40 - 4:50 PM	Q & A	
Session 5- Vulvar Cancer		
Expert: Dr Sabhyata Gupta **Chairpersons:** Dr Mamta Dagar, Dr Swasti, Dr Sarita Singh		
4:50 - 5:05 PM	Staging and Types of Surgery for Vulvar Cancer	Dr Saritha Shamsunder
5:05 - 5:15 PM	Simple Vulvectomy	Dr Archana Mishra
5:15 - 5:30 PM	Radical Vulvectomy+ Inguinofemoral Lymphadenectomy	Dr Vijay Zutshi
5:30 PM	**Vote of Thanks**	Dr Saritha Shamsunder

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Adolescent Health : Challenges & Controversies

Organised by: AOGD Adolescent Subcommittee

18th August, 2023 | 1:30 PM - 5:30 PM

Guest Of Honour

Dr Sharda Jain

Convener

Dr Jyoti Bhaskar

Co-Convener

Dr Kiran Chhabra

Dr Sujata Agrawal

PROGRAM

Time	Topic	Speaker
1:00 - 1:30 PM	Registration	
Challenges: Looking Beyond The Medical Skeleton		
Experts: Dr Deepshikha Goel, Dr Lata Bhat, Prof Renu Gulati, Mrs Ruma Purkayastha, Dr Suyesha Khanijao, Dr Uma Vaidyanathan		
1:30 - 2:30 PM	Wandering Pain	Dr Jyoti Bhaskar
	Vaginal Discharge	Dr Neha Kapoor
	Body Shamming	Dr Sujata Agrawal
	Dysmenorrhea	Dr Taruna Dua
2:30 - 2:45 PM	**Inaugration** **Guest Of Honour:** Dr Sharda Jain **Chief Guest:** Dr Amita Suneja	
Controversies: Exploring The Grey Areas		
Chairpersons: Dr AG Radhika, Dr Taru Gupta, Dr Vandana Gupta		
2:45 - 3:05 PM	Medical Management of Obesity in Adolescents	Dr IPS Arora

3:10 - 4:00 PM	**Dialogue, Debate & Decision**	
	Adolescent Endometriosis **Discussants:** Dr Neerja Varshney, Dr Renu Chawla	**Expert:** Dr Anjila Aneja
	Adolescent PCOS **Discussants:** Dr Meenakshi Sabharwal, Dr Rajni Mittal	**Expert:** Dr Deepti Goswami
	Adolescent AUB **Discussants:** Dr Dipti Nabh, Dr Meenakshi Sharma	**Expert:** Dr Achla Batra
	Life Style Modifications: Are they different from Adults **Discussants:** Dr Kanika Garg,Dr Akshira	**Expert:** Dr Meenakshi Ahuja
Pocso Act- Understanding It's Implication		
Chairpersons: Dr Deepa Gupta, Dr Jyotsna Suri, Dr Nidhi Khera, Dr Poonam Goyal, Dr Raj Bokaria		
4:00 - 4:15 PM	POCSO ACT 2012 & Amendments	Dr Shakuntala Kumar
4:15 - 4:30 PM	Limitations of POCSO ACT	Dr Vinita Gupta
Discussion & Comments		
4:30 - 5:30 PM	**PanelDiscussion:** Real Case Based Discussion **Panelists:** Dr Ajay Gupta (Pediatrician), Dr Chandan Kachru (Gynecologist), Mrs. Deeba Naseem (Member Juvenile Justice Board), Dr Gaurav Aggarwal (Medicolegal Expert), Dr. Richa Sharma (Gynecologist), Mrs. Sangeeta Goel (Ex Member Child Welfare Committee), Dr Shivani Agarwal (Gynecologist), Mr. Sumit Malhotra (High Court Lawyer)	**Moderators:** Dr Kiran Chhabra Dr Kiranjeet Kaur
Vote of Thanks		

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Enhancing Knowledge Upscaling Skills

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Workshop On Preventive Oncology: From Principles To Practice

18th August, 2023 | 1:30 - 5:30 PM

Convener

Dr Neerja Bhatla

Co-convener

Dr Jyoti Meena

In Technical Collaboration with Jhpiego

PROGRAM

Time	Topic	Speaker
1:00 - 1:30 PM	**Registration**	
1:30 - 1:35 PM	Inauguration	
Session 1: Cervical Cancer Screening Guidelines & Triage Techniques		
Chairpersons: Dr Kamal Buckshee, Dr Rupinder Sekhon, Dr Nirmala Agarwal		
1:35 - 1:45 PM	Overview of Women's Cancers	Dr Amita Suneja
1:45 - 2:00 PM	WHO Guidelines for Screening & Management of Precancerous Lesions of Cervix	Dr Jyoti Meena
2:00 - 2:15 PM	Triage Techniques- When & How? (VIA, HPV Genotyping & Biomarkers)	Dr Gauri Gandhi
2:15 - 2:25 PM	Discussion	
Session 2: Understanding Colposcopy		
Chairpersons: Dr V L Bhargava, Dr Sunesh Kumar, Dr Mala Srivastava		
2:30 - 2:45 PM	Evolution of Colposcopes & New Technologies	Dr Saritha Shamsunder
2:45 - 3:00 PM	Colposcopy Procedure, IFCPC Nomenclature & Scoring Systems	Dr Sarita Kumari
3:00 - 3:40 PM	**PanelDiscussion:** Interesting Colposcopy Cases **Panelists:** Dr Dipanwita Banerjee, Dr Kanika Gupta, Dr Mamta Dagar, Dr Rakhi, Dr Satinder Kaur, Dr Seema Singhal, Dr Swasti	**Moderator:** Dr Aruna Nigam **Co-moderator:** Dr Nidhi Gupta

Session 3:Tips & Tricks of Treatment Methods from the Masters		
Chairpersons: Dr Reva Tripathi, Dr Sunita Malik, Dr Anita Sabharwal		
3:45 - 3:55 PM	Management of CIN	Dr Sweta Balani
3:55 - 4:03 PM	Thermal Ablation (Video Session)	Dr Partha Basu
4:03 - 4:11 PM	Large Loop Excision of Transformation Zone (Video Session)	Dr Neerja Bhatla
4:11 - 4:20 PM	Cold Knife Conization (Video Session)	Dr Vijay Zutshi
Session 4: Hands-on Session		
Chairperson: Dr Swaraj Batra		
4:20 - 4:30 PM	90-70-90, How do We do It? Implementation Lessons from Jhpiego	Dr Ayesha Nawaz
4:30 - 5:30 PM	Hands-on Workstations on Thermal Ablation, Cryopop, LEEP, Breast Examination, Portable Colposcopes (NSV, SmartScope, MobileODT), VIA Cards	**Coordinators:** Dr Rajesh Kumari Dr Swati Tomar **Demonstrator:** Dr Anupama Rao **Facilitators:** Dr Divya Sehra Dr Haritha Maddirala Dr Shivangi Mangal
5:30 PM	Vote of Thanks & Closing	Dr Jyoti Meena

FocusOn:

- Screening methods
- Management of screen positive women
- Treatment methods- ablative and excisional procedures

WhoShouldAttend:

- All gynaecologists
- Post graduates, MCh residents,
- Medical officers, Medical students, Nurses

Objectives:

- Latest WHO guidelines for screening and treatment of precancerous lesions of cervix
- Various triage strategies for screening in the “Screen Triage and Treat” Approach
- Colposcopy procedure and types of colposcopes
- Case-based discussion on colposcopy
- Tips and tricks of treatment modalities for preinvasive lesions

Dr Neerja Goel

Aging Gracefully- A Poem from Heart

Is it a word or a concept ?
Which depicts the life's move ahead
A child's aspiration limited to a feed or a toy
As she grows surroundings impact the nurturing soil

A full bloom lady blossoms to attract
Finds a partner of her choice in the world at best
Conviction with education are the goals to attain
No matter what hurdles come in the way but all go in vain

Accomplishments are the ultimate aim
Along with this service all around carries her name
Time passes with expansion of family
Little little fingers hold her eternally

Gives the best at the cost of her coziness
To make the sunshine from darkness to brightness
As the years gradually pass by in life's lane
An emptiness syndrome attacks her but go in vain

As she tries to catch the life by materialistic gain
To get best food clothing cool air and plenty rain
A realization gradually comes what for I am alive
To give or to live with comfort in the world so wide

Ultimately an eternal power comes from within
To dictate terms and conditions for her optimism to begin
Tries to find laughing companions all around
To play to the music of happiness throughout

Children become immaterial with realization in God
Give me peace and spirituality for my life to Nod
Again I become a child to find happiness in nature
Do not depend on any physical comfort and relatives anywhere

This is the circle of life which one must understand
What you were born with goes with you in the eternal world at end

Orations, Key Notes & Invited Lectures

PRECOCIOUS PUBERTY: CASE BASED SCENARIOS

Dr Rashmi Malik

UCMS & GTB Hospital, Delhi

Precocious puberty (PP) is defined as appearance of pubertal signs at an earlier age than is considered normal. It occurs ten times more frequently in girls than boys. PP is diagnosed in girls if occurs before 8 years. There are also racial differences regarding age at puberty and it occurs earlier in black girls.

For managing a girl with PP, she needs to be evaluated for the cause and treatment is required to avoid adverse outcome of early onset of puberty even if there is no underlying pathology.

Causes of Precocious Puberty:

PP can be due to Central or Peripheral Causes.

Central Precocious Puberty (CPP)

This type of precocious puberty represents true pubertal development due to early activation of the pulsatile gonadotrophin- releasing hormone secretion from the hypothalamus leading to activation of the hypothalamo pituitary- gonadal (HPG) axis mimicking normal puberty.

In girls with CPP, mostly it is idiopathic (>90%). In about 10% of the affected girls, one of the following causes may be there:

- CNS tumors – Hypothalamic hamartoma, optic glioma, arachnoid cysts, astrocytoma, ependymoma, hydrocephalus, septo optic dysplasia, pineal tumors
- CNS injury- head trauma, cranial irradiation, cerebral palsy, infections (Tuberculous meningitis)
- Genetics – Loss of function mutation encoding the MRF3 (Makorin ring finger 3) gene, a gain of function mutation encoding the kisspeptin (KISS1) and its receptor (KISSR) genes. Central precocious puberty could be genetic with an autosomal-dominant inheritance.
- Syndromes – Neurofibromatosis type 1, Sturge Weber syndrome, Tuberous sclerosis
- Environmental – internationally adopted children, withdrawal from sex steroid therapy.
- Familial precocious puberty

Improved nutrition is considered a reason for decrease in pubertal age and over-weight girls tend to have earlier menarche than girls with normal weight.

Peripheral precocious puberty (PPP) also known as precocious pseudo-puberty is the development of secondary sexual characteristics independent of the GnRH pulsatile secretion. PPP occurs due to the production of sex steroids from endogenous or exogenous sources. It is less frequent compared to the CPP. The causes of PPP can be:

- Estrogen-secreting tumor
    - Gonadal tumors – Sex cord-stromal tumors, Germ cell tumors such as dysgerminoma, teratoma, and embryonal tumors.
    - Adrenal tumors
- Ovarian cysts
- McCune-Albright syndrome
- Exogenous estrogen exposure
- Congenital Adrenal Hyperplasia
- Primary hypothyroidism

Clinical Presentation

First step in the evaluation is to differentiate between CPP and PPP

The central precocious puberty (CPP) is always isosexual and there occurs full spectrum of normal puberty changes. Breast development is the first clinical signs. Other signs and symptoms including increased linear growth, acne, muscular changes, changes in body odour, and the development of pubic and axillary hair. Girls with CPP have at least 1 Tanner stage progression per year; and have advanced bone age (BA) beyond chronological age (CA). If untreated, CPP can lead to early fusing of growth plates, a reduction in adult stature and premature menarche.

In peripheral precocious puberty (PPP), the sexual characteristics may be isosexual or heterosexual (contrasexual). Some of the secondary sex characters tends to appear in peripheral precocious puberty, but there is no activation of the normal HPG axis. Therefore, there are deviations from normal pubertal progression.

Premature adrenarche and premature thelarche are two common, benign, normal variant conditions that can resemble true precocious puberty but that progress slowly or not at all. Premature thelarche refers to the isolated appearance of breast development, usually in girls younger than 3 years; premature adrenarche refers to the appearance of pubic hair without other signs of puberty in girls younger than 7-8 years.

Diagnostic Evaluation

History and Physical

Important points in history are the actual age of onset of puberty, sequence and progression of pubertal changes. Rapid progression of puberty, although started at a normal age, is also considered abnormal. Presence of neurological symptoms such as headache, increased head circumference, seizures, visual and cognitive changes along with symptoms of anterior and posterior pituitary deficiency (polyuria, polydipsia, and decreased growth velocity) may suggest pathological cause of CPP. Ovarian pathology might present with abdominal pain. Any relevant history of head trauma, brain infections, or use of unusual creams, pills, or diet that might expose them to estrogen or testosterone should be explored. It is also essential to take a complete family history about the onset of puberty in parents and siblings, which may point to the possibility of a familial condition.[5]

Linear growth acceleration is one of the important features of early puberty. The exact height, weight, growth velocity (cm/year) and BMI should be documented. In females, accurate Tanner staging of the breast should take place.

A thorough examination should be done to look for acanthosis nigricans, café au lait macules, neurofibromas which might indicate specific causes such as neurofibromatosis type 1 and McCune-Albright syndrome.

Further Evaluation

Girls with early onset CPP, rapid progression of pubertal changes, Breast Tanner stage e"3 or stage 2, with increased growth velocity, neurological symptoms, suspected PPP need further evaluation. In females who are between the ages of seven and eight, a comprehensive history and physical examination may be sufficient if this examination does not raise any additional concerns.

Laboratory Evaluation:

Initial screening tests usually include bone age, measurement of LH, FSH, Estradiol, Dehydroepiandrosterone sulfate (DHEA-S), 17 OH progesterone levels, and thyroid function tests.

Bone age: Radiography of the hand and wrist is a quick and helpful means of estimating the likelihood of precocious puberty and its speed of progression. A bone age advanced by 2 years relative to chronologic age is considered significant and seen in CPP. Though rare Hypothyroidism may cause precocious puberty but bone age is less than chronological age.

Hormonal testing differentiates peripheral and central causes. A baseline prepubertal LH level of greater

than 0.3 IU/L is suggestive of CPP. Levels under 0.3 are indicative of peripheral causes or benign variants. If there is a high suspicion for central causes with low LH levels, a GnRH stimulation test, should be done. A rise to>5 IU/L is seen in CPP.

For girls, estradiol levels are usually elevated but are less reliable indicators of the stage of puberty.

Levels of adrenal androgens (eg, dehydroepiandrosterone [DHEA], DHEA sulfate [DHEA-S]) are usually elevated in girls with premature pubarche (Usually 20-150 mcg/d). In rare patients with virilizing adrenal tumors, levels may exceed 500 mcg/dL.

Pelvic ultrasonography In cases of PPP, pelvic ultrasonography is done to detect ovarian tumors or cysts in females. Though not diagnostic, increased uterine and ovarian volume relative to the chronological age is suggestive of CPP.

Magnetic resonance imaging of Brain is to be performed if hypothalamic lesion is suspected. It is also to be considered in females who present with early pubertal changes (less than 6 years of age) or very rapid progression.

Treatment / Management

If there is an underlying cause, treatment is directed to that.

Peripheral Precocious puberty

Surgery is indicated in gonadal and adrenal tumors. Classic congenital CAH is treated with glucocorticoids. In McCune-Albright syndrome, some benefit occurs with blocking the estrogen synthesis using aromatase inhibitors (anastrozole, letrozole) and selective estrogen selective receptor modulator (tamoxifen). Hypothyroidism is treated with replacement hormones.

Central precocious puberty

If there is underlying cause, it should be treated.

The main goals of treatment in true CPP include preservation of linear growth potential (preserving adult height), suppression of menses, shrinkage or softening of the glandular breast tissue and alleviation of the associated psychosocial stress.

Decision to treat depends on age at presentation, rapid progression and bone age. For preservation of adult height treatment is given if predicted height, based on bone age, is less than 5 feet in a girl, also bone age should be <12.5 years for treatment effect. Treatment is more beneficial in CPP if onset is < 7 years.

GnRH agonists are given for management of CPP. The choice of the formulation depends on the patient and clinician preference. Depot Inj Leuprolide acetate 3.75 mg monthly or 11.25 mg administered every 3 months is the most commonly used. Doses are increased if needed to achieve adequate suppression.

GnRH agonist therapy is generally considered safe, with no reported significant adverse effects except for local skin reactions and hot flushes.

While on treatment, periodic monitoring is done every 4-6 months for pubertal progression, growth velocity, and skeletal maturation. Clinical indicators of response include slowing of the growth velocity to <7 cm/year and shrinkage or softening of the glandular breast tissue.

Therapy should be discontinued when the patient is at the appropriate age to resume normal pubertal development or when their calculated predicted final adult height is at about their target height or their bone age is more than 12.5 years in girls.

AMBIGUOUS GENITALIA IN YOUNG GIRLS –A MANAGEMENT DILEMMA

Prof Pratap Kumar

HOD Dept of Reproductive Medicine and Surgery

Kasturba Medical College
Manipal Academy of Higher Education
Manipal (Karnataka)

Introduction:

Understanding the basics of physiology is important to arrive at a diagnosis in Ambiguous genitalia in young girls.

SRY gene (Sex determining region of Y chromosome)

The SRY Gene induces male sex determination by producing a protein named the SRY protein. When activated, the SRY protein initiates the determination of unspecified cells into testes during embryonic development. This protein trigger produces a male phenotype and male hormones in mammals.

Sexual development – depends on:

Genetic (Genes)composition, Gonadal (Gonads) differentiation, Genital expression

Sexual differentiation-Duct development

Both sexes start out with two systems:

- Mullerian ducts - will develop into fallopian tubes, uterus, inner vagina
- Wolffian ducts - will develop into epididymis, vas deferens, and seminal vesicles

Reproductive Ducts During the indifferent phase

Two Phases internal genital organs completed by 10 weeks

First Phase – formation of gonads (depends on chromosome) XX - Ovary XY – Male

controlled by TDF (testicular determining factor on Y chromosome) & sex determining genes - in its absence ovary is formed. Hence, presence of Y chromosome is not enough for maleness.

Second Phase – external and internal genital organs develop and continue up to 20 weeks.

Chromosomal sex determines gonadal sex, which determines phenotypic sex. Type of gonad present determines the differentiation/regression of the internal ducts (i.e, müllerian and wolffian ducts) and ultimately determines the phenotypic sex.

Does chromosome alone determine the external genitalia?

Development of external genitalia towards male or female – depends on presence or absence of androgens and its receptors and not on chromosomes. Excess androgens – more towards male even with XX. Normal androgens and absence of receptors – more towards female.

Chromosomal anomalies do not always lead to sexual ambiguity

Turners' syndrome (45XO) or Klinefelters Syndrome (47 XXY) there is no sexual ambiguity of external genitalia. Classical Androgen Insensitive Syndrome (Testicular feminization Syndrome) also there is no ambiguity of external genitalia.

Gonadal factors

Testis produces - testosterone, AMH. Presence of testosterone and absence of AMH - uterus and fallopian tubes in male phenotype and male external genitalia. Deficiency of Leydig cell function- less testosterone – micropenis with cryptorchidism.

CAH

Most common cause of intersex

- 60% of intersex cases
- 1/15,000
- Enzymatic defect

Previous Terminology and Revised Nomenclature of Disorders of Sexual Development

PREVIOUS	REVISED
• Female pseudohermaphrodite	• 46, XX DSD
• Male pseudohermaphrodite	• 46, XY DSD
• True hermaphrodite	• Ovotesticular DSD
• XX male	• 46, XX testicular DSD
• XY sex reversal	• 46, XY complete gonadal dysgenesis

Female genitals will develop if unexposed to embryonic testicular secretion. With testosterone and 5 alpha dihydrotestosterone develops into male genitals.

Sexual ambiguity androgen-mediated

Inappropriate over-exposure to androgens, Deficiency of androgens, Inability to recognize androgens.

Examination of the external genitalia should include the following:

Note the size and degree of differentiation of the phallus, since variations may represent clitoromegaly or hypospadias. Note the position of the urethral meatus.

Labioscrotal folds may be separated or folds may be fused at the midline, giving an appearance of a scrotum. Labioscrotal folds with increased pigmentation suggest the possibility of increased corticotropin levels as part of adrenogenital syndrome. Abnormal findings are phallus size, penis < 2 cm stretched, clitoris > 7 mm, labia/scrotum, fusion abnormalities, rugation, color, gonads palpable in scrotum – invariably testes

Investigations

Karyotype, Fish – presence or absence of SRY, Measures of adrenal and gonadal steriod secretion, 17 OHP, electrolytes, imaging techniques, androgen-receptor levels, 5-Alpha-reductase type II levels.

Based on the karyotype three categories

XX Virilization

XY undervirilization

Mixed chromosome pattern

We all thought that individual sex is determined by the sex chromosomes. People with two X chromosomes are females. People with an X chromosome and a Y chromosome are males. However, sexual development is not quite that simple.

Conclusion:

A proper understanding of the various contributors of external genitalia is important to do further evaluation.

HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY (HIPEC)

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Background

Hyperthermic intraperitoneal chemotherapy (HIPEC), is a technique for delivering a chemotherapeutic agent, in which a heated solution of chemotherapy agent is perfused throughout the peritoneal space. The aim is to target residual disease after cytoreductive surgery (CRS) by directly acting on the cancer cells present on the peritoneal surface.

Rationale of HIPEC-

- Direct cytotoxic effect on cancer cells by the increased production of lysosomes.
- Synergistic effect with anti-mitotic agents which potentiates their action.
- Heat improves the penetration of chemotherapy, leading to the increased sensitivity of tumor cells to chemotherapy and interrupting DNA repair.
- Reducing resistance to cisplatin by decreasing the mechanisms of cellular resistance.
- Immunomodulatory role- improves the immune response against tumour cells by inducing heat shock proteins, activating antigen-presenting cells and lymphocyte migration.

Although the rising body temperature is associated with significant risks, various methods have been developed for raising the temperature of the intraperitoneal cavity with a minimal increase in the temperature of the rest of the body. During HIPEC, heat is applied loco-regionally and the body's core temperature is controlled.

Technique

After resection of all gross disease, the abdominal cavity is initially irrigated with normal saline to remove all particulate matter that may block the outflow circuit and to ensure that there is adequate haemostasis prior to HIPEC delivery. Hyperthermia can be generated by various perfusion systems that are available. These systems include closed circuit pumps, which deliver heated chemotherapy drugs through inflow catheters with drainage accomplished via outflow catheters. HIPEC can be performed using two techniques, the open or coliseum technique and the closed technique.

Open Technique

A big, nonporous synthetic mesh is sewed to the edges of the skin incision, using sturdy suture material like Ethibond and the abdomen is tented up using retractors. The surgeon manually stirs the perfusate in the abdomen for even distribution and adequate exposure of organs to heated chemotherapy. Inflow and outflow catheters are located on the lateral abdominal wall.

Open colosseum Technique- Book-Walter retractor is used to retract the abdominal wall all around and the skin is sutured to the frame. The frame is fixed about 3 to 4 inches above the abdomen. This ensures that there is no spillage of the drug. Once sutured, the abdomen is closed with a clear X-ray cassette dressing with a small opening made in the dressing so as to allow for mixing of the drug. The technician heats the circulating fluid using D5 or NS solution to 40p C to 42p C before injecting the chemotherapy drug.

Closed Technique

In the closed technique, after cytoreduction, the inflow and outflow catheters are introduced into the abdominal cavity through the midline incision. The abdominal incision is sutured ensuring a watertight closure. The abdomen is then instilled with the carrier solution following which perfusion begins. Once the goal temperature of 40p C-42p C is reached, the chemotherapy drug is filled in the reservoir and perfused for

30 to 120 minutes. During the procedure, the abdominal wall may be agitated to facilitate even drug distribution. This can be done by tilting the OT table in various angles, after securely strapping the patient. After the perfusion cycle is complete, the chemotherapy drug is drained through the outflow catheter and the abdomen is then irrigated with normal saline.

Timing of HIPEC

Intraperitoneal chemotherapy is usually performed immediately after cytoreduction. There is uncertainly on whether the complications are increased if done after any gastrointestinal anastomosis. In most centres, HIPEC is preferably performed just prior to closure.

Temperature

The synergistic effect of hyperthermia and intraperitoneal chemotherapy is observed from a temperature of 39°C and thereafter increases linearly. Shimizu et al. found that heat administered intra-abdominally in rats was safe at a temperature of 39°C. However, the application of heat at a temperature of 46°C or 45°C leads to a mortality of 100% and 90%, respectively. Also, 100% survival was found at 44°C. Retrospective studies in humans show that an intra-abdominal temperature above 42°C is associated with a higher complication rate. A general consensus is to attain temperature of 41°C-43°C as the desired level of intra-abdominal hyperthermia.

Duration

The duration of HIPEC varies from 60 minutes to 120 minutes depending on the institutional protocol and other factors like the pharmacokinetics of chemotherapy drugs, patients' cell count, and renal function.

Safety

The morbidity of HIPEC, when combined with cytoreduction, is mainly due to surgical complications such as anastomotic leaks, intra-abdominal haemorrhage and sepsis. Toxicities specific to HIPEC are mainly haematological and renal. Transient bone marrow suppression, anaemia, leukopenia, thrombocytopenia are the frequently reported haematological complications. Acute kidney injury is the most common toxicity when Cisplatin is used for HIPEC. Cisplatin-associated nephrotoxicity can be prevented by using nephro protectants such as sodium thiosulphate.

Role of HIPEC in primary ovarian cancer

Lim et al (2017) conducted a RCT in women with stages 3 and 4 primary ovarian cancer. There was no significant difference found in PFS in the HIPEC versus control groups (43.2% vs. 43.5% at 2 years and 20.9% vs. 16.0% at 5 years; P= 0.569). Five-year OS was also found to be similar in both groups. Van Driel et al (2018) conducted a phase 3 RCT in women with EOC, after three cycles of NACT (N=122). Patients were randomly assigned to receive intraperitoneal cisplatin (100 mg/m2) after an intra-peritoneal temperature of 40°C was achieved with heated saline. 123 women underwent CRS without HIPEC. Patients received an additional three cycles of adjuvant chemotherapy. The median OS rate was 33.9 months and 45.7 months in the surgery and surgery with HIPEC groups, respectively. The median RFS was 10.7 months in the surgery group and 14.2 months in the surgery with HIPEC group. Grades 3 and 4 toxicities were similar in both groups (25% vs 27% in the surgery and surgery with HIPEC, respectively).

Recurrent Ovarian Cancer

Spiliotis conducted the 1st RCT for HIPEC use in recurrent Ca ovary. RCT: Secondary CRS + HIPEC + systemic chemotherapy (n= 60) vs Secondary CRS + systemic chemotherapy (n=60). Mean overall survival: HIPEC: 26.7 months, No HIPEC: 13.4 months (P<0.006), which was significant. It was the first RCT to show survival benefit of adding HIPEC to CRS in the recurrent setting for ca ovary. In the CHIPOR trial (2022), 415 patients with ovarian cancer recurrence were randomized to either undergo surgery with HIPEC or surgery alone. There was significant OS and peritoneal relapse benefit in the HIPEC arm showing promising results.

Consensus guidelines

Most of the guidelines do not recommend HIPEC as first-line therapy. As per ESMO guidelines, HIPEC is not considered a standard of care as first-line treatment and its use should be limited to well-designed RCTs. HIPEC should not be considered as the standard of care or first-line treatment in the management of ovarian cancer. NCCN recommends HIPEC with cisplatin (100 mg/m2) to be considered as an option following interval debulking surgery (IDS) in women with stage 3 ovarian cancer.

ABNORMAL THYROID REPORT - WHEN TO ACT

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The diagnosis of thyroid disease during pregnancy requires an understanding of the changes in thyroid physiology and thyroid function tests that accompany normal pregnancy.

The major changes in thyroid function during pregnancy which influence thyroid function in pregnancy

- There is increase in renal excretion of Iodine
- Increase in thyroid binding proteins under the influence of estrogen
- Increase in thyroid hormone production
- Increase in thyroid stimulating effects of hCG

Following conception circulating Thyroid binding globulin (TBG), total T4(TT4) start increasing by week 7 and peak at 16weeks of gestation and concentration remain high till delivery hCG stimulate thyroid receptor and increase thyroid hormone production and subsequent reduction in serum TSH concentration.

TBG excess leads to both total but not free T4 and T3 production

To maintain adequate free thyroid hormone concentration during this period, thyroxine (T4) and Tridothyroxine (T3) production by thyroid gland must increase.

Levels of T4and T3 rise by approximately 50% during first half of pregnancy, plateauing at approximately 20weeks of pregnancy. That time a new steady state is reached.

Serum hCG concentrations increase soon after fertilization and peak at 10 to 12 weeks. During this peak, total serum T4 and T3 concentrations increase. Serum free T4 and T3 concentrations increase slightly, usually within the normal range, and serum TSH concentrations are appropriately reduced. However, in 10 to 20 percent of normal women, serum TSH concentrations are transiently low or undetectable. This transient, usually subclinical, hyperthyroidism should be considered a normal physiologic finding. It is not known if this action of hCG benefits the mother or fetus. Later in pregnancy, as hCG secretion declines, serum free T4 and T3 concentrations decline and serum TSH concentrations rise slightly to or within the normal range.

As per the Indian thyroid association, trimester specific recommended TSH reference range is as follows- First trimester—2.5mIU/L, Second and third trimester -3.0mIU/L. According to American thyroid association (ATA), locally derived trimester and population specific reference ranges should be used. In the absence of trimester specific normal ranges ATA suggest the following for interpretation of thyroid function tests

From weeks7-12, reduce the lower limit of reference range of TSH by approximately 0.4mIU/L and upper limit by 0.5mIU/L and reference range for TSH approximately 0.1-4mIU/L

In second and third trimester, there should be a gradual return of TSH towards the nonpregnant normal range.

Assessment of thyroid function in pregnancy—While evaluating thyroid tests TSH and T4 is measured. If the test shows subclinical disease then test is repeated in couple of weeks to confirm the abnormality as finding may vary even when using pregnancy –specific reference range

Interpretation of abnormal Thyroid reports -

Normal TSH—If TSH is between 0.1-2.5mIU/L, no further work up is needed

Low TSH— If TSH is <2.5th percentile or<0.1mIU/L get free T4 and T3 level done. If levels exceed trimester specific normal reference range or total T4 and T3 exceeds 1.5 times the nonpregnant range. The biochemical diagnosis of overt hyperthyroidism is confirmed in the presence of suppressed or undetectable serum TSH and inappropriately elevated TT4/FT4 or T3

But if free T4 and T3 are with in normal range or total T4and T3 are less than 1.5 times than then the nonpregnant range it is labeled as Subclinical hyperthyroidism.

Diagnosis of the cause of disease is essential in any patient with thyrotoxicosis.In early pregnancy differential diagnosis is between Graves' hyperthyroidism and gestational transient thyrotoxicosis mediated by Hcg .In both cases common clinical manifestation include palpitation ,anxiety ,tremor and heat intolerance. A careful history and physical examination is of utmost importance in establishing the etiology. No prior history of thyroid disease and symptoms of emesis favour the diagnosis of gestational transient thyrotoxicosis.

If other causes of thyrotoxicosis are suspected, measurement of TRAb is indicated. Serum T4 is disproportionately elevated more than T3 in cases of thyrotoxicosis caused by direct thyroid hyperactivity. In comparison T4 tend to be disproportionately elevated beyond T3when thyrotoxicosis is caused by destructive process such as thyroditis

Treatment –hCG mediated hyperthyroidism is usually transient and only supportive therapy is indicated and does not require treatment with antithyroid drugs

A good maternal and fetal outcome depend on controlled hyperthyroidism and treatment with Antithyroid drugs like thionamide is required only for grave's disease. Goal of treatment is to reduce and maintain maternal free T4 concentration in the higher normal range with lowest dose and free T4 and total T4 to be repeated at 4 weeks interval.

High TSH— Elevated TSH between 2.5-10mIU/L or as per population and trimester specific reference range or if reference range is not available then more than 4.0mIU/L.

If TSH is elevated, but freeT4 is normal it is subclinical hypothyroidism. But whether to start treatment or not depends on presence of thyroid antibodies. Thyroid peroxidase Antibodies (TPOAb) are tested. If positive consider treatment with Levothyroxine. If TSH is upper limit of reference range i.e 10mIU/L, treatment with levothyroxin is recommended.

If TPOAb negative and TSH value is 2.5 mIU/L-upperlimit of reference range –No treatment is required. And if TSH is upper limit of reference range -10mIU/L-Consider treatment with levothyroxine

If TSH is more than or equal to 10mIU/L, then it Overt Hypothyrodism. In these cases there will be decreased free T4 concentration. The most common cause of hypothyroidism during pregnancy is chronic autoimmune thyroditis

Treatment in these cases –An optimal maternal and fetal outcome depend upon treating maternal hypothyroidism with Thyroid hormone (T4). The goal of treatment is to maintain maternal TSH in the population and trimester specific reference range. If local reference range not available then between 0.1-4.00mIU/L.

If a known case of hypothyroid conceives, then dose of Thyroxine is increased by 30 % in pregnancy and may increase up to 50% and it should be increased by as early as 5th weeks

In woman who are Euthyroid but have TPOAb positive with prior history of pregnancy loss may be

considered for Levothyroxine in the dose or 25-50 microgram daily

Conclusion- There is insufficient evidence to recommend for or against universal screening for abnormal TSH concentration in early pregnancy. All pregnant women should be verbally screened at the initial prenatal visit for any history of thyroid dysfunction and prior or current use of either thyroid hormone or antithyroid medication, age more than 30years, obesity, history of pregnancy loss, preterm delivery, family history of autoimmune thyroid disease, diabetes mellitus. Accordingly should be subjected to Serum TSH and depending on the value as per trimester specific, should be interpreted and depending on that further testing for T4and T3 or thyroid antibody testing to be advised and treatment to be advocated as per discussed above in the text

EPILEPSY: WHAT ALL OBSTETRICIANS SHOULD KNOW?

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Infertility affects 7.1% of women not using antiepileptic drugs (AEDs), 31.8% treated with monotherapy, 40.7% treated with two drugs, and 60.3% treated with three or more AEDs .

Incidence: 0.3–0.5% of women giving birth suffer from epilepsy.

A woman planning pregnancy should take folic acid (5 mg/day) 3 months before & during the first trimester of pregnancy. Discontinuation of medication may be considered in women after a three-year seizure-free period .

Pregnant women who have had seizures a year before conception require increased monitoring of their epilepsy treatment. With the planned pregnancy, seizures are less frequent, treatment is more often managed with a single drug, and Valproic Acid is used less frequently .

The occurrence of at least two epileptic seizures for the first time in life, or the recurrence of epileptic seizures after a long break, is an indication to initiate AED therapy during pregnancy. The risk of congenital malformations in children of women with epilepsy not using AEDs is found in the range of 1.1–3.3% and is similar to the risk of malformations in the general population

(2.1–2.9%) .

The risk of congenital defects in children of women with epilepsy and using AEDs is 4–9% and increases with Valproic Acid and polytherapy. Levetiracetam and Lamotrigine are considered safe for pregnancy. Mechanisms of foetal congenital malformations include: **conversion of AEDs to toxic, unstable metabolites** and folic acid deficiency with subsequent increase in homocysteine levels .

The most commonly reported congenital malformations in children of women using AEDs are: cleft palate, neural tube defects, skeletal abnormalities, and congenital heart and urinary tract defects. Phenobarbitone seems more likely to induce the development of heart defects than phenytoin (PHT) or Carbamazepine. The use of Valproic Acid is found to be associated with an increased incidence of spina bifida, cleft palate, cardiac abnormalities, and hypospadias, among other things]. The occurrence of cleft palate is more frequently observed with the use of Phenobarbitone, Valproic Acid, or TPM. The children of mothers using Valproic Acid during pregnancy were also found to display a higher incidence of autism spectrum disorders (ASD) and attention-deficit hyperactivity disorder (ADHD) symptoms. Serum concentrations of most AEDs may fluctuate in pregnancy due to changes in pharmacokinetics during absorption, metabolism, or excretion.

It has been found that concentrations of Lamotrigine, Levetiracetam, or Oxcarbazepine in pregnant women can decrease by up to 30–50%. Lower drug concentrations may lead to intensified seizures. It is therefore

recommended to monitor the serum levels of these drugs before pregnancy and at least once during each trimester of pregnancy and additionally in special situations such as lack of seizure control or the occurrence of adverse symptoms.

Antenatal Care during Pregnancy: During antenatal period, there is higher risk of spontaneous miscarriage, antenatal haemorrhage, hypertension-related disorders, foetal stunting, premature birth, need for induction of labour, caesarean section, and postpartum haemorrhage. AEDs that are inducers of hepatic enzymes, such as Carbamazepine, Phenytoin, Phenobarbitone, primidone (PRM), Oxcarbazepine, Topiramate, are competitive inhibitors of prothrombin precursors, posing a risk of haemorrhage into body cavities and brain in neonates.

To reduce this risk, it is recommended that pregnant women using AEDs, that induce hepatic enzymes, be given vitamin K at a dose of 20 mg per day during the last two weeks before delivery, and that 1 mg of vitamin K be given to the new-borns.

Delivery of Women with Epilepsy: There is no indication for earlier delivery in women with epilepsy without obstetric risk factors whose seizures are well controlled. Caesarean section may be considered for a small percentage of women with a significant increase in seizures, cluster seizures, and a high risk of status epilepticus. Administration of AEDs should be continued during labour. If they cannot be administered orally, parenteral administration should be an alternative (Valproic Acid, Levetiracetam, Phenytoin may be administered intravenously).

Adequate hydration and pain relief through epidural anaesthesia reduce the risk of a seizure during labor. Early epidural anaesthesia can minimize risk factors for seizures during labor, such as hyperventilation, sleep deprivation, pain, and stress.

Postpartum in Women with Epilepsy: Due to increased stress, lack of sleep, anxiety, and missing an AED dose, the immediate period after birth involves a high risk of more frequent seizures. Mothers should be supported in the postpartum period to minimize risk factors for seizures; in particular, they should be ensured a continuous 4–6 h period of sleep. If a drug dose had been increased during pregnancy, then the drug concentration should be determined within 10 days postpartum and the dose reduced accordingly to avoid postpartum toxicity.

Breast Feeding: Women with epilepsy taking AEDs during pregnancy should be encouraged to breastfeed. Breastfeeding is safe and should be recommended for the period of at least 6 months, preferably 12 months.

Drugs considered **safe** include: Phenytoin, Valproic Acid, Carbamazepine.

Drugs considered **moderately safe**: Lamotrigine, Oxcarbazepine, Levetiracetam, Topiramate, Gabapentin, Pregabalin, vigabatrin, Tiagabine.

KEYNOTE ADDRESS

INTERVENTIONS IN HIGH ORDER MULTIPLE PREGNANCIES

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Introduction

ART have revolutionized obstetric practice. Many infertile couples have benefited by begetting children and some of them have also faced many challenges like high order pregnancies and complications related to them are maternal complications like preeclampsia, anemia, pre term deliveries, gestational diabetes. Labor difficulties. Post-partum hemorrhage n last but not the least psychological disturbances in a woman. Fetal and neonatal complications include may be higher incidence of abortion, Congenital malformations, pre-term birth with associated morbidity n mortality.

In 2006 International Federation of Gynecologists and Obstetricians (FIGO) Committee Report stated that "multiple pregnancies of an order of magnitude higher than twins involves great danger for the woman's health and also for her fetuses, which are likely to be delivered prematurely with a high risk of either dying or suffering damage," and that "where such pregnancies arise, it may be considered ethically preferable to reduce the number of fetuses rather than to do nothing".

Thence came the need for iatrogenically reduction of one or more fetuses in high order pregnancies to twins with the aim of improving perinatal outcomes of the surviving fetus. This procedure has become both clinically and ethically accepted as therapeutic option in high order pregnancy.

Fetal Reduction

Fetal reduction was an approach developed by the genetic researchers who were actively involved in the human genome project. Berkowitz and colleagues described this technique as the medical justification for performing multifetal pregnancy reduction Is philosophically similar to lifeboat analogy where it is justifiable to sacrifice some innocent fetal lives to increase the chances of survival or decrease the risk of serious morbidity in the survivors of the procedure.

Moral, religious, social, cultural and economic factors all play a role in understanding the ethical principles and weighed by a given women in her unique decision-making process.

Methods of Reduction:

Fetal reduction can be done using different techniques under ultrasound guidance. Different approaches like transabdominal, transvaginal or transcervical route can be taken.it depends on the expertise of the clinician and his or her comfort.

Mechanical Trauma:

Here by transvaginal route as early as 7-8 weeks,25cm long needle is taken which is attached to a 20ml syringe. The tip of needle is placed in close contact of the fetus to be reduced and brief suction is applied till complete cessation of cardiac activity of the embryo.

Disadvantage: Although reducing quiet early may be psychologically more acceptable but the anomalous fetus cannot be ruled out.

Aspiration:

Martene Duplan described this procedure in 1980s.

Under lithotomy position, using abdominal probe, vaginal approach is taken, using sims speculum, expose the cervix, catch hold of the cervix with tenaculum and it is dilated with hegar's dilator, the embryo located near internal Os is then aspirated with a brisk suction using Karman's canula attached to 20ml syringe

manually.

Drawback: although can be done early at 9 weeks unfortunately screening for fetal abnormalities is not possible, secondly, significant bleeding per vaginum can occur due to dilatation of cervix, thirdly, rate of abortion is higher.

Needling:

Earlier Air, Saline, mechanical trauma was used but they altered the quality of sonographic image which was not successful.

Nowadays Pharmacological Agent-Potassium chloride is commonly used in fetal reduction. When injected in fetus it causes asystole followed by slowing and complete cessation of fetal heart.

Termination

Termination of the entire pregnancy has generally not been acceptable to women, especially for those with a past history of infertility. Attempting to continue with all the fetuses is associated with inherent problems of preterm birth, survival and long-term morbidity. The other alternative relates to reduction in the number of fetuses by selective termination. The acceptability of these options for the couple will depend on their social background and underlying beliefs.

	Number (n)	Outcome immediate loss	Late loss	Preterm delivery	Term delivery
No. of MFPR	148				
No of Quads to twins	09	01 (11.1%)	-	02 (22.2%)	06 (66.6%)
No. of Triplets to twins	135	17 (12.5%)	12 (8%)	27 (28.1%)	67 (69.7%)
No. of twins to singletons	04	01 (25%)	-	01 (25%)	02 (50%)

Fig 1

Selective Reduction:

It is somewhat different than multifetal reduction wherein the fetus to be reduced is chosen based on the technical consideration, the one which is easily accessible to intervene.

It is usually done wherein the fetus shows some congenital anomaly either on ultrasonography or any prenatal diagnostic procedure. At times, the fetus showing lesser growth than other fetusesis selected to be reduced.

Conclusion:

Fetal Reduction is one of the invasive procedures to reduce higher order pregnancy in view of reducing long term complications related to multiple pregnancies and improving the perinatal outcome of surviving fetus and reducing perinatal morbidity and mortality. However, the best solution would be to optimize assisted reproductive technologies and minimize multiple pregnancy rate.

Other Interventions

Complications specific to Monochorionics…

Challenges arise from the shared placenta and vascular placental anastomosis that are almost universal and

connect fetal circulation of both twins

- Twin-Twin Transfusion Syndrome (TTTS)
- Twin Reversed Arterial Perfusion (TRAP Sequence)
- Twin Anaemia Polycythemia sequence (TAPS)
- Single Intrauterine demise
- HOMP
- Selective single twin FGR
- Conjoint twins
- Increased malformation rates
- Increased placental vacular abnormality

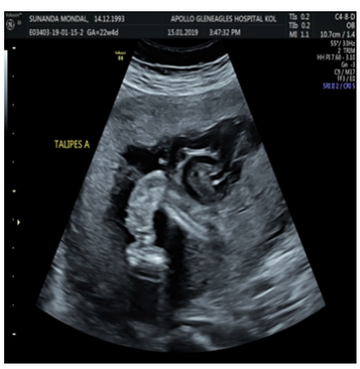

Fig 2

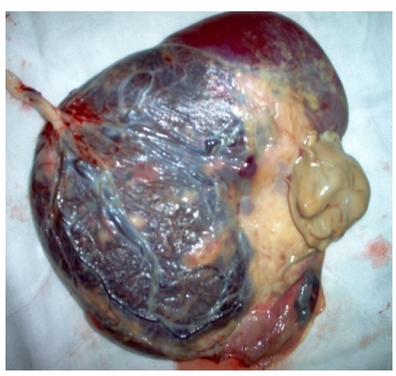

Fig 3

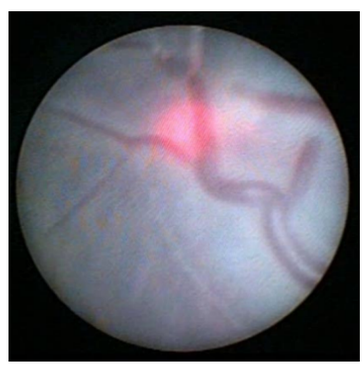

Fig 4

IS THERE A TTTS Staging

- Stage 1: donor bladder visible, EDF positive in both vessels in both fetuses.
- Stage 2: donor bladder not visible, EDF positive in both vessels in both fetuses.
- Stage 3: EDF absent or reversed in either vessel in either fetus.
- Stage 4: presence of ascites or hydrops in either fetus; usually the recipient

Monitoring and management of TTTS

- Although Quintero staging does not always predict accurately outcome or chronological evolution of TTTS, it remains the classification system of choice
- In monochorionic twin pregnancy, screening for TTTS should start at 16 weeks, with scans repeated every 2 weeks thereafter
- Monochorionic twin pregnancies with uncomplicated amniotic fluid discordance can be followed up on a weekly basis to exclude progression to TTTS
- Laser ablation of anastomotic vessels is the treatment of choice for TTTS at Quintero stages II and above
- Conservative management with close surveillance or laser ablation can be considered for Quintero stage I
- When laser treatment is not available, serial amnioreduction is an acceptable alternative after 26 weeks' gestation

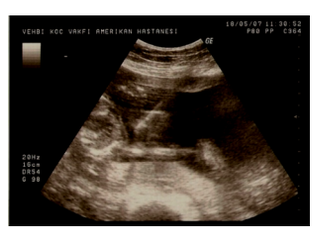

Fig 5

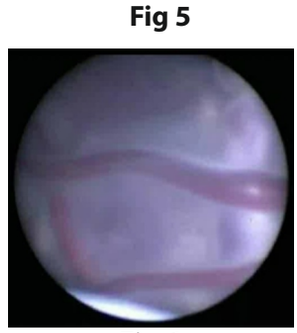

Fig 6

Twin Anaemia Polycythemia sequence TAPS

- Occurs spontaneously in MCDA twins is up to 5%. However, it may complicate up to 13% of cases of TTTS following laser ablation
- TAPS is believed to be due to the presence of miniscule arteriovenous anastomoses (< 1 mm) which allow slow transfusion of blood from the donor to the recipient, leading to highly discordant hemoglobin concentrations at birth
- The prenatal diagnosis of TAPS is based on the finding of discordant MCA Doppler abnormalities, including MCA-PSV > 1.5 multiples of the median (MoM) in the donor, suggesting fetalanemia, and MCA-PSV < 1.0 MoM in the recipient, suggesting polycythemia.
- The commonest options of treatment include conservative management, early delivery, laser ablation or intrauterine blood transfusion (IUT) for the anemic twin, combined IUT for the anemic twin and partial exchange transfusion to dilute the blood of the polycythemic twin

TRAP sequence

- TRAP sequence is a rare complication of monochorionic twin pregnancy (1% of monochorionic twin pregnancies and 1 in 35000 pregnancies overall).
- It is characterized by the presence of a TRAP or acardiac mass perfused by an apparently normal (pump) twin
- The perfusion occurs in a retrograde fashion through arterioarterial anastomoses, usually through a common cord insertion site
- Cord coagulation, cord ligation and photocoagulation of the anastomoses, as well as intrafetal methods, such as RFA and intrafetal laser therapy, are performed as a means of preventing the demise of the pump twin.
- The survival rate of the pump twin using these treatment modalities is approximately 80%.

Conclusion

Can we do Invasive procedures in multiple pregnancy

- Indications as in Singletons: Advanced maternal age Positive screening test Anomalies Balanced translocation
- Special indications in twins: Therapeutic procedures

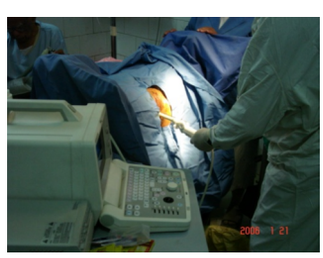

Fig 7

Diagnostic

- CVS
- Amniocentesis
- Fetal Blood sampling

Therapeutic

- Amnioreduction
- Cord ligation
- Laser ablation
- Interstitial laser
- Radiofrequency ablation
- Selective fetal reduction

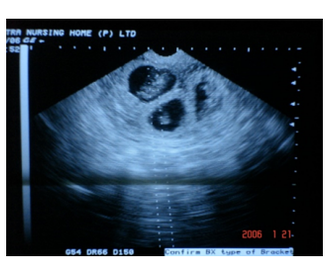

Fig 8

HIGH ORDER MULTIPLES ROLE OF EMBRYO REDUCTION WHY REDUCE?

Maternal complications

Higher risks of Mechanical side effects

- Anaemia
- Preterm labour requiring tocolysis
- Hypertensive disorders
- (12.7% vs 6.5% in singletons)
- Severe Pre-eclampsia, Eclampsia, HELLP
- DIC
- Acute renal failure
- Gestational diabetes
- Postpartum haemorrhage
- Instrumental delivery
- Caesarean delivery
- Thromboembolism

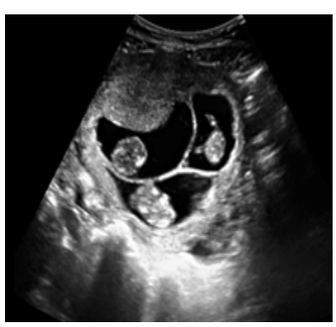

Fig 9

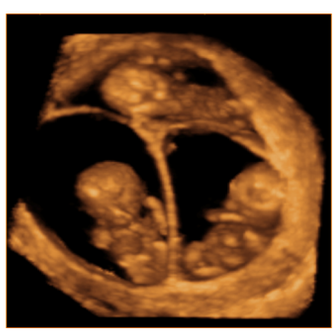

Fig 10

Maternal complication	Singleton Pregnancy	Multiple Gestation
Preeclampsia & Hypertensive Disorders of pregnancy	6%	13%
Placental abruption	0.8%	2%
Urinary Tract Infections	6.7%	8.7%
Anemia	4%	9%
Gestational Diabetes	3%	22%-39%
Post-term gestation	4%	<1%

Fig 11

Take home message

- Multiple pregnancies, especially twins on the rise.
- Chorionicity, most important determinant of outcome and hence detailed First Trimester scan
- Early Detection and Timely referral in Monochorionic pregnancies.
- Ultrasound monitoring and Doppler assessment are the most important tools in the management
- Delivery (34-36 weeks in DCDA and 32-34 weeks in MCDA twins) in a centre with adequate neonatal back up.

DETORSION FOR ALL OVARIAN TORSIONS DESPITE AGE?

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Ovarian torsion refers to the twisting of the ovary alone or with fallopian tube, along the axis of their vascular pedicle. This presents as a gynaecological emergency accounting for 2.7 % of casualty admissions, mostly affecting reproductive age women. Although prepubertal girls, young women and post-menopausal females can also be affected but the diagnosis in such cases becomes even more challenging, especially in emergency settings. As the degree of vascular occlusion progresses, unrelieved torsion is followed by haemorrhagic infarction and delay in diagnosis can result in loss of ovarian function. Patients usually present with vague abdominal symptoms or sometimes may present with excruciating acute pain abdomen not responding to analgesics, often accompanied by nausea or vomiting.

Risk factors

It can be seen at any age but most commonly seen in women of reproductive age group at around 30 year of age group. Age wise distribution shows that 16% of all occurrences seen in neonatal age group mostly diagnosed prenatally, 15% occurring in teenager. The length of the ovarian ligament is correlated with the risk of ovarian torsion. Torsion is about 1.5 times more likely to occur on the right ovary than the left. One reason may be because the right ovary is near relatively mobile structures-the cecum and ileum-while the left ovary is near the sigmoid colon which is comparatively immobile. Other risk factors include ovulation induction, ovarian hyperstimulation syndrome, and polycystic ovarian syndrome.

Imaging

Ultrasound is considered to be the most reliable method but shows highly variable appearance for a torsed adnexa. Most frequent findings are that of an enlarged, oedematous ovary with peripherally arranged follicles. Compromised arterial flow may be observable through abnormal Doppler tracings-although normal Doppler tracings do not exclude torsion, as abnormalities are only observed in about half of all cases. The 'whirlpool sign' is another sonographic finding that may be present, although it cannot be reliably obtained in all cases. Ovarian perfusion may or may not be compromised and presence of perfusion within the ovary does not exclude the diagnosis, hence, misleading the clinician in most of the cases.

Current Management

Traditionally, due to the hypothesized risk of thromboembolism and risk of peritonitis secondary to necrotic ovaries in abdomen, salpingo-ophorectomy was considered the standard treatment option for treating ischemic looking adnexa. But now, conservative treatment is preferred method and is supported in many studies reported in literature which stress on preserving the ovaries despite their grossly necrotic appearance and favour detorsion whenever, future fertility is desired. In a case series by Parelkar SV et al they reported that even in ovaries looking brown or black intraoperatively three quarters of patients had promising results of good vascularity and follicular development on follow up ultrasounds.

Aziz D. et al. and Ziv Tsafir et al. in their retrospective studies compared the results of conservative surgery and oophorectomy in the management of ovarian torsion and the studies concluded that detorsion should be the preferred treatment for the majority of cases of ovarian torsion in children. The best course of treatment for ovarian torsion in premenarchal children is specifically detorsion, followed by cystectomy or ophoropexy. American College of Obstetrics and Gynaecology (ACOG) recommends a minimally invasive approach followed by detorsion and preservation of adnexal structures regardless of the appearance of the ovary. Oophorectomy is recommended when it is unavoidable, such as the necrotic ovary falls apart.

Conclusion

Diagnosis of ovarian torsion is a difficult and challenging task. High index of clinical suspicion is essential. Ultrasound with Doppler helps in diagnosing adnexal mass with torsion. Surgery is the mainstay of diagnosis and treatment once torsion is suspected. Laparoscopy is not only useful for diagnosis, but also for treating

torsion with less morbidity. Conservative surgery is preferred for young girls and women in the reproductive age group.

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GENITAL AESTHETICS: IS THERE A LIMIT (AGAINST THE MOTION)

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The Natural cycle of female development and geographical ages of woman have been long described since WWII. The universal standards of beauty have been well known as complexion, symmetry and youth which ae nothing but blatant display of reproductive mate value. The pressure to live up to UNREALISTIC appearance ideas profoundly shape lives of girls & young women. The very premise of FGCS is fallacious as on one hand FGM is being condemned across the globe but FGCS is being promoted left, right and center. The hay wired indications with nonmedical terminology is nothing but an advertising gimmick exploiting the very psychology of the already distressed women. FGCS is a pandora box of problems with unreported complications , lack of standardized protocols for evaluation, lack of legislation, cosmetic company funding, and above all, no whatsoever evidence attached to endorse it. To conclude "At the present time, the field of female cosmetic genital surgery is like the old Wild, Wild West: wide open and unregulated"

FOTHERGILL OPERATION FOR POP IN YOUNG WOMEN: IS IT STILL RELEVANT (AGAINST)

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Treatment modalities for uterine prolapse are complex, and they include nonsurgical procedures (such as pelvic floor exercises and placement of pessaries) and surgical procedures (such as vaginal hysterectomy, the Manchester operation, anterior and/or posterior colporrhaphy, and Hysteropexy). This poses a dilemma in younger women, where hysterectomy may be considered too radical for this indication. However, a question that needs to be answered is whether Fothergill – Manchester repair should even be offered to these young women who may want to retain their reproductive potential in future. Amputation of cervix a critical step of this surgery poses a great threat not only to future child bearing but also leads to other complications like cervical stenosis (as high as 11.7%), recurrence of prolapse (4-6%), reoperation rates (21% in 6-12 years post surgery). With other effective modern uterine conserving surgical options like sacrohysteropexy, hystero pectopexy (abdominal), Sacrospinous hysteropexy: transvaginal, Uterosacral hysteropexy: transvaginal, transabdominal (open, laparoscopic, robotic) why should we resort to a historical surgery.

COMPLICATIONS OF HYSTEROSCOPY – CASE SCENARIOS

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Diagnostic and Operative hysteroscopy are relatively safe procedures. Majority of complications occur due to ignorance of contraindications, poor surgical techniques, inadequate knowledge and wrong application of instruments (Table 1). Diagnostic procedures have lower complications than the operative procedures (0.13% vs 0.95%). Overall complication rate for operative hysteroscopy is 2%. The greatest risk of complications occurs with adhesiolysis (4.48%), followed by endometrial resection (0.81%), myomectomy (0.75%), and polypectomy (0.38%)

Case 1 A 28-year-old woman with Primary infertility,was posted for diagnostic hysterolaparoscopy,her Gynecologist failed to perform the diagnostic hysteroscopy at first attempt and on second attempt a false passage was created.

When a hysteroscope cannot be negotiated through the cervical os and the procedure is abandoned is called failed hysteroscopy. Failures occur due to acutely flexed uterus or cervical stenosis.

Acutely Anteflexed uterus; Place a long-bladed, open-sided speculum deep in the anterior or posterior fornix to push the fundus to the midposition,which can facilitate dilation. Speculum can be removed once,hysteroscope is inserted.

Acutely Retroflexed uterus: Place a tenaculum on the posterior lip of the cervix and apply traction, which straightens the cervical canal

Cervical stenosis: Preoperative cervical priming with misoprostol or hygroscopic dilators (dilapan S) or intracervical injection of vasopressin solution (4 IU in 100 cc sodium chloride) at the 4 and 8 o'clock positions. Use mini hysteroscope, try to hydrodilate the canal or make a cruciate incision at the site of os with needle electrode or scissors and incise through stroma until the canal is seen or pass USG guided lacrimal duct probe or spinal needle no.20.

Case 2 A 29 years, multiparous woman was undergoing hysteroscopic myomectomy for a 3 cm grade 2 fibroid, suddenly vision turned RED and nothing can be visualized?

Rule out perforation first, electrocoagulation with wire loop or roller ball can be done if bleeding point is visible. If bleeding point is not visible and is excessive then abandon the procedure and consider the following options:

Hemostasis via balloon tamponade: Insert Foley's catheter and inflate bulb with 30 cc saline

Uterine Packing: ½ inch roller gauge soaked in dilute vasopressin solution 20 U (1 ml) in 60 ml normal saline

Case 3 24 years old P0A4 was undergoing hysteroscopic septal incision for partial septate uterus and suddenly surgeon discovered collapse of uterine cavity while operating with previous good visibility, hysteromat pump was working fine but there was consumption of large quantity of irrigation fluid?

Simple perforation by dilators – observe, discontinue further procedure as adequate distension is not possible and repeat hysteroscopy after 2-3 months

Scissors or Complex perforation by thermal energy - Laparoscopic evaluation of bowel injury. If bowel injury is not identified then close observation for 2 weeks must be done to rule out delayed perforation.

Case 4 A 32 years old P1L1, known case of chronic renal disease, underwent hysteroscopic adhesiolysis for severe Asherman's syndrome (saline was used as distension media, her BP was normal during postoperative period but developed repeated episodes of vomiting, headache and blurring of vision.

Hypotonic Fluid Overload

management of symptomatic hyponatraemia -

Multidisciplinary involvement - Anaesthetists, Physicians and Intensivists in ICU

Strict fluid balance during intraoperative & postoperative period

Urinary catheterization & input - output charting

Frequent (hourly) oxygen saturations, electrolytes, calcium, urea and creatinine monitoring

Echocardiogram and chest X-ray (If signs of cardiac failure or pulmonary oedema)

100 ml bolus of 3 % saline over 10 min & repeat upto 3 times followed by, slow iv infusion of 3 % hypertonic sodium chloride infusion (typically 1–2 mmol/l/h to prevent pontine myelinolysis) until serum Na+> 125 mmol/l

[Prevention - Monitoring fluid deficit every 10 min & at the end of each fluid bag used]

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SCAR ECTOPIC: UPDATE IN MANAGEMENT OPTIONS

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Rising rates of cesarean delivery worldwide have resulted in increasing numbers of pregnant women with a cesarean section (CS) scar. Pregnancies occurring after cesarean delivery are considered to be at high risk for cesarean scar pregnancy (CSP), low-implanted and invasive placenta (placenta accreta spectrum (PAS), failure to progress during labour, and uterine dehiscence or rupture in the second or third trimester of pregnancy. A CSP occurs when the pregnancy implants on the uterine scar or in the niche after a previous CS. Although a CSP is often considered for pregnancy termination, some cases have reportedly progressed towards an intrauterine pregnancy and resulted in viable births. Determination of the exact location of the gestational sac (GS) and invasion of the placenta is necessary to estimate the patient's risk and advise whether to terminate or continue the pregnancy. However, there is no uniform reporting system for CSP.

Two-dimensional (2D) B-mode transvaginal ultrasound (TVS) alone or in conjunction with three-dimensional (3D) ultrasound and colour Doppler has been generally considered to be the gold standard for the diagnosis of CSP. Some authors have also described the use of magnetic resonance imaging (MRI). However, there is no standardized guideline on how to locate the GS in relation to the CS scar in early pregnancy by using ultrasound. Early detection is key and requires a high index of suspicion, strict diagnostic criteria, and properly trained experienced sonographers. Several classification systems for cesarean scar ectopic pregnancy have been proposed so far. However, these classification systems do not present quantitative ultrasonographic measurements based on risk factors for intraoperative haemorrhage during treatment and do not suggest specific clinical treatment options based on classification type. Management of CSP should be discussed in a multidisciplinary team including minimal invasive surgeons, the accreta team, and interventional radiologists. Treatment of CSP is challenging. Currently, the recommendation is to offer early termination of pregnancy because of the potential risks of continuing the pregnancy. Current treatment options include hysteroscopic-guided suction evacuation, laparoscopic-guided suction evacuation, laparoscopic-guided vaginal repair, methotrexate medical treatment or laparotomy in cases of life-threatening haemorrhage.

INDUCTION PROTOCOLS FOR SAFE VBAC: A NEED OF THE HOUR

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The current evidence favours trial of labor after one caesarean in the absence of any other contraindications, recognizing that risks with both trial of labor after cesarean (TOLAC) and elective repeat cesarean section (ERCS) birth are relatively uncommon. Women should be informed of 2-3fold increased risk of uterine rupture & around 1.5fold increased risk of cesarean delivery in induced or augmented labour compared to spontaneous VBAC.

Induction of labour (IOL) following a previous caesarean needs a shared decision making based on the current available evidence. The approach, however, needs to be tailored, taking into account the individual's history, initial examination and response to the ongoing process of induction to optimize the maternal and foetal outcomes. The current recommendations are for a planned VBAC in a suitably staffed and equipped birthing suite with continuous intrapartum care and monitoring, with resources available for immediate

caesarean section and advanced neonatal resuscitation. When IOL is performed in women with prior caesarean, it is important to understand what factors can predict a successful outcome.

Induction of labour using mechanical methods (Foleys catheter/amniotomy) is associated with decreased risk of scar rupture compared to induction with prostaglandins. RCOG

Low dose PG E2 is a safe option for induction of labour in women undergoing VBAC with no appreciable increase in rates of uterine rupture or maternal & perinatal morbidity. RCOG

There is insufficient evidence available to recommend a regimen of misoprostol for use at more than 26 weeks' gestation in women who have had a previous cesarean or transmural uterine scar. FIGO Misoprostol use after previous caesarean section is associated with a high rate of uterine rupture; according to international guidelines it is therefore contraindicated in this setting. However, the evidence basis for this recommendation comprised of case reports, one randomized trial that was discontinued prematurely, and numerous low quality retrospective data analyses published between 1997 and 2004. New insights into e.g. resorption kinetics, dosage and application intervals, dose dependant uterine hyperstimulation rates, as well as increasing clinical experience with misoprostol have leads to a critical reappraisal of these "historical" studies. According to the evidence supporting a ban on vaginal and particularly oral misoprostol for labour induction in the context of a scarred uterus is currently insufficient for a convincing guideline recommendation.

Wall strometal 2018 compared three methods (balloon catheter, vaginal PGE2 gel, oral PGE1) for IOL in women with unfavourable cervix and previous one CD. [Group 1-PG E2 gel - 1-2 mg given vaginally, assessed after 6 hours, maximum three doses (6 mg). Group 2- PGE1 – 200 µgm dissolved in 20 ml water to make 2.5 ml with 2.5ugm - 2.5 ml given orally every 2 hours up to max eight doses or 200µgm in 24 hrs. Group 3- balloon inserted beyond internal os, inflated with 50 ml sterile water, catheter was stretched every 30 minutes, kept for maximum 10 hours]

They found that 3% induced women had uterine rupture (2% with orally administered cytotec, 2.1% with balloon catheter, 5% with PG E2 gel). They concluded that orally administered Cytotec & balloon catheter had a high success rate of vaginal delivery (70%) despite an unfavourable cervix.

Lelaidieretal 1994 evaluated efficacy & tolerance of mifepristone for labor induction after a previous CD. They administered 200 mg on day 1& 2 and concluded that drug is safe & useful with no adverse effect on fetus and mother.

Anda PetronelaRadanetal 2017 studied the safety & efficacy of balloon catheter vs oxytocin for labour induction after CD. They had used balloon catheter in patients with Bishop's score <6 and intact membranes; oxytocin in patients with Bishop's score > 6 &/ premature rupture of membrane. They detected vaginal delivery success rate of 45.8% in catheter group and 63.9% in oxytocin group. Previous vaginal birth was an independent predictive factor for successful vaginal delivery in both groups. Neonatal admission was less likely with oxytocin. Uterine rupture occurred with similar frequency in both the groups.

Multiple induction techniques and protocols are available for use, the optimal method for a patient needs to be individualized. In terms of comparing the outcomes of one technique with another, there is limited evidence of the established superiority or inferiority of one method over the other. Cochrane reviews aiming at the comparison of different methods of IOL in pregnancies with prior caesarean section do not provide any definite conclusions.

Although spontaneous labour is associated with the lowest risk of complications, awaiting the onset of spontaneous labour beyond 40 weeks may be associated with a lower likelihood of a successful vaginal birth and increased risk of adverse pregnancy outcomes. IOL at 39 weeks but no later than 41 weeks should therefore be considered.

ORATION

BREAST CANCER – EVERY PINK RIBBON MAKES A DIFFERENCE

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Collaboration between gynecologist and oncologist is essential for comprehensive care and prevention of breast cancer.

Breast cancer has ranked number one among Indian females. Statistically significant increase has been seen (1982-1014) in all population based cancer registries. 179,700 women in India developed breast cancer in the year 2020.

Mortality to incidence ratio was found as high as 66 in rural registries whereas it was as low as 8 in urban registries. Besides young age has been found as a major risk factor for breast cancer in Indian women.

Mortality from breast cancer in the west has come down partly due to early detection (thanks to better health awareness and availability of breast cancer screening programmes) and advances in treatment options.

Mammography as per guidelines is still the gold standard screening procedure. Breast self examination and clinical breast examination does downstage the disease and should be encouraged. Timely detection is vital. Newer screening procedure like advanced thermography and breast screening though simpler, easier and cost effective has not replaced mammography.

Advances in management includes the biology of breast cancer, individualized management, genetic profile in appropriate patients and multidisciplinary treatment. Breast cancer is not a single disease. Biology profile includes hormone receptors, her-e-neu and ki67.

Major advances in novel targeted drugs like trastuzumab, pertuzumab and tdm-1 in her-2-neu positive tumors has improved the outcome of her-2-neu positive disease with overall survivor from 25% to 80%

Neo-adjuvant chemotherapy in early stage triple neg or her2 pos tumors has become the standard of care in improving outcomes

It not only reduces the size of main tumor in the breast and axilla but also manifest the sensitivity of chemotherapy.

BCS and sentinel node biopsy in early stage breast cancer is the standard of care. 20 years follow-up of patients with BCS plus radiation has shown equal overall survival as the mastectomy.

Oncoplastic surgery has enabled BCS even in large breast tumor sizes. Breast cancer requires a multidisciplinary approach including surgery, radiation and medical oncology besides genetic counselling and psycho-social support. Gynecologist should be a part of comprehensive and individualized care, especially in the young breast cancer where bone health, sexual and menopausal symptoms management play an important role in survivor ship.

By working and interacting together we can strengthen the continuum of care for breast cancer patients, enhance preventive strategies, and promote early detection and improve treatment outcome.

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ROLE OF FERTILITY PRESERVATION IN ENDOMETRIUM CANCER

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CA endometrium is fifth most common cancer worldwide. Average age of diagnosis is 62 years and 14-25% of patients are pre-menopausal. 5% are younger than 40 years of age. Because of changing trends in age of diagnosis of endometrial cancer and delayed child bearing there is need for fertility preservation in women with endometrial cancer. The pre-requisites for this are well differentiated endometroid adeno carcinoma, disease limited to endometrium without metastasis with strong desire to preserve fertility. There should be no contraindications to medical therapy.

Hysteroscopic guided endometrial biopsy is gold standard in diagnosis of endometrial cancer. Treatment can be medical or surgical. Oral progestins include Megestrol acetate (MA) and medroxy progestrone acetate (MPA). The doses are 160-320 mg/day and 400-600 mg/day for MA and MPA respectively. Average duration for treatment is 6 months. Remission rate with MA is more than MPA.

LNG is another alternative but no randomized controlled trials are available comparing the efficacy of oral progestins with LNG-IUS. It is usually used in combination with oral progestins or GnRH analogues and remission rate is more than LNG-IUS alone.

In focal lesions hysteroscopic resection can be done. For follow up endometrial sampling is to be done at 3 months, every 6 months for 2 years and yearly till pregnancy is achieved or definitive surgery is done.

ProMise molecular classification can be applied in endometrial biopsy or curettage specimens, with high concordance with hysterectomy material

Patient with MMR-D should be tested for Lynch syndrome. Fertility-sparing treatment in women with Lynch syndrome should be discussed on a case-by-case basis.

Obstetrical outcome is quite good. Successful pregnancy significantly reduces risk of recurrence and IVF does not increase risk of recurrence. Young patient with no history of infertility can try for natural conception. Total surgery should be performed after child bearing is complete.

VIN: WHOM TO TREAT, HOW TO TREAT

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VIN is an increasing common problem in women of 40 years and above. It should be considered as premalignant condition even if regression has been reported in some cases.

Table 8.17 Major Classification Schemes Proposed for Squamous Precursor Lesions of the Vulva Over Time

1958	*1976 ISSVD*	*1986 ISSVD*	*2004 ISSVD[a] 2003 WHO[a]*	*2005 Bethesda-like*	*2012 LAST 2014 WHO 2015 ISSVD*
CIS	Mild atypia	VIN I	[a]	LG-VIL • Condyloma • VIN 1	LSIL • VIN 1 • Condyloma • Mild dysplasia • Koilocytic atypia
	Moderate atypia	VIN II	uVIN • VIN 2 • VIN 3	HG-VIL • VIN 2–3 • dVIN	HSIL • VIN 2–3 • Moderate/severe dysplasia • Bowen disease • Bowenoid dysplasia • CIS
	Severe atypia or CIS	VIN III, severe atypia or VIN III, CIS			
–	–	VIN III, differentiated type	dVIN		dVIN[b]

Vaccination with quadrivalent or 9-Valent HPV vaccine has been shown to decrease the incidence of VIN usual type (HSIL). Cigarette smoking is strongly associated with Vulvar HSIL and cessation should be encouraged. Screening for VIN and Vulvar cancer is not recommended till now and detection is limited to visual assessment followed by histopathology.

Indications of biopsy:

- Visible lesions for which definitive diagnosis cannot be made on clinical grounds
- Possible malignancy, visible lesions with presumed clinical diagnosis that is not responding to usual therapy
- lesion with atypical vascular pattern
- Stable lesion that rapidly changes in color border or size.
- Postmenopausal women with apparent genital warts
- Women of all ages with suspected condyloma in whom topical therapies have failed.

All women with vulvar HSIL should be treated. Occult invasion is a definite possibility so wide local excision should be performed if there is clinical suspicion of cancer even if biopsy shows Vulval HSIL. In other case vulval HSIL (VIN usual type) can be treated by excision, laser ablation or topical imiquimod. Follow up is a must at 6 months or 12 months by vulvoscopy. VIN usual type is known to have slow progression. So, follow up visits maybe scheduled at yearly basis. Women with vulvar HSIL are at risk of recurrent disease and vulvar cancer throughout their lifetime. There is always a potential for occult invasion. Wide local excision should be performed is clinical suspicion of cancer.

1. Lesion is raised from surface
2. Ulcerative
3. Has irregular borders
4. or any risk factors for invasive disease (previous VIN or vulvar carcinoma, Immunosuppression, tobacco use, age >45 years, lichen sclerosus.

When occult invasion is not a concern, vulvar HSIL can be treated with excision, laser ablation or topical imiquimod. Occult cancer has'been reported in 3% of women undergoing surgery for VIN

Differentiated VIN [dVIN] occurs in less than 5% of women specially in postmenopausal women. It is unifocal and unicentric. It is often associated with Lichen Sclerosus, but not with HPV infection. Risk of vulvar squamous cell carcinoma in patients with Lichen sclesus is approximately 5%. dVIN is found adjacent to 80% of vulvar squamous cell carcinoma.

Goals of Treatment

1. To prevent development of squamous cell carcinoma.
2. To relieve symptoms while preserving normal vulvar anatomy and function.

Whom to treat

Vulvar LSIL is not a precancerous lesion and does not need to be treated unless symptomatic

Treatment is recommended for all women with vulvar HSIL.

How to treat

dVIN is associated with associated with a high risk of developing invasive carcinoma. Surgical excision is recommended rather than ablative or pharmacologic therapy.

How to treat

Management options for VIN

[1] Wide local excision

[2] Skinning Vulvectomy

[3] Ablative therapy

[4] Topical therapy

ROLE OF INTERCURRENT MAGNESIUM SULPHATE IN PRE-ECLAMPSIA WITH SEVERE FEATURES

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Hypertensive disorders in pregnancy are a spectrum of medical disorders known to complicate 5 to 10 percent of pregnancies[1]. In this disease spectrum, the overall incidence of preeclampsia with severe features is approximately one percent.[2] Studies limited to nulliparous women report 2 to 2.5 % incidence of preeclampsia with severe features and approximately 30% of cases occur prior to 34 weeks of gestation.[3,4]

These disorders have a direct adverse impact on maternal and perinatal morbidity and mortality. A study by Huang et al reported a 26% higher risk of mortality in newborns of mothers with hypertensive disorders of pregnancy.[5]

Patient characteristics: Preeclampsia with severe features calls for termination of pregnancy for maternal benefit however in a few selected cases expectant management is preferred for fetal viability and to reduce neonatal morbidity and mortality. It encompasses steps for strict maternal and fetal surveillance which includes inpatient blood pressure monitoring and control with antihypertensive drugs, monitoring maternal biochemical profile, steroid cover for fetal lung maturation, non-stress test, fetal ultrasonographic evaluation and use of magnesium sulphate for prevention of eclampsia as well as for neuroprotection in gestations less than 33+6 weeks.

Intercurrent MgSO4 implies the prophylactic administration of magnesium sulphate in women who have pre-eclampsia with severe features and are remote from term. In such cases intensive maternal and fetal monitoring is needed to prolong pregnancy and prevent premature delivery and its neonatal consequences. Preterm gestational ages are being considered for expectant care; if investigations reveal that they do not require immediate birth, it is reasonable to stop magnesium sulphate and re-evaluate its need when timed birth is considered or there is spontaneous onset of labour.[6]

The risk of delaying delivery is that worsening maternal endothelial dysfunction and continued poor perfusion of major maternal organs may lead to severe injury to these end-organs. Fetal risks include progressive growth restriction and demise from placental abruption or uteroplacental insufficiency.

Limited data in the past few years suggest that expectant management results in pregnancy prolongation of approximately two weeks, with more favorable newborn outcomes than prompt delivery and low maternal risks.[4,7]

Literature Review

The earliest published large RCT by Sibai et al (1994) on 95 women grouped them into expectant and intervention arms. It reported an increase in latency of 15.4 ± 6.6 days and birth weight by 400 gms.[4]

Sibai (1994) RCT (Total Number=95)	Expectant group	Aggressive management group	Significance
Number in each group	49	46	
Pregnancy prolongation	15.4 ± 6.6 days	2.6 days	p < 0.0001
Gestational age at delivery (weeks)	32.9 ± 1.5	30.8 ± 1.7	p < 0.0001
Placental weight (gm)	435 ± 117	355 ± 88	P < 0.01
Birth weight (gm)	1622 ± 360	1233 ± 287	P = 0.0004
Admitted to neonatal intensive or intermediate care unit (No., %)	37 (76)	46 (100)	P = 0.002
Days in neonatal intensive or intermediate care unit	20.2 ± 14.0	36,6 ± 17.4	p = 0.0001
Small for gestational age (No., %)	15 (30.1)	5 (10.9)	P = 0.04
Respiratory distress syndrome (No., %)	11 (22.4)	23 (50)	P = 0.002
Necrotizing enterocolitis (No., %)	o (0)	5 (10.9)	P = 0.02

Maternal characteristics like the incidence of cesarean section, abruption, HELLP syndrome, and duration of postpartum stay among the expectant and the aggressive group of women were not significant.

The MEXPRE Latin study conducted a multicentric RCT on expectant management of severe pre-eclampsia remote from term on 267 women.[8]

Total Number =267	Expectant group	Aggressive group	Significance
Number of patients in each group	134	133	
Pregnancy prolongation	10.3 days	2.2 days	P=0.0001
Rate of perinatal mortality	12 (8.7)	13 (9.4)	.81 (Not significant)
Composite neonatal morbidity	70 (55.6)	70 (56.4)	.89 (Not significant)
SGA	30 (21.7)	13 (9.4)	.005
Apgar score	10 (7.6)	2 (1.5)	.01

They reported a significant increase in pregnancy prolongation but at a risk of increase in small for gestational age fetuses. The reduction in perinatal mortality and composite neonatal outcomes were not significant and there was no significant difference in maternal morbidity in the expectant management group compared with the prompt delivery group.

A systematic review by L.A Magee et al in 2009 collected the data from observational studies only on delaying delivery of appropriately selected patients with preeclampsia with severe features less than 34 weeks. (39 studies, 4650 patients).[9] Expectant management was associated with pregnancy prolongation ranging from 7 to 14 days; only one-third of patients remained pregnant beyond seven days. Expectant care of HELLP <34 weeks (12 cohorts, 438 women) was associated with fewer days gained (median 5), but more serious maternal morbidity (e.g., eclampsia, median 15%).

The Cochrane database of systematic reviews conducted in 2018 by Churchill D et al evaluated the comparative benefits and risks of a policy of early delivery by induction of labor or by cesarean section, after sufficient time has elapsed to administer corticosteroids, and allow them to take effect; with a policy of delaying delivery (expectant care) for women with severe pre-eclampsia between 24- and 34-weeks' gestation.[10]Six trials were included, with a total of 748 women in this review. There were insufficient data for reliable conclusions about the comparative effects on most outcomes for the mother.

This review suggested that an expectant approach to the management of women with severe early-onset pre-eclampsia may be associated with decreased morbidity for the baby. However, this evidence was based on data from only six trials. Further large, high-quality trials are needed to confirm or refute these findings and establish if this approach is safe for the mother.

Maternal Parameters	Expectant group	Immediate delivery group
Reduction in Eclampsia	Uncertain	
Reduction in Pulmonary edema	Uncertain	
HELLP syndrome	Little or no clear difference	
Incidence of cesarean section	No difference	

Fetal parameters	Expectant group	Immediate delivery group
perinatal deaths	Insufficient to draw any conclusions	
IVH	Less	More
RDS	Less	More
Gestational age	Higher	Lower
Ventilation needs	Less	More
Longer stay in NICU	Less	More
Small for gestational age	More likely	Less likely

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PLATELET RICH PLASMA –PRP: THE PANACEA FOR ALL AILMENTS

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Background: Platelet rich plasma (PRP) is one of the most commonly used preparation in regenerative medicine these days, which aims to support the regeneration and repair process utilising growth factors present in platelets in order to achieve the clinical effect of these growth factors, platelets must be activated.

Physiological role: During the physiological process of natural healing process, body's first response to tissue injury is to deliver platelets to the site of injury. Platelets contain high concentration of cytokines and growth factors stored in alpha granules. These growth factors include Platelet derived growth factor (PDGF), Insulin-like growth factor (IGF), Vascular Endothelial growth factor (VEGF), Platelet derived angiogenic factor (PDGF), Transforming Growth factor-beta (TGF), Fibroblast growth factor (FGF), Epidermal growth factor (EGF) and Interlekin-8. In addition, other substances like Fibronectin, Vitronectin, Sphingosine-1 phosphate that initiate healing process are also released. To release these growth factors, platelet activation is required. All these growth factors help in angiogenesis, proliferation, chemotaxis, differentiation and anti-inflammatory action. PRP, owing to its anti-inflammatory action has the potential to eliminate the results of infection.

Types: Depending on method of preparation and activation, Dohan-Ehrenfest et al classified PRP. These are pure platelet rich plasma (P-PRP), Leukocyte and platelet rich plasma (L-PRP), Pure platelet rich fibrin(P-PRF), Leukocyte and platelet rich fibrin(L-PRF). The classification is based on cell content and fibrin density. Advantages: Being autologous, these are free, not only from risk of immune reaction but also the transmission of infection from donor. It has a simple low cost and fast preparation. The contraindications for its usage include thrombocytopenia, active infection, Patient on NSAIDS etc.

Limitation: Different kits and different methods have been used to prepare PRP. However, there is lack of standardisation as to how to prepare PRP. Steps of preparation: Step-1 Blood collection. Step-2 Separation of blood components so as to separate Platelet rich plasma. Step 3-Processing the separated plasma leading to activation of platelets. Step 4-administration of PRP.

Uses in Gynaecology: Because of its growth factors releasing action and anti-inflammatory potential, PRP has gained importance in Gynaecology. Till few years back, its role was limited to specialities like Dentistry, Orthopaedics, Dermatology and plastic surgery. So far, the widest application is in reproductive medicine especially for thin endometrium, Asherman's syndrome, premature ovarian failure. Its use has now been extended to wound healing and Lower urinary tract symptoms (LUTS) like Urinary incontinence and genito-urinary fistula.

Endometrium: Thin endometrium refers to endometrial thickness<7 mm and remains one of the main factors of implantation failure. This remains a therapeutic challenge to the reproductive physicians. PRP has been used as an intra-uterine infusion to induce endometrium thickness enhancement as well as increase the clinical pregnancy rate. This is now backed well with enough literature. It helps by not only the thickness but also the vascularity thereby helping in achieving significant pregnancy rates.

Asherman's Syndrome: Intrauterine PRP administration has been used post-adhesiolysis in Asherman's syndrome. Several sessions of this method, help in achieving both endometrial thickness as well as its vascularity. It even leads to improvement of hypomenorrhea and resumption of periods in amenorrhic women.

Ovaries: Poor Ovarian Reserve (POR) is one of the important causes of female infertility contributing to as high as 30-40% to overall infertility. Intra-ovarian PRP is emerging as revolutionary treatment option for these women who are left with no other option for these women then donor oocyte, by improving AMH,

decreasing FSH, improving number of M-II oocytes, achieving clinical pregnancy and live birth rates.

Wound healing: PRP promotes angiogenesis and healing by stimulating MMP synthesis increasing intraovarian fibroblast growth as well as extracellular matrix production of components like collagen and elastin. Availability of enhanced PRP(EPRP) in powder form is another revolutionary step. This property has been used to prevent wound breakdown after gynaecological cancer surgeries and irradiated tissue. This property can bed in genital rejuvenation by injection of PRP with or without hyaluronic acid to address vaginal atrophy and vaginal laxity leading to improved sexual health.

Uro-gynaecology: small fistulae have been treated, conservatively with PRP with success ranging from 67 to 100%. This is a novel, minimally invasive approach for closure of genital fistulae. It has even been used in management of cystocoele too. This has been successfully used in Stress Urinary Incontinence (SUI) cases, as it helps in regeneration of damaged ligament (pubourethral ligament). Urethral sphincter injection of PRP is an effective treatment modality in case of urinary incontinence with urodynamic and clinical evidence. In addition, there is literature-supporting use of intra-vesical PRP to reduce chronic inflammation in bladder pain syndrome and interstitial cystitis by helping regeneration of urothelium.

Other uses: PRP is also being used as a treatment modality in other gynaecological conditions like cervical ectopy, chronic cervicitis, chronic endometritis and even vaginal prolapse.

Conclusion: PRP is a simple, easily obtainable, low cost minimally invasive option without any adverse reaction, which owing to its released growth factors and proteins have a beneficial effect in regenerative process. This regenerative potential of PRP is being used widely across various gynaecological disorders ranging from reproductive medicine across uro-gynaecology to chronic wound management. Thus, PRP can be aptly referred to as panacea for all ailments. Preparation method of PRP, however, needs to be standardized.

ECLAMPSIA DRILL

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Clinical management of critical events during eclampsia is as an important component of obstetric care. Eclampsia drills help in successful implementation of measures to optimize management of eclampsia. Salient points are rapid activation of emergency team after one call for help, development and dissemination of evidence-based protocol for eclampsia, strategically placed "Emergency and eclampsia trays,"and education of health care providers.

Eclampsia is a critical event which has convulsive manifestation of pre-eclampsia and one of the severe spectrum of pre-eclampsia. Despite advances in detection and management, it remains the common cause of morbidity and mortality among pregnant women, especially in low resource settings. The risk factor of eclampsia is same as pre-eclampsia like nulliparity, pre-eclampsia in previous pregnancy, age>40 years or <18 years, chronic hypertension, chronic kidney disease and many more.

The clinical presentation of eclampsia includes generalized tonic-clonic seizure (GTCS), may be associated with loss of consciousness. It may be associated with loss of sphincteric functions, tongue bite and frothing. Eclampsia is usually preceded by hypertension (75%), headache (66%), visual disturbance (27%), right upper

quadrant pain (25%) and sometimes asymptomatic in 25% cases. It is associated with altered behavior and brisk tendon reflexes. The post ictal phase ends when twitching stops which is followed by deep sleep and then the waking up. Women usually recovers in 10-20 mins after GTCS. Even if criteria for hypertensive disorder of pregnancy is not met, the diagnosis can be made in the pregnant women with seizures who has typical clinical and neurological imaging findings. Approximately 60% eclampsia occurs antepartum (out of that 50% are pre term), 20% intrapartum and 20% postpartum (90% within one week of delivery).

The principal of eclampsia management includes maintenance of airway patency and prevent aspiration to prevent maternal hypoxia. Other issues include termination and prevention of further seizures, treatment of severe hypertension and delivery of fetus.

The initial step is to call for help, place the women in left lateral position, a mouth gag is inserted, oral secretion and vomitus are suctioned, airway patency is secured and oxygen if administered at 8-10 litre/min through face mask to treat hypoxemia during seizures. The bedrails are raised to avoid fall. The vitals are monitored including oxygen saturation. Use of physical restraints can be used, if required. Once the seizure ends, large bore cannula (18G) is put, blood sample for blood grouping and cross matching, complete blood count, liver function test, kidney function test including electrolytes and coagulogram is taken and intravenous fluid is started at 75-100ml/hour. Urinary catheter is put to monitor urine output and urine sample is taken to assess proteinuria.

To control and prevent further seizures, magnesium sulphate is considered the drug of choice. For intravenous loading dose 20 ml of 20% magnesium sulphate (4 gm) is slowly administered over 5-15 minutes at a rate not exceeding 1gm/minute. For making 20% solution of magnesium sulphate, 4 ampoules (2ml each, 1 gm/ampoule) of 50 % magnesium sulphate (available form) is diluted in 12 ml of normal saline, making it a total 20 ml solution. It is followed by 10 g (50% magnesium sulphate solution) Intramuscular (5 g in each buttock) dose which is followed by 5 g IM every 4 hours (change sides with each injection) which is continued for 24 hours after the last fit or 24 hours post delivery whichever is later. Recurrent fits should be treated with a further dose of 2 g to 4 g magnesium sulphate solution given intravenously over 5 to 15 minutes.

Careful monitoring is required for women receiving magnesium sulphate solution to prevent serious side effects. The clinical variable to be monitored are urine output (atleast 50 ml/hr), patellar/ deep tendon reflexes, respiratory rate and pulse oximetry.

The blood pressure is controlled by giving intravenous bolus of 20 mg labetalol initially followed by 40 mg and then 80 mg at an interval of 15-20 minutes interval.

During and immediately after seizures initial fetal bradycardia is common and lasts for atleast 3-5 mins. The fetal heart generally improves after maternal and feral resuscitation.

Delivery of the fetus is the only definitive treatment of eclampsia. Once the women is stabilized, mode of delivery depends on gestational age, fetal presentation and bishop's score. Following the seizures, labour often ensues spontaneously or can be induced. Women who adequately progress in labour can be allowed for vaginal delivery. Cesarean delivery may be indicated in presence of prolonged fetal bradycardia, unfavourable cervix, inadequate BP control or poor progress in labour.

Anti-hypertensive treatment should be continued throughout assessment and labour. In cases where delivery does not occur vaginally within 24 hours, the mode of delivery should be reconsidered by a senior obstetrician.

Postpartum care includes continuation of magnesium sulfate for further 24 hours post delivery. Decision for maternal activity, newborn care and oral intake should be individualized. The postpartum hypertension should be managed with the drugs compatible with breast feeding. Further neurological follow up is required in the atypical cases who do not fit in the criteria of pre-eclampsia.

Key Events:

Seizure starts
Call for help
Correct patient positioning
Airway assessment and management
Oxygen therapy
I.V. Access
Pharmacological Intervention Correct choice of drugs and their dosage monitoring side effects contraindications and complications
Arrival of registrar/Consultant Obs & gynae
Bladder catheterisation
Monitoring Blood Pressure Heart rate and rhythm Respiratory rate Oxygen saturation Urine output MgSo4 toxicity Investigations
Fetal monitoring
Arrival of anaesthesiologist
Seizure ends
Planning for delivery
Observation
Postpartum care

MATERNAL COLLAPSE: A SHIVER DOWN THE SPINE

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Maternal collapse is an acute life-threatening event in which the mother becomes unconscious due to cardiorespiratory or neurological compromise during pregnancy or up to 6 weeks postpartum. (1) The outcome for mother and the fetus depends on effective resuscitation team work.

The maternal mortality rate (MMR) is very low in developed countries and has been steadily decreasing in India also over the last few years. In the year 2018-2020, the MMR in India was 97/100000 live births. (2) However, it remains high in the lesser developed states of the country. A substantial number of these deaths are due to sudden maternal collapse, the incidence being 1 in 36000 pregnancies. (3) Because of the complexity of the situation (resuscitation of the mother and fetus) and its overall rare occurrence, we shudder at the thought of facing such an event in our clinical practice.

Resuscitation of maternal collapse is a special situation, which requires multi-disciplinary approach, team work and co-ordination. The goal is to save the mother. All patient care areas should be well-equipped in terms of resuscitation equipment, airway management equipment and emergency drugs. These areas include the ante-natal clinics, wards, labour rooms, operating rooms and post-surgical areas.

Mothers at high risk of collapse should be identified early using the maternal early warning score and should be kept under surveillance. If the patient becomes unresponsive and has an absent carotid pulse along with absent respiration or gasping, she is considered to be in cardiac arrest. Time of detecting pulselessness should be documented. The emergency response system should be activated immediately and the multidisplinary team consisting of the obstetrician, anaesthesiologist, neonatologist should be alerted. Aorto-caval compression should be relieved by a manual left uterine displacement. Immediate chest compressions should be initiated along with early bag mask ventilation with supplemental oxygen. Fetal

monitors should be removed and defibrillator should be attached to identify the rhythm and deliver shock, if indicated. In the meanwhile, an intravenous canula should be secured to administer drugs and blood samples should be sent for laboratory investigation. Airway of the patient must be secured with an endotracheal tube early without interrupting chest compression. Chest compression and ventilation should be continued in a ratio of 30 compressions to two ventilations. If there is no return of spontaneous circulation (ROSC) within 4 min of pulselessness, perimortem cesarean section should be done at the site of arrest and the lengthy aseptic procedure should be curtailed. Chest compression and ventilation should be continued throughout the procedure. A midline vertical or Pfannensteil incision should be given and the fetus should be delivered within 5 min of arrest. This will relieve the aorto-caval compression and improve the venous return. The uterus should be packed or repaired in a single layer to allow resuscitative attempts. Anatomical repair can be done once there is ROSC. Upon ROSC, targeted temperature management should be initiated for post cardiac resuscitation care and recovery. Uterotonics should be given. The neonate should be handed over to the neonatologist for further resuscitation and management. Throughout the resuscitative efforts, the causes of cardiac arrest which are the 5H's and 5T's, eclampsia and amniotic fluid embolism should be searched for and if found, treated as soon as possible.

Since the resuscitation of the maternal patient requires multidisciplinary team-work and is a rare event, it becomes imperative to hold regular drills/training/ simulation based learning exercises to familiarize ourselves and be prepared to tackle this situation with confidence.

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HIGH UTEROSACRAL LIGAMENT SUSPENSION

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Female pelvic organ prolapse is a condition with varied etiological and causative factors starting from the congenital elongation of the cervix to hypoestrogenic related laxity of the endopelvic fascia and connective tissue surrounding the pelvic structures. The repair of the descendant structures of the pelvis and putting them into place is a challenging job for gynaecologist.

As very little is advocated to regain the tonicity or strength of the connective tissue of the pelvis, in most of the cases we take the help of the native connective tissue of the pelvis in form of ligaments to suspend the descendant pelvic structures or apex of the prolapsed vault for the permanent support high up in the pelvis.

In this type of suspension procedure, we select the uterosacral ligament as the supportive structure both for utero cervical descent and the vault. The uterosacral ligament is a very lengthy and tough ligament measuring around 12-15 cm in length, originating from the side wall of the lower sacrum bone and the coccyx. The fibers of the ligament arise in a fan shaped manner and gradually conglomerate to form the uterosacral ligament proper.

The uterosacral ligament has three parts. The proximal one third ligament fibers arise directly from the sacrum and the coccyx. The intermediate one third part is the tough ligament structure which is proximal to

the ischial spine. This is considered to be the ideal portion of the uterosacral ligament on which most of the suspension procedures are undertaken. The distal one third part of the uterosacral ligament is attached to the proximal one third of the vagina. It's inner surface is curved anteriorly to get inserted to the posterior aspect of the cervix upto internal os. This portion may get denuded with age and chronic prolapse.

The different types of suspension procedures through uterosacral ligament are hysteropexy and colpopexy. Various methods for suspension on the uterosacral ligament have been described.

In case of conservative repair of the pelvic organ prolapse where uterus is to be preserved multiple suspension sutures (delayed absorbable or non -absorbable) are passed through the substance of the intermediate part of the uterosacral ligament and then through the pericervical ring constituting the mackenrodt's and the uterosacral ligament complex on both the sides and finally both these are tied with each other to suspend the cervix high up in the pelvic cavity. When the uterus is to be removed then the same structures are passed through the full thickness of the proximal vaginal vault and thus elevating the vault permanently. The distal one third of the uterosacral ligament can be plicated to make it short to elevate the corpus passively. Both the uterosacral ligaments at its distal part are approximated to each other to make it short and then suspended to the vault, specially to the posterior wall of the vault – known as McCall's culdoplasty.

These types of procedures are considered to have a high success rate and the most advantageous factor are that the native or autologous pelvic tissue of the patient is used to suspend the pelvic structures and having maximum length helps the surgeon to accommodate any severity of pelvic organ prolapse. It maintains the axis in length as well as breadth with the diameter of the proximal vault to have best functional outcome at the end of the procedure. Only pitfall of this procedure is the risk of ureteric involvement (1-11%) due to its anatomical proximity in the form of injury or kinking which requires additional intraoperative check cystoscopy evaluation to rule out the ureteric involvement. With adequate training and expertise high uterosacral ligament suspension procedure can be a boon for patients with pelvic organ prolapse.

ARTIFICIAL INTELLIGENCE IN GYNECOLOGY: SCOPE AND CHALLENGES

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At its heart, AI is about enabling machines to emulate human intelligence. This can range from simple tasks like identifying patterns in data to more complex ones like diagnosing diseases or predicting health outcomes. In healthcare, AI has the potential to revolutionize how we diagnose and treat diseases, enhancing the overall quality of care.

Data is a crucial component of successful AI applications in healthcare. It's the fuel that powers AI algorithms. By analysing vast amounts of data, AI algorithms can learn and make predictions. In gynecology, this could involve analysing patient medical records, imaging data, genetic information, and more to predict disease risk, diagnose conditions, and recommend treatments.

However, not all data is of the same quality. For AI algorithms to function effectively and make accurate predictions, they need high-quality, reliable data. This is where the concept of 'gold standard data sets' comes in. A gold standard dataset is a high-quality, thoroughly reviewed, and universally accepted dataset that is used as a benchmark for evaluating the performance of machine learning models. These datasets are typically created and verified by subject matter experts to ensure the data is accurate and reliable.

The importance of gold standard datasets in AI applications cannot be overstated. They serve as the benchmark for evaluating the accuracy and reliability of machine learning models and algorithms. They help to ensure that medical diagnoses and other important applications are as accurate and reliable as possible. They facilitate collaborations and standardization across different industries and organizations. Examples of applications that require gold standard datasets include medical image analysis, natural language processing, speech recognition, and fraud detection.

Recognizing the need for such datasets in the field of gynecology, the Indian Council of Medical Research (ICMR) and the Indian Institute of Science (IISc) have launched an initiative to create a bank of gold standard datasets. This initiative aims to develop better AI/ML tools and provide a platform for the comparative evaluation of algorithms and tools. It is a significant step forward in the quest to harness the power of AI in gynecology and improve patient outcomes.

The process of onboarding these datasets into the ICMR-IISc bank involves a thorough review and validation process to ensure the data meets the required standards. This includes checking for compliance with ethical and legal requirements, adherence to industry and organizational standards, and incorporation of feedback and updates over time.

As we move forward with this initiative, we are actively seeking contributions from researchers and healthcare professionals who have potential gold standard datasets. If you have a dataset that you believe has the potential to be transformed into a gold standard dataset, we strongly encourage you to consider contributing it to this initiative. Your contribution could play a crucial role in the development of superior AI-based health products and the improvement of public health.

In conclusion, the intersection of data, AI, and gynecology holds significant promise for the future of healthcare. Through initiatives like the ICMR-IISc bank of gold standard datasets, we are making strides towards realizing this potential. We invite you to join us in this journey and contribute to the advancement of AI-driven healthcare. Your dataset could be the next cornerstone in this exciting field. Let's work together to make this vision a reality.

HOLISTIC CARE OF MENOPAUSE OSTEOPOROSIS-ADDING LIFE TO YEARS

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Osteoporosis is one of the most prevalent skeletal disorders and has a similar lifetime risk as of coronary heart disease.

"There is indeed one thing I have learnt – that an accurate diagnosis, which is relatively simple, can save women from a lot of suffering, fractures and emotional damage."-Carmen Sanchez, osteoporosis patient from Spain, speaking at an IOF press conference held in Brussels"

Osteoporosis characterized by low bone mass density, microarchitectural deterioration, decreased bone strength and resulting in falls and fractures which is global burden on the individuals and public health expenditure.

10% loss of vertebral bone mass can double the risk of a vertebral fracture.

According to statistics given by the World Health Organization (WHO), 30 percent of postmenopausal women suffer from osteoporosis. It has been reported that **61 million people in India** have osteoporosis and, out of these, 80 percent are women. Globally an osteoporotic fracture occurs every 3 seconds

This menopausal osteoporosis is an issue of public health concern as with increasing life expectancy incidence of osteoporosis in on rise.

The projections indicate that the number of hip fractures occurring in the world each year will rise from 1.66 million in 1990 to 6.26 million by 2050 and this increase would be more in developing countries and less in developed countries.

This escalation is causing increase in disability adjusted life years (DALYs) because of premature deaths and YLL (years of life lost) and that is a huge burden for the persons, families and public health expenditure

As there is no cure, it is important to identify early life influences on later bone mineral density, which may aid the development of interventions to optimize bone health and reduce osteoporosis risk.

Bone mineral content (BMC) and bone mineral density (BMD) in adulthood depends predominantly on growth and mineralization of the skeleton and the resultant peak bone mass achieved and then, to a lesser extent, on the subsequent loss, which can be due to a number of factors along with hypoestrogenic state of menopause, exercise diet, calcium, Vit. D Smoking alcohol, some medications and associated comorbidities like rheumatoid arthritis, steroid use and genetic causes, family history of osteoporosis is very important

Reduced peak bone mass in childhood is associated with increased fracture risk and has been proposed as one of the most accurate predictors of later life fracture risk Genetic predisposition accounts for up to 50% of the variance in bone mass and gender also influences bone composition with males attaining greater bone mass than females.

Environmental influences during both childhood and adulthood, such as smoking corticosteroid use and exercise.

There is compelling evidence for the developmental origins of osteoporosis. It highlights the importance of osteoporosis prevention at all stages of the life course, including optimising the in utero environment and maternal nutrition, and the importance of infant nutrition as preventative strategies for future osteoporosis.

It is imperative to continue to determine the mechanisms behind skeletal programming to further aid the development of preventative strategies by future research in India.

Bone is a living tissue which goes on remodelling throughout life. Estrogens play a part in osteoporosis at the level of Estrogen affects bone through the following mechanisms:

1) Lowering the sensitivity of bone mass to PTH (parathyroid hormone), thus reducing bone resorption,
2) Increasing the production of calcitonin, thus inhibiting bone resorption,
3) Accelerating calcium resorption by the intestine,
•4) Reducing the calcium excretion from the kidney,
5) Estrogen can also have direct effects in the bone since there are estrogen receptors.
6) After menopause, due to the lack of estrogens, the rate of bone turnover increases, resulting in accelerated bone loss.

Management consists of prevention by attaining Peak bone mass in adolescent by proper diet, exercise of high impact aerobics, calcium and Vit D and balanced exercise, exposure to sunlight is very important.

In the perimenopause women should be assessed by risk factors. Diagnosis by dual dexa scan or other tools like OSTA risk assessment tools

MHT in menopause transition and postmenopause women along with pharmacological treatment antiresoptive and anabolic drugs, fall prevention and later on surgical treatment when fractures occur are the main stay of treatment. The basket of pharmacological medications is very vast.

We have to keep women moving and on their feet with logo of: STAND TALL SUPPORT YOUR BONES AS THEY SUPPORT YOU!

USE OF TOURNIQUET TO DECREASE BLOOD LOSS IN PLACENTA ACCRETA SPECTRUM(PAS): A NOVEL METHOD

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PAS has a global impact on maternal health as its incidence is steadily rising worldwide, possibly due to rise in number of pregnancies following various surgical procedures on uterus including caesarian section. The main risk associated with this condition is torrential life-threatening obstetric haemorrhage and associated secondary complications.

It has become a leading cause of peripartum hysterectomy, maternal morbidity and even mortality. Hysterectomy remains the definitive surgical treatment for PAS disorders. A primary caesarian hysterectomy is the safest and most practical option especially in low resource settings. In order to minimize the haemorrhage and risk of urologic injury surgeons worldwide have modified their techniques over the years to achieve an optimal outcome.

Successful stepwise devascularization of the hypervascular uterus especially the lower segment with abnormally invasive placenta in situ, is the key to prevent haemorrhage while performing caesarian hysterectomy in PAS.

One such novel technique utilizes application of a tourniquet (Figure 1 and 2) around the lower uterine segment just below the invasive placenta (after lateralization of the ureters) through an avascular window in the broad ligament on both sides which helps to compress the uterine arteries and extensive deep pelvic neovascularization (collaterals). This also facilitates to control the vesicouterine pouch neovascular connections needed for mobilizing the bladder away from lower uterine segment to complete the hysterectomy.

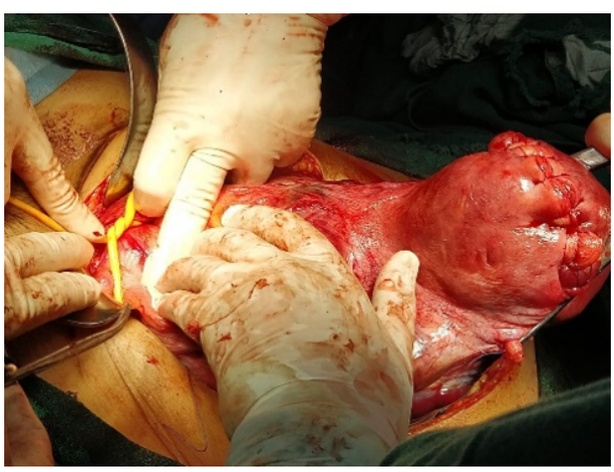

Figure 1

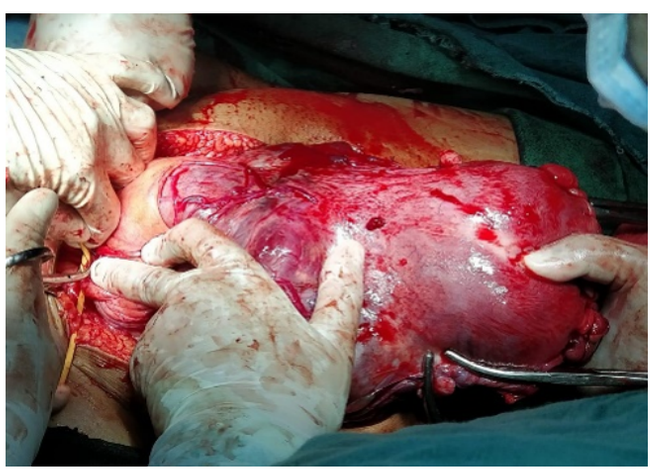

Figure 2

UNEXPLAINED RECURRENT PREGNANCY LOSS

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A pregnancy loss (miscarriage) is defined as the spontaneous demise of a pregnancy before the fetus reaches viability. The term therefore includes all pregnancy losses from the time of conception until 24 weeks of gestation. The definition of recurrent pregnancy loss (RPL) has been variable over the years. European Society of Human Reproduction and Embryology (ESHRE) in 2022[1] defined recurrent pregnancy loss as the loss of two or more pregnancies, confirmed at least by either serum or urine b-hCG, excluding ectopic and molar pregnancies. However, the most recent guideline from RCOG published in June 2023 defines recurrent miscarriage as three or more first trimester miscarriages. It further adds that clinicians are encouraged to use their clinical discretion to recommend extensive evaluation after two first trimester miscarriages, if there is a suspicion that the miscarriages are of pathological and not of sporadic nature.[2]

The incidence of RPL varies from 1-5% depending on the definition of pregnancy loss, whether biochemical pregnancies are included or not. The risk for females to have a spontaneous abortion after a prior single miscarriage is 12–20%, after suffering two miscarriages, the risk rises to 29%, and after three to 36%.[3]

Several factors have been suggested to contribute to RPL, which include maternal age, uterine anatomic anomalies, endocrine/hormonal abnormalities, genetic/chromosomal abnormalities, thrombophilias and autoimmune disorders. However, there is no identifiable cause in more than 50% of these cases and remain unexplained (URPL). These are the cases which are most frustrating, and the desperation of the patient and the clinician leads to a number of interventions which are not scientifically proven to be beneficial, and sometimes may even be potentially harmful. But then the question remains, how do we counsel and manage these couples?

Counselling

Women should be counselled that age is an independent risk factor for miscarriage. The lowest risk of pregnancy loss is in women aged 25–29 years (9.8%), which rises sharply to 33.2% in women aged 40–44 years.[4] The age-related risk of recurrence after two miscarriages increases from 24% at 25–29 years to 44% at 40–44 years.[5] Besides the female age, advance paternal age has also been now shown to increase the risk of miscarriage.[6] Other modifiable risk factors include psychological stress, alcohol, smoking, and obesity. The couple must be counselled regarding these risk factors and offered help to modify them. Women with recurrent miscarriage should be advised to maintain a BMI be-tween 19 and 25 kg/m2, smoking cessation, limit alcohol consumption and limit caffeine to less than 200 mg/day.[2]

Diagnosis

Exploring the etiological factors in unexplained RPL cases, reproductive genetics has made great advances targeting genetic polymorphisms and mutations, karyotypic abnormalities, and embryonic chromosomal abnormalities in RPL couples.[7] Several genetic factors linked with RPL have been identified. These include DNA methylation, sperm DNA fragmentation, chromosome heteromorphisms, and single nucleotide genetic variation. However, none has been proven to be a stand-alone risk factor for RPL.

Well known genetic causes of RPL are gross chromosomal defects and variations of allelic expression. Genetic risk factors, including abnormal embryonic genotypes and parental chromosomal rearrangements, could be a background for more than 50% of RPL cases.[8] An algorithm for diagnosis has been therefore proposed based on cytogenetic analysis of the products of conception (Figure 1). The analysis should be done by Array CGH. Conventional karyotyping is limited by culture failure in approximately 20% and maternal cell contamination rates of approximately 22%. Array CGH avoids the limitations of conventional karyotyping and FISH, such as culture failure and limited chromosome examination, and essentially scans

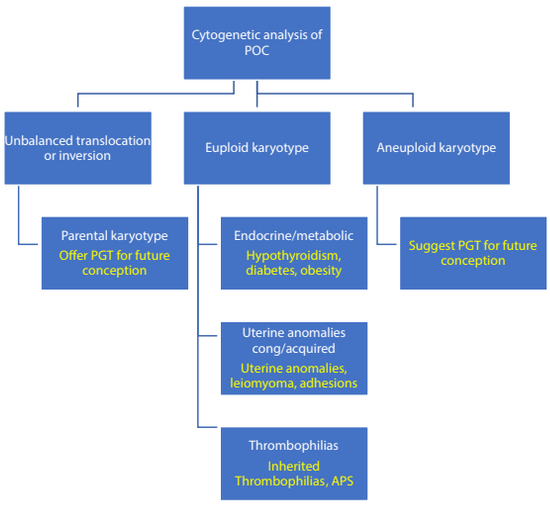

Figure 1: Algorithm for diagnostic testing for RPL based on cytogenetic examination of POC.

the entire genome providing additional information such as DNA copy number variants.

Treatment

Perimplantation genetic testing. Given that fetal chromosomal abnormalities are one of the main reasons for unexplained RPL, embryo implantation using preimplantation genetic testing for aneuploidy (PGT-A) to select the embryo with normal chromosomes has been hypothesized as an alternative. Implantation genetic screening may increase the possibility of implantation, pregnancy and lower the incidence of early spontaneous abortion.[9] Non-invasive PGT-A technologies in future may make it more feasible and cost effective.

Progesterone therapy. A multicentric, prospective, randomized placebo-controlled study found that the use of progesterone did not boost the live birth rate of URPL patients.[10] Another meta-analysis of 8 double-blind placebo-controlled studies suggested that administration with progesterone can effectively reduce the miscarriage rate of URPL patients.[11] However, there is need to further investigate about the initiation and duration of therapy, and the dosage and route of administration.

Anticoagulant therapy. Low-dose aspirin, low-molecular-weight heparin or both can be used to treat URPL. A recent meta-analysis on the effect of LMWH in the patients with URPL combined 5 RCTs including 1452 participants. It concluded that LMWH decreased the risk of subsequent pregnancy loss in women having a history of 3 or more miscarriages, but no significant effect was observed in women with 2 or more miscarriages.[12]

Immunomodulatory therapy. A number of therapies for immunomodulation or immune suppression have been tried to improve live birth rates in URPL cases, but none of these have shown conclusive benefit. Thus, it is imperative that the couple is counselled regarding the pros and cons and any potential risk whenever such therapeutic interventions are considered. These include the following:

- Corticosteroids – Not recommended unless an autoimmune condition is present.
- Lymphocyte Immunization Therapy (LIT) - using husband's lymphocyte infusion has shown benefit in some studies. However, there are concerns regarding hematogenous infections and therefore not recommended.
- Intravenous Immunoglobulin (IVIG) - has been found to be beneficial in selected women with more than 3 or 4 pregnancy losses.
- Newer drugs which are under investigation for the treatment of URPL include TNF-α antagonists (adalimumab), Granulocyte-colony stimulating factor (G-CSF), immune-suppressive agents (Tacrolimus

and Rapamycin).

Recurrent pregnancy loss is a complex condition with poorly understood pathogenesis. Genetic studies may provide further insight. Newer drugs for immunomodulation are under investigation. When nothing else seems to work, psychological support may be helpful.

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PPROM: WHEN TO TERMINATE?

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Preterm prelabour rupture of membranes (PPROM) is defined as the spontaneous rupture of the fetal membranes before 37 weeks gestation and preceding the onset of labour. PPROM complicates approximately 3% of pregnancies and causes approximately one-third of all preterm deliveries. The management of PPROM is among the most controversial issues in perinatal medicine.

The key decision is whether to induce labour (or perform cesarean delivery) or to manage the pregnancy expectantly. Expeditious delivery of women with PPROM is appropriate in the setting of intrauterine infection, placental abruption, or non-reassuring fetal testing. The early preterm fetus (ie, <34 +0 weeks) who is otherwise stable will benefit by prolonging the time it remains in the uterus if the duration is sufficient to allow a significant reduction in gestational age-related morbidity. The late preterm fetus (34+0 to 36+6 weeks) may benefit as well, although there is less consensus at this gestational age and the benefit needs to be balanced with the risks of PPROM-associated complications and their sequelae in expectantly managed pregnancies.

Until recently, immediate birth (IB) was recommended from 34 + 0 to 36 + 6 weeks' gestation. This paradigm has changed over the last few years after the publication of three RCTs, a meta-analysis, and an individual patient data meta-analysis (IPD-MA). These studies in Late preterm PROM show that expectant management until 37 weeks of gestation is associated with lower overall neonatal morbidity. More recently, a Cochrane review of 3617 women explored the effect of planned early delivery versus expectant management for women with PPROM. The authors concluded that in women with PPROM 'with no contraindications to continuing the pregnancy, expectant management with careful monitoring is associated with better outcomes for the mother and baby'. The Cochrane review found no differences between early birth and expectant management in neonatal sepsis or infection. Early delivery increased the incidence of respiratory distress syndrome (RR 1.26, 95% CI 1.05–1.53), and an increased rate of caesarean section (RR 1.26, 95% CI 1.11–1.44). There were no differences in overall perinatal mortality or intrauterine deaths when comparing early delivery with expectant management. Early birth was associated with a higher rate of neonatal death and need for ventilation.

Based on these studies, RCOG now recommends women whose pregnancy is complicated by PPROM after 24+0 weeks' gestation and who have no contraindications to continuing the pregnancy should be offered expectant management until 37+0 weeks; timing of birth should be discussed with each woman on an individual basis with careful consideration of patient preference and ongoing clinical assessment.

POST PARTUM HAEMORRHAGE

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Dr Shashi Lata Kabra

Dr Shakun Tyagi

Introduction

Postpartum haemorrhage (PPH) is an obstetric emergency complicating 1–10% of all deliveries.[1]Severe PPH occurs in around 1–2% of deliveries and PPH is a leading cause of maternal mortality, accounting for approximately 25% of all maternal deaths worldwide.[2] It has been defined as estimated blood loss greater than 500 mL associated with vaginal delivery or greater than 1000 mL estimated blood loss associated with cesarean delivery. This was redefined by the American College of Obstetrics and Gynecology in 2017, as cumulative blood loss greater than 1000 mL with signs and symptoms of hypovolemia within 24 hours of the birth process, regardless of the route of delivery.[3] This loss after 24 hours but within 12 weeks of pregnancy is defined as secondary PPH. However estimated blood loss greater than 500 mL should alert the clinician and with the potential need for intervention. In certain conditions such as pre-eclampsia and heart disease, lesser amount of blood results in hemodynamic instability.

Aetiology and Risk Factors

1. Uterine atony, characterized by the failure of the uterine muscles to contract effectively after delivery, is the most common cause of PPH. Factors contributing to uterine atony include prolonged labour, large fetal size, multiple pregnancies
2. Placental complications such as retained placenta or placenta accreta.[4]
3. Trauma to the birth canal or uterus during delivery can lead to severe bleeding. Uterine rupture, though rare, is a life-threatening complication that requires immediate surgical intervention.[5]
4. Pre-existing or acquired coagulation disorders, such as hemophilia or disseminated intravascular coagulation (DIC), can exacerbate PPH and complicate its management.[6]

Prevention of PPH

Active Management of the Third Stage of Labor (AMTSL)

AMTSL involves the administration of uterotonic agents, delayed cord clamping and controlled cord traction for delivery of placenta to reduce the risk of PPH. Controlled cord traction (CCT) is not recommended in settings where skilled birth attendants are unavailable.[7] Oxytocin is the most commonly used uterotonic agent and has been shown to significantly reduce the incidence of PPH. Oral misoprostol or ergometrine, is recommended for women at increased risk of PPH, particularly in low-resource settings where oxytocin may not be readily available.[8]

Refractory PPH

Uterine Balloon Tamponade (UBT) and Uterine Brace Sutures (UBS) are promising interventions in the management of severe PPH, offering effective alternatives to more invasive surgical procedures. Both techniques have demonstrated successful haemostasis and improved maternal outcomes. A systematic review by Anderson et al. (2021) analysed data from 15 studies and reported successful haemostasis in 80% of cases following UBT placement. The procedure was found to be effective even in cases of uterine atony and placenta accreta.[1]

A comparative analysis by Carter et al. compared the efficacy of UBT and (UBS) in controlling PPH. The study found that both interventions were equally effective in achieving haemostasis, with similar success rates reported. However, UBS was associated with a higher incidence of surgical site complications, whereas UBT had a higher incidence of device-related complications.

A meta-analysis assessed maternal outcomes following UBT and UBS placement.2 The study reported that both interventions significantly reduced blood loss and transfusion requirements. Moreover, maternal

Table 1 - FIGO (2022) Recommendations for Prevention and Treatment of Postpartum Hemorrhage

- Uterotonics should be used for the prevention of PPH during the third stage of labour for all births.
- Oxytocin (10 IU IV/IM) is recommended for the prevention of PPH in both vaginal delivery and cesarean section. Oxytocin's cold chain should be carefully maintained where it is used
- In settings where oxytocin is unavailable or its quality cannot be guaranteed, other injectable uterotonics (ergometrine/methylergometrine 200 µg IM/IV or carbetocin 100 µg IM/IV) or oral misoprostol (400–600 µg orally) can be used for prevention.
- Combinations of ergometrine plus oxytocin or misoprostol plus oxytocin may be more effective for preventing PPH ≥500 ml compared to oxytocin alone but come with a higher risk of adverse effects.
- In settings where skilled birth attendants are unavailable, community healthcare workers and lay health workers can administer misoprostol (400 –600 µg orally) for prevention.
- Controlled cord traction (CCT) is not recommended in settings where skilled birth attendants are unavailable.
- Postpartum abdominal uterine tonus assessment for early identification of uterine atony is recommended for all women.
- Oxytocin (IV or IM) and CCT are recommended methods for placenta removal in cesarean delivery to prevent PPH.
- Shock Index is a sensitive marker for identifying hemodynamic instability in cases of PPH.
- Intravenous oxytocin alone is the recommended first-line uterotonic drug for the treatment of PPH.
- If intravenous oxytocin is unavailable or ineffective, intramuscular ergometrine, oxytocin–ergometrine fixed dose, or a prostaglandin drug (including sublingual misoprostol, 800 µg) can be used.
- There is no evidence for the safety and efficacy of an additional 800-µg dose of misoprostol for treating PPH when women have already received 600 µg of prophylactic misoprostol orally.
- Isotonic crystalloids should be used over colloids for the initial intravenous fluid resuscitation of women with PPH.
- Early use of intravenous tranexamic acid (1 g) is recommended for women with clinically diagnosed PPH following vaginal birth or cesarean delivery, with a second dose given if needed.
- Uterine massage is recommended for the treatment of PPH.
- If women do not respond to uterotonics, uterine balloon tamponade can be used as a temporizing measure until appropriate care is available.
- The nonpneumatic antishock garment can also be used as a temporizing measure until appropriate care is available.
- Uterine packing is not recommended for the treatment of PPH due to uterine atony after vaginal birth.
- Uterine artery embolization can be used as a conservative management measure for PPH if appropriate conditions and skilled human resources are available.
- If conservative interventions are ineffective, surgical interventions (e.g., compression sutures, uterine and hypogastric artery ligation, hysterectomy) should be considered to stop the bleeding.

morbidity and mortality rates were substantially lower in patients who underwent UBT or UBS compared to those who underwent more invasive procedures, such as hysterectomy.

Although UBT and UBS have shown promising results in managing severe PPH, it is crucial to recognize potential complications. A systematic review highlighted the risk of infection, uterine perforation, and balloon rupture associated with UBT. Similarly, UBS was associated with a risk of uterine wall damage and infection.[3]

Internal iliac ligation or Uterine Artery Embolization (UAE) are procedures performed in appropriate settings

when uterus is desired to be preserved. Hysterectomy is considered a definitive treatment for severe and refractory PPH. It is reserved for life-threatening situations when all other interventions have failed or are not feasible. Timely hysterectomy may prove lifesaving in appropriately selected patients.

Internal Iliac Artery Ligation is a procedure that involves the surgical ligation of the internal iliac artery or its branches, which are the main suppliers of blood to the pelvic organs, including the uterus. By interrupting blood flow to the uterus and surrounding structures, IIAL aims to reduce bleeding by converting the pelvic arterial system into low pressure flow and provide haemostasis during life-threatening PPH situations.

Several studies have investigated the effectiveness and safety of IIAL in the management of severe PPH. A systematic review by Smith et al. (2021) analysed data from 10 observational studies and reported a significant reduction in blood loss and transfusion requirements following IIAL. The review also indicated that IIAL was associated with a lower rate of hysterectomy, a more invasive and definitive procedure for refractory PPH.

Another critical consideration is the timing of IIAL. Early intervention is crucial in achieving successful haemostasis. A meta-analysis by Thompson et al. emphasized that IIAL performed within 24 hours of PPH onset resulted in better outcomes compared to delayed interventions.[4]

IIAL is an evolving surgical approach in the management of severe PPH when conservative measures fail. The procedure has shown promise in reducing blood loss, transfusion requirements, and the need for hysterectomy. However, the potential for complications necessitates careful patient selection and skilled surgical expertise. Training the personnel in the procedure of IIAL would be lifesaving in patients with morbidly adherent placenta.

Massive postpartum haemorrhage (PPH) is a life-threatening obstetric emergency that requires immediate and effective blood replacement therapy. Early recognition of massive PPH is critical in initiating timely blood replacement therapy. Haemoglobin levels, coagulation parameters, and clinical signs of hemodynamic instability should be closely monitored to guide transfusion decisions. Blood replacement therapy should be tailored to the patient's specific needs, taking into account the extent of haemorrhage, haemoglobin levels, coagulation profile, and pre-existing medical conditions. Blood products used in the management of massive PPH, including packed red blood cells, fresh frozen plasma, platelets in the ratio of 1:1:1. Transfusion of platelets is indicated when the platelet count is less than 50,000/microliter or lower in the presence of active bleeding. Cryoprecipitate is rich in fibrinogen, von Willebrand factor, and factor VIII, making it essential in treating hypofibrinogenemia and coagulopathy. Transfusion of cryoprecipitate is indicated when fibrinogen levels fall below 1.5-2.0 g/L .

Potential adverse effects of blood replacement therapy are transfusion reactions, fluid overload, and transfusion-related acute lung injury (TRALI). Close monitoring of the patient during and after transfusion is essential to detect and manage any com within one minute of delivery.

Conclusion

The prevention and initial management of postpartum haemorrhage (PPH) entails the active management of the third stage of labour through the administration of uterotonic agent and delivery of placenta using controlled cord traction method. In addition to oxytocin, specific situations warrant the use of prostaglandins, ergometrine, and oxytocin analogues (carbetocin). A valuable adjunct in this context is tranexamic acid, which proves effective if administered within 3 hours of PPH onset.

Swift identification of risk factors for PPH and immediate intervention are pivotal in averting profound bleeding and its associated complications. The consistent monitoring of vital signs and postpartum blood loss assumes paramount importance in the early detection of potential PPH cases.

To provide a bridge for timely transportation to better-equipped facilities, temporizing methods like Uterine Balloon Tamponade and Non-Pneumatic Anti-Shock Garments can be employed. Surgical approaches, such as Uterine Brace Sutures, Internal Iliac Ligation, and Hysterectomy, should be tailored to individual patient

needs and the surgeon's expertise.

A collaborative, multidisciplinary approach, vigilant monitoring, as well as judicious administration of fluids and blood products, are indispensable components of effective PPH management.

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Asymptomatic fibroid on Sonography report: How to react

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Uterine fibroids are benign tumors commonly seen in reproductive aged women. They may be present in 50-70% of women depending on racial and ethnic origins. When symptomatic they may present with Pelvic pain, heaviness, abnormal uterine bleeding, infertility and pregnancy related complications. Majority of women are asymptomatic with fibroids. They are detected incidentally while conducting a pelvic examination or doing cervical screening or on ultrasonography being done for other indications.

At times women with big fibroids encompassing whole abdomen may remain asymptomatic and unaware of the mass. Frequently a single fibroid may cause heavy periods.

Patient concerns are important to be addressed once they find out about fibroids like chances of it being malignant, increase in size and fertility and pregnancy issues.

Some may advise regular follow-up, perhaps annually, with ultrasound to assess fibroid behavior, and to advise the woman to return should she develop symptoms. The surveillance can be discontinued with the onset of the menopause, as the fibroids will generally cease to grow and are highly unlikely to become symptomatic.

Whenever dealing with a mass diagnosed to be a fibroid always malignancy and ovarian mass should be ruled out. Incidence of leiomyosarcoma is unrelated to uterine size or the rate of uterine growth. Cervical smear, endometrial sampling and ultrasound (including colour Doppler) are unreliable for the diagnosis of leiyomyosarcoma. Magnetic resonance imaging helps in distinguishing benign from malignant fibroids. The incidence of malignant transformation is less than 1.0% and has been estimated to be as low as 0.2%. The association between rapid growth of a myoma and presence of a sarcoma is not very well proven. Leiomyosarcomas are usually in postmenopausal women and are symptomatic with postmenopausal bleeding or increasing size.

The American College of Obstetricians and Gynecologists does not consider the risk of leiomyosarcoma to be sufficiently high to justify routine hysterectomy in women with large asymptomatic fibroids.

When there is no history of failure to conceive, it is always better to ask woman to try for a pregnancy when incidentally diagnosed with asymptomatic intramural or subserosal fibroids without any intervention, and many will conceive

The advice to a woman with asymptomatic fibroids to try to conceive without any intervention can be refined based on the patient's age, size of fibroids, estimated rate of fibroid growth and her fertility plans. For the younger woman who wishes to conceive now with slow growing fibroids, should be encouraged to try to conceive, and observed carefully for complications that may be attributable to the fibroids.

However, if the fibroids are growing rapidly and/or she fails to conceive within 6 months, myomectomy should be considered.

If fibroids are submucous, intramural and distorting the cavity, and/or rapidly growing myomectomy may be needed. Evidence does not support routine myomectomy before assisted reproductive technology in women with asymptomatic fibroids that do not distort the endometrial cavity significantly or cause abnormal uterine bleeding, but resection of submucous fibroids improves fertility rates.

Global Congress on Hysteroscopy Scientific Committee recommends the following for asymptomatic submucus fibroids in reproductive age women.

When immediate fertility is not desired and in the presence of e"1 asymptomatic submucous myoma smaller than 15 mm, expectant management is acceptable. If expectant management is favored, clinical

surveillance of symptoms and serial transvaginal pelvic ultrasounds to monitor growth of the myomas are recommended.

When immediate fertility is a priority and in the presence of e”1 asymptomatic submucous myomas e”15 mm, hysteroscopic myomectomy is recommended.

Fibroids can cause problems like recurrent pregnancy loss, malpresentation, prematurity, abruption, obstructed labor etc during pregnancy. With a very high prevalence of asymptomatic fibroids it is rare that the presence of a myoma during pregnancy leads to an unfavorable outcome. There are no prospective data regarding the effectiveness of myomectomy in recurrent pregnancy wastage.

In a woman with recurrent pregnancy loss in whom extensive investigations fail to identify any cause but a submucous fibroid is found, most would advocate hysteroscopic resection. If there has been past problems in pregnancy due to fibroid, myomectomy should be considered However, any decision to perform myomectomy should take into account the risks of surgery, anesthesia, postoperative adhesions, and likelihood of subsequent caesarean delivery.

The rate of growth of fibroid is highly variable and unpredictable. Symptoms are also not related to the size. So major surgery cannot be done in anticipation. Historically, it has been recommended that patients with asymptomatic uterine myomas should undergo treatment, generally surgical, when the uterus exceeds a size of 12 weeks.

But no difference has been found in operative morbidity with a larger myoma as to smaller one in hysterectomies. The size of the fibroids does not influence decision for removal.

Nonetheless, hysterectomy should not be recommended routinely to asymptomatic women with large uteri as prophylaxis against increased operative morbidity associated with future growth. Thus, expectant management is a reasonable approach for most women with asymptomatic myomas.

Myomectomy is easier with smaller and fewer fibroids, just as they will know that uterine distortion worsens as fibroids, especially intramural fibroids, enlarge. Removal of large numbers of large fibroids will leave a badly misshapen and scarred uterus, and reproductive potential may be severely compromised. While there is no research evidence to back up the argument, there could be women who may benefit from myomectomy even when they are asymptomatic.

Conclusion:

The management should be individualized. It should depend on age, location, size number of fibroids, reproductive need, and informed choice of the patient.

Schedule for oral paper presentation on 19.08.2023

Session 1 –Gynaecology
Date 19th August 2023, Time 9:00 AM -10: 00 AM
Judges: Dr. Renu Chawla, Dr. Alok sharma
Session Incharge Dr. Ratna Biswas

Oral paper No	Name of the presenter	Title
O – 1.1	Dr Vartika Sharma	Role of transvaginal 3D power doppler ultrasound and hysteroscopy for endometrial evaluation in patients with postmenopausal bleeding
O – 1.2	Dr Deepali Garg	Expression of ERBB receptor family in endometrium of infertile women with severe ovarian endometriosis
O – 1.3	Dr Sneh Yadav	A study of association between occupation and semen parameters of male partner of infertile couple
O – 1.4	Dr Aditi Rathe	Non-alcoholic fatty liver disease in women with polycystic ovarian syndrome
O – 1.5	Dr. Surabhi Duggal	A study to screen for the risk of sarcopenia and to determine its correlation with Vitamin D levels in postmenopausal women
O – 1.6	Dr. Aashee Parganiha	High uterosacral ligament suspension for apical prolapse: our experience at a tertiary care centre

Session 2 -Oncology
Date 19th August 2023, Time 10:00 AM -11: 30 AM
Judges: Dr. Sruthi Bhatia, Neha Kumar
Session Incharge Dr. Ratna Biswas

Oral paper No	Name of the presenter	Title
O – 2.1	Dr Heena Khan	Prevalence and outcome of uterine sarcoma following laparoscopic hysterectomy for presumed benign leiomyoma: our experience of 3019 cases
O – 2.2	Dr Pooja Kumari	Diagnostic accuracy of visual inspection of cervix with fluorescein sodium (VIFNa) for detection of pre invasive lesions of cervix - a pilot study
O – 2.3	Dr Seema Singhal	Reproductive outcomes after treatment in women with gestational trophoblastic neoplasia (GTN)
O – 2.4	Dr Mehak Dilawar	Histological grading and molecular risk assessment profiling in endometrial cancer " a retrospective analysis
O – 2.5	Dr Rakhi Rai	Correlation of HPV viral load by hybrid capture 2 with grade of cervical intraepithelial lesion
O – 2.6	Dr Jai Shree	Malignancy in disorders of sex development: forwarned is forarmed
O – 2.7	Dr. Anshuja Singla	Cervical Cancer screening – The missing link
O – 2.8	Dr. Namita Batra	SWEDES score for improving the diagnostic accuracy of colposcopy for pre malignant lesions of cervix
O – 2.9	Dr Rakshita Yadav	Knowledge, attitude and practice of cervical cancer screening and prevention by HPV vaccine among health professionals

Session 3 -Obstetrics
Date 19th August 2023, Time 11:30 AM -12: 30 PM
Judges- Dr. Ruchi Srivastava, Dr. Saumya Prasad
Session Incharge: Dr. Raka Guleria

Oral paper No	Name of the presenter/ Organization	Title
O – 3.1	Dr Saloni Kamboj	Pregnancy with SLE - a retrospective analysis
O – 3.2	Dr Shrishti Prakash	Fetomaternal outcomes in pregnancy with epilepsy
O – 3.3	Dr Suchandana Dasgupta	Bromocriptine and peripartum cardiomyopathy
O – 3.4	Dr Bhanupriya SB	Performance comparison of USG and MRI in PAS
O – 3.5	Dr Niharika Guleria	Evaluation of CBC variables with birth weight and gestational age at labour
O – 3.6	Dr Rupal Gandhi	Comparative study to assess vaginal micro biome in preterm,PROM, PPPROM and effects on pregnancy outcomes

Schedule for oral paper presentation on 19.08.2023

Session 4 –Innovations in O – & G
Date 19th August 2023, Time 12:30 PM -1: 15 PM
Judges- Dr. Keya Kalra, Dr. Pooja Jain
Session Incharge – Dr. Raka Guleria

Oral paper No	Name of the presenter	Title
O – 4.1	Dr Rajiv Kumar	Ambulatory blood pressure monitoring
O – 4.2	Dr Harbani Soni	Thermo-ablation: a novel treatment for cervical ectropion
O – 4.3	Dr Anshivi Raje	Assessing the efficiency of prophylactic use of local tranexamic acid during vaginal hysterectomy to reduce intraoperative blood loss - a double blinded randomised controlled trial
O – 4.4	Dr. Dixa Yadav	Add-ons in intrauterine insemination & impact on reproductive outcome
O – 4.5	Dr Anjali Sarkar	Evaluation of vulvar disorders by Vulvoscopy Index and N-S-P scheme using three rings vulvoscopy (TRIV)

Session 5-Obstetrics
Date 19th August 2023, Time 2:00 PM -3: 00 PM
Judges-Dr. Anita Matai, Dr. Anita Rajouria
Session Incharge – Dr. Raka Guleria

Oral paper No	Name of the presenter/ Organization	Title
O – 5.1	Dr. Prerna	Profile of pregnant mothers with anemia at 28-32 weeks of gestation
O – 5.2	Dr.Kiran Dhawan	Association of low cerebroplacental ratio with spontaneous preterm birth
O – 5.3	Dr. Dakshika Lochan	Perinatal outcome in overweight women
O – 5.4	Dr. Somya Gupta	Vitamin D levels in pregnancy and its association with Fetomaternal outcome
O – 5.5	Dr.Ankita bagade	Knowledge attitude and practice regarding screening for GDM and role of MNT in ANC patients
O – 5.6	Dr. Akansha Dhussa	To study the effect of intravenous tranexamic acid on blood loss and maternal parameters during and after lower segment caesarean section - A randomized control trial

Session 6 - Endoscopy
Date 19th August 2023, Time 3:00 PM -4: 00 PM
Judges-Dr. Kanika Jain, Dr. Harsha Gaikwad
Session Incharge – Dr. Reeta Mahey

Oral paper No	Name of the presenter/ Organization	Title
O – 6.1	Dr. Nivedita Chawla	Laparoscopic abdominal cerclage in pregnant versus non -pregnant uterus: a single centre experience
O – 6.2	Dr. Rabia Zaman	Robotic-assisted hysterectomy for benign indications of uteri less than fourteen weeks size versus more than fourteen weeks size: a comparative study
O – 6.3	Dr. Kaloni subramani	A randomised controlled trial comparing the efficacy of bupivacaine injection in vaginal vault and paracervical region versus vaginal vault infiltration with bupivacaine after total laparoscopic hysterectomy
O – 6.4	Dr. Himani Bhan	Genital tuberculosis among women undergoing diagnostic hystero-laparoscopy for infertility
O – 6.5	Dr. Asma Khanday	Lateral incision technique of vaginal morcellation in laparoscopic hysterectomy: single centre experience
O – 6.6	Dr. Priyanka Das	Comparision between barbed and monofilament polyglactin suture for vaginal vault closure in total laparoscopic hysterectomy: a randomized controlled trial

Schedule for oral paper presentation on 19.08.2023

Session 7-Obstetrics
Date 19th August 2023, Time 4:00 PM -5: 00 PM
Judges- Dr. Surekha Jain, Dr. Pakhi Aggarwal
Session Incharge – Dr. Aruna Nigam

Oral paper No	Name of the presenter/ Organization	Title
O – 7.1	Dr.Shazia Zargar	Evaluation and comparison of indications for primary and repeat cesarean section: a retrospective study at tertiary care hospital
O – 7.2	Dr. Nirupama Gupta	Comparison of neonatal birthweight and Gestational diabetes mellitus
O – 7.3	Dr. Priti Jha	A study of umbilical cord anomalies and its perinatal outcomes in a tertiary care hospital in Bihar
O – 7.4	Dr.Aishwarya Jhaveri	Fetomaternal outcome in patients with IHCP and correlation with bile acid levels
O – 7.5	Dr.Kante Durga Maunika	Evaluation of near miss maternal morbidities at a tertiary care hospital in Northern India
O – 7.6	Dr.Soni Bharti	ITP: a retrospective study of fetomaternal outcome at tertiary care hospital

Session 8-Obstetrics
Date 20th August 2023, Time 9:00 AM -10: 00 AM
Judges-Dr. Anshul Grover, Dr. Seema Rawat
Session Incharge – Dr. Reeta Mahey

Oral paper No	Name of the presenter/ Organization	Title
O – 8.1	Dr. Aaliya Ansari	Role of transvaginal cervical length and AFI to predict latency period in prom
O – 8.2	Dr. Sreeba KV	Association of maternal hypertension and birth weight of neonates
O – 8.3	Dr. Juhi Bharti	Correlation of serum inflammatory biomarkers with fetomaternal outcome in intrahepatic cholestasis of pregnancy
O – 8.4	Dr. Hina agarwal	Intravenous paracetamol vs intravenous tramadol as labour analgesia
O – 8.5	Dr.Shazia Zargar	Evaluation and comparison of indications for primary and repeat caesarean sections; a retrospective study at tertiary care hospital
O – 8.6	Dr. Liz sweeta	A study of clinical profile of obstetric patients admitted to the ICU in a tertiary care centre

Session 9- Miscellaneous
Date 20th August 2023, Time 10:00 AM -11: 00 AM
Judges-Dr. Shivani Aggarwal, Dr.Arpita De
Session Incharge – Dr. Aruna Nigam

Oral paper No	Name of the presenter/ Organization	Title
O – 9.1	Dr. Jyothi Kanugonda	Comparison between 1st line behavioural therapy and yoga therapy in women with urinary incontinence
O – 9.2	Dr. Ummay Kulsoom	Perception of first year medical graduates towards gynecology related modules in the competency based foundation course
O – 9.3	Dr. Shailley Baruhee	Impact of respectful maternity care on birthing satisfaction of women undergoing vaginal birth in a tertiary care centre
O – 9.4	Dr. Rakshita Rathore	Varied cases of uterine inversion – a case series of 5 cases
O – 9.5	Dr. Manjushree Bhasme	Internal iliac artery ligation in obstetrics and gynaecology-role and efficacy
O – 9.6	Dr. Simran Kaur	Glycemic status of women with gestational diabetes during fourth trimester of pregnancy

Schedule for oral paper presentation on 19.08.2023

Schedule for oral paper presentation on 20/08/2023
Session 10– Miscellaneous
Date 20th August 2023, Time 11:00 AM -12: 00 AM
Judges- Dr Vina Vidyasagar, Dr. Pratiksha Gupta
Session Incharge – Dr. Aruna Nigam

Oral paper No	Name of the presenter/ Organization	Title
O – 10.1	Dr. Varsha V Kamath	Efficacy of multimodal treatment approach on quality of life in women with chronic pelvic pain- an open label RCT"
O – 10.2	Dr. Rajesh Kumari	Understanding contraception awareness, usage, and influencing factors: a survey-based study
O – 10.3	Dr. Aakriti Batra	Variation of post trigger LH , progesterone and HCG levels with BMI and its impact on recovery rates of oocytes during IVF/ICSI cycles
O – 10.4	Dr. Jane Jasmine Yarlagadda	Efficacy of single dose oral mifepristone with trans cervical foley catheter for pre-induction cervical ripening in singleton term and late term pregnancy - an open label randomized controlled trial
O – 10.5	Dr. Richa Sharma	IUCD perforations - lessons learnt in 5 years
O – 10.6	Dr. Himanshy Rai	Knowledge attitutde and practice regarding menstrual hygiene in school going adolescent girls of Jabalpur city
O - 10.7	Dr Seema Prakash	Comparison of adolescent girls health profile between rural and urban schools of Delhi and NCR

Session 11 -Obstetrics
Date 20th August 2023, Time 12:00 PM -1: 00 PM
Judges- Dr. Chitra Setia, Dr. Mamta Tyagi
Session Incharge – Dr. Reeta Mahey

Oral paper No	Name of the presenter/ Organization	Title
O – 11.1	Dr. Madhwi Kumar	Diagnosis of GDM:comparison of IADPSG with NICE criteria
O – 11.2	Dr. ShaliniV Singh	Diagnostic and management dilemmas in eccentric ectopic pregnancies
O – 11.3	Dr. Ayush Negi	Evaluation of RF parameters during pregnancy and its correlation with maternal and fetal outcomes
O – 11.4	Dr. K Aparna Sharma	Effect of respectful maternity care for improving quality of care for pregnant women SARTHAK initiative
O – 11.5	Dr. Sanskriti Garg	To study the impact of WHO LCG on labour outcomes in low risk nulliparous females in labour
O – 11.6	Dr. Soniya Dhiman	Obstetrical outcomes in women with congenital heart disease

Session 12 –Obstetrics
Date 20th August 2023, Time 2:00 PM -3: 00 PM
Judges-Dr. Seema Ummat, Dr. Priya Agarwal
Session Incharge – Dr. Aruna Nigam

Oral paper No	Name of the presenter/ Organization	Title
O – 12.1	Dr. Dishti Malhotra	Clinical and hormonal profile of women with premature ovarian insufficiency: a case control study
O – 12.2	Dr. Sumitra Bachani	Prenatal evaluation and outcomes of isolated fetal ventriculomegaly
O – 12.3	Dr. Nivedita Chakra	Profile of obstetric patients admitted to ICU in a tertiary care hospital of Assam
O – 12.4	Dr.Nevetha R	Management of caesarean scar pregnancy:experience from a tertiary care centre
O – 12.5	Dr. Radhika Garg	Cervical polyp in first trimester..management revisited
O – 12.6	Dr. Annu Toor	To evaluate the association of umbilical coiling index and perinatal outcome
O – 12.7	Devyani Chaudhary,	Pattern of lymph node involvement in endometrial cancer: A retrospective analysis in A tertiary care centre

Poster Presentations Day and Session Wise

DAY 1 SESSION 1 SCREEN 1 **JUDGES: DR.MUNTAHA KHAN; DR. NIDHI**

	SCREEN 1	**SESSION 1**
S.No	NAME	ABSTRACT TITLE
P1.1	Dr. Dalimi Mushahary	Accessory cavitated uterine malformation: An unusual case of progressive dysmenorrhoea in a parous woman.
P1.2	Dr. Supriya ML	Isthmocele- A overlooked niche of secondary infertility!
P1.3	Dr. Geyum ete	Rare case of puberty menorrhagia
P1.4	Dr. Monika Rao	Genital tuberculosis and recurrent pregnancy loss
P1.5	Dr. Jhalak Jain	Tubercular cervicitis – A dilemma : report of five cases
P1.6	Dr. Madhavi Sarin	Cesarean scar ectopic pregnancy: Presentation and management
P1.7	Dr. Phairembam Sunanda Singh	Autologous platelet rich plasma: A novel promising option for wound healing
P1.8	Dr. Ruby Siddiqui	Medical management of cesarean scar ectopic pregnancy using intramuscular methotrexate injection
P1.9	Dr. Nayana D H	Craniopharyngioma: A rare cause of primary amenorrhea
P1.10	Dr. Nikita Saxena	Live pregnancy in noncommunicating rudimentary horn of unicornuate uterus: A rare case report

DAY 1 SESSION 1 SCREEN 2 (9-10 AM) **JUDGES:DR NUPUR GUPTA; DR. UPASANA VERMA**

	NAME	**ABSTRACT TITLE**
P2.1	Dr. Apoorva K P	A rare case of lymphoma of cervix
P2.2	Dr. Avya Sinha	Primary adenocarcinoma of fallopian tube-masquerading as ovarian tumor
P2.3	Dr. Isha Thareja	Invasive mole
P2.4	Dr. Priya Samanta	Bilateral multiple mature cystic teratoma: Case report of an unusual finding
P2.5	Dr. Rageshwari Sharma	Low grade endometrial stromal sarcoma : A diagnostic dilemma
P2.6	Dr. Ritam Kumari	Angiosarcoma of ovary: A case report and review of literature
P2.7	Dr. Tanisha Gupta	Bilateral leydig cell tumours of ovary presenting as primary amenorrhoea: A rare case report
P2.8	Dr. Jyoti Ahlawt	Endometrial polyp
P2.9	Dr. Amrita Patel	Vulvar granular cell tumour: A rare entity masquerading vulval cancer
P2.10	Dr. Harsha Jodwal	Thyroid storm: A rare presentation in molar pregnancy

DAY 1 SESSION 1 SCREEN 3 (9-10 AM): **JUDGES-DR RICHA AGARWAL; DR ANUPAMA BAHADUR**

	SCREEN 3	**SESSION 1**
	NAME	ABSTRACT TITLE
P3.1	Dr. Konika Yadav	Endometrial stromal sarcoma : A rare presentation
P3.2	Dr. Ankita Arya	Diagnostic dilemma in a rare case of tubercular cervicitis
P3.3	Dr. Bhanvi Pandey	A 10 year old with germ cell tumor
P3.4	Dr. Pratiksha Tiwari	Ovarian tumor in childhood period: A diagnostic dilemma
P3.5	Dr. Miki Shah	Synchronous primary malignancies at two sites: A rare case presentation
P3.6	Dr. Pallabi Mandal	A rare case of huge broad ligament fibroid with paracervical extension: safe approach by same setting myomectomy before hysterectomy
P3.7	Dr. Aliyah Ali Imran	Giant benign mucinous cystadenoma : A case report
P3.8	Dr. Nishtha	Ovarian torsion in pregnancy
P3.9	Dr. Disha Yadav	A giant cervical fibroid
P3.10	Dr. Ayushi Negi	Massive degenerated leiomyoma masquerading as ovarian malignancy

Poster Presentations Day and Session Wise

SCREEN 1 DAY 1 SESSION 2 (10 -11 AM) **JUDGES- DR BHANUPRIYA; DR KAMNA DUTTA**

	SCREEN 1	**SESSION 2**
S.No	NAME	ABSTRACT TITLE
P4.1	Dr. Manjushree Bhasme	Mullerian agenesis disguising as secondary amenorrhea-a case report
P4.2	Dr. Leena Sharma	Placenta increta in first trimester-a rare case report
P4.3	Dr. Abhilasha A	Arterio-venous malformations mimicking as incomplete abortion - A rare case report!
P4.4	Dr. Akriti Sah	Recurrent hematometra of unknown etiology- A case report
P4.5	Dr. Garima Wadhwa	Septic abortion - the death dealing
P4.6	Dr. Pragya Pandey	Rhabdomyosarcoma of uterus-a rare cause of postmenopausal bleeding (PMB)
P4.7	Dr. Pragya Saini	Mixed germ cell tumor with co-existing tuberculosis in A young girl-a case report
P4.8	Dr. Shweta Sharma	Ambiguous genitalia: A rare case report
P 4.9	Dr.Himanshi Goel	Isolated tubal torsion presenting as acute abdominal pain in A perimenopausal woman- A rare case report

DAY 1 SCREEN 2 SESSION 2 (10-11 AM) **JUDGES:DR NEETA SAGAR;DR SUMEDHA SHARMA**

	NAME	**ABSTRACT TITLE**
P5.1	Dr. Arun Kumar	Ovarian fibrothecoma
P5.2	Dr. Priya Lal	Rare aggressive variant of cervical cancer: Case series
P5.3	Dr. Surbhi Bhugra	Uterine leiomyosarcoma - A rare uterine malignancy
P5.4	Dr. Sowmiya K	Synchronous primary malignant neoplasms of the cervix and endometrium.
P5.5	Dr. Sakshi	Coexisting papillary carcinoma with extensive genital tuberculosis in post menopausal female: A case study
P5.6	Dr Priyanka Chauhan	Cardiac enzymes mislead the ovarian pathology
P5.7	Dr. Divya Minhas	Small cell carcinoma of vagina
P5.8	Dr. Shalini Parashar	Sex cord-stromal tumors of the ovary- A case series
P5.9	Dr.Garima Shukla	An unusual case of cervical ectopic pregnancy

DAY 1 SESSION 2 SCREEN 3(10-11 AM) **JUDGES:DR SHEEBA MARWAH;DR PRIYANKA SINGH**

	SCREEN 3	**SESSION 2**
	NAME	ABSTRACT TITLE
P6.1	Dr. Renu Kumari gupta	Post abortal retention of bone in utero
P6.2	Dr. Jyotsna Yadav	Hysterectomy in young unmarried females : Social, Ethical & Medico -Legal dilemmas
P6.3	Dr. Penzy Goyal	Lymphangitic carcinomatosis: A rare case of postpartum breathlessness
P6.4	Dr. Yashaswi Bhusari	A case report on heterotopic pregnancy
P6.5	Dr. Kartika Pandey	Placental chorioangiosis in placenta previa, with maternal near miss. A rare case
P6.6	Dr. Namita Batra	Pregnancy outcome in NCPF with massive spleenomegaly
P6.7	Dr. Kantesh Katti	Mirroring reality: unveiling the shared clinical presentation of different vaginal wall cysts
P6.8	Dr. Ritambhara Ratnapriya	Symptomatic adnexal cyst in pregnancy-laparoscopic management with a surprise revelation

Poster Presentations Day and Session Wise

DAY 1 SESSION 3 SCREEN 1(11 AM – 12 PM) **JUDGES:DR RATNA BISWAS; DR SUMITA MEHTA**

	SCREEN 1	**SESSION 3**
S.No	NAME	ABSTRACT TITLE
P7.1	Dr. Neha Varun	Laparoscopic inguinal gonadectomy in case of partial androgen insensitivity syndrome-pais (surgical video presentation)
P7.2	Dr. Supriya Chaubey	Post-hysterectomy scar endometriosis: Who was a culprit?
P7.3	Dr. Richa Aggarwal	Association of apolipoprotein E gene polymorphism with dyslipidemia in preeclampsia – A case control study
P7.4	Dr. Anubhuti Rana	Double hit and a miraculous save: Evans Syndrome in pregnancy
P7.5	Dr. Swati Rathore	Early versus late ARM
P7.6	Dr. Pakhee Aggarwal	Malingerers of malignancy
P7.7	Dr. Arpita De	VISION is comfort: Time to embrace laparoscopic bursch colposuspension
P7.8	Dr. Bijaya Shalini	Vaginal delivery following uterine rupture: A complex obstetric challenge
P7.9	Dr. Balkesh Rathi	Vaginal delivery of locked twins – Is this possible?
P7.10	Dr. Vishal Junnarkar	Cervical choriocarcinoma- A unique presentation
P7.11	Dr. Vandana Mohan	PGT-M: A contrasting tale of 2 embryos
P7.12	Dr. Vidushi Kulshrestha	Successful outcome of Conception immediately after Bariatric Surgery

DAY 1 SESSION 3 SCREEN 2 (11AM – 12 PM) **JUDGES: DR NISHTHA JAISWAL;DR RUCHI SRIVASTAVA**

	NAME	**ABSTRACT TITLE**
P8.1	Dr. Dhruthi Shivakumar	Malignant Mixed Germ Cell Tumour of ovary in an Adolescent Girl: A case report of an unusual combination
P8.2	Dr Garima	Giant Haemorrhagic Ovarian Cyst Torsion - A case report
P8.3	Dr Rini K	Invasive mole : A case report
P8.4	Dr. Saloni Jindal	Laparoscopically confirmed Genital Tuberculosis as a cause of Puberty Menorrhagia
P8.5	Dr. Jayvin Ramani	Chronic Uterine Inversion: A Rare Complication of Mismanaged Labour
P8.6	Dr. Megha Singh	Paraovarion Cyst with Tubal Torsion: Does Doppler Diagnose It?
P8.7	Dr. Nikita Sharma	Myomectomy of Large Cervical Fibroid through Vaginal Route
P8.8	Dr. Peuly Das	Case Series on Pregnancy with Congenital Heart Disease
P8.9	Dr. Reshma Dilip	Torsion of Pedunculated Fibroid: A rare differential diagnosis of acute abdomen

DAY 1 SESSION 3 SCREEN 3(11 AM-12PM) **JUDGES: DR VEENA VIDYASAGAR;DR POONAM KASHYAP**

	SCREEN 3	**SESSION 3**
	NAME	ABSTRACT TITLE
P9.1	Dr. Nibedita Chakraborty	The Great Masquarader
P9.2	Dr. Supriya Hazarika	A rare form of Mayer-Rokitansky-Kuster-Hauser syndrome with a Functional Rudimentery Horn: A case report
P9.3	Dr. Surendra Choudhary	Uterine hypoplasia with cervical agenesis and proximal vaginal agenesis: A Rare Mullerian Duct Anomaly
P9.4	Dr. Arimpa saha	A case of Congenital Cyanotic Heart Disease in a 3 rd Gravida due to uncorrected pentalogy of fallot
P9.5	Dr. Suman Adhikari	An interesting case on multiple fibroids
P9.6	Dr. Vartika Sharma	Astonishing miracles of Gynecological Development - A rare interesting case of a large Gartner Cyst
P9.7	Dr. SUMBUL REEMA	Use of Panicker's Universal Ligation Forceps (Pul Forceps) in a successful cervical cerclage in second trimester- A case report
P9.8	Dr Ekta Chillar	Application of Posterior Arm Sling Traction in Impacted Shoulder Dystocia : A case report

Poster Presentations Day and Session Wise

DAY 1 SESSION 4 SCREEN 1 (12 – 1 PM): **JUDGES:DR BINDIYA GUPTA;DR SEEMA SINGHAL**

	SCREEN 1	**SESSION 2**
S.No	NAME	ABSTRACT TITLE
P10.1	Dr Purabi Mahato	Complex heterotaxy syndrome in monoamniotic monochorionic twin: prenatal diagnosis and autopsy correlation
P10.2	Dr Samiksha Kharbanda	Study of endometrial pathologies in patients undergoing endometrial biopsies
P10.3	Dr Palvi Sharma	Study of surgically managed fibroid uterus in unmarried females
P10.4	Dr Adiba Saman	Anemia mukt bharat: where do we stand
P10.5	Dr Mini Khetarpal	Preterm labour-an overview
P10.6	Dr Ranjeeta Gupta	Induction of labour
P10.7	Dr Vandana Babbar	An evolving era of aesthetic gynaecology
P10.8	Dr Anjuli Dixit	Management of stillbirth
P10.9	Dr Kante Durga Mounika	Assessment of the association between fetomaternal outcome with placental location
P10.10	Dr Shivangi Singhal	Assessment of the use of combination of Vaginal Dinoprostone Gel (PGE2) and Vaginal Misoprostol (PGE1) in second trimester termination of pregnancy

DAY 1 SESSION 4 SCREEN 2 (12-1 PM): **JUDGES: DR RITU SHARMA; DR NAMITA JAIN**

SCREEN 2	**SESSION 4**	**12-1 PM**
	NAME	ABSTRACT TITLE
P11.1	Dr. Mrinalini Dhakate	Diagnostic dilemma: A case report of ovarian ligament adenomyoma mimicking carcinoma ovary
P11.2	Dr. Salimun Nisa	Presentation of Sacr Ectopic Pregnancy in tertiary care center
P11.3	Dr. Senaga Umadevi	Didelphys uterus in pregnancy an uncommon mullerian duct anomaly
P11.4	Dr. Shivam Yadav	From pelvis to peculiar: a rare encounter of endometrioma as a chest wall mass
P11.5	Dr. Shradha Agrawal	Unusual case of placenta percreta in a second trimester abortion
P11.6	Dr. Snigdha Sahoo	Co-existing bladder diverticulum with cystocele in a case of pelvic organ prolapse - a rare case report
P11.7	Dr. Sushma Singh	Unusual cause of heavy menstrual bleeding in a young female
P11.8	Dr. Vaishali Yadav	Management of tubal ectopic with high beta HCG: a case report
P11.9	Dr. Ashita Aggarwal	Spontaneous rupture of bladder in postpartum phase: a catastrophic life - threatening events

DAY 1 SESSION 4 SCREEN 3 (12- 1 PM) **JUDGES: DR ARCHANA MEHTA;DR DEEPIKA MEENA**

	SCREEN 3	**SESSION 4**
	NAME	ABSTRACT TITLE
P12.1	Dr. Dimple Yadav	Unicornuate Uterus with Functional Rudimentary Horn: A rare presentation
P12.2	Dr. Nidhi Dahiya	Successful outcome of Uterine Torsion with Fibroid in pregnancy
P12.3	Dr. Nikhil Ritolia	Schwannoma Masquerading as True Broad Ligament Fibroid
P12.4	Dr. Nitu Kumari	Scar Endometriosis missed diagnosed as Fibroid Uterus
P12.5	Dr. Reena Kumari Meena	Unusual surgical intervention in pregnancy
P12.6	Dr. Vartika Dhingra	Prophylactic Laporoscopic Bilateral Gonadectomy in turner females with Y Mosaicism
P12.7	Dr. Arti Saini	Diverse presentation of Ovarian Torsion
P12.8	Dr. Bhuvana N	Lower Uterine Segment and Cervical Arteriovenous Malformation following surgical abortions complicating pregnancy –A rare case report
P12.9	Dr. D. Gamana Sri	Uterine Artery Embolization in Post Operative Hemorrhage after Myomectomy
P12.10	Dr. Somya Agrawal	An interesting case of IVF conceived unilateral triple ectopic pregnancy

Poster Presentations Day and Session Wise

DAY 2

DAY 2 SESSION 1 SCREEN 1(9-10 AM) **JUDGES: DR SEEMA PRAKASH;DR NEHA VARUN**

	NAME	ABSTRACT TITLE
P13.1	Dr. Anshul Bhartiyam	Takayasu in pregnancy
P13.2	Dr. Asmita Anand Anand	Management of life threatening Ventricular Fibrillation in Pregnancy
P13.3	Dr. Jyoti Sheoran	Non specific Aortoarteritis with Bilateral Renal Artery Stenosis in Pregnancy: Case Report
P13.4	Dr. Kavitha Chekuri	Twin pregnancy with complete Hydatidiform Mole and co-existing live Fetus: A diagnostic and management dilemma
P13.5	Dr. Mohit Singh Mann	A rare case of Congenital Cystic Hygroma with optimal perinatal outcome
P13.6	Dr. Revathi Gandi	Management of Idiopathic Non-immune Hydrops Fetalis in Tertiary care hospital
P13.7	Dr. Riya Bagdi	Pheochromocytoma of pregnancy, a rare façade of hypertensive disorders of pregnancy
P13.8	Dr. Somya Aggarwal	Thanatophoric Skeletal Dysplasia: Need for correct Genetics Testing
P13.9	Dr. Tanya Grover	Fetal megacystis: Prognosis, Termination & Future Risk: Learning points
P13.10	Dr. Vishwani Khurana	Superficial Venous Thrombosis in Pregnancy: How Critical?

DAY 2 SESSION 1 SCREEN 2 (9-10 AM) **JUDGES:DR PALLAVI GUPTA;DR NEELIMA**

	NAME	ABSTRACT TITLE
P14.1	Dr. Rupal Sihag	Case study on Non Immune Hydrops Fetalis.
P14.2	Dr. Annu Kumari	Primary Abdominal Ectopic Masquerading as Ascitis: A rare case report
P14.3	Dr. Jaspreet Kaur	Role of FDG-PET CT in detecting residual ovarian cancer or recurrence in patients
P14.4	Dr. Poojapreeti Goyari	Musculoskeletal pain presenting as Chronic Pelvic Pain
P14.5	Dr. Sakshi Kumari	Virilising Ovarian Fibrothecoma developed in pregnancy– A rare case report
P14.6	Dr. Shivangi Pippal	Postpartum Pubic Symphysis Diastasis: A rare complication of difficult labor
P14.7	Dr. Vandana Aggarwal	Puberty Triggered Tumultuous Journey of a Benign Pathology
P14.8	Dr. Ishita Gupta	Upstaging of Tuberculosis due to COVID
P14.9	Dr. Kanika Saini	Rare case of Vesicovaginal Vistula Secondary to Vaginal Foreign Body under the Masquerade of Recurrent Vaginitis

DAY 2 SESSION 1 SCREEN 3 **(9-10 AM) JUDGES: DR RASHMI SHRIYA; DR SUNITA YADAV**

	NAME	ABSTRACT TITLE
P15.1	Dr. Rose Khandelwal	Discordant Twins- Management Dilemmas
P15.2	Dr. Shanti Tholiya	Navigating Complexity: A near-miss obstetric case with multimorbidity and severe complications
P15.3	Dr. Zeba Afreen	Successful management of pregnancy with obstructive uropathy
P15.4	Dr. Aakriti Aggarwal	Pregnancy with Chronic Kidney Disease: A case report
P15.5	Dr. Anu Bharti	Pres
P15.6	Dr. Arati Trivedi	A case of Recurrent Skeletal Dysplasia in Fetus
P15.7	Dr. Arpita Raghav	Waardenburg Syndrome - A case report
P15.8	Dr. Ira Arora	Conservative management of Caeserean Scar Site Ectopic Pregnancy with Morbidly Adherent Placenta : A challenging scenario
P15.9	Dr. Lavanya Tanguturi	Case report of Peripartum Cardiomyopathy
P15.10	Dr. Muskan Agrawal	Broad Ligament Pregnancy: Facing the battle unarmed

Poster Presentations Day and Session Wise
DAY 2

DAY 2 SESSION 2 SCREEN 1(10-11 AM) **JUDGES: DR. MONISHA GUPTA; DR. SUNITA GULATI**

	NAME	ABSTRACT TITLE
P16.1	Dr. Ashwani Balayan	Sad Fetus Syndrome- A rare presentation of Partial Molar Pregnancy with Live Fetus
P16.2	Dr. Bhagyashree Dhanaji	Genetic Testing and Fetal Autopsy an important adjunct in Uninvestigated Previous Prenatal Losses
P16.3	Dr. Harshita Tanwar	From challenges to triumph: exploring the intersection of Systemic Lupus Erythematosus, Pregnancy, and Congenital Heart Block
P16.4	Dr. Sadhana S Pai	Multidisciplinary approach for a case of Severe Refractory IHCP with bad obstetic history
P16.5	Dr. Sanjeevani Nanda	Recurrent Oligohydramnios without any identifiable cause - A rare case report
P16.6	Dr. Souravi Karmakar	Severe Hypertension in Pregnancy: Not-Gestational
P16.7	Dr. Shreshtha Aggarwal	Silent Scar Rupture after Vaginal Birth in a Previous Caesarean Section
P16.8	Dr. Megha Gupta	Pregnancy in patient of Empty Sella Syndrome
P16.9	Dr. Sai Aiswarya Arikatla	An unusual presentation of Compound Sickle Cell Syndrome in pregnancy

DAY 2 SESSION 2 SCREEN 2(10-11 AM) **JUDGES: DR RACHNA AGRAWAL; DR HARVINDER KAUR**

	NAME	ABSTRACT TITLE
P17.1	Ms. Madhulika Kotwal	Successful outcome of Valvuloplasty in Second Trimester of Pregnancy.
P17.2	Dr. Shiny Anuhya	Status Epilepticus in Pregnancy – A Life Threatening Challenge
P17.3	Dr. Sonam Yadav	Atypical Miller Fischer Syndrome Variant during pregnancy: A Diagnostic Dilemma
P17.4	Dr. Smriti Thakur	Management in an Unruptured Heterotropic Pregnancy
P17.5	Dr. Sushma Meena	Meig's Syndrome Mimicking Malignancy in Pregnancy
P17.6	Dr. Aarushi Mehta	Klippel Trenaunay Syndrome: A Rare Case Report
P17.7	Dr. Anushka Gupta	A Rare Case Report of Twin Pregnancy with Complete Hydatidiform Mole and Co-existing Normal Live Fetus.
P17.8	Dr. Nisha Nisha	Successful outcome of a conservatively managed case of Placenta Percreta Causing Haemoperitoneum: A Rare Case Report

DAY 2 SESSION 2 SCREEN 3(10-11 AM) **JUDGES: DR PARIDHI GUPTA; DR. RAJESH KUMARI**

	NAME	ABSTRACT TITLE
P18.1	Dr. Nikita Sharma	A Rare Case of Spontaneous Rupture Of Placenta Accreta in second Trimester
P18.2	Dr. Preethikka RM	Prenatal Diagnosis and successful outcome of Fetal Cardiac Rhabdomyoma associated with Tuberous Sclerosis
P18.3	Dr. Puneet Kaur	Infectious Granulomatous Diseases in Pregnancy - A Case Report
P18.4	Dr. Rahul Amitabh	A Rare Case of Fetal Brain Tumor - Case Report
P18.5	Dr. Ritu Yadav	Unusual case of Traumatic PPH: A Case Report
P18.6	Dr. Soumya Kore	Ruptured Cornual Pregnancy with Adherent Placenta : A Rare Presentation
P18.7	Dr. Himakshi Boro	Case series of Portal Hypertension in Pregnancy
P18.8	Dr. Shamaila Rashid	Gilbert Syndrome: Course during Pregnancy and Postpartum

Competition paper write-ups

Cp1.

STUDY OF AGREEMENT BETWEEN INTERNATIONAL ENDOMETRIAL TUMOR ANALYSIS (IETA) ULTRASOUND TERMINOLOGY AND HISTOPATHOLOGY IN PRE AND POST MENOPAUSAL WOMEN PRESENTING WITH ABNORMAL UTERINE BLEEDING

A Agarwal, B Gupta, A Suneja, A Chaudhary, A Tandon, P Diwakar

University College of Medical Sciences and GTB hospital, Delhi

Objective:

To study the co-relation and agreement between ultrasound and histopathological findings using IETA terminology in pre+post-menopausal women with AUB. Secondary objective: to compare IETA ultrasound simple risk scoring model between malignant and benign pathology.

Method:

This was a prospective cross-sectional study in which 74 cases were assessed with transvaginal and/or transabdominal ultrasound (USG) in women with abnormal uterine bleeding or post-menopausal bleeding who underwent biopsy. USG done considers 8 parameters in accordance with IETA USG terminology and histopathology as gold standard. IETA score was calculated using IETA simple scoring method.

Based on histology, two groups were made, Benign/Malignant.

Statistical analysis:

For all USG characteristics, the p value between USG and HPE diagnosis were calculated using Chi square/Fischer test.

The kappa agreement between USG and HPE diagnosis was calculated. An ROC curve was generated to determine the cut-off value of IETA score to calculate sensitivity,specificity,positive and negative predictive values. Area under curve was calculated. p value of <0.05 was taken as significant.

Result:

Out of the 74 cases taken, 61 were benign and 13 malignant on histology. The IETA USG parameters of endometrial thickness, echogenicity, midline,endo-myometrial junction, intracavitary fluid, colour doppler score and vascular pattern were statistically significant (p value<0.05) in differentiating between benign/malignant lesions. At the IETA score cut-off=3.5, the sensitivity, specificity, positive and negative predictive values of IETA score were 91%, 88%, 60%, 98% respectively and area under curve was 0.933

The kappa value of agreement between the USG and HPE diagnosis of endometrial lesions, was Kappa(?)=0.7305, indicating a strong agreement.

Conclusion:

IETA USG terminology can be used to assess the benign and malignant endometrial lesions accurately. The agreement between USG and HPE diagnosis was strong, hence emphasizing its diagnostic efficacy. In IETA ultrasound characteristics simple scoring method, a cut-off of=3.5 points could reliably differentiate between benign and malignant endometrial lesions.

CP.2

IMMATURE PLATELET FRACTION (IPF) IN PREECLAMPSIA: A PROSPECTIVE COMPARATIVE STUDY

Ediga Asha Jyothi, Vidushi Kulshrestha, Tushar Sehgal, Richa Vatsa, Vatsla Dadhwal

All India Institute of Medical Sciences, New Delhi

Objective: To study immature platelet fraction (IPF) in pregnant patients with preeclampsia from diagnosis to delivery compared to normotensive pregnant controls.

Method:

This prospective comparative observational study was conducted on pregnant women aged 18-40 years diagnosed with preeclampsia(Group-1, n=30). Normotensive women were recruited as controls(Group-2, n=30). Platelet disorders, aplastic anaemia, anticoagulant-therapy, renal and ischemic heart disease, collagen vascular and autoimmune disorders were excluded. Venous blood was drawn and IPF was analyzed by flow-cytometry using oxazine dye by SysmexXN9000. Samples were taken twice: at baseline when preeclampsia was diagnosed and subsequently at delivery in group-1; and at recruitment and delivery in group-2. IPF was correlated with the severity, onset and composite adverse feto-maternal outcomes.

Results:

Median(range) IPF was 2.1(0.5-11.5) in group-1 at diagnosis which was significantly higher than 0.4(0.2-0.8) in group-2, ($p<0.0001$). IPF at delivery was 2.8(0.6-8.6) and 0.5 (0.2-0.8) in group-1 and group-2 respectively($p<0.0001$). IPF differed significantly between group-1 and 2 at both time-points, but rise from baseline to delivery was not significant in either group. Total 17/30 (56.67%) cases were early onset preeclampsia and 13(43.33%) patients had severe features. IPF was neither different between PE with and without severe feature nor between early and late onset preeclampsia, though when seen longitudinally, IPF increased significantly only in late onset group, by 28.57% from baseline to delivery($p=0.014$). ROC analysis showed cut-off of IPF as 0.75 with 93% sensitivity and 97% specificity in diagnosing preeclampsia. Area under curve(AUC) was 0.97(95% CI: 0.94 – 1.0); standard error(SE) of 0.05.

Conclusions:

IPF levels were significantly higher in preeclampsia than in normotensive controls, both at diagnosis and at delivery; though there was no correlation with severity, onset and feto-maternal outcomes. Overall IPF did not change longitudinally from diagnosis to delivery except in late-onset preeclampsia. IPF may be explored as simple, inexpensive lab test for clinical utility.

Cp3.

PREDICTION OF OVARIAN FUNCTION IN REPRODUCTIVE AGE WOMEN WITH BREAST CANCER UNDERGOING GONADOTOXIC CHEMOTHERAPY USING OVARIAN RESERVE BIOMARKERS – A PROSPECTIVE COHORT STUDY

Gunupuru Gayatri Swetha, Neena Malhotra, Juhi Bharti, Aakash Jha

All India Institute of Medical Sciences, New Delhi

OBJECTIVE:

Early diagnosis and treatment of breast cancer have led to increased survival in these patients. There is a paucity of Indian literature on the pattern and decline of ovarian bio-markers. This study was planned to utilize ovarian reserve biomarkers for predicting ovarian function in breast cancer women of reproductive age undergoing gonadotoxic chemotherapy.

METHODS:

A prospective cohort study was conducted at AIIMS, New Delhi over a period of 2 years in 40 breast cancer patients who were planned for neo-adjuvant or adjuvant chemotherapy. Age-matched healthy parous women were included as controls for comparison of baseline ovarian reserve markers (AMH, FSH, LH, Estradiol). Post chemotherapy, subjects underwent follow-up at 1 month, 3 months, and 6 months and information about the resumption of menses, side effects, menopausal symptoms, and concomitant medications were noted.

RESULTS:

The median baseline serum FSH and LH were significantly higher in the study group than in the controls, whereas the serum AMH and estradiol levels were comparable. All measures of ovarian reserve showed acute impairment after chemotherapy. There is a significant rise in the levels of serum FSH, LH post-chemotherapy (at day 0, 3 months, 6 months) ($p<0.0001$) as compared to the baseline, and a reduction in the levels of FSH, LH from 3 months to 6 months period has been noted denoting a trend towards recovery. At the cessation of chemotherapy, 95% were amenorrheic and by the end of six months, 75% were amenorrheic. By the end of chemotherapy, 12% of patients had mild symptoms of menopause, most of which were hot flushes and 27.5% had them at the 6-month follow-up period.

CONCLUSION:

This study provides insight into the patterns of decline in ovarian reserve over six months, which may be useful in counseling these women about their future reproductive potential and impact on ovarian function.

CP.4

DIAGNOSTIC PERFORMANCE OF IOTA SIMPLE RULES, IOTA ADNEX, GIRADS AND ORADS REPORTING SYSTEM IN EVALUATION OF ADNEXAL MASSES

Shagun Kapoor, Seema Singhal, Neena Malhotra, Ekta Dhamija, Smita Manchanda, Jyoti Meena, Vatsla Dadhwal, Sandeep R Mathur, Vanamail Perumal, Maroof Khan, Neerja Bhatla

All India Institute of Medical Sciences, New Delhi

Objective:

To evaluate and compare the diagnostic performance of IOTA SR, IOTA ADNEX, GIRADS and O-RADS USG-based reporting systems for discriminating benign and malignant adnexal masses

Methods:

A single-centre prospective observational study was conducted at a tertiary care teaching institute, and 80 women with adnexal masses undergoing surgical management were recruited. Demographic features, detailed history, examination and tumour markers were recorded. Ultrasound was done for all patients at least one day prior to surgery and four reporting system were applied. Histopathology was taken as gold standard. Data analyses was carried out using statistical software STATA 17.0. Categorical data was expressed as frequencies and percent values. Quantitative variables expressed as mean +/- SD and median (Min, Max). Chi square/ Fischer exact test used to check association between categorical variables.

Results:

Of the 80 masses 44(55%) were benign, whereas 36 (45%) were malignant. The sensitivity of IOTA SR, ADNEX, GIRADS and ORADS was 100%, 86.1%, 100% and 100% respectively whereas the specificity was 97.1%,90.9%,70.5% and 70.5% respectively.11 masses were labeled as inconclusive by SR and on including these masses specificity of SR reduced to 75%. All classification systems were comparable with p value 0.7. However, two step strategy applied for inconclusive and false positive cases, where ADNEX identified 72.7% (8/11) of inconclusive lesions correctly and GIRADS/ORADS identified 27.2% lesions (3/11) correctly. Similarly, when evaluating false positive cases by GIRADS/ORADS, SR correctly classified 30.7% benign and 7.6% malignant masses, however, it remained inconclusive in 61.5% masses (8/13). ADNEX again had better performance and correctly identified 76.9% benign lesions (10/13) and incorrectly categorised 30.7% (3/13) masses as malignant.

Conclusion:

All classification systems were equivalent, however two-step strategy for better discrimination of masses might have added advantage for accurate assessment of adnexal masses, especially the malignant masses.

CP.5

MATERNAL SERUM PROCALCITONIN AND LACTATE LEVELS FOR PREDICTION OF CHORIOAMNIONITIS IN PRETERM PREMATURE RUPTURE OF MEMBRANES

Shravya R N, Sumitra Bachani, Jyotsna Suri, Divya Pandey, Monika Gupta, Ankita Jain

Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi

Introduction:

Preterm premature rupture of membrane (PPROM) can have profound impact on pregnancy outcomes most adverse being chorioamnionitis and neonatal sepsis There is a lacunae of biomarkers for prediction of chorioamnionitis thus limiting the period of latency.

Objective:

To correlate the levels of maternal serum procalcitonin and lactate with chorioamnionitis and neonatal morbidity in women with PPROM till delivery.

Methods:

A prospective Cohort study conducted on 125 women with PTPROM from 28-36+6weeks of gestation along with equal number of controls (antenatal women at similar period of gestation without PPROM). Serum procalcitonin and lactate levels were done for both cases at admission and similar controls from antenatal clinic followed by second sample 24 hours before delivery for each group. Results of both biomarkers were blinded. Women were managed as per Institutional protocol. Placental membranes culture was done in all cases. All delivery and neonatal outcomes were recorded.

Results:

Both groups had similar demographics, amongst cases mean gestation at admission was 34 weeks (33.98 ± 2.39). Controls were delivered at term or earlier for any maternal-fetal indication other than PPROM Chorioamnionitis developed in 14 (10.5%) cases and 7.14% neonates developed sepsis however both had no relation with the latency. Early neonatal death occurs in five cases amongst which three died because of low birth weight and two had neonatal sepsis. Total Leucocyte Count (TLC) included in the management had sensitivity and specificity of 64.29% and 83.19% at recruitment and 78.57% and 76.47% at delivery for prediction of chorioamnionitis.

Conclusion:

Serum procalcitonin for chorioamnionitis has the best predictive performance value for chorioamnionitis in women with PPROM than lactate and total leucocyte count. It should be incorporated in management protocol of such cases.

CP.6

'TELE-ABORTION' MODEL FOR QUALITY COMPREHENSIVE ABORTION CARE: AN INNOVATIVE FEASIBLE APPROACH FOR PUBLIC SECTOR IN INDIA

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Objective:

To assess the feasibility, safety and acceptability of 'Tele-Abortion' model in terms of provider, process and recipient. To determine barriers and facilitators to its implementation and robustness of the model in delivering comprehensive abortion care.

Methods:

A single center prospective feasibility study on 35 eligible women seeking abortion upto 9 weeks, comprised of 1st physical visit which included history, examination and medications {Mifepristone 200 mg (directly observed), Misoprostol 200µg (8 tablets) for subsequent use, and analgesics}; followed by 3 virtual visits (audio/video calls/SMS) on day 3, 7 and 14. Virtual visits assessed for completeness, need of additional misoprostol dose and adverse events. Both provider and recipient filled satisfaction proforma (on a 5-point likert scale) after each virtual visit. Quantitative data presented as mean ± SD and categorical as number and percentages. Data analysed using SPSS software.

Results:

Majority clients were young, urban, literate, multiparous, 60% not on any contraception, 20% having prior abortion history and visiting alone (50%) from >5 km distance (75%). Mean gestational age at recruitment was 7.4 weeks. Each client on an average made 1 physical and 4 virtual visits. The mean time and money saved was 5.5 hours and INR 490 respectively. Minimal technological barriers were encountered in implementing this model.

89% clients achieved complete abortion and 11% required D&C. One needed blood transfusion and no one had abortion related sepsis.

Mean (SD) satisfaction scores ranged from 4.14(0.35) to 4.51(0.50) for the provider and 4.32(0.58) to 4.51 (0.59) for the recipient. All the clients accepted post abortal contraception, 50% adopting IUCD.

Conclusion:

'Tele-abortion' model is a feasible, innovative, safe, efficacious and acceptable economical model for both provider and recipients in delivering comprehensive abortion care in low resource setting/ public sector. It has a future potential of replacing the traditional model of abortion care.

CP.7

COMPARISON OF CARPREG II AND MODIFIED WHO CLASSIFICATION FOR PREDICTING MATERNAL OUTCOME IN PREGNANT WOMEN WITH HEART DISEASE

Supriya Hazarika, Jyotsna Suri, Preeti Gupta, Sumitra Bachani, Divya Pandey, Monika Gupta

Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi

Introduction:

The modified WHO (mWHO) classification is commonly used as gold standard to estimate cardiac risks in pregnant women with heart disease but it does not take the functional condition of the patient while stratifying the risk. CARPREG II is a recently developed score which includes 10 predictors (5 general,4 lesion specific,1 delivery care predictor) with a range of points 0 to >4 corresponded to cardiac events rate ranging from 5% to 41%.

Objective:

To compare the predictive value of CARPREG II and modified WHO classification for assessing the risk of cardiovascular events in pregnant women with heart disease.

Methods:

A prospective cohort study was conducted on 92 antenatal women with heart disease. A detailed obstetric history and past medical history for any cardiac interventions in the past was followed by a general physical, cardiovascular and obstetric examination. 2D echocardiography was done for all recruited patients. Each patient was assigned a risk score as per CARPREG II as well as mWHO classification and they were followed till delivery and discharge from the hospital for any cardiovascular events, maternal mortality and adverse foetal outcomes.

Results:

Out of 92 cases, 36(39.13%) had cardiovascular events during follow up and maternal mortality occurred in 4(4.35%) of them. 40 cases(43.48%) had adverse foetal outcome. CARPREG II score had a sensitivity of 55.56% while specificity of 92.86%. The mWHO risk category had a sensitivity of 80.56% while specificity was low i.e, 53.57%. Highest positive predictive value was found in CARPREG II(83.30%) and highest negative predictive value was found in mWHO risk category(81.10%) .Discriminatory power of CARPREG II (AUC 83.8%;95% CI:0.746 to 0.906) was excellent and discriminatory power of mWHO risk category(AUC 66.3%;95% CI:0.557 to 0.759) was acceptable.

Conclusion:

Among the two, CARPREG II was the best predictor of cardiovascular events at cut off point of >6 with AUC of 0.838 for correctly predicting cardiovascular events. Thus, CARPREG II can be used as a better risk assessment score than mWHO classification for predicting risk of cardiovascular events in pregnant women with heart disease.

Oral paper write-ups

Abstract of Oral Paper Presentation on 19th August 2023

Session 1 –Gynaecology

O -1.1

Role Of Transvaginal 3d Power Doppler Ultrasound And Hysteroscopy For Endometrial Evaluation In Patients With Postmenopausal Bleeding

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Background & Objectives:

The purpose of this study was to evaluate the role of three dimensional transvaginal Power doppler ultrasound (3DPD) and hysteroscopy to evaluate various benign and malignant endometrial lesions in females with postmenopausal bleeding.

Materials & Methods

This prospective observational study was conducted from February 2021 to November 2022 in department of obstetrics and gynecology, All india institute of medical sciences, New delhi. We recruited 75 females with postmenopausal bleeding satisfying inclusion and exclusion criteria. Selected candidates underwent Transvaginal two dimensional and three dimensional ultrasound followed by hysteroscopic evaluation of endometrial cavity and endometrial biopsy.

Results

Out of 75 patients, 65(86.6%) were diagnosed with benign while 10(13.4%) with malignant lesions. Endometrial vascularity, Vascularity indices (VI, FI, VFI) and endometrial volume were higher in malignant group. Sensitivity and Specificity achieved were as mentioned respectively- Vascularisation index (80%, 78.46%), Flow Index (70%, 70.77%), Vascularisation flow index (80%, 73.85%) and Endometrial volume (80%, 80%). While diagnostic hysteroscopy proved to be 100% sensitive for endometrial malignancies and endometrial polyps , it was 88% and 83.3% for endometrial atrophy and endocervical polyps respectively.

Conclusion

Three dimensional power doppler ultrasound and hysteroscopy are useful tools in evaluation of postmenopausal bleeding. In this study 3DPD with hysteroscopy agreement was found in 70% cases.

O- 1.2

Expression of ERBB receptor family in endometrium of infertile women with severe ovarian endometriosis

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Background & Objectives:

Endometriosis is associated with high proliferative bias in eutopic endometrium during secretory phase. This could probably be associated with increased incidences of implantation failure and resultant increased association of infertility in endometriosis. The ErbB family of proteins (ErbB receptors-1 to -4) regulates the proliferation capacity in different body tissues and could potentially be regulating the proliferation in eutopic endometrium. However, our knowledge regarding the involvement of the ErbB family in human endometrium during the window of implantation (WOI) in endometriosis-associated infertility is scant. We performed this study to assess the expression of the ErbB family of proteins in endometrium of endometriosis-free, infertile women and in eutopic endometrium of infertile women diagnosed with severe (i.e., stage IV) ovarian endometriosis during WOI.

Materials & Methods

It was a prospective observational comparative cohort study. The endometrium of endometriosis-free, infertile women (Group 1; n = 11) and in eutopic endometrium of infertile women diagnosed with stage IV ovarian endometriosis (Group 2; n = 13) during the mid-secretory phase were compared for the expression of the ErbB family of proteins using immunohistochemistry (IHC) using standardized guidelines. Statistical analyses between two groups were performed using the Mann–Whitney U-test using Graph Pad version 9 (GraphPad Software Inc., La Jolla, CA, USA) statistical packages.

Results

In women with primary infertility associated with stage IV ovarian endometriosis compared with disease-free endometrium of control infertile women during the WOI, Computer-aided standardized combinative analysis of immunoprecipitation in different compartments of endometrial tissue revealed an overexpression of ErbB-1 in the epithelial, stromal and vascular compartments, along with marginally higher ErbB-3 expression ($p < 0.06$) in the vascular compartment and ErbB-4 expression ($p < 0.05$) in the glandular epithelium and stroma in the endometrium

Conclusion

It is possible that this overexpression of ErbBs family of proteins in the eutopic endometrium in endometriosis during WOI induces excessive inflammatory, proliferative and angiogenic activities in this, which can adversely affect endometrial milieu for implantation of embryo. This could help in introducing new avenues in the treatment of endometriosis-associated infertility, as well as pre-empting the oncogenic potential of endometriosis.

Abstract of Oral Paper Presentation on 19th August 2023
Session 1 –Gynaecology

O- 1.3

A study of association between occupation and semen parameters of male partner of infertile couple

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Background & Objectives:

Male factor infertility accounts for 40-50%of Infertility and affects approximately 7% of all men. There is association between infertility and occupational exposure to heat, pesticide, chemicals, sedentary lifestyle, smoking. This study is to find out association between occupation and semen parameters of male partners of infertile couple according to WHO 6th edition

Materials & Methods

This study is an observational,prospective cohort study . Men working in same occupation since last 3 months attending Infertility clinic were included (n=229). Based on occupation they were further divided into 4 groups ,group 1- clerical work(n=52), group 2-heat work(n=53),group 3-paint work(n=55) ,group 4-arduous work(n=69). Semen samples of all male were collected after 1 day abstinence and different parameters of semen like semen volume, ph ,total motility and progressive motility were assessed according to WHO 6th edition

Results

The mean semen volume (1.7 ml) of heat workers was found to be significantly low when compared to clerical(2 ml), paint(2 ml) and arduous work(2 ml) with P value 0.02. Similarly sperm count(34 million) of heat worker were significantly low from other 3 groups(clerical, paint, arduous work-60, 60,66 million) (P value-0.0003). Mean %of total motile sperms(35%,59%)were found to be significantly low in heat and paint workers compared to clerical (66%)and arduous work(66%) with P value- 0.0002. Progressive motility (22%) of heat workers were found to be significantly low compared to clerical,paint and arduous group with P value-0.0015. There was no significant difference between semen ph and morphology among occupation groups .

Conclusion

This observational study found that work place exposure to heat and paint significantly lead to impairment of semen parameters as compared to clerical and other arduous work according to WHO 6th edition. Awareness about these work place hazards ,wearing protective gears , avoiding constant exposure may help in decreasing male infertility associated with work place hazards.

O- 1.4

Non-alcoholic fatty liver disease in women with polycystic ovarian syndrome

Dr. Aditi Rathi, Dr Nayana DH, Dr Deepti Goswami
Maulana Azad Medical College

Background & Objectives:

To study the occurrence of Non-Alcoholic Fatty Liver Disease (NAFLD) in patients with Polycystic ovarian syndrome (PCOS).

Materials & Methods

This study included 78 patients with PCOS and 78 age and BMI-matched controls with normal menstrual cycles and no clinical evidence of hyperandrogenism. PCOS was diagnosed on basis of Rotterdam criteria. Clinical examination, biochemical and hormonal investigations and transabdominal sonography were done for all. Metabolic syndrome was diagnosed on the basis of National Cholesterol Education Program's Adult Treatment Panel III (ATP III) criteria.

Results

The mean age and BMI of patients and controls were comparable (27.4±4.7 vs28.6±4 years; P=0.14) and (26.4±5.3 vs 25.2± 3.2kg/m2; P=0.31). Women with PCOS had higher prevalence of fatty liver (53.9% vs 18.4%; P

Conclusion

NAFLD is three times more prevalent in PCOS patients than healthy controls. Early detection of fatty liver can help in timely management of this condition.

Abstract of Oral Paper Presentation on 19th August 2023
Session 1 –Gynaecology

O- 1.5

A study to screen for the risk of sarcopenia and to determine its correlation with Vitamin D levels in postmenopausal women

Surabhi Duggal and Dr Kavita Mandrelle

Department of Obstetrics and Gynaecology, Christian Medical College and Hospital, Ludhiana, Punjab

Background

Sarcopenia is a syndrome characterized by progressive loss of skeletal muscle mass (SMM) along with loss of muscle strength and physical performance (PP) that creates adverse outcomes such as physical disability, poor quality of life and death. Menopause marks varieties of derangement in muscle mass and functions leading to

sarcopenia. This study was carried out to examine the factors associated with measures of sarcopenia, skeletal muscle mass (SMM), muscle strength and physical performance (PP) in a group of postmenopausal women.

Aims and Objectives

To screen for the risk of sarcopenia using SARC-F, SARC - Calf questionnaire along with anthropometric parameters and to determine its correlation with Vitamin D in postmenopausal women.

Materials and Methods

It was a prospective cross-sectional study which was conducted on thirty postmenopausal women presenting to out-patient and in-patient department of Christian Medical College and hospital Ludhiana. Skeletal Muscle Mass was measured using Sarc - f, Sarc-Calf questionnaire. Other measurements included were 24hr dietary recall, pattern of physical activity, Anthropometric measurements, hand grip strength and a serum sample of Vitamin D in postmenopausal women.

Results

In our study we noted that risk of sarcopenia showed significant association with calf circumference (63.3%), hand grip strength (66.6%), Vitamin D(66.6%) and combined score of SARC f and SARC-Calf score(46.6%). Most patients were without the risk of sarcopenia by SARC f score alone, Appendicular Skeletal Muscle Mass score.

Conclusion: Our study concluded that the risk of sarcopenia can be assessed with different screening tools and are simple, quick, low cost and non-invasive ways of assessment and should be used in clinical practice to screen the risk of sarcopenia.

O- 1.6

High uterosacral ligament suspension for apical prolapse: our experience at a tertiary care centre

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Background & Objectives

High Uterosacral ligament suspension is a transvaginal native tissue repair procedure, where vaginal apex is attached bilaterally to intermediate part of uterosacral ligament, thus suspending vaginal vault in hollow of sacrum, maintaining normal vaginal axis & significantly preventing recurrence of vault & anterior/posterior compartment prolapse. Patients who underwent Vaginal hysterectomy (VH) with HUSL were assessed to evaluate results of HUSL & its effectiveness in prevention of prolapse recurrence. Parameters considered were: 1. Age 2. Indication 3. Parity 4. Prolapse stage 5. Bladder/bowel symptoms 6. Blood loss 7. Duration of surgery 8. Complications 9. Hospital-stay 10. Pre & Post-Operative Quality of life assessment

Materials & Methods

A Retrospective & prospective study of 55 patients who underwent Vaginal hysterectomies with HUSL, between 2019-2023 was done. Patient data collected, POP-Q stage assigned, symptoms & bother scores measured on standard questionnaires. (PFDI-20, PFIQ-7, ICIQ-VS) Blood loss, surgery duration, hospital stay and complications (Clavien -Dindo And ICS/IUGA classification) noted. Quality of life assessments recorded (PGI-I & ICIQ-satisfaction scores). Additional procedures done were- Anterior-colporrhaphy 34(61.8%), Posterior-colpoperineorrhaphy 28(50.9%), TOT 10(18.1%).

Results

Mean age of patients 55.3 years. All patients had correction of prolapse to stage I, no recurrence over a follow-up of 6months to 3years. High satisfaction rate (PGI-I score of 2[much better]) reported by 50(90.9%) cases. 19(34.5%) patients had LUTS preoperatively which resolved in 14(73.7%) cases. Average operative time 113 minutes. Ureteric injuries identified & managed intraoperatively in 4(6.7%) cases.

Conclusion

HUSL can be procedure of choice for apical suspension during VH. More studies comparing various apical suspension surgeries are needed.

Abstract of Oral Paper Presentation on 19th August 2023
Session 2 - Oncology

O- 2.1

Prevalence and outcome of uterine sarcoma following laparoscopic hysterectomy for presumed benign leiomyoma: our experience of 3019 cases

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Background & Objectives

To determine the prevalence and outcome of undiagnosed uterine sarcoma in women undergoing laparoscopic hysterectomy for suspected benign leiomyomas.

Materials & Methods

Retrospective, cohort study involving patients undergoing laparoscopic hysterectomy from May 2016 to June 2023 at a single centre for presumed benign leiomyoma and diagnosed post-operatively as uterine sarcoma. All the cases that were included in this study had undergone standard pre-operative investigations.

Results

A total of 3019 patients who underwent hysterectomies were included. Out of these, Four patients were identified with uterine sarcoma on post operative histopathology. Three patients had leiomyosarcoma and one had Endometrial stromal sarcoma on histopathology. Of the four hysterectomies, in bag morcellation was used in two cases and vaginal morcellation was done in 2 cases. Out of the four patients, three succumbed to the disease within a year of diagnosis and one after one and half years of diagnosis, in spite of post-operative chemotherapy and radiotherapy.

Conclusion

Occult uterine sarcoma is a rare malignant disease. They are also associated with a high mortality rate.The prevalence of uterine sarcoma was 0.0024 in our population. In all the cases, malignant diagnosis was confirmed post-operative. Morcellation of any type whether manual or power worsen the prognosis. In bag morcellation may prevent abdominal spread and recurrence but the overall prognosis is same. So morcellation within an isolation bag is important to prevent the worsening of its already adverse consequences.

O- 2.2

Diagnostic accuracy of visual inspection of cervix with fluorescein sodium (VIFNa) for detection of pre invasive lesions of cervix - a pilot study

Pooja Kumari

Background & Objectives

Introduction-Visual inspection of cervix with acetic acid (VIA) is predominantly used as a screening tool for cervical cancer screening but it has limitations as it is associated with high false positive (4-33%) and false negative rate (40-60%) .VIFNa can be used as a screening method for early detection and treatment of neoplasia as FNa gets accumulated preferentially in tumor cells and gives green fluorescence when seen under blue light. Objective- To compare the diagnostic accuracy, sensitivity, specificity, positive and negative predictive values of VIA with VIFNa

Materials & Methods

Method- In this observational cross sectional study, 455 patients were screened with Pap smear, VIA and VIFNa. Screen positive patients were subjected to colposcopy and biopsies were taken from abnormal areas or in case of normal colposcopy, random biopsy from anterior and posterior lip of cervix were taken.

Results

Out of total 455 patients, 95 patients were screen positive with VIA and 80 were positive with VIFNa whereas, 19 patients out of these screen positive were found to have CIN (I/II/III). Diagnostic accuracy of VIA was around 39% and VIFNa was around 50% in detection of pre invasive lesions of cervix. Sensitivity of VIA and VIFNa were same that is around 89%. Specificity and positive predictive value of VIFNa was 85% and 21% respectively whereas that of VIA was around 82% and 17%.

Abstract of Oral Paper Presentation on 19th August 2023
Session 2 - Oncology

O-2.3

Reproductive outcomes after treatment in women with gestational trophoblastic neoplasia (GTN)

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Background & Objectives

GTN is a rare malignancy of women in reproductive age group with an excellent survival. The reproductive function is often the major concern for cancer survivors especially those who have not completed their conception plan. The reproductive function of the patients may be affected with an exposure to chemotherapy. The aim of current study was to assess the reproductive function including menstrual function and pregnancy outcomes among the GTN survivors.

Materials & Methods

Retrospective observational study was conducted and records of 110 GTN cases were reviewed. 77 women were below 30 years and 41 were desirous of pregnancy. Data concerning clinical characteristics , risk scoring , nature and number of chemotherapy cycles, menstrual irregularity, treatment received for conception, pregnancy outcome was recorded.

Results

Most patients were in low risk group. Methotrexate was the most common first line chemotherapy. Only 10% had menstrual abnormalities, commonest being delayed menstrual resumption, prolonged cycles, or amenorrhea. The mean age of 41 women who were desirous of pregnancy, was 28.7 years and parity was 0.5 compared to 40.4 years and 2.1, respectively. 53.6% (22/41) patients conceived. The median interval time after complete treatment to pregnancy was 2.7-27.2 months. Total of 25 pregnancies were achieved resulting in 84.8% live births, 12.1% abortions and one repeated molar pregnancy (3.0%).

Conclusion

90% of GTN patients (90%) could resume normal menstruation. Slightly more than half of the patients who desired for pregnancy could have at least 1 pregnancy after treatment with chemotherapy. Live births were achieved in 84.8% without perinatal adverse events.

O- 2.4

Histological grading and molecular risk assessment profiling in endometrial cancer " a retrospective analysis

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Background & Objectives

The aim of this study was to evaluate changes in prognostic risk profiles of women with endometrial cancer by comparing the histological grading of the endometrial cancer with the integrated molecular risk assessment profiling. This retrospective analysis included 45 patients with biopsy proven endometrial cancer treated between January 2021 to February 2023. Patient clinical data was assessed and categorized according to the currently valid European Society of Gynecological Oncology, European Society for Radiotherapy and Oncology, and European Society of Pathology (ESGO/ESTRO/ESP) guidelines on endometrial cancer

Materials & Methods

A retrospective analysis included 45 patients with biopsy proven endometrial cancer treated between January 2021 to February 2023. A Molecular tumour characterization included determination of the immunohistochemical specimen evaluation on the presence of mismatch repair deficiencies (MMRd), p53 abnormalities (p53abn) and presence of nuclear beta catenin.15 were classified as MMRd (33.3%), 12 were classified as p53abn, high copy number (26.6%), 33 were p53 wild type , low copy number (73.3%) , of which 10/45 were beta catenin positive (22.2%).One tumour (2.22%) had multiple molecular classifiers

Results

The clinical-pathological risk-assessment classified 20 women (44.4%) as low-risk, 13 women (28.8%) as low intermediate risk, 5 women as high-intermediate risk (11.1%), 5 women (11.1%) as high risk and 2 patient as advanced metastatic (4.44%). The integrated molecular classification changed risk for 12 women (26.6%).

Conclusion

Integrated molecular risk improves personalized risk assessment in endometrial cancer and could potentially improve therapeutic precision. Further molecular stratification with biomarkers is especially needed in the low p53 copy number, negative beta catenin group to improve personalized risk-assessment.

Abstract of Oral Paper Presentation on 19th August 2023
Session 2 - Oncology

O- 2.5

Correlation of HPV viral load by hybrid capture 2 with grade of cervical intraepithelial lesion

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Background & Objectives

Primary HPV screening is recommended by WHO for all resource settings. While interpreting the HPV test report, the significance of HPV viral load in the detection of cervical lesions is not clear. The present study was conducted with an aim to evaluate the correlation of HPV viral load with cervical intra-epithelial neoplasia (CIN).

Materials & Methods

A retrospective study was conducted in the Department of Obstetrics & Gynaecology, AIIMS New Delhi from August 2021 to May 2022. The women between 30-49 years of age who were screened using Hybrid capture 2 HPV test were recruited. High-risk HPV (hrHPV) viral load of more than 1.0 RLU/Cut off was considered positive. Viral load was divided into low (RLU d" 10), moderate (RLU 11-100). Women with positive HPV test underwent colposcopy and guided biopsy. The viral load was correlated with the grade of CIN.

Results

1501 women underwent HPV test and 145 (9.6%) were tested positive. Amongst 145 HPV positive women, 125 underwent colposcopy and guided biopsy, 20 were lost to follow up and 5 were triaged with Pap smear. CIN 1 was detected in 20 (16.0%) patients, CIN 2 in 2 (1.6%) patients, CIN 3 in 9 (7.2%) and invasive cancer in 1 (0.8%) patient on histopathology. There was significant association between high HPV viral load with grade of CIN (p 0.001). 18.5% of women with high viral load had CIN 3 as compared to 7.2% with low viral load.

Conclusion

High hrHPV viral load is associated with high grade CIN.

O- 2.6

Malignancy in disorders of sex development: forwarned is forarmed

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Background & Objectives

To study clinical presentation, challenges in diagnosis, and outcomes of patients with disorders of sex development (DSD).

Materials & Methods

Retrospective data was collected for 15 patients with DSD who underwent gonadectomy from August 2019 to August 2023. Descriptive analysis was done.

Results

Mean age of presentation was 19.6 years (Range:12-28 yrs) with chief complaint of primary amenorrhea in all. On examination, clitoromegaly was noted in 5/15 (33.3%) (3 partial AIS, 1with turner mosaic, 1 with Swyer), inguinal swelling noted in 3/15 (20%) who were partial AIS. One patient had abdominopelvic mass. After evaluation, eight (53.3%) patients were of Swyer syndrome, six (40%) with AIS and one was (6.6%) of turner mosaic. Karyotype was 46XY in 14 (93.3%) patients while 1 (6.7%) had XO+XY cell lines. Laparoscopic gonadectomy was performed in 14/15(93.3%) patients to mitigate risk of gonadal tumors and two among these diagnosed with gonadoblastoma on histopathology. One patient with abdominal mass underwent laparotomy with bilateral gonadectomy and was diagnosed with dysgerminoma. All 3 patients with malignancy had Swyer syndrome, diagnosed at 22- 28 years of age due to delay in referral and seeking treatment considering gonadectomy a taboo in society.

Conclusion

Despite the established role of bilateral gonadectomy in dysgenetic gonads (with Y-chromosome), there is delay in diagnosis and timely referral. Comprehensive evaluation and proper counselling regarding gonadectomy can mitigate risk of malignancy and associated morbidity.

Abstract of Oral Paper Presentation on 19th August 2023
Session 2 - Oncology

O- 2.7

Cervical Cancer screening – The missing link

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Introduction: India alone contributes to 25.4% and 26.5% of the global burden of cervical cancer. Cultural barriers, feeling of embarrassment, reluctance, access to healthcare facilities and indirect costs are some of the main reasons for under/never utilization of cancer screening among our population.

Objectives: To evaluate the performance of self and clinician collected samples for hr HPV DNA detection and to assess the acceptance and attitude of women towards self collection.

Methodology: This was a randomized blind study done in 396 women (30-50 years) attending the Gynecology OPD. Cervical swabs were collected in duplicate (self and clinician) in transport medium and stored at 4°C till further processing. Pap smear was also collected. High risk HPV DNA was tested using real time PCR. The samples positive for HPV DNA in any of the samples underwent a colposcopy guided biopsy.

Results: A total of 396 women underwent screening. 2.5% women complained of post coital bleeding. Pap smear was inadequate in 15% & ASCUS & above was reported in 3.7 % samples. Overall agreement between self and clinician sampled HPV was 91.4% with Kappa Unadjusted being 43.4%[95% CI: 35.8 to 51.1]. Overall agreement between C-HPV and pap smear was 79.5% with Kappa Unadjusted of 19.2%[95% CI: 12.8 to 25.5]. Overall agreement between self and pap smear was 80.0% with Kappa Unadjusted value of 21.7%[95% CI: 14.7 to 28.7].23 women underwent biopsy of which 19 were CIN 1 & above with a positive predictivity rate of 100% with either screening result being positive.

Conclusion: HPV DNA Self sampling can be a major breakthrough in breaking the shackles of underutilization of cervical cancer screening & thus decrease the morbidity & mortality of cervical cancer.

O -2.8

SWEDES SCORE FOR IMPROVING THE DIAGNOSTIC ACCURACY OF COLPOSCOPY FOR PRE MALIGNANT LESIONS OF CERVIX

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Abstract

DIAGNOSTIC ACCURACY OF SWEDE SCORE FOR PREMALIGNANT LESIONS OF CERVIX Cervical cancer accounts for 342000 deaths worldwide and 84% are limited to low income countries. In resources limited countries , it is the 2nd most common type of cancer in females and third most common cause of cancer related mortality. Due to its long standing pre-cancerous stage and pre- invasive lesions, effective strategies for cervical cancer screening and treatment of cervical intraepithelial neoplasia have a major role in reducing the incidence and mortality due to cervical cancer. Colposcopic evaluation and guided biopsy are diagnostic for the abnormal cytological findings and is useful to pick up pre-malignant lesions of cervix. Abnormal cervical cytology findings like Atypical squamous cells where high grade lesion cannot be ruled out (ASC-H), low grade squamous intraepithelial neoplasia (LSIL) , high grade squamous intraepithelial neoplasia (HSIL), atypical glandular cells (AGC), also conditions where there is discrepancy between cytology and clinical examination, repeated unsatisfactory PAPS smear or positivity for high grade HPV on screening tests colposcopy is performed. To standardize the technique of colposcopy, Reids colposcopic index was most commonly used, with sensitivity of 56-89% and specificity of 57.5% and 92.9% for low grade and high grade cervical lesions respectively. A new scoring system, Swede score to further standardize and enhance the accuracy of colposcopy and colposcopic directed biopsies is being used. The aim of this observational study was to assess the diagnostic accuracy of swede score for pre-invasive cervical lesions in 60 patients in a tertiary care centre. 60 women were subjected to colposcopic examination for various indications , swede score was calculated for all cases and colposcopic directed biopsies were taken where indicated. Histopathology reports of these patients were followed and reports were correlated with the swede score calculated at the time of examination.

Abstract of Oral Paper Presentation on 19th August 2023

Session 2 - Oncology

O- 2.9

Knowledge, attitude and practice of cervical cancer screening and prevention by hpv vaccine among health professionals

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Background & Objectives

Health professionals, as key stakeholders in healthcare delivery, have a critical role in promoting cervical cancer screening and vaccination among women. Our study aims to assess this group's knowledge, attitudes, and practices to identify areas that need improvement and intervention.

Materials & Methods

The research employed a cross-sectional survey design and collected data from a sample of 500 healthcare professionals working in various healthcare settings. A structured questionnaire with 35 items was used to gather information on participants knowledge about cervical cancer, awareness of HPV vaccination, attitudes towards screening and vaccination, and their own practices in recommending and receiving these interventions.

Results

Among the 500 respondents, 93% were aware of cervical cancer, 79% were aware that PAP smear detects cervical cancer, and 82% knew that HPV causes cervical cancer.18% of the respondents/their relatives had undergone screening for cervical cancer. Only 9% were vaccinated. 99% were willing to get vaccinated and recommended vaccination for their family members.

Conclusion

This study provides valuable insights into health professionals' knowledge, attitudes, and practices regarding cervical cancer screening and prevention through HPV vaccination. This study highlights the need for ongoing education and training programs to improve the same. The findings will inform the design of tailored educational programs, healthcare policies, and interventions to enhance healthcare providers engagement in cervical cancer prevention and reduce the global burden of this disease.

Session 3 - Obstetrics

O -3.1

Pregnancy with systemic lupus erythematosus (sle) : A retrospective analysis

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AIIMS, New Delhi

Background & Objectives

Pregnancy with Systemic Lupus Erythematosus (SLE) is assosciated with several risks for mother and fetus. The aim of the present study was to analyse the course and outcome of pregnancy in women with SLE.

Materials & Methods

A retrospective cohort study was conducted for single unit at a tertiary care teaching hospital for the last 15 years (January 2008- December 2022). The hospital records of 50 pregnancies with SLE and 150 low-risk pregnant women who served as controls were reviewed.

Results

The mean age of our cohort was 28.2 ± 4.2 years. Manifestations were mainly cutaneous (82%), articular (73%), chronic hypertension and secondary APLA (24%) each. The live birth rate for our cohort was 62%. Lupus flare was seen in about 9% cases. Pre-pregnancy optimisation was seen in about 40% cases. A high incidence of adverse perinatal outcomes was observed in women with SLE when compared with age-matched controls. The incidence of prematurity, fetal growth restriction (FGR), and low birth weight were high in women with SLE.

Conclusion

A high incidence of adverse perinatal outcomes was observed in women with SLE. Pregnancies in women with SLE should be planned. The multidisciplinary team approach and pre-pregnancy optimization of the disease improve maternal and fetal outcomes.

Abstract of Oral Paper Presentation on 19th August 2023
Session 3 - Obstetrics

O- 3.2

Fetomaternal outcomes in pregnant women with epilepsy

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Background & Objectives:

Introduction: Epilepsy is a commonly encountered neurological disorder in pregnant females. Incidence of epilepsy in pregnant women is estimated to be 0.3-0.5% of all births. Pregnancy in women with epilepsy(WWE) is considered high risk as it is associated with increased maternal morbidity and mortality, pregnancy and neonatological complications. Treatment of seizure disorder in WWE is another challenge as most anti-epileptic drugs(AEDs) are known teratogens. To meet such challenges posed by seizures during epilepsy and its treatment, this study was done to study the fetomaternal outcome in pregnant women with epilepsy Aims and objectives: To compare fetomaternal outcome in pregnant women with and without epilepsy.

Materials & Methods

A prospective cohort study was conducted in the department of obstetrics and gynecology of Vardhman Mahavir medical college and Safdarjung hospital in which 40 women with epilepsy and 40 age matched controls were enrolled after informed consent.

Results

Women with epilepsy had significantly increased incidence of hypertensive disorder of pregnancy ($p<0.001$), premature rupture of membrane ($p=0.005$), anemia ($p<0.001$), post-partum hemorrhage ($p=0.003$), induction of labor ($p<0.001$) and cesarean section ($p=0.045$). In addition, babies of WWE were at higher risk of fetal growth restriction ($p<0.001$), low birth weight ($p<0.001$) and NICU admission ($p<0.001$). Moreover, the seizure frequency during pregnancy was significantly higher in women with seizure free interval of less than 9 months before pregnancy ($p<0.001$) and ANC visits less than 4 ($p=0.039$). No significant difference was noted in rates of gross congenital anomaly between two groups.

Conclusion

Women with epilepsy have a higher risk of maternal and fetal morbidity. Hence, they require a comprehensive planning before and during pregnancy and should be under vigilance of obstetrician and neurologist.

O- 3.3

Does bromocriptine affect the outcome in women with peripartum cardiomyopathy? An observational study in a tertiary care centre

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Background & Objectives:

The incidence of peripartum cardiomyopathy (PPCM) reported in different studies vary markedly, from 1 to 100 in 10,000 live births. The Study Group on peripartum cardiomyopathy of the Heart Failure Association (HFA) of the European Society of Cardiology (ESC) defined PPCM as an idiopathic cardiomyopathy occurring towards the end of pregnancy or in the months following delivery, abortion or miscarriage, without other causes for heart failure, and with a left ventricular (LV) ejection fraction (EF)

Materials & Methods

It was an observational study done in Department of Obstetrics and Gynecology, Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi over 12 months. Women presented with cardiac failure were screened and a total 25 women included in the study. Bromocriptine was used in 12 women as per respective unit's management protocol and rest didn't receive the drug. There was one mortality during admission, one mortality after 4 weeks if discharge and one woman was lost to follow up. Total 22 were followed up at 6 weeks and maternal and fetal outcomes were noted.

Results

Majority of women were between 21-30 years and were multigravida. The mean improvement of left ventricular ejection fraction was 12.45 ± 4.76 and 17.27 ± 4.52 in bromocriptine non-user (n=11) and user (n=11) group respectively and the improvement was significant. ($p=0.024$) There was 8% mortality and all were in bromocriptine non-user group. All (100%) had improved NYHA grade at follow up with bromocriptine use. However, there was difficulty in breastfeeding and more infant diarrhoea reported in bromocriptine user group.

Conclusion

There is paucity of study regarding effectiveness of bromocriptine use in PPCM. This study concludes a promising result with bromocriptine. However, the limitation of the study is a small sample size.

Abstract of Oral Paper Presentation on 19th August 2023
Session 3 - Obstetrics

O -3.4

Performance comparison of usg and mri in placenta accreta spectrum and maternal and fetal outcome: experience in a tertiary care centre

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Background & Objectives:

OBJECTIVE: To compare diagnostic accuracy of ultrasonography and MRI in detecting placenta accreta spectrum (PAS). To study the maternal and fetal outcome in patients with PAS.

Materials & Methods

METHODS: This is a retrospective study. Clinical records of 25 patients with PAS treated in our unit in last 5 years was reviewed. The demographic details, presence of various risk factors, USG and MRI findings, need for multiple transfusions, intraoperative and postoperative complications including neonatal outcome was noted.

Results

RESULTS: Mean age of patients was 32.24(±4.1)yrs. 9 had history of previous 1 caesarean,9 were previous 2 caesarean while 3 had previous 3 caesarean. History of D&C, placenta previa was present in 8 and 3 respectively. 1 had history of uterine septal resection. 92% were diagnosed before 32wks(USG). No significant difference was found between USG and MRI in diagnosing PAS. 16(64%) needed e"2 hospital admission. Intraoperatively 6 had accreta, 9 had increta, 6 were percreta and rest 4 were placenta previa. 19 required caesarean hysterectomy, 5 were managed by classical caesarean whereas 1 underwent LSCS. Uterine artery balloon was placed in 20(80%) patients. 13(52%) had blood loss e"2lts. 5(20%) required >24hrs of ICU care. 12(48%) patients required e"4 units transfusion. 9(36%) had bladder injury. >28days of hospitalization was required in 7(28%) patients.16 babies had low birth weight, 8 babies required prolonged NICU admission.

Conclusion

PAS leads to significant morbidity hence early diagnosis and multidisciplinary preparedness to treat them is necessary for better outcome. USG and MRI are comparable in diagnosing PAS.

O- 3.5

Evaluation of CBC variables with birth weight and gestational age at labour

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Background & Objectives:

Fetal development is affected by the maternal environment and one of the environment determinants is inflammation. Neutrophil lymphocyte ratio (NLR) and platelet lymphocyte ratio (PLR) have been used as markers of inflammation in many disciplines because of easy availability.The purpose of this study was to investigate a possible relationship between between the maternal systemic inflammatory markers such as neutrophil to lymphocyte ratio (NLR) and platelet to lymphocyte ratio (PLR) and other complete blood count (CBC) variables with gestation age and birthweight of patients.

Materials & Methods

This prospective study was performed with 500 patients. The maternal age, parity, gestational age, type of delivery, values of CBC variables, and the weight of newborn were recorded. We analyzed the statistical differences between the NLR, PLR, HGB, PDW, RDW, MPV, platelet count, neutrophil count, lymphocyte count, and WBC in terms of the birth weight and gestation age

Results

There was statistically significant corelation between the gestational age with NLR values (p=0.001).There was no statistically significant corelation between the gestational age with PLR values (p=0.077). When we compare the NLR and PLR values with birth weight of the infant, no statistically significant correlation was detected (p=0.058 and p=0.030, respectively). A linear, negative, weak correlation, and statistically significant correlation was detected between mean platelet volume (MPV) with the infant's birth weight (p=0.021). Statistically significant correlation was detected between hemoglobin (HGB) with gestational age (p=0.026)

Conclusion

CBC values during labour could be a cost-effective method to predict correlation with gestation age and birth weight at time of labour

Abstract of Oral Paper Presentation on 19th August 2023

Session 3 - Obstetrics

O- 3.6

Comparative study to assess vaginal micro biome in preterm,PROM, PPPROM and effects on pregnancy outcomes

Rupal Gandhi, Kamlesh Yadav, Balmukut

Sardar patel Medical College

Background & Objectives

To compare vaginal microbiome in term, threatened preterm, preterm labour, PPROM ,PROM and select suitable antibiotic therapy and pregnancy outcome

Materials & Methods

All pregnant females with live fetus of gestational age above 28 weeks till term with history of PPROM, PROM, threatened preterm, preterm labor, term labor. Swab from posterior fornix of vagina was taken & sent for microbiological examinantion& identified pathogen was evaluated for antimicrobial susceptibility.

Results

Out of 230 patients, 194 were culture positive & 36 were sterile. Out of 194 positive, majority have E.coli (n=83, 36.11%), (n=42, 18.26%) have Candida, (n=51, 22.1%) have COPS, (n=5, 2.1%) have Klebsiella infection.

Conclusion

Vaginal infection being common cause for preterm, PPROM, PROM, threatened preterm. Early recognition & prompt treatment of vaginal infection aid in prevention of preterm labour and neonatal morbidity & mortality. E.coli (MC) is sensitive to cefotaxime, ceftriaxone, clindamycin & amoxicillin, cefepime.

Session 4 - Innovations in O & G

O-4.1

Role of ambulatory blood pressure monitoring in diagnosis of hypertensive disorders during pregnancy in high-risk antenatal females: a randomized controlled trial

Rajiv Kumar

Background & Objectives: We conducted a RCT over a period of 18 months from January 2022 to June 2023, to compare which modality can effectively predict HDP early in pregnancy. We aimed to find out the overall incidence of HDP in both the groups, to compare maternal and fetal outcomes in both the groups and to measure burden of non-sustained hypertension.

Materials & Methods: We enrolled antenatal women at 20-34 weeks of gestation who were having high-risk factors for HDP and randomised. In the ABPM group, patients were sent for ABPM on the same day or the next day of enrollment and followed up with institutional protocol thereafter. In the HBPM group, daily HBPM was advised for one week, followed by institutional protocol follow-up.

Results:110 cases were analysed after dropouts. Baseline characteristics were comparable in both the groups. The overall incidence of HDP in the ABPM group was 27.27% and in the HBPM group was 10.90%, (P-0.02). The mean gestational age of HDP diagnosis and mean age at which antihypertensive was started were statistically insignificant (P-0.27). HDP related complications were significantly higher in the ABPM group (n=19 versus 8) than the HBPM group (P-0.01). Postpartum antihypertensive requirement was significantly higher in the ABPM group (18.18% versus 3.64%) than the HBPM group (P-0.01). The non-dipping pattern on ABPM was frequently associated with HDP occurrence. In the HDP group non-dipping pattern was seen in 86.66% cases, whereas in the non-HDP group, it was seen in 22.50% cases (P-0.00001)

Conclusion: It is concluded that ABPM is a better reflector of the patient's whole day BP profile, and it can diagnose many more HDP cases when compared with routine HBPM. The non-dipping pattern had a significant association with the development of HDP later in pregnancy. Hence, ABPM can be considered as a tool for secondary prevention of HDP in high-risk antenatal females

Abstract of Oral Paper Presentation on 19th August 2023
Session 4 - Innovations in O & G

O -4.2

Thermo-ablation: A Novel Treatment For Cervical Ectropion

Harbani Soni, Swati Agrawal, Kanika Chopra, Reena
Lady Hardinge Medical College

Background & Objectives

Although most occurrences of cervical ectropion are asymptomatic, it can occasionally cause vaginal discharge, post-coital bleeding, and intermenstrual bleeding. The most popular form of treatment for this condition is cryotherapy, however it has drawbacks such as excessive watery discharge and limited application in large lesions. A relatively recent technique called thermoablation is quick and capable of treating larger lesions. However there is paucity of studies that show it's effectiveness in treating cervical ectropion. This study was hence undertaken to study the effect of thermoablation on the size of ectropion, symptomatology, and quality of life (QOL) in women with symptomatic ectropion.

Materials & Methods

The research included 41 women over the age of 21 who had symptomatic cervical ectropion that was >0.5 cm in size and had a normal PAP smear. All of the patients underwent detailed colposcopic examination, followed by thermoablation using a hand held device. The size of the ectropion was recorded before the procedure and followed up after 12 weeks. A self-reported VAS severity scale was used to measure the degree of symptoms both before and 12 weeks after the procedure. At both visits, the QOL was also evaluated using the WHOQOL-BREF questionnaire.

Results

Women who had cervical thermoablation saw a reduction in ectropion size from an average of 2.5 cm to 0.51 cm, a decrease in symptom severity from 7.72 to 2.32, and an improvement in WHO BREF score from 53 to 71 after 12 weeks. No significant side effect was recorded by any patient.

Conclusion

Thermoablation is an excellent treatment modality for the management of symptomatic cervical ectropions.

O -4.3

Assessing the efficiency of prophylactic use of local tranexamic acid during vaginal hysterectomy to reduce intraoperative blood loss - a double blinded randomised controlled trial

Anshivi Raje

Background & Objectives

Hysterectomy is one of the most frequently performed major Gynecological procedures. The intra-operative blood loss which requires transfusion is one of the common complications. Tranexamic acid (TXA) is an antifibrinolytic agent that has shown to effectively reduce bleeding complications within other surgical and medical areas. To evaluate the efficiency of Prophylactic use of local Tranexamic acid (TXA) in vaginal hysterectomy to reduce intraoperative blood loss and to compare it with normal saline infiltration.

Materials & Methods

A Double blinded Randomized Control Trial enrolling women scheduled for benign vaginal hysterectomy, randomized in Group A: Intervention Group (Local Tranexamic Acid) and Group B: Control Group (Local Saline infiltration).Prior to incision, 1 gm of tranexamic acid in 20 ml saline (Total 30 ml) or saline (30 ml) is infiltrated locally on both sides of paravesical spaces, paracervical part of Mackenodt ligaments and bladder pillars. Block randomization was carried out. Intraoperative blood loss was calculated by measuring the volume in suction apparatus and weight of mops and gauzes. Two groups compared for age, body mass index, hemoglobin and hematocrit, blood loss, duration of surgery and blood transfusion requirements.

Results

An ongoing study enrolling 50 patients till July 2023 (25 cases and 25 controls). No significant difference was found between the two groups for age, body mass index, parity. Statistically significant differences were found for intraoperative total blood loss (p

Conclusion

Prophylactic Use of local Tranexamic acid can significantly reduce intraoperative blood loss during Vaginal Hysterectomy .No incidences of adverse events occurred.

Abstract of Oral Paper Presentation on 19th August 2023
Session 4 - Innovations in O & G

O - 4.4

Add-ons in intrauterine insemination & impact on reproductive outcome

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Objectives Of The Study

To Evaluate the Effect of Intrauterine Instillation of Hyaluronic Acid Enriched Media on Pregnancy outcome Rates in Intrauterine Insemination Treatment.

Materials And Methods

It was a single centre, hospital based, randomised controlled trial in which patients planned for intrauterine insemination were taken. Block randomisation with block of 10 was done and patients divided into control and intervention group. Controlled ovarian stimulation followed by Serial Transvaginal ultrasound was done. When the lead size of follicles reached 17-19 mm, HCG given. After 36-40 hours IUI was done. In the intervention group, 4 days following IUI, 0.4 ml of hyaluronic acid was instilled using IUI catheter at internal OS. Patients were followed up for missed periods or menses. Patients underwent 3-4 cycles of IUI.

Result:

Total 100 patients approached for the study and after subjecting them to exclusion and inclusion criteria 90 were randomised, 45 in each group. After follow up, In control group 42 patients and in intervention group 41 groups were finally analysed. All the demographic parameters were comparable between the two groups. Reproductive outcomes which were analysed in terms of Biochemical pregnancy rate, clinical pregnancy rates and ongoing pregnancy rates were higher in the intervention group as compared to control group. Miscarriages were comparable in the two groups. There were no adverse outcomes.

Conclusion:

It was a single centre study with limited sample size, it showed beneficial effect of using hyaluronic acid during implantation window in Intrauterine insemination treatment without any adverse effects. But additional large studies are required before clinically using it on large scale

O 4.5

Evaluation of vulvar disorders by vulvoscopy index and N-S-P scheme using three rings vulvoscopy (TRIV)

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Background and Objective

TRIV is a new and promising technique based on fact that Vulva can be divided into three circular zones on the basis of 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 categorised into 5 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, 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.

Abstract of Oral Paper Presentation on 19th August 2023
Session 5 - Obstetrics

O- 5.1

Profile of pregnant mothers with anemia at 28-32 weeks of gestation

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Background & Objectives

Anemia in pregnancy represents a common and potentially reversible risk factor associated with increased antepartum, intrapartum and postpartum maternal morbidity and mortality. Despite attending regular antenatal clinics and getting IFA tablets free of cost, pregnant women remain anemic at the time of childbirth. Hence this study is planned to find out the prevalence of anemia in pregnant women at 28-32 weeks of gestation and find out the reasons and type of anemia so that corrective steps can be taken to reduce anemia at childbirth.

Materials & Methods

Study Design- Prospective observational analytical study Study Population-Booked pregnant women attending antenatal clinics in Sucheta Kriplani Hospital, New Delhi at 28-32 weeks of gestation Methodology- 200 pregnant women attending antenatal clinic between 28-32 weeks gestation were screened by spot Hb assessment. A detailed sociodemographic and personal history was taken and anemia profile was done in those with Hb

Results

Prevalence of anemia in pregnant women was 46% 50% were mild anemic, 47% moderate and 3% were severe anemic 95.6% of anemic women were 20-35 years of age 39% of anemic women were primigravida and 61% were multigravida 73% of anemic women lived in joint families and 50% belonged to lower middle SE status 43% had received secondary education, 26% primary, 19% were graduated and 11% were illiterate 41.3% of anemic women were vegetarian by diet Only 49% had full compliance to IFA tablets 33% had side effects due to IFA tablets 53% of anemic women showed microcytic hypochromic morphology on peripheral smear 79% of anemic women were deficient in Iron, 30% in vitamin B12 and 15% in Folic acid 25% of them were deficient in both iron and vitamin B12

Conclusion

Prevalence of anemia in booked pregnant women in third trimester of pregnancy is 46% among which mild anemia is the most common. Majority of anemic women were of 20-35 years of age and were multigravida. Anemia is more common in low SE and joint families. Most common type is microcytic hypochromic anemia. Iron deficiency is the most common cause followed by Vitamin B12 and folic acid. Dimorphic anemia is present in about 25%.

O-5.2

Association of low cerebroplacental ratio with spontaneous preterm birth

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Background & Objectives

OBJECTIVES- To study the association of low Cerebroplacental Ratio with Spontaneous Preterm Birth. INTRODUCTION- The Cerebroplacental ratio (CPR) is the ratio of the MCA Pulsatility Index (MCA PI) to the UA Pulsatility Index (UA PI). Increased cerebral blood flow is a fetal adaptive response to hypoxia and this is reflected by a reduction in MCA resistance (decreased PI) which thereby reduces the CPR. Literature suggests fetuses with low CPR are predisposed to preterm birth. However the asscociation is confounded by the fact that many studies have included fetuses with growth restriction. The aim of this study is therefore to find the association between low cpr in Appropriate for gestational age fetuses and spontaneous preterm labour.

Materials & Methods

This is a prospective study of 86 women who presented at Dr. RML Hospital Delhi between June 2022 and May 2023 in preterm labour. Inclusion criteria included a non-anomalous singleton fetus between 28 – 36+6 weeks gestation. Data was recorded for both the MCA PI and UA PI enabling calculation of the CPR and only cases with positive end diastolic flow in the umbilical artery were included in the study. Exclusion criteria included females with hypertensive disorders of pregnancy, fetal growth restriction and coagulation disorders.

Results

During the study, 46 of women had spontaneous preterm birth out of which 21.7% (10/46) had CPR < 10 th centile.

Conclusion

The results of the study demonstrate a correlation between the CPR and gestational age at birth. It is seen that overall risk of preterm birth is increased in fetuses with a CPR < 10th centile.

Abstract of Oral Paper Presentation on 19th August 2023
Session 5 - Obstetrics

O- 5.3

Perinatal outcome in overweight women

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Background & Objectives

Obesity in pregnancy is associated with a myriad of well documented complications. But the outcomes of pregnancy in overweight females, who are not classified as obese, have not been studied. The aim of the study was to assess foeto-maternal outcomes in primigravida who are overweight and compare them to normal weight patients.

Materials & Methods

It was a cross sectional study and included primigravida with full-term gestation (between 38 and 42 weeks), with live singleton foetus, and vertex presentation were admitted for labour induction. Based on pre-pregnancy weight patient were divided into normal weight (BMI 23kg/m2) categories or groups A and B respectively. Data was collected for gestational age, demographics (age, education, occupation), obstetric and labour related parameters as per pre-designed proforma. Parameters included were reason for induction, number of PGE2 gel used, duration of labour, induction to delivery interval, and mode of birth- operative/ non-operative. Data was also collected for peri-partum maternal complications, neonatal Apgar score and need for NICU admissions.

Results

150 patients were recruited in the study and divided based on weight into two groups- 115 in group A (normal weight) and 35 in group B(overweight). Compared to Group A, significantly more patients in group B needed 3rd dose of PGE2 gel (20.8% vs 51.4%). Also, more patients in group B had induction to delivery time of longer than 30 hours (20% vs 4.3%), and had higher incidence of failed induction needing caesarean section (25.7% vs 11.3%). Neonates born to overweight mothers had worse Apgar score at 1 min and were more likely to require admission to NICU- 5.7% vs1.7% compared to normal weight mothers.

Conclusion

Pregnancy in overweight females is associated with prolonged labour, higher instances of failed induction and worse neonatal outcome. Thus, perinatal counseling and management should focus on weight control while also planning appropriate strategies for monitoring and treating pregnancy related complication if weight control measures fail. Although obesity is main focus of research, we suggest including overweight but non-obese females in studies as they have similar adverse outcomes and complications.

O- 5.4

Vitamin D levels in pregnancy and its association with Fetomaternal outcome

Somya Gupta

Background & Objectives

To estimate the levels of Vitamin D in healthy women with singleton pregnancies up to 32 weeks of gestation attending a tertiary care centre of western Uttar Pradesh, India and its association with feto-maternal outcomes.

Materials & Methods

Method A total of 700 women with singleton pregnancies upto 32 weeks of gestation were recruited. Women with known medical disorders like diabetes, hypothyroidism, hyperparathyroidism, chronic hypertension, ovarian tumor, collagen disorders, pulmonary illness or those taking medications known to influence calcium or vitamin D levels were excluded. Vitamin D levels were measured at booking using ARCHITECT 25(OH) Vitamin D Assay. All women were followed till delivery in a routine manner.

Results

The mean 25(OH)D was 15.29 ng/mL. Prevalence of severe vitamin D deficiency, deficiency, insu!ciency, and su!ciency were 35%, 49.5%, 10.2%, 4.7% respectively. Only 654 women were assessed as 46 women (7%) were lost to follow up. The incidence of gestational hypertension, preeclampsia, gestational diabetes mellitus, anaemia, preterm birth, antepartum haemorrhage and postpartum haemorrhage - was 1.07% (7 cases), 3.36% (22), 0.3% (2), 6.88% (45), 0.76% (5), 0.61% (4), 1.225 (8) respectively. Mode of delivery was vaginal in 92.05% and cesarean in 7.95% women. No association of vitamin D levels was seen with adverse pregnancy outcome (p value>0.05)

Conclusion

Even though only 4.7% women in this cohort of otherwise healthy pregnant women had su!cient levels of Vitamin D, the vitamin D levels did not appear to result in adverse feto-maternal outcomes. Further studies are needed to prove or disprove any association between vitamin D level and its effect on maternal or fetal health.

Abstract of Oral Paper Presentation on 19th August 2023
Session 5 - Obstetrics

O -5.5

Knowledge attitude and practice regarding screening for GDM and role of MNT in ANC patients in LNJP

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Background & Objectives

This study aims to assess the knowledge, attitude and practice regarding screening for GDM and the role of MNT in antenatal patients in tertiary care hospital.

Materials & Methods

The cross-sectional study was conducted in MAMC and LNH Hospital Delhi with participation of 250 subjects attending the hospital for antenatal checkups. The structured questionnaire with 48 items was used to gather information on participants' knowledge about GDM, awareness regarding screening, attitudes towards screening and MNT, and their practice for MNT to prevent complications and for better outcomes.

Results

Out of 250 participants,46% had knowledge of GDM, 33% were aware of screening for GDM, 88% screened for GDM with OGTT with 75gm Glucose,45% were aware about MNT for blood sugar control, only 42% were practising MNT, and 80% did not require additional treatment, 88% were not aware of complications of GDM.

Conclusion

This study reveals that there is paucity of knowledge regarding GDM in pregnant Indian women attending the antenatal clinic of LNH, Delhi. This might have an adverse effect on maternal and fetal well-being. Hence, antenatal women need to be educated regarding GDM, its screening and the role of MNT in controlling blood sugar levels. If women are aware of the complications and role of MNT, chances of attitudinal changes, compliance to MNT and regular follow-up will improve, resulting in a better pregnancy outcome.

O- 5.6

To study the effect of intravenous tranexamic acid on blood loss and maternal parameters during and after lower segment caesarean section - A randomized control trial

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Background

In obstetrics, tranexamic acid reduces bleeding-related mortality in women with postpartum haemorrhage, especially when administered during delivery. Post-partum hemorrhage is one of the leading causes for maternal morbidity and mortality. This study evaluates the efficacy and maternal effects of tranexamic acid in reducing blood loss during and after lower segment caesarean section (LSCS).

Objectives

1.To study the effect of intravenous tranexamic acid on blood loss when given within 30 minutes before LSCS.

2.To study maternal parameters and adverse drug reactions with pre operative administration of tranexamic acid.

Materials and methods

A single blind randomized control trial in which a total of 40 pregnant women who underwent elective or emergency lower segment caesarean section at term were studied prospectively. Group I comprised 20 patients who received tranexamic acid 1 g intravenous 30 minutes prior to caesarean section and 20 patients in Group II did not receive tranexamic acid. Blood loss was calculated intraoperatively and post operatively from end of LSCS to 2 hours postpartum.

Results

It was observed that administering injection tranexamic acid preoperatively lead to significant difference in the blood loss , without causing any serious adverse effect. It was observed mean intraoperative blood loss was less than 500 ml in group I (85% of participants) and more than 500 ml in group II .

Conclusion

Tranexamic acid is economical and easy to administer drug with no serious adverse effects which can be used in women undergoing LSCS to decrease blood loss.

Abstract of Oral Paper Presentation on 19th August 2023
Session 6 - Endoscopy

O- 6.1

Laparoscopic abdominal cerclage in pregnant versus non-pregnant uterus: a single centre experience

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Background & Objectives

In this study, we present our experience with laparoscopic abdominal cerclage in pregnant and non-pregnant women.

Materials & Methods

An observational study was conducted in ten patients who were at high risk of preterm labour and underwent laparoscopic abdominal cerclage by single surgical centre and team. The outcomes were compared on the basis of feasibility of procedure, complication rates and pregnancy outcomes.

Results

A total of ten cases were included, amongst them four were pregnant and six were interval cases. There were no intra-operative and post-operative complications in interval cases. Out of the four pregnant patients, two patients had PPROM, one during and one in the immediate post operative period which led to abortions. The other two pregnant patients continued till 37 weeks and were delivered through caesarean section. Of the 6 interval cerclage patients, follow up of three patients was available who had a healthy baby and delivery after 34 weeks. Three patients were lost to follow up.

Conclusion

Laparoscopic abdominal cerclage is an established procedure with encouraging results. However training and surgical skill is required to achieve maximum results.

O- 6.2

Robotic-assisted hysterectomy for benign indications of uteri less than fourteen weeks size versus more than fourteen weeks size: a comparative study

Rabia Zamin

Background & Objectives

This study was conducted to evaluate the feasibility of robotic hysterectomy for benign indications in patients with small size (14 weeks) uterus.

Materials & Methods

This prospective study was conducted in a single centre from August 2018 to January 2020 in the Department of Obstetrics and Gynecology at All India Institute of Medical Sciences, Rishikesh (Uttarakhand). Surgical outcomes of 216 patients who underwent a robotic hysterectomy in our institution for benign indications were analysed. Women opting for definitive surgical management by minimally invasive technique were divided into two groups according to the size of the uterus less than 14 weeks (group 1) versus more than equal to 14 weeks (group 2). Data collected in both groups included intra- operative and post-operative parameters, length of hospital stay and morbidity if any.

Results

The demographic profile was comparable in both groups. The mean estimated blood loss was 180.78 ±68.0 ml (range, 10-340 ml) in group 1 and 253.49 ±57ml (range, 60-360 ml) in group 2 (p-value < 0.0001). However, the fall in haemoglobin level after 24 hours of surgery was not statistically significantly different between the two groups. The total duration of surgery in group 1 was 97.86 ± 12.0 minutes (range, 78-132 minutes) and in group 2 was 116.60 ± 15.4 minutes (range, 97-156 minutes), the difference being statically significant (p-value < 0.0001, 95% CI 103±2.1). Console time in group 1 was 43.84 ±6.0 minutes (range, 34-57 minutes) and in group 2 53.22 ±5.5 minutes (range, 44-66 minutes), the difference being statistically significant (p-value < 0.0001, 95% CI 46.57±0.97). There was no difference observed in terms of intra- operative and post-operative complications between the two groups.

Conclusion

The total duration of surgery and estimated blood loss were directly proportional to the size of the uterus. However, complication rate, hospital stay and requirement of post-op analgesia were comparable in both groups. Robotic surgery in a larger uterus is a feasible option in terms of better surgical outcomes and postoperative course. Thus, robotic hysterectomy in women with a large uterus is a suitable approach in the narrow region of the pelvis.

Abstract of Oral Paper Presentation on 19th August 2023
Session 6 - Endoscopy

O- 6.3

A randomised controlled trial comparing the efficacy of bupivacaine injection in vaginal vault and paracervical region versus vaginal vault infiltration with bupivacaine after total laparoscopic hysterectomy

Kaloni Subramani

Background & Objectives

To compare the efficacy and safety of bupivacaine injection in vaginal vault versus paracervical block and vault infiltration with bupivacaine after total laparoscopic hysterectomy.

Materials & Methods

Prospective two-armed double blinded Randomized Comparative Trial. Thirty patients undergoing total laparoscopic hysterectomy (TLH) for benign conditions were recruited and randomly allocated into two groups. Fifteen patients in group I received vault infiltration with bupivacaine after TLH. Fifteen patients in group II received paracervical block with bupivacaine before application of manipulator and vault infiltration after TLH. Pain scores were recorded 1 hour , 2 hour and 6 hours post-surgery and compared between the two groups.

Results

It was seen that VAS scores were significantly lower in group II on comparison with group I at 1st , 2nd and 6th hour post-surgery. Mean VAS score at 1st hour post-surgery was 3.67 in group I vs 1.2 in group II (p -

Conclusion

This trial shows that these two novel methods of administering local anaesthetic to alleviate post TLH pain when used in conjunction can significantly reduce pain and analgesia requirements making shorter hospital stay and early return to daily activities possible hence reducing cost per procedure.

O- 6.4

Genital tuberculosis among women undergoing diagnostic hystero-laparoscopy for infertility

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AIIMS Rishikesh

Background & Objectives

Background: Genital TB is one of the leading causes of infertility in developing countries. Diagnosing genital TB as the cause of infertility remains challenging, due to lack of standardized diagnostic protocols. Objective: To evaluate the role of hystero-laparoscopy as diagnostic modality for genital tuberculosis in patients with infertility.

Materials & Methods

A retrospective study was conducted in one unit of Department of Obstetrics &Gynecology at AIIMS, Rishikesh. A total of 45 women who underwent diagnostic hystero-laparoscopy for the cause of infertility evaluation from November 2021- June 2023 were included in the study. The patients were primarily assessed for infertility including clinical evaluation along with ovarian, tubal, and male factors. Preliminary investigations were done along with HSG and endometrial biopsy.

Results

The mean age of women was 29.6 ± 5.7 years of age. The mean duration of infertility was 6.7±5.1 years. Out of 45 women included in the study, 14 out of 45 women (31.1%) had findings suggestive of genital tuberculosis on hystero-laparoscopy (6 on laparoscopy - 42.8%, 3 on hysteroscopy - 21.8%, and 5 on both hystero-laparoscopy - 35%). Of these 14 women 7 (50%) presented with primary infertility and 7 with secondary infertility. The history of pulmonary TB was evident in four women. The findings for Mycobacterium TB were negative for all patients on histopathological examination and ZN staining for AFB. CBNAAT was positive for one out of 14 patients (7%).

Conclusion

As CBNAAT and histopathological examination (endometrial aspiration) for endometrial TB do not always confirm the diagnosis, hystero-laparoscopy improves the detection of genital TB in women with infertility.

Abstract of Oral Paper Presentation on 19th August 2023
Session 6 - Endoscopy

O- 6.5

Lateral incision technique of vaginal morcellation in laparoscopic hysterectomy: single centre experience

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Background & Objectives

Background and Objectives: Transvaginal uterine morcellation has been described in the literature for more than a century. Despite an extensive body of literature documenting its safety and feasibility, there are concerns about morcellating large uterus more than 12 weeks. In this study, we looked at a single teaching institution's experience with transvaginal morcellation for uterus size more than 12 weeks lateral incision technique.

Materials & Methods

Methods: Case sheets of women who underwent total laparoscopic hysterectomy for leiomyoma from 1st June,2021 through june 31, 2023, were reviewed. Cases were included in which transvaginal morcellation technique was performed and duration of surgery along with specimen removal duration was written. Till sept 2022, we were using either bissection or choring technique of vaginal morcellation. From oct 2022, lateral incision technique of morcellation was used to reduce the volume of the specimen and make it elongated. Time duration of specimen removal was noted in all cases. Baseline demographics and intra- and postoperative outcomes, duration of specimen removal was compared in both the groups.

Results

Results:106 women who underwent laparoscopic hysterectomy for uterus size more than 12 weeks during the study duration were recruited (52 patients in lateral incision group and 54 patients in morcellation with other techniques. Mean specimen removal time was significantly less in lateral incision group as compared to other techniques (3-8 min Vs 10-30 min). Post operative pain score was also less in the former group (p

Conclusion

Conclusions:Transvaginal uterine morcellation using lateral incision technique appears to be a safe technique for the removal of large uterine specimens.

O - 6.6

Comparison between barbed and monofilament polyglactin suture for vaginal vault closure in total laparoscopic hysterectomy: a randomized controlled trial

Priyanka Das

Background & Objectives

This randomized single blinded study included 50 patients divided in two groups of 25 each, who underwent TLH with vault closure by barbed suture or polyglactin 910. Demographic details, indication for surgery, mean suturing time, total operating time, intraoperative blood loss, average hospital stay, post operative VAS score, vault complications, female and male sexual dysfunction were compared between two groups.

Materials & Methods

A prospective randomized comparative trial. All laparoscopic hysterectomies were performed by a single consultant gynaecologist by the standard technique. Total time taken for vaginal vault closure starting from the beginning of the first suture till the last stitch until cut intraoperatively and total operating time was determined. Postoperatively VAS score recorded at 4 hours, 12 hours and 24 hours. On postoperative 7th day, 6 weeks and 3 months follow up, complaints noted, vaginal cuff complications like discharge, bleeding, cellulitis, granulation and dehiscence identified. At 3 months follow up both female and male sexual dysfunction was assessed with standard validated questionnaire.

Results

Advent of barbed suture has significantly reduced vaginal cuff closure time (p value

Conclusion

The introduction of barbed suture in TLH for vaginal cuff closure has significantly reduced operating time, eliminate technical challenges often encountered thus compounding to ease of surgery and shortening the learning curve, making it a prospective strength in laparoscopic hysterectomies.

Abstract of Oral Paper Presentation on 19th August 2023
Session 7 - Obstetrics

O- 7.1

Evaluation and comparison of indications for primary and repeat cesarean section: a retrospective study at tertiary care hospital

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Background & Objectives

Objectives: The uncontrolled wave of cesarean rates has increased globally which has resulted in a significant amount of maternal mortality and morbidity. The present retrospective study aims to evaluate the clinical indications, demographic characteristics for repeat cesarean sections and then compare them with primary cesarean sections to draw some valid inferences.

Materials & Methods

Methods: The present retrospective study has been carried out at the department of Obstetrics and Gynaecology, SMGS Hospital, Jammu, India. The data regarding to total number of primary and repeat cesarean sections during (Mar 2020- April 2022) were collected from the record section of the hospital. All patients who underwent for cesarean sections during the study period were included in the study.

Results

Results: in the current study we observe that the most common indication for cesarean deliveries is elective which nearly accounts for (41%) and the other indications for repeat cesarean were fetal distress (15.5%), dystocia (11.4), breech (7.8%).

Conclusion

Conclusion: we suggest strategically focusing on elective category patients and making them favorable for normal vaginal delivery which is only possible by establishing proper counseling cells at gross root level.

O -7.2

Comparison of neonatal birthweight and Gestational diabetes mellitus

Nirupama Gupta

Background & Objectives

OBJECTIVES- To study the relationship between neonatal birthweight and gestational diabetes mellitus. INTRODUCTION- Gestational diabetes is defined as any degree of glucose intolerance with onset or first recognition during pregnancy irrespective of the gestational age at which it was diagnosed. Once diagnosed, management can be by pharmacological and non-pharmacological methods. Literature suggests that neonate birth weight was highest in the group managed by insulin therapy as compared to those managed by metformin and MNT.

Materials & Methods

METHODS- This was a retrospective cohort study of 75 women who delivered at Dr. RML Hospital Delhi between May 2022 and June 2023. Inclusion criteria included a non-anomalous singleton fetus diagnosed as Gestational Diabetes Mellitus by DIPSI criteria. Outcomes analysed included birth weight of baby and need for neonatal resuscitation and its relation with diabetic status and control at term.

Results

RESULTS- During the study period, 172 women were studied, of which 74% were on MNT, 11.6% on OHA, and 10.4% on insulin and OHA and 4% on insulin. The mean baby weight in the first group is 2890, in the second group is 2894, in the third group is 2950, and in the fourth group is 2968 whereas the mean baby weight in low-risk term pregnancy is 2900. Out of 172 patients 26 i.e 15%, delivered baby weigh more than 3500, which are large for gestational age. Though, the mean neonatal birthweight in the three groups were comparable, with no significant difference. Detailed evaluation of blood sugar control was done and it was found that poor control of blood sugar was one of the contributing factors. 6% of neonate out of all required resuscitation.

Conclusion

CONCLUSION- Early detection of hyperglycemia in pregnancy and blood sugar control during pregnancy is essential for optimum maternal and neonatal outcome.

Abstract of Oral Paper Presentation on 19th August 2023
Session 7 - Obstetrics

O- 7.3

A study of umbilical cord anomalies and its perinatal outcomes in a tertiary care hospital in Bihar

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Background & Objectives

To evaluate the perinatal outcome in cases with morphological abnormalities of the umbilical cord. To detect early for improving perinatal outcome.

Materials & Methods

This retrospective analytical study was conducted at Mata Gujri Memorial Medical College Kishanganj, Bihar. This study included 576 pregnancies from July 2022 to June 2023 (1 year) These cases were followed up during third stage of labour to detect any morphological abnormalities of the cord and if found so, to detect any adverse fetal effects.

Results

Nuchal cords - Nuchal loop (multiple loop) - 3.2%,False knot-13.4% ,True knot-1.1% Single Umbilical Artery 2.5% Velamentous Cord Insertion - Umbilical Cord Knots Short cord -3.4%, Long cord-33.6% Vasa Previa 0.4% Umbilical Cord Cysts 0% Umbilical Cord Varix 0%

Conclusion

68.67% fetal and neonatal complications were detected in cases with morphological abnormalities of the umbilical cord. Early detection can improve perinatal outcome.

O- 7.4

Fetomaternal outcome in patients with IHCP and correlation with bile acid levels

Aishwarya Jhaveri

Background & Objectives

A.T. JHAVERI, B.DAS sgt medical college and research institute Background: - Intra Hepatic Cholestasis of Pregnancy (IHCP) / Cholestasis of Pregnancy(OC) is the most common liver disorder of pregnancy and it is associated with an increased risk of adverse perinatal outcomes like sudden fetal demise. It is typically seen in the late second to early third trimester. Aims and objectives: - To study the maternal and fetal outcomes in patients with IHCP and its correlation with serum bile acid levels.

Materials & Methods

This is a prospective observational hospital-based study conducted in Department of Obstetrics and Gynecology , SGT Hospital in which 80 consecutive pregnant women attending the OPD or admitted in labor room with complains of itching without rash and serum bile acid >10 µmol/L were included. These patients were followed till delivery and outcomes were observed.

Results

Among the study group majority of the patients belonged to 26-30y age group. 46 patients were primigravida and 34 patients were multigravida. Preterm and term deliveries were 30% and 70% respectively. 50 patients delivered vaginally and 30 underwent LSCS. 34 babies were admitted in NICU. There were no stillbirths. PPH occurred in 8 patients. The 25% of patients had bile acid levels(10-18 µmol/L), 25% patients had a mild form of the condition (bile acids 19–39 µmol/L). These women were exposed to the same risk of fetal complications as an ordinary obstetrical population. A severe form of IHCP (bile acids >100 µmol/L) occurred in 5%.

Conclusion

Majority of the patients started complaining of itching from 25-30 weeks of gestation. The patients with bile acids e"40 µmol/L, suffered a significantly higher rate of fetal complications such as asphyxia, spontaneous preterm deliveries and meconium staining.

Abstract of Oral Paper Presentation on 19th August 2023
Session 7 - Obstetrics

O- 7.5

Evaluation of near miss maternal morbidities at a tertiary care hospital in Northern India

Kante Durga Maunika

Background & Objectives

Near miss' is a term used in medical literature to describe a serious ailment that was life-threatening but did not actually result in death. But in 2009, WHO developed a thorough set of standards for identifying close calls. The goal of the current study was to examine maternal near-miss morbidity (MNMM) cases and related morbidity in a local context.

Materials & Methods

The present study was single-center, retrospective, observational study, conducted in 60 maternal near miss cases which met the comprehensive criteria of WHO, admitted during study period and survived.

Results

In present study, majority of cases were 20-29 years (73.3%), multigravida (56.7%), in third trimester and postpartum (48.3%), had phenotype as class I MNMM (maternal near miss with healthy infant) (41.7%), In near miss cases, near miss on arrival were 75.0% while 25.0% were near miss after admission, 11.7% had disorder on admission and became near miss and 28.3% had no disorder on admission but became near miss. Only 3.3% cases were affected by COVID-19.

Conclusion

The most prevalent causes of near miss situations were hypertensive diseases and haemorrhage. Anaemia and previous LSCS appeared to be risk factors for developing MNMM. Low mortality index indicates high level of care.

O- 7.6

ITP: a retrospective study of fetomaternal outcome at tertiary care hospital

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Background & Objectives

Immune thrombocytopenia (ITP) is one of the causes of isolated thrombocytopenia occurring in pregnancy. It is an autoimmune disorder associated with accelerated clearance of platelets coated by anti-platelet autoantibodies as well as decreased platelet production. It is not a common entity encountered in pregnancy. We are sharing data of maternal and neonatal outcome of ITP cases managed from June 2022 to may 2023.

Materials & Methods

This is a retrospective study conducted in one unit at department of Obstetrics and Gynaecology, from June 2022-May 2023. The cases of ITP booked with unit were taken from birth register and details were noted from record section.

Results

Total 13 cases were taken. Majority 11/13(84%)were referred to AIIMS for management in 2nd /3rd trimester after diagnosis. Four out of thirteen(30%) were diagnosed prior to pregnancy while rest were diagnosed during. The platelet count in first trimester ranged from 40,000-1.5lac/cumm, second trimester from 30,000-1.6lac/cumm and 10,000-1.2 lac/cumm in third trimester. Eight out of thirteen(61%)required two or more admissions for management of severe thrombocytopenia. For management ,12/13(92)% patients were started on tab prednisolone 0.5mg/kg/day and titrated accordingly, 10/13(76%) patients were also given IV Immunogloublin 1gm/kg/day for 2days. This combination therapy was required by 10/13(76%) patients.8/13(61%) patients required SDP/RDP transfusion among which 41% required 4 or less blood products. One patient with refractory ITP required 61RDP,7SDP and 6PRBC transfusion. Three out of thirteen(23%)were refractory to combination therapy and were administered inj romiplostim 500mcg weekly. With advancing gestation,16%patients developed gestational hypertension out of which one developed impending eclampsia and was given MgS04.16% developed stage 1 FGR, 16%IHCP ,25% GDM. One had term IUD.8/13(61%) patients delivered vaginally, 5/13(39%) delivered by lscs as per obstetrics indication. Intrapartum atonic pph occurred in 16% patients and were managed medically. Intrapartum splenectomy was done in one patient for refractory ITP. There was none maternal mortality/ICU stay/neonatal complication/prolonged NICU stay. Postnatally,16% patients were started on tab eltrombopag (thrombopoeitin receptor agonist)50mg od and were advised biweekly follow up in hematology.

Conclusion

Outcome of pregnancy with ITP is favourable with multidisciplinary team of obstetricians, anaesthetist, haematologist and neonatologist at tertiary care

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 8 (Obstetrics)

O- 8.1

Role of transvaginal cervical length and AFI to predict latency period in prom

Aaliya Ansari

O- 8.2

Association of maternal hypertension and birth weight of neonates

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Background & Objectives

The risks and adverse health outcomes associated with elevated blood pressures have been well documented and recognized in neonates. It leads to intrauterine growth restriction resulting in Low Birth Weight (LBW) neonates. LBW remains a signiûcant cause of under-ûve mortality in India and Asia. To correlate maternal hypertension and birth weight of neonates and compare it with women with low-risk pregnancy.

Materials & Methods

A retrospective study was conducted at Dr RML hospital wherein 100 women having varying degree of hypertensive disorder of pregnancy, who delivered between the time period of 1-June -2022 to 1-June-2023 were enrolled and the neonatal birth weight were compared to 100 women with no known co morbidities, classified as low risk. The period of gestation was classified as extremely preterm.

Results

Among the 100 neonates born to mothers with hypertensive disorder of pregnancy, the average weight of neonates

Conclusion

The mean birth weight of neonates born to mothers with hypertensive disorder of pregnancy was lower compared to those born to mother without any comorbidities, classified as low risk. It was also seen that the discrepancy in birth weight of neonates born to mother having hypertensive disorder and to low-risk pregnancy was more in early onset of hypertension in pregnancy

O- 8.3

Correlation of serum inflammatory biomarkers with fetomaternal outcome in intrahepatic cholestasis of pregnancy

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Background & Objectives

To assess the correlation of inflammatory biomarkers with the maternal and fetal outcome in patients with intrahepatic cholestasis of pregnancy (IHCP).

Materials & Methods

A prospective cohort study was done for a period of 2 years in 121 pregnant women, 61 women with IHCP and 60 controls (maternal age and gestational age matched healthy pregnant women). Inflammatory markers such as neutrophil lymphocyte ration (NLR), platelet lymphocyte ratio (PLR), mean platelet volume (MPV), C-reactive protein (CRP), red cell distribution width (RDW) were compared in both the groups and also among the severe and mild IHCP groups antenatally. The patients were followed up till delivery for fetomaternal outcomes.

Results

The inflammatory biomarkers CRP, NLR and MPV were higher in patients with IHCP when compared with healthy pregnant women in control group (p

Conclusion

Inflammatory markers are easy to measure and may be used to predict the severity and prognosis of the disease, though larger studies are required to assess the impact on fetomaternal outcome.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 8 (Obstetrics)

O- 8.4

Intravenous paracetamol vs intravenous tramadol as labour analgesia

Hina Agarwal

Background & Objectives

Labour pain described as the most horrible affects both physiological and psychological aspects of labour. Majority of obstetrics services are in the hands of trained nurses and non specialized doctors and thus awareness of pain relieving for women in labour does not exist . Therefore drugs like paracetamol and tramadol with advantage of - easy availability and inexpensive with no special technique of administration are a boon for labour analgesia . Aim - to compare the role of intravenous paracetamol vs intravenous tramadol as an intrapartum labour analgesic.

Materials & Methods

A total of 60 pts , primigravida and multigravida with term gestation , singleton pregnancy with vertex presentation in active phase of labour cx dilatation (equal to > 4 cm) were taken. Group p (30 pts) and group T (30 pts) received 100 ml iv 1 gm pcm infusion single dose and 100 mg tramadol diluted in 100 ml NS . VAS (visual analogue score) was used to assess pain intensity before administrating drug , after 1 hr and 3 hr of drug administration . Primary outcome measured were difference in VAS score in both the groups . Secondary outcome analysed were - mode of delivery , duration of labour , drug delivery interval , maternal side effects and neonatal outcomes in terms of (birth wt , APGAR scores and NICU admissions).

Results

The mean VAS score decreased significantly to a greater extent in group p than group t and showed a significant statistical difference among both the groups, p (< 0.001) .

Conclusion

Intravenous paracetamol is more effective labour analgesic with fewer maternal adverse effects and shortens labour as compared to intravenous tramadol.

O-8.5

Evaluation and comparison of indications for primary and repeat caesarean sections: a retrospective study at tertiary care hospital

Shazia Zargar

Background & Objectives

The uncontrolled wave of cesarean rates has increased globally which has resulted in a significant amount of maternal mortality and morbidity. The present retrospective study aims to evaluate the clinical indications, demographic characteristics for repeat cesarean sections and then compare them with primary cesarean sections to draw some valid inferences.

Materials & Methods

The present retrospective study has been carried out at the department of Obstetrics and Gynaecology, SMGS Hospital, Jammu, India. The data regarding to total number of primary and repeat cesarean sections during (Mar 2020- April 2022) were collected from the record section of the hospital. All patients who underwent for cesarean sections during the study period were included in the study.

Results

In the current study we observe that the most common indication for cesarean deliveries is elective which nearly accounts for (41%) and the other indications for repeat cesarean were fetal distress (15.5%), dystocia (11.4), breech (7.8%).

Conclusion

We suggest strategically focusing on elective category patients and making them favorable for normal vaginal delivery which is only possible by establishing proper counseling cells at gross root level.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations: Session 8 (Obstetrics)

O- 8.6

A study of clinical profile of obstetric patients admitted to the ICU in a tertiary care centre

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Background & Objectives

Maternal morbidity and mortality is the critical illness or death of a woman from pregnancy related causes during pregnancy or within 6 weeks of puerperium period To describe the risk factors and outcome of the obstetric patients and to assess the predictors of maternal mortality among the obstetric patients admitted in tertiary hospital ICU To study the perinatal outcome of the critically ill mothers admitted in ICU

Materials & Methods

All pregnant, postpartum, postabortion women in the age of 18 years to 45 years, 42 days after delivery/ abortion, who are critically ill, admitted in ICU at tertiary hospital over a period of 6 months. No specific exclusion criteria. Detailed history and examination of women (including presenting symptoms, examination, demographic details, co morbidities, relevant lab investigations) and clinical assessment with SOFA score assessment will be done. Prognosis will be followed up throughout the course of her stay in the hospital. Data will be recorded on a Proforma, and a master chart will be used to assess the data. Data will be entered into Standard MS Excel spreadsheet and analyzed.

Results

Out of total 1045 deliveries, 22 obstetric patients were admitted to ICU during this study period. 84.2% were in the age-group of 20–35 years, 76.7% of patients were below poverty line, 58.1% of patients reside in rural areas and Antenatal care was not adequate in 42.4% of patients.76.6% patients were admitted in ICU for a period of 1-5 days and total duration of hospital stay in about 43.2% was more than 10 days. Blood transfusion (67.1%), the use of inotropic drugs (40.6%), central line placement (32.5%) and mechanical ventilation (56.08%) were the major interventions performed in ICU. Obstetric hemorrhage was the most common cause leading to ICU admission (39.5%) followed by hypertensive disorders (28%).

Conclusion

Predictable causes like PPH and PIH to be identified and effective strategies devised to prevent them. ICU's and HDU's dedicated solely for obstetric patients helps in appropriate treatment and prevention of mortality.

Session 9 (Miscellaneous)

O- 9.1

Comparison between 1st line behavioural therapy and yoga therapy in women with urinary incontinence

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Background & Objectives

To compare the effect of 1st line behavioral therapy and Yoga therapy in women with urinary incontinence.

Materials & Methods

152 Eligible women with urinary incontinence aged 25-60 years, who consented to participate in the study were randomized into 2 groups, 75 in the control arm, and 77 in the intervention (Yoga) arm. Participants were made to fill out a 3-day bladder diary, ICIQ SF, PFDI 20, PHQ9, and SF 36 questionnaires which served as baseline data for the severity of incontinence and quality of life. The control arm received behavioral management for incontinence for 3 months, while the intervention arm received specific Yoga in addition to behavioural measures, which was provided twice weekly with three days self -practice at their home for 3 months. After 3 months, symptoms were reassessed by the same questionnaires. Two sample t-test and Chi-squared test (or Fisher Exact Test) were used to compare the pre-intervention characteristics of continuous and categorical variables respectively. For within-group analysis, paired t-test or Wilcoxon signed-rank test was used. Intention to treat analysis was performed. 0.05 was set as the cut-off for statistical significance. Stata ver. 14.2 was used for statistical analysis.

Results

Significant improvement was noted in mean incontinence episodes ($p < 0.001$), incontinence severity as per ICIQ SF UI ($p=0.01$), pelvic floor dysfunction as per PFDI 20 ($p = 0.01$), and quality of life as per SF-36 questionnaires, in the intervention group compared to control. Urge incontinence had a statistically significant improvement with Yoga, with a significant reduction in ICIQ scores ($p=0.01$), and incontinence frequency ($p<0.001$).

Conclusion

It is one of the major prospective RCTs, studying the role of Yoga as 1st line management in urinary incontinence symptoms, pelvic floor health, and the overall quality of life as well. Further multicentric RCTs were required to explore this area of interest.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 9 (Miscellaneous)

O- 9.2

Perception of first year medical graduates towards gynecology related modules in the competency based foundation course

Ummay Kulsoom, Nidhi Gupta, Aruna Nigam

Background & Objectives

Medical profession requires extensive knowledge and skills, making it a demanding and challenging profession. To help first year medical students transition from a highly protected school environment to a professional course, a one-month orientation program has been introduced by the National Medical Council (NMC) in India. This study aimed to evaluate the feedback and perception of first-year medical students on the various modules with emphasis on gynaecology related modules like family practice and communication in competency-based medical education foundation course.

Materials & Methods

A cross-sectional study was conducted on 525 first-year MBBS students from the 2022-2023 batch in various medical colleges across different states. A predesigned and validated questionnaire was used to obtain feedback on a five-point Likert scale.

Results

The feedback of 525 students was obtained and analysed. In the orientation module, majority of students in all states (p0.05) but they appreciated the need for understanding of local language and proper communication with patients and their families along with awareness of various communication barriers and appropriate ways to respond to them.

Conclusion

Majority of the students rated the foundation course as very useful teaching program aiding in smooth transition and adaptation to the various challenges while providing care and treatment at various levels.

O- 9.3

Impact of respectful maternity care on birthing satisfaction of women undergoing vaginal birth in a tertiary care centre

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Background & Objectives

We aimed to ascertain the association between Respectful maternity care and birth satisfaction scores in mothers undergoing normal vaginal birth in the labour ward.

Materials & Methods

This study was conducted in the Department of Obstetrics and Gynaecology, Lady Hardinge Medical College, New Delhi. All women eligible and willing to participate were enrolled and their personal, sociodemographic and clinical details filled as per Semi structured proforma. They were assessed for respectful maternity care and birth satisfaction score by PCMC and BSS-R tools respectively in post-natal wards after 48 hours of delivery (sample size=100). The mean score for BSSR and RMC (PCMC) were 30 and 60 respectively. Correlation between RMC (PCMC) score and BSSR score were analyzed using Karl Pearson Correlation Coefficient Method.

Results

The results showed linear correlation of Respectful maternity care score with Birth satisfaction score. Amongst demographic parameters, multiparous women, lower socio-economic status and women in spontaneous and short duration of labour perceived more Respectful care.

Conclusion

Improving the Respectful and dignified care to the birthing women can improve their birth satisfaction and motivate more institutional and safe deliveries.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 9 (Miscellaneous)

O- 9.4

Varied cases of uterine inversion – a case series of 5 cases

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Background: Uterine inversion is a serious complication that can occur during childbirth,
posing a potentially fatal risk to the mother. The incidence of uterine inversion can range from 1 case in 2000 births to 1 case in every 50,000 births. It is crucial to promptly recognize this condition to prevent severe blood loss, which is often underestimated and can lead to hypovolemic shock and maternal death.

Case Presentation: There were 5 cases, 4 in reproductive age group (P2L2, P4L4, P1L1) and one post-menopausal (P3L3). All patients presented with mass coming out of vagina, three had associated bleeding, three had pain in abdomen and one post-menopausal patient had associated watery discharge. 3 patients had history of mass like structure protruding from vagina during delivery after removal of placenta. At presentation, four had BP 80/60 mmHg. P/A findings, in all patients, fundus of uterus not palpable. P/V examination shows fleshy mass at level of introitus and outside introitus . Four patients were diagnosed as acute uterine inversion and one post-menopausal patient as chronic uterine inversion. Hb was <8gm% in all patients. After stabilization, all patients underwent surgery. Two patients underwent successful reposition by Huntington method. One patient underwent reposition by Johnson method. As one patient was still hemodynamically unstable, patient underwent obstetrics hysterectomy and one patient with chronic presentation, underwent hysterectomy.

Conclusion: Uterine inversion needs immediate diagnosis and urgent medical intervention.
Due to its infrequency, a high level of suspicion is necessary to identify this condition. It is crucial to refrain from prematurely attempting to remove a partially separated placenta or applying fundal pressure.

O- 9.5

Internal iliac artery ligation in obstetrics and gynaecology-role and efficacy

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Background & Objectives:

Ligation of internal iliac arteries may be lifesaving in the control of severe pelvic haemorrhage occurring spontaneously or operatively. Because of the effectiveness, simplicity, and safety of ligating the internal iliac artery, the operation deserves greater emphasis than it has received in the past The purpose of this study is to determine the function and efficiency of internal iliac artery ligation in practice of obstetrics and gynaecology

Materials & Methods

Between January 2022 and December 2023, 50 women who underwent emergency or elective Internal iliac artery ligation undertook a retrospective study of their full clinical data. The procedure were carried out at tertiary care hospital, Maharashtra, for a variety of obstetrical or gynaecological purposes.

Results

Of the 50 instances that were included in the study, 7 were operated for gynaecological reasons and 43 were conducted for obstetrical reasons. The mean age of 31.5 (24 – 38 years). In obstetrics, a morbidly adherent placenta and uterine atony were the main indications for internal iliac artery ligation, but in gynaecological patients, the predominant rationale was a radical hysterectomy. We found statistically significant association between emergency internal iliac artery ligation and requirement for blood transfusions (all p values 0.005). The effectiveness of bilateral internal iliac artery ligation was assessed by preservation of the uterus which was achieved in 72.5% of the 43 instances carried out for obstetrical purposes, highlighting the significance of Internal iliac artery ligation.

Conclusion

In comparison to an obstetrical hysterectomy, internal iliac artery ligation is a comparatively less invasive option for treating severe bleeding in young women with low parity. This treatment keeps the prospect of future fertility while having fewer risks. Internal iliac artery ligation continues to be an essential intervention for protecting both the uterus and the lives of women in resource-constrained regions where sophisticated treatments are not available.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 9 (Miscellaneous)

O- 9.6

Glycemic status of women with gestational diabetes during fourth trimester of pregnancy

Simran Kaur

Background & Objectives

Women with GDM are at high risk of developing type 2 diabetes, metabolic syndrome, cardiovascular morbidity and recurrence of GDM in future pregnancies. Although guidelines suggest follow up at 4 -12 post-partum but only a negligible number follow due to multiple factors. Metabolic abnormalities recognized during 4th trimester provides a window for future NCDs. Objective: Evaluate the glycemic status of women during the fourth trimester of pregnancy.

Materials & Methods

Prospective cohort study, 300 women with GDM were followed up after delivery and were counselled for follow up during the 4th trimester, between 6-12 weeks postpartum for assessment of their blood sugar profile using 75 gm oral glucose tolerance test(OGTT). Women were classified as having abnormal glucose status if fasting blood sugar value >100mg/dl, and 2 hr post 75 glucose value > 140mg/dl.

Results

Out of 300 women, 273 came for follow up between 6-12 weeks after repetitive reminder phone calls. Out of those who followed up 48 (17.6%) had abnormal glucose status post partum. 4(1.46%) patients had only impaired fasting glucose(IFT) ,19(6.96%) patients had only impaired glucose intolerance (IGT) and 20(7.32%) among them had both, 5 (1.8%) had type 2 DM.

Conclusion

In this study we observed that 17.6% women with history of GDM had abnormal glucose status at 6-12 weeks post partum. Early post-partum identification and intervention during 4th trimester will slow down or prevent progression to diabetes and its sequelae.

Session 10 (Miscellaneous)

O- 10.1

Efficacy of multimodal treatment approach on quality of life in women with chronic pelvic pain- an open label RCT"

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AIIMS Rishikesh

Background & Objectives

Chronic pelvic pain (CPP) poses significant challenge in outpatient gynaecology due to its impact on quality of life (QOL) and healthcare utilization. The prevalence of CPP is 2% to 27% globally. ACOG defines CPP as pain for more than 6 months perceived to originate from pelvic organs. To assess the efficacy of multimodal treatment on quality of life and pain intensity and to ascertain the causes of Chronic Pelvic Pain.

Materials & Methods

This RCT was conducted over 18 months at AIIMS Rishikesh. Women diagnosed with CPP between 21 and 65 years at OPD were recruited. 100 women were selected, with 50 allocated to intervention arm and 50 to control arm. At baseline, all participants underwent history and clinical examination using standardized proforma designed by International Pelvic Pain Society (IPPS). The QOL was assessed using WHO Quality of Life Assessment Questionnaire and Pain intensity was assessed using Visual Analog Scale (VAS). The intervention group received multimodal management approach, including lifestyle modifications (sleep and diet), pelvic floor physiotherapy, counseling (in 2-3 sessions), and medical/surgical treatment as appropriate. The control group received single-mode approach (medical/surgical). Follow-up assessments were conducted at 12 weeks, where QOL was reassessed.

Results

The most common cause of CPP was endometriosis (30% in intervention group, 26% in control), followed by normal study results (24% vs 36%), and adenomyosis (14% vs 16%). Over the course of 12 weeks, both groups showed an improvement in the physical and psychological domain with intervention group demonstrated statically significant improvement compared to control. There was no significant difference in the social and environmental domains. The intervention group showed greater reduction in pain severity compared to control.

Conclusion

This study demonstrated that multimodal approach lead to significant improvements in QOL and pain severity compared to single-mode approach. The findings support efficacy of multimodal approach in managing CPP and suggest its potential benefits in improving the overall well-being of affected women.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 10 (Miscellaneous)

O 10.2

Understanding contraception awareness, usage, and influencing factors: a survey-based study

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Background & Objectives:

The objective of this research paper was to explore the level of contraception awareness, usage patterns, and factors influencing contraceptive decision-making among a diverse group of individuals.

Materials & Methods

A survey was conducted among 70 participants, collecting data on demographics, knowledge of contraception methods, sources of information, access to family planning (FP) needs, past contraceptive use, opinions on the importance of contraception, and factors influencing contraceptive decision-making. Data analysis involved descriptive statistics and thematic analysis of open-ended responses

Results

Out of the 70 participants, the majority (65%) were female, aged between 18 and 45. 95% of the respondents had heard of the term "contraception" and obtained information from various sources, including television (40%), the internet (30%), health workers (20%), and FP counselling clinics (5%). Access to family planning (FP) needs varied, with 45% having access through health centers, hospitals, or private shops, while 55% reported having no access.75% of the respondents had used contraceptive methods in the past, with condoms (60%), oral contraceptive pills (OCPs) (40%), injectable DMPA (35%), Cu-T (intrauterine device) (20%), and ligation (15%) being the commonly known methods. Among those who used contraceptive methods, 40% reported experiencing side effects, including nausea/vomiting (10%), headaches (15%), weight gain (20%), irregular periods (25%), amenorrhea (10%), and heavy menstrual bleeding (HMB) (20%). Only 25% of the respondents were aware of lactational amenorrhea as a contraceptive method. The majority of respondents (80%) believed that contraception is important for women, and 70% considered partners equally responsible for adopting contraception. Around 60% of the respondents recognized the need for contraception to space between children.

Conclusion

This research paper provides valuable insights into contraceptive awareness, patterns of use, and influencing factors among the surveyed population. The findings highlight the need for targeted educational campaigns, improved access to family planning services, and individualized counselling to address concerns about side effects, costs, and cultural beliefs. The results contribute to existing knowledge in the field of family planning and reproductive health and inform policymakers and health professionals working to promote effective and informed contraceptive method choice.

O-10.3

Variation of post trigger LH, progesterone and HCG levels with BMI and its impact on recovery rates of oocytes during IVF/ICSI cycles

Aakriti Batra, Surveen Ghumman Sindhu

Reproductive Medicine & IVF at Max Healthcare

Background & Objectives

To assess the variation in post trigger LH, progesterone and HCG levels with BMI after agonist/HCG trigger during ART cycles and its impact on recovery rate of oocytes.

Materials & Methods

A prospective study was conducted at Max Multispeciality Hospital Panchsheel Park, New Delhi from May 2018 – June 2023. A total of 174 patients (101 in agonist trigger and 73 in HCG trigger group) met the inclusion and exclusion criteria, were enrolled after taking written consent. Agonist trigger patients received either decapepty 0.3 mg or lupride 3 mg trigger. HCG trigger group received ovitrelle 500 mcg. Trigger day and 10–12 hours post trigger LH, progesterone and HCG was done and its correlation to BMI and oocyte recovery rate analyzed. P value

Results

In Agonist group, post trigger LH and progesterone decreased with increasing BMI though the difference was not statically significant. In subgroup analysis the highest oocyte retrieval , post trigger LH and progesterone were seen with normal BMI. In the HCG group highest post trigger LH and progesterone were in seen in normal BMI group .HCG levels showed significant negative correlation with increasing BMI (P-.001)

Conclusion

BMI should be considered while deciding dose of the trigger keeping in mind the variation of Post trigger LH, progesterone and HCG levels with BMI.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 10 (Miscellaneous)

O- 10.4

Efficacy of single dose oral mifepristone with trans cervical foley catheter for pre-induction cervical ripening in singleton term and late term pregnancy - an open label randomized controlled trial

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Background & Objectives

To determine and compare the efficacy, i.e., change in Bishop score and the safety of oral Mifepristone with trans cervical Foley catheter in women with singleton term and late term pregnancy undergoing pre-induction cervical ripening.

Materials & Methods

After Institute Ethics Committee approval, we conducted an open-label, non-inferiority Randomized Control Trial from December 2021 to April 2023 at a tertiary care centre in South India. A total of 266 women fulfilling the eligibility criteria were recruited. The participants were equally randomized into two groups; 133 in Group A (Single dose Oral Mifepristone 400mg) & 133 in Group B (22 Fr Transcervical Foley for 24 hours). The primary outcome was to assess the change in Bishop's score at 24 and 48 hours of intervention, and the secondary outcome was to assess the maternal and perinatal outcomes.

Results

Among 266 participants, the baseline characteristics were comparable in both groups. The mean Bishop score at 24 hours was 5.14 ± 1.72 (n=85; 95% CI= 4.77 to 5.51) and 5.48 ± 1.32 (n=91; 95% CI= 5.21 to 5.76) in Group A & B, respectively. At the end of 48 hours, no significant difference in Bishop score was found between both the groups [Group A vs. Group B: 5.27 ± 1.4 (n=37; 95% CI= 4.79 to 5.75) and 5.29 ± 1.0 (n=34; 95% CI= 4.95 to 5.64) respectively, p-value = 0.94]. Group A recruits had a shorter mean duration from ripening to delivery within the first 24 hours, and 6% had hyperstimulation. 6.8% of group A & 8.3% of group B babies required NICU admission. 2.3% (n=3) of babies required therapeutic hypothermia in group A compared to 0.7 % (n=1) in group B.

Conclusion

The pre-induction cervical ripening in singleton term and late term pregnancy with single dose oral mifepristone is as efficacious as transcervical foley catheter with a slightly increased risk of hyperstimulation with Mifepristone. The maternal and perinatal outcomes were comparable in both groups.

O- 10.5

IUCD perforations - lessons learnt in 5 years

Richa Sharma

Background & Objectives

Intrauterine contraceptive devices (IUCDs) are highly effective form of long-acting reversible contraception having least number of complications. We aimed to find the incidence, risk factors and the management done for incarcerated and transmigrated intrauterine contraceptive devices at a Tertiary Care Teaching Hospital during past 5 years.

Materials & Methods

Cross-sectional retrospective analysis of 5 years was done, and the case records from Medical Record Department and Family Planning Unit of our institution were analysed. Results Total number of IUCD insertions.

Results

Total number of IUCD insertions done in last 5 years (from January 2013 to December 2017) in our institution was 4557. Misplaced IUCDs requiring surgical interventions were 71 (1.6%) out of which 63 (88.7%) were incomplete perforations or embedded and 8 (11.3%) were complete perforations or transmigrated IUCDs. Transmigration sites were omentum, uterovesical fold, mesentery and bladder. Laparotomy was needed in 4 (5.6%), and 2 (2.8%) needed each laparoscopy and cystoscopy. Main risk factors identified were postpartum previous on or two caesarean sections, low parity, grade of operator and IUCD and uterocervical length discrepancy.

Conclusion

The risk of perforation should not be a reason to defer IUCD insertion and every effort should be made to bring down its failure and complication rates.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 10 (Miscellaneous)

O-10.6

Knowledge attitude and practice regarding menstrual hygiene in school going adolescent girls of Jabalpur city

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Background & Objectives

To assess knowledge and attitude of adolescent school going girls about menstruation. To evaluate menstrual hygiene practice, they follow. To know psychological effect of menstruation in their life.

Materials & Methods

Cross sectional observational study conducted via pre structured questionnaire involving knowledge, attitude and practices regarding menstrual hygiene for the duration of 12 months (1 Aug 2022 to 30 June 2023)

Results

Only 70 % of girls use menstrual hygiene products among which 45% belong to private school and 35% belong to government school. Knowledge seems insufficient, and practice they follow is mainly governed by social, economic and cultural factors.

Conclusion

Adolescence is a critical period of change from girlhood to womanhood. Girls experience menstruation for first time during this period. Menstruation is a periodic and cyclical shedding of endometrium accompanied by blood loss. Menstrual hygiene is principally defined as maintaining cleanliness of body during menstrual flow. This topic needed to be more focused and it's need of time to improve knowledge and Practices regarding menstrual hygiene for better health

O-10.7

Comparison of adolescent girls health profile between rural and urban schools of Delhi and NCR

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UCMS & GTB Hospital Delhi[1], DHAS Delhi[2], Tyagi Hospital Agra UP[3]

Background: Adolescent health problems constitute major share of disease burden and morbidities which are still unrecognized. Globally more than 1.3 billion are adolescents making 16% of total population . Adolescent population in India is 250 million constituting 20% making adolescent health crucial to achieving sustainable development goals (SDGs)The study will help to know about various health problems study population so that recommendations may be drafted for necessary actions for betterment of the existing health infrastructure in India and help in implementation of Programmes for adolescent population.

Methodology: The present study was conducted in various schools of Delhi and National capital region of Delhi (U.P. & Haryana) in association with numerous non government organizations from year 2020 to 2023.

Study design: Community-based cross-sectional study.

Sample size : 700 adolescent girls in age group 10-19 years were included from various schools through medical camps

Exclusion: Adolescent girls who were unwilling/ not ready to interact and had not achieved their menarche were excluded from study.

Results: Most of the subjects 208 (44.0%) belong to 14-16 year age group and 242(34.6%) are in 17-19 year age group. Out of total 700 subject 664 (94.9%) were unmarried and 36 (5.1%) were married. Most of the study subjects 456(65.1%) belonged to Lower middle class (IV). 35% were underweight, 6.6% were overweight and remaining 1.7%were obese. 28% had mild pallor, 18% had moderate and remaining had severe pallor.Most of the study subjects 500 (71%) did not have any RTI/STI symptoms. RTI/STI symptoms were seen in 29%. 35.% subjects were underweight and 56.85% were found anemic Majority 678(96%) of the study subjects had no obstetric history, 6(.85%) had history of abortion, 4(.57%) still birth. About 254(36. %) preferred allopathic treatment, 204(30%) preferred home remedy and 240 (34.%) did not take any treatment.

Conclusion:. The various problems of adolescent girls are anemia , infections, nutritional deficiency disorders (stunting, wasting), iodine deficiency disorders, childhood obesity, menstrual disorders, skin, dental and eye problems, diseases due to poor hygiene and RTIs/STIs/HIV.Morbidity due to these conditions was common as well as schools drop out rates. As per different studies majority of health problems in adolescent girls are preventable.

The study will help to know about various health problems amongst adolescent girls so as to bring change for the betterment of the existing health infrastructure and government programs. It is crucial to increase awareness regarding reproductive health so as to build healthy nation.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 11 (Obstetrics)

O-11.1

Diagnosis of GDM: comparison of IADPSG with NICE criteria

Madhwi Kumari

Background & Objectives

Background: Gestational Diabetes Mellitus is associated with increased risks to mother and child. Both the screening and the diagnostic criteria of GDM has been the subject of considerable controversy. Objective: To calculate the prevalence of GDM using IADPSG criteria and NICE criteria and to assess agreement between IADPSG and NICE criteria.

Materials & Methods

This prospective cohort study was conducted in the Department of Obstetrics and Gynecology, AIIMS Jodhpur. A total of 309 women were analyzed and screened for GDM between 24-28 weeks of period of gestation. Based on OGTT value, women were diagnosed as GDM by either IADPSG or NICE criteria. The enrolled cohort was categorized into 4 groups. Group 1 included women who were non-GDM and there were 215 (69.58%) women in group 1. Group 2 included those who were diagnosed as GDM by IADPSG criteria only and there were 40 (12.94%) women in group 2. Group 3 included women who were diagnosed as GDM by both NICE and IADPSG criteria and there were 42 (13.59%) women in this group. Group 4 included those who were diagnosed as GDM by NICE criteria only, comprising 12 (3.88%) women. We calculated the prevalence of Gestational Diabetes Mellitus (GDM) by the International Association of Diabetes and Pregnancy Study Groups (IADPSG) and National Institute for Health and Care Excellence (NICE) criteria and found out the level of agreement between them. We also compare the maternal and neonatal outcomes between non GDM women to women with GDM diagnosed by either of IADPSG or NICE or by both in our study. Statistical analysis was done using SPSS software. P Value less than 0.05 was considered significant.

Results

Results: Out of 319 women recruited, 10 were lost follow up. IADPSG criteria diagnosed 82 (26.53%) women as GDM and 54 (17.47%) were diagnosed as GDM by NICE criteria. On stratification of women with GDM into different groups based on IADPSG/NICE criteria, 40(12.9%) of women were diagnosed as GDM by IADPSG criteria only, 12 (3.9%) of women by NICE only, and 42(13.59%) of women were diagnosed by both IADPSG and NICE criteria. We applied kappa statistics to investigate the level of agreement between the IADPSG and NICE criteria. The level of agreement between the two criteria was moderate with kappa value being 0.516 (95% CI: 0.403 to 0.628). We also analyzed the differences in the maternal outcomes by comparing non GDM women with women who was diagnosed as GDM, we found that women diagnosed as GDM by either IADPSG / NICE criteria or by both had significant increase in maternal complications such as GHTN, PROM, preterm delivery, and caesarean section. We also found that mean birthweight of newborns and NICU admission between non GDM and GDM group were comparable with p value of 0.189 and 0.5 which were not significant.

Conclusion

IADPSG criteria has high pickup rate compare to NICE criteria for diagnosis of GDM. The Gestational diabetes-associated maternal complications were significantly higher in women who were diagnosed as GDM by either IADPSG or NICE criteria or by both in comparison to non-GDM population.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 11 (Obstetrics)

O- 11.2

Diagnostic and management dilemmas in eccentric ectopic pregnancies

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Background & Objectives

Diagnosing rare forms of ectopic pregnancy, is a significant clinical challenge for obstetrician and gynecologist. Eccentric pregnancy is defined as implantation of pregnancy within the supero-lateral aspect of endometrial cavity/uterine corpus. Intramural, Interstitial and Angular pregnancies are different types of eccentric pregnancies. These types of pregnancies occur when the fertilized egg implants in the upper region of the uterus, near the fallopian tubes. To describe the diagnostic challenges encountered in eccentric ectopic pregnancies considering the absence of definitive criteria and rarity of such cases.

Materials & Methods

Four different cases of angular ectopic pregnancy are described in patients who presented in different situations.

Results

Average time of diagnosis was 6-8 weeks in all cases. Case 1 was a misdiagnosed intrauterine pregnancy and after failed D & C, 4-D scan confirmed the diagnosis of angular pregnancy. Injection methotrexate was given for medical management. After inadequate fall of beta-hCG after 2 doses, repeat 4-D scan showed extension of ectopic gestation into the myometrium. She underwent laparotomy and exicison of myometrial pregnancy near right cornu. Case 2 presented with acute abdomen and 4-D scan showed angular/ cornual pregnancy with left fornicial tenderness. On laparoscopy, no abnormality was detected in any tube. USG guided suction evacuation was done. Case 3 presented as a case of recurrent ectopic pregnancy following IVF and had stump ectopic pregnancy post salpingectomy. She underwent laparoscopic ectopic excision via loop and stitch technique. Case 4 presented with acute abdomen and MRI revealed small gestation sac in the interstitial part of tube. She had spontaneous fall in beta-hCG levels so kept on expectant management. All had uneventful post-operative period.

Conclusion

In addition of 2-D scan, 4-D transvaginal scan may help to exactly confirm the exact location of angular pregnancies. Early diagnosis and prompt management can reduce the maternal morbidity and mortality associated with uterine rupture in pregnancy and also improve the future fertility outcome.

O- 11.3

Evaluation of RF parameters during pregnancy and its correlation with maternal and fetal outcomes

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Background & Objectives

Pregnancy involves significant anatomical and physiological changes in the female body to accommodate the growing foetus. Kidneys are the most affected organs during pregnancy. This study aims to study changes in kidney function parameters early in pregnancy, their trend, and correlation with maternal and fetal outcomes.

Materials & Methods

A prospective Observational study conducted in AIIMS, New Delhi, over a period of 2 years after ethical clearance. We included 250 pregnant women above 18 years of age attending the outpatient clinic of the department. All the patients underwent routine antenatal blood investigation at 11+6 -14 weeks, 18-20 weeks POG and added investigation including Serum Creatinine, Spot protein Creatinine ratio, Creatinine Clearance, Estimated glomerular filtration rate.

Results

In this study the mean age and BMI of study was 27.53 ± 4.16 years, 25.12 ± 4.25 Kg/m2 respectively. Gestational trend of renal parameter at 11+6-14 weeks and 18-20 weeks, mean GFR 190.90 ± 49.62, 205.66 ± 57.62 ml/min/1.73m2 (p value 0.5mg/dl at early pregnancy was associated with poor fetal outcome.

Conclusion

This study provides the data of renal parameters from the apparently normal pregnant Indian female and to see the causal relationship of abnormal renal functions in pregnancy and adverse outcome needs to understand the implication of renal health on pregnancy and vice versa. This study may be useful in counseling the women about the pregnancy outcome and careful follow up.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 11 (Obstetrics)

O- 11.4

Effect of respectful maternity care for improving quality of care for pregnant women SARTHAC initiative

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AIIMS, New Delhi[1], LHMC Delhi[2], MAMC Delhi[3], Pronto International, WHO4, India, DFW, WHO5, India, AIIMS, WLH, India[6]

Background & Objectives

Background Respectful Maternity Care is the missing link between availability of resources and utilization of services. Objectives The aim of the activity was to start a clinician-led organised movement to inculcate RMC using "SARTHaC" toolkit for various cadres of health care providers in a phase wise manner at all delivery points in the NCT of Delhi.

Materials & Methods

Methodology This was a collaborative initiative between AOGD QI Committee and WHO, India Country office. Content partner of activity is Pronto International. In the first phase, a five-day training of trainer workshop on respectful maternity care was conducted which was attended by the doctors and nurses from nine public and private facilities to create a pool of master trainers. In the second phase, "SARTHaC" toolkit was abridged to be conducted as half a day workshop. In the third phase, the developed tool kit was pilot tested in two medical colleges and finalized. A series of 10 workshops were conducted at health facilities. A team of at least two to three master trainers attending each of the workshops along with the local team of faculty. There was a pre-test proforma which was shared before the workshop and a feedback form which was collected after the workshop.

Results

Result we designed a Pretest Form for participants to determine the basic knowledge of respectful care around labour and delivery. A total of 190 responses were collected and analysed. It was noticed that 60% of the participants introduced themselves to the patients, 90% responded that they communicated adequately regarding any complication, 69% felt that verbal abuse was not acceptable in labour but 20% felt it acceptable. Another 10% felt that it was acceptable if the patient was not responding after repeated requests. The practice of birth companion was acceptable to 80% of the participants while the rest did not feel the need or did not respond. The concept of SBAR, Pre-brief and de-briefing was well understood by 70%, 67.1% and 52% of the respondents respectively.

Conclusion

Discussion it is a clinician-led initiative that makes the proposition feasible and realistic. Content was tailored to suit the clinical and cultural sensibilities of the audience. r participants to determine the basic knowledge of respectful care around labour and delivery. A total of 190 responses were collected and analysed. It was noticed that 60% of the participants introduced themselves to the patients, 90% responded that they communicated adequately regarding any complication, 69% felt that verbal abuse was not acceptable in labour but 20% felt it acceptable. Another 10% felt that it was acceptable if the patient was not responding after repeated requests. The practice of birth companion was acceptable to 80% of the participants while the rest did not feel the need or did not respond. The concept of SBAR, Pre-brief and de-briefing was well understood by70%, 67.1% and 52% of the respondents respectively.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 11 (Obstetrics)

O- 11.5

To study the impact of WHO LCG on labour outcomes in low risk nulliparous females in labour

Sanskriti Garg

Background & Objectives

Background: The WHO Labour Care Guide was released for effective implementation of new labour definitions laid by WHO guidelines on intrapartum care (2018). Objective: To determine the effect of WHO LCG in low risk nulliparous females in spontaneous labour on mode of delivery, rate of NICU admissions, Apgar score (5 minutes), post partum complications, duration of hospital stay.

Materials & Methods

Study design-open label Randomised control study at tertiary teaching institution in Low-risk Nulliparous females between 18-35 years of age at a gestational age of 37-40 weeks with cephalic presentation in spontaneous labor over 14 months INCLUSION CRITERIA Nulliparous women, 18-35 years between 37-40 weeks. Cephalic presentation. Spontaneous labor. EXCLUSION CRITERIA Medical disorders in or associated with pregnancy e.g. diabetes mellitus, hypertension, liver disorders, renal disorders, pulmonary, cardiac disorders etc., antepartum haemorrhage, multiple gestations, malpresentation, preterm, post-dated, premature rupture of membranes for>18 hours, fetal growth restriction. Congenital malformations. Intrauterine death. Bad obstetrics history The study was approved by IEC. Study registered under National registry of controlled trials. CTRI/2022/09/058160 Sample size was 500 . The labor progress was monitored, following the WHO LCG (2020) in the study group and the WHO-modified partograph (2000) in the control group. In the study group, the active phase of labor started with a 5-cm cervical dilatation. The alert parameters were highlighted, and a corresponding response was recorded. For each centimeter of cervical dilatation, a lag time has been mentioned (eg, 5 cm [e"6.0 hours], 6 cm [e"5.0 hours], 7 cm [e"3.0 hours], 8 cm [e"2.5 hours], and 9 cm [e"2 hours]). The alert was triggered if lag time at a particular dilatation exceeded with no progress. In the control group, the active labor started froma cervical dilatation of 4 cm. Deviation of labor progress to the right of the alert or action lines indicated reevaluation or intervention Each partograph was analyzed for its role in influencing decision-making in labour management In the study group, protracted or arrest of labor was defined as cervical dilatation of e"5 cm with ruptured membranes with slow or no cervical change despite adequate contractions or e"6 hours of maximum dose of oxytocin administration in the absence of adequate contractions respectively In the control group, protracted or arrest of labor was defined as slow or no improvement in cervical dilatation or descent of the head in the active phase of labor (e"4 cm) for e"4 hours with adequate uterine contractions or e"6 hours with inadequate uterine contractions even after a maximum permissible dose of oxytocin. The women in both groups were followed from active labor until 6 weeks after discharge from the hospital.. The primary outcome was mode of delivery, whereas the secondary outcomes were duration of the active stage of labor, intra- or postpartum labor"related complications (postpartum hemorrhage [PPH] or infection), duration of hospital stay, Apgar score at 5 minutes

Results

RESULT-study and control group comprised of 246 and 254 women respectively. The normal vaginal delivery was achieved 95.93 % in study group compared to 90.94% in control. The normal vaginal delivery was achieved in study group.

Conclusion

LCG has potential to achieve successful vaginal delivery.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
Session 11 (Obstetrics)

O- 11.6

Obstetrical outcomes in women with congenital heart disease

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Background & Objectives

Maternal heart disease complicates between 1-4% of pregnancies and accounts for up to 15% of maternal deaths. Pregnant women with congenital heart disease (CHD) experience a higher frequency of adverse obstetric events, such as pre-term labour, operative vaginal delivery, and cesarean delivery. This study was conducted to assess the obstetrical outcome in women with congenital heart disease.

Materials & Methods

A retrospective study was conducted from January 2017 to December 2022 and data was collected for pregnant women with congenital heart disease. Obstetrical outcome was noted in terms of mode of delivery, POG at delivery, maternal mortality, need of ICU admission, preterm birth, fetal growth restriction, congenital heart defect in fetus, APGAR at 1 and 5 minutes, NICU admissions, neonatal mortality.

Results

A total of 30 patients were admitted with CHD. Out of these, majority presented with atrial septal defect (ASD) (9/30), five had complex congenital heart disease (CCHD), 3 had ventricular septal defect (VSD), two were with tetralogy of fallot (TOF), two were with congenital heart block with pacemaker, one had ASD+VSD and others were eight. Average age at delivery was 26.63 years and mean period of gestation was 37+3 weeks. 60% delivered by lower segment cesarean section (LSCS). 20% delivered preterm. In 33% cases, neonates had low birth weight (

Conclusion

Advancements in early diagnostic capabilities, improvements in surgical success rates, and wider availability of follow-up care have improved the survival of individuals born with CHD. A multidisciplinary team is needed to successfully manage these cases.

Session 12 (Obstetrics)

O- 12.1

Clinical and hormonal profile of women with premature ovarian insufficiency: a case control study

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Background & Objectives

To study the clinical and hormonal profile of women with premature ovarian insufficiency and compare it with age matched controls.

Materials & Methods

This case control study included 50 treatment naïve women with spontaneous premature ovarian insufficiency (POI) attending gyne-endocrinology clinic at our hospital. Controls were 50 age matched healthy women with regular menstrual cycles. Data on menstrual history, age at onset of amenorrhea, clinical symptoms, infertility were collected and clinical examination was performed. Serum LH, FSH, E2, thyroid profile, DHEAS, androstenedione levels were assessed. The recorded data were analyzed using SPSS-PC-25 version.

Results

The mean age of POI patients was 33.8±7.18 years. Majority presented with secondary amenorrhea (90%) and primary infertility (46%). The mean duration of amenorrhea was 7.1±2.1 months. Most common clinical symptoms included vasomotor symptoms (n=26, p

Conclusion

Majority of patients presented at a mean age of 34 years with secondary amenorrhea and reported vasomotor symptoms. Serum DHEA and androstenedione levels were lower in POI patients. Prevalence of hypothyroidism did not differ between patients and controls in the studied set of subjects. Timely diagnosis will help in instituting appropriate hormone replacement.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 12 (Obstetrics)

O-12.2

Prenatal evaluation and outcomes of isolated fetal ventriculomegaly

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Background & Objectives: Fetal ventriculomegaly is the commonest brain disorder, the incidence being 1:1000 live births. Ventriculomegaly is said to be "isolated" when the fetus has no other anomalies, except those that are a direct result of the ventricular enlargement. We aim to evaluate antenataly diagnosed cases of isolated fetal ventriculomegaly and correlate with progression and neonatal outcomes.

Materials & Methods: This prospective observational study included 51 cases of isolated fetal ventriculomegaly, which were diagnosed sonographically over a period of 2 years. All couples were offered fetal karyotyping and if indicated Chromosomal Microarray (CMA), maternal TORCH screen, fetal MRI and serial sonograms. The neonate was evaluated by neurosonogram to correlate antenatal findings and further management.

Results : Mild ventriculomegaly was present in 58.8%, moderate in 19.6% and severe in 21.5% cases. Invasive testing was done in 41 cases, one amongst 36 karyotypes had deletion of 11.2 in chromosome 10. Clinical exome in one amongst two cases (both with previous baby affected by hydrocephalus) and one case of absent corpus callosum had a pathogenic variant. CMA was done in three cases and was normal with good perinatal outcomes. Amongst 19 MRI four cases of absent corpus callosum and four obstruction were confirmed. Three women opted for termination, two preterm demise occurred one of which was positive for Rubella infection. Labour and delivery was as per obstetric protocols. Four babies with gross hydrocephalus underwent Ventriculoperotineal shunt placement, two had global developmental delay one of which was CMV positive. Six neonatal deaths occurred amongst which one had an anomaly detected postnatally, three had severe progressive dilatation and one was mild ventriculomegaly. At six months follow up thirty two babies are doing well with no neurologic impairment. Strength: Prospective single centre longitudinal study. Limitation : None of the couples detected with pathogenic variant opted for carrier testing due to financial constraints.

Conclusion: Most of the isolated mild and even moderate ventriculomegaly have good outcomes. Neurologic, motor and cognitive impairment are more likely with severe ventriculomegaly and those with cranial and extracranial anomalies. A complete sonographic evaluation, infection screen, MRI and genetic testing aids in counselling the couple regarding prognosis, follow up, postnatal treatment and recurrence risk in subsequent pregnancies.

O- 12.3

Profile of obstetric patients admitted to ICU in a tertiary care hospital of Assam

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Background & Objectives: There is a story behind every maternal death. Better knowledge of the characteristics, treatment and outcome of high risk patients will be a step ahead for reduction of maternal mortality and morbidity. MMR has shown a decline from 167 in 2011-2013 to 97 in 2018-2020. Though Assam recorded a marginal improvement it is still the highest in the country. One measure to reduce the maternal mortality is providing timely intensive care. A better knowledge of the spectrum, characteristic and outcome of the diseases involving this group of patients is the first step towards achieving prevention and the present study was to supplement the present knowledge of obstetric emergencies requiring ICU care. Objectives- To identify the obstetric, surgical and medical disorders of obstetric patients admitted to ICU

Materials & Methods: Type of study-Cross sectional Observational study Place of study-Assam medical college and Hospital Period of study-1 year Sample size-90 Inclusion Criteria-All pregnant and postpartum women within 42 days of delivery admitted to ICU for obstetric or non obstetric reason irrespective of age, parity, mode of delivery fulfilling the criteria for ICU admission Criteria for ICU admission-RR 35, HR 140/min, SBP 160, Serum k 7, SPO2

Results: Obstetric complication leading to ICU admission was HDP(76.6%) followed by Obstetric haemorrhages(28.9%), early pregnancy complications(7.8%), rupture uterus(5.6%) and obstructed labour(2.2%). Of the medical complications presence of respiratory morbidity was 58.9% followed by severe anemia(55.6%), renal pathology (42.2%), Septicaemia(34.4%) DIC (13.3%) and heart disease (5.6%).One patient had surgical complication.

Conclusion : HDP and Obstetric haemorrhages often followed by severe maternal morbidity. A multidiscipliniary team involvement is essential to tackle such emergencies and to alleviate the threat to maternal health.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations : Session 12 (Obstetrics)

O- 12.4

Management of caesarean scar pregnancy: experience from a tertiary care centre

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Background & Objectives: Background: Caesarean scar pregnancy (CSP) is a type of ectopic pregnancy where implantation occurs in a previous caesarean scar. It is rare condition but incidence has been increasing in the last decade (1 in 2000 pregnancies) Treatment options include medical, surgical and surgically assisted medical management. Objectives: To assess the various treatment modalities used in our centre on scar ectopic resorption.

Materials & Methods: This study was conducted in the Department of Obstetrics and Gynaecology at AIIMS Rishikesh. Patients CSP managed from January 2016 to March 2023 were included. Demographic, clinical data, details of management and follow-up were recorded.

Results: Thirteen cases of CSP were managed during study period. Management modalities included intralesional with systemic methotrexate administration in 10 (76.92%) patients, laparotomy with scar ectopic excision in 1 (7.69%) patient, laparoscopic scar excision in 1 (7.69%) and open hysterectomy in 1 (7.69%). Seven (70%) patients that underwent intralesional & systemic methotrexate administration had successful resolution. Mean duration for β HCG normalisation was 52.25 ± 45.11 days and mean duration for disappearance of lesion on ultrasound was 110.3 ± 82.7 days. Two patients had haemorrhage during follow-up and were managed with laparotomy with scar excision and emergency abdominal hysterectomy. Third patient had non resolution of CSP even after 4 months; was managed with laparoscopic scar excision.

Conclusion: There is considerable ambiguity regarding best modality of management of CSP. Intralesional with systemic methotrexate is a viable option for management that can reduce need for major surgery. But there are chances of hemorrhage/nonresolution and considerable anxiety associated with prolonged follow up periods.

O-12.5

Cervical polyp in first trimester. Management revisited

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Background & Objectives: Cervical polyp are benign neoplasms occurring in 2-5% of reproductive-age women but their exact prevalence in pregnancy in unknown. Although the exact etiology is unknown, they are thought to arise secondary to reactive changes from high circulating hormone levels and from congestion of blood vessels in the cervix. When detected they cause significant anxiety to the patient. Coupled with it is the obstetrician's challenge of dealing with the situation that has no definitive guidelines for management and also whether conservative management or polypectomy should be done during pregnancy. To study the impacts of cervical polyp on pregnancy. To identify various polyp related risk factors for spontaneous late miscarriage/preterm delivery. (sLMC/PTD)

Materials & Methods: Pregnant females presenting with first trimester bleeding were evaluated and those diagnosed with cervical polyp were taken into the study. They were thoroughly evaluated as to the gestational age at which they presented, no. of episodes of bleeding during ANC period and size of polyp and their outcomes were recorded and statistically analysed.

Results: We present series of 15 pregnant patients with cervical polyps who presented with 1 to 8 episodes of first trimester bleeding. Three of these had a giant polyp measuring > 4cm, and two thirds had presented after 10 weeks of gestation. Almost 50% of our patients ran a stable course and in around half of the patients, the polyps had regressed by the third trimester. Most patients were underwent conservative management while polypectomy was required in only one patient. 11 patients had a favourable outcome delivering at or after 37 weeks.

Conclusion: Some cervical polyps can be misdiagnosed in the early pregnancy as abnormal vaginal bleeding and can lead to the diagnosis of an inevitable miscarriage. A good clinical examination can help prevent over use of progesterone. Ultrasound characteristics should be considered for risk stratification and patient counselling prior to formulating a treatment plan. Managements depends on factors such a polyp type, symptoms, gestational age, prior history and the type of operative management. Strict cervical length surveillance with transvaginal ultrasound is necessary in pregnant women with cervical polyp in early pregnancy.

Abstract of Oral Paper Presentation on 20th August 2023
Day 2 Oral Presentations
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O-12.6

To evaluate the association of umbilical coiling index and perinatal outcome

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Background & Objectives:

The objective of this study is to assess the degree of umbilical cord coiling, the effect of umbilical coiling on perinatal outcome and to find out the association between the degree of umbilical cord coiling, perinatal outcome and selected demographic variable.

Materials & Methods

A prospective observational study was conducted in the Department of Obstetrics and Gynaecology, ESIC-PGIMSR, Model Hospital Basaidarapur, New Delhi from December 2020-October 2022 in which 144 patients were included in the study who delivered either vaginally or by lower segment caesarean section, were examined and umbilical coiling index was calculated.

Results

The hypercoiling (UCI>90th percentile) of the umbilical cord is associated with IUGR and hypocoiling (UCI)

Conclusion

Abnormal coiling index is associated with poor perinatal outcome. The abnormal coiling index should be an important part of the routine antenatal ultrasound. Hypercoiling is termed as UCI more than 90th percentile. Hypocoiling is termed as UCI less than 10th percentile. The hypocoiling is associated with APGAR score at 1 min less than 4 and APGAR score at 5 min less than 7. Therefore, if the UCI is measured in antenatal period it would act as a good predictor of adverse perinatal outcome. Hence the antenatal detection of UCI will identify the fetus at risk and helps in further management.

O-12.7

PATTERN OF LYMPH NODE INVOLVEMENT IN ENDOMETRIAL CANCER: A RETROSPECTIVE ANALYSIS IN A TERTIARY CARE CENTRE

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Objective: The aim of this retrospective analysis was to investigate the patterns of lymph node involvement in endometrial cancer patients treated at a tertiary care center.

Methods: A total of 40 patients with histologically confirmed endometrial cancer who underwent lymph node dissection as part of their surgical management were included in the study. The medical records and pathological reports of these patients were reviewed to collect data on patient demographics, tumor characteristics, and lymph node involvement. The lymph node stations included in the analysis were pelvic and para-aortic lymph nodes.

Results: Among the 40 patients, 16 (40%) had pelvic lymph node involvement, while isolated paraaortic nodes positive 2(5%) patients. Four patients (10%) showed involvement of both pelvic and para-aortic lymph nodes. The remaining 18 patients (45%) had no lymph node involvement. Among 40 patients had a median of 15 pelvic lymph node(4 to 40) and 10 para aortic lymph node (3 to 17)removed. Among 40 patients Stage 1 endometrial catch in 14(35%),Stage 2 in 4 (10%),Stage 3 in 20 (50%), Stage 4 in 2 (5%) patients was observed. Among the patients with lymph node involvement, the most commonly affected lymph node station was the obturator lymph nodes in the pelvic region, followed by the common iliac lymph nodes. In the para-aortic region, the most frequently involved lymph node station was the para-aortic lymph nodes above the renal vessels.

Conclusion: This retrospective analysis highlights the patterns of lymph node involvement in endometrial cancer patients. The findings demonstrate that lymph node involvement is common in these patients, with the pelvic lymph nodes being more frequently affected than the para-aortic lymph nodes. The knowledge of these patterns can help guide surgical and treatment strategies, such as lymph node dissection and adjuvant therapy, improving patient outcomes and optimizing care for endometrial cancer patients. Further prospective studies with larger sample sizes are warranted to validate these findings and explore their clinical implications.

Poster Abstract

P 1.1

ACCESSORY CAVITATED UTERINE MALFORMATION: AN UNUSUAL CASE OF PROGRESSIVE DYSMENORRHOEA IN A PAROUS WOMAN

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Introduction

Accessory cavitated uterine malformation (ACUM) is a rare uterine anomaly of unknown origin, seen in young nulliparous women who presents with progressive dysmenorrhea.

Case Report

26 years old, P1L1, presented with worsening progressive dysmenorrhoea for 3 years, initially relieved by oral analgesics and on hormonal pills. USG and MRI showed 2.0 x 2.1 x 2.3 cm isointense lesion in the myometrium with central hyperintense area showing central diffusion restriction in left anterolateral aspect of body of uterus. Decision for surgical intervention was taken in view of worsening symptoms. Laparoscopy showed a uterus with a globular swelling in the left uterine wall below the left round ligament. Hysteroscopy showed normal uterine cavity. The diagnosis of ACUM was confirmed and laparoscopic excision was done. The specimen comprised of 2.2 cm cavitated cystic lesion with chocolate coloured fluid inside the cavity. Histopathology revealed accessory uterine cavity showing endometrial cavity lined by functional endometrium and surrounded by smooth muscle.

Clinical Relevance

ACUM is a rare cause of dysmenorrhoea in young adolescent and nulliparous women. In parous women, it should be suspected in a case of progressive dysmenorrhea where it can be a diagnostic challenge and is often underdiagnosed. Surgical management with excision is recommended in such cases due to severe dysmenorrhoea

P 1.2

ISTHMOCELE- A OVERLOOKED NICHE OF SECONDARY INFERTILITY!

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Introduction

Isthmocele (caesarean scar defect, niche or diverticulum) is a myometrial discontinuity in the anterior uterine wall at the LSCS scar site whose presentation ranges from incidental finding to prolonged spotting to chronic pelvic pain to secondary infertility. TVS, Sonohysterography and MRI are various modalities used in it's detection. In the light of above context, we present two cases of Isthmocele evaluated and operated at our institution.

Case Report

Case 1: A 30 year old P1L1 with h/o LSCS 6yrs back underwent laparotomy f/ b scar abscess drainage 2yrs ago i/v/o frequent prolonged scanty menses with dysmenorrhea. As the symptoms persisted post-laparotomy she visited SJH where her transvaginal ultrasound showed a hypoechoic, cystic collection measuring 9×6 mm seen at LSCS scar site suggesting Isthmocele formation. She was taken up for laparotomy and intraoperatively, 1.5 ×2cm of bulging defect was seen over the anterior wall of LUS which was excised and repaired. Case 2:A 34 year old P2L2A1 with prev 2 LSCS(last 6yrs ago) presented with frequent, prolonged, heavy menstrual bleeding since 1 year. On transvaginal ultrasound, anterior uterine wall defect of 8.2 mm was seen along with polyp of 1.3 ×1.6 cm coming through the defect. She was taken up for laparotomy as well and intraoperatively, 1×1 cm of anterior uterine wall defect and a polyp of 1×1 cm seen at the same site both of which are excised and uterine wall repaired. Postoperative outcome of both the patients were satisfactory.

Clinical Relevance

While making the diagnosis of Isthmocele is rather simple,all thanks to advanced imaging, deciding who needs to be treated and their appropriate line of management remains an enigma. Many studies recommend minimally invasive surgical repair of Isthmocele in symptomatic patients and also in asymptomatic patients, if future pregnancy is planned. Owing to its increasing incidence and it's camouflage under the umbrella of various differentials, it's important to make a prompt diagnosis of Isthmocele and treat it.

P 1.3

RARE CASE OF PUBERTY MENORRHAGIA

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Background

Heavy menstruation between menarche and 19 years of age is called puberty menorrhagia. Heavy menstrual bleeding is defined as bleeding over 80 ml per menstrual period or lasting more than 7 days. The most common cause for puberty menorrhagia is anovulatory uterine bleeding. The other reasons may be idiopathic thrombocytopenic purpura, hypothyroidism, genital tuberculosis, PCOD, leukemia and coagulation disorders (12-33%) etc.

Case Report

We hereby present a case of a 13 year old female who presented with complaints of heavy menstrual bleeding associated with passage of clots , multiple episodes of fever, fainting episodes, bone pain. On examination she was extremely pale, bilateral cervical lymph nodes were palpable,liver was palpable on per abdominal examination. Complete blood count revealed pancytopenia, bone marrow aspiration revealed normoblastic erythroid hyperplasia, Ultrasound of neck revealed bilateral enlarged lymph nodes which on FNAC showed reactive lymphadenitis with atypical cells, ultrasound of abdomen showed hepatosplenomegaly, peripheral blood flow cytometry revealed CD 20 +, CD10+ cells,bone marrow biopsy revealed myelosuppressive disorder. Patient was diagnosed with acute lymphoblastic leukemia.

Clinical Relevance

All young patients with heavy menstrual bleeding need to be investigated thoroughly to find out the cause of bleeding before dismissing it to be due to anovulation.

P 1.4

GENITAL TUBERCULOSIS AND RECURRENT PREGNANCY LOSS

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Introduction

Genital TB is a major public health problem. It is a frequent cause of infertility. However it's association with recurrent pregnancy loss(RPL) is less well understood.

Case Report

A 20 year old P2L2A4 female presented with 1.5 month amenorrhea followed by continuous bleeding P/V for last 1.5 month. Her 1st child birth was by LSCS i/v/o breech presentation followed by VBAC. She had prior four abortions Clinically patient was pale at time of admission and had tachycardia. Her Hb was 6.8 g/dl for which she received a packed cell transfusion. USG pelvis showed increased vascularity in uterine fundus which was suggestive of AV malformations and moderate amount of free fluid with septations in pouch of douglas. Culdocentesis was done and straw colour clear fluid obtained. Microscopy of fluid -Count-50 cells /microlt, DLC = N2L45M3 (out of 50 cells). On ZN staining AFB seen (2+). TP/Alb/Glu = 5.2/2.75/115. LDH = 140. ADA -11. On CxR, right pleural effusion and paratracheal lymphadenopathy was observed. She was started on ATT.

Clinical Relevance

Genital tuberculosis affects the endometrium in 50-80% of cases, causing destruction of endometrium eventually leading to Asherman's syndrome. However, low grade inflammation may result in implantation failure . Mechanisms involved in the etiopathogenesis are ,vascular micro thrombus formation in the endometrium, release of cytokine like TNFα and other immunological mediators of inflammation making the endometrium unfavourable for implantation. Genital tuberculosis may cause recurrent pregnancy loss and early initiation of ATT may reverse the endometrial damage.

P 1.5

TUBERCULAR CERVICITIS – A DILEMMA: REPORT OF FIVE CASES

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Introduction

Cervical tuberculosis is a rare disease affecting women of reproductive age group(20-45years) , indicating hormone dependence of infection. Clinical presentation can vary from post coital bleed, intermenstrual bleed to infertility in some cases . Cervical lesions presents either a as papillary/vegetative growth or ulceration mimicking cervical cancer. Cervical Papanicolaou (Pap) smear, being a non-invasive procedure is considered as first line of investigaton .Presence of epithelioid and Langhan's type of giant cells is diagnostic however, other causes of granulomatous cervicitis should always be ruled out. Ziehl-Neelsen (ZN) stain for acid fast bacilli, fluorescent technique, colposcopy guided biopsy and culture help in confirming the disease. We hereby report a case series of five patients, each presenting with different symptomology of tubercular cervicitis. Diagnosis in all cases is confirmed by biopsy.

Case Report

Case 1 A multipara, 42 years, presented with menometrorrhagia and post-coital bleeding since 1 year. Per-speculum examination revealed a hypertrophied cervix. Pap smear showed granulomatous cervicitis consistent with tuberculosis. VIA / VILI examination was negative but on colposcopy small acetowhite areas were present on whole transformation zone, which on biopsy revealed caseating epitheloid granulomas suggesting tubercular cervicitis Case 2 A multipara, 32 year, presented with pain lower abdomen and post-coital bleeding for one year. Per-speculum examination revealed congested cervix which bled on touch. Pap smear was granulomatous cervicitis consistent with tuberculosis. VIA was negative and VILI was positive at 12 O'clock position ; colposcopy directed biopsy which showed caseating granulomas and langhans giant cells in the cervical stroma suggesting tuberculous cervicitis. Case 3 Twenty-one year old infertile nullipara came with post-coital bleeding for 6 months. Per-speculum examination showed unhealthy cervix with circumoral ectropion. Pap smear was normal. VIA/VILI was positive at 5, 7 and 11 O'clock position . On colposcopy raised rolled out areas were seen which on biopsy showed granulomatous cervicitis consistent with tuberculosis. Case 4 40 year old multipara came with complaint of post-coital bleeding and intermenstrual spotting since last 1year. On per speculum examination a fluffy growth arising from endocervical canal was seen which bleed on touch. Pap smear could not be taken as the cervix was smeared with blood. Colposcopic guide biopsy taken which showed necrotizing epithelial cell granulomas with Langhan's giant cell which is consistent with tuberculosis. Case 5 26 year old primipara presented with complaint of post coital bleed for 6 months. On per speculum examination circumoral ectopy was seen with a growth at 9 o'clock position. Pap smear came out to be unsatisfactory twice. On colposcopic examination, low grade aceto-whitening seen from 6 o'clock to 9 o'clock position with raised vascularity surrounding the growth which was seen at 6o'clock position. Although no atypical vascularity was noticed. Biopsy taken from all four quadrants including the growth and acetowhite areas which showed granulomatous cervicitis suggesting tuberculosis.

Clinical Relevance

Female genital tuberculosis is a rare yet important cause of morbidity and infertility among females of countries with high overall prevalence of TB . Incidence of FGTB 3%-26%1 among Indian females, some other countries with high incidence rate of FGTB are Nigeria (17%)2, South-Africa (6-21%)3 , Pakistan(2-20%)4 and Yemen(7%)5. FGTB in almost all cases is secondary to extragenital tuberculosis and very rarely it involves cervix. Cervical tuberculosis accounts for 0.1-0.65% of all cases of tuberculosis, and 5-24% of female genital tract tuberculosis6 . TB is usually secondary to a primary focus elsewhere in the body most commonly from lungs. Spread to cervix is either by hematogenous, lymphatic dissemination or by direct extension6 . The lesion on the cervix can be either exophytic, ulcerative although interstitial and endocervical polypoid form may also occur. Patients with cervical TB present with persistent offensive discharge, abnormal bleeding, malaise and other constitutional symptoms of infection. Diagnosis depends upon the isolation of tubercle bacilli on microscopy and histopathology. Early diagnosis and treatment with ATT are the key t prevent long term complication.

P 1.6

CESAREAN SCAR ECTOPIC PREGNANCY: PRESENTATION AND MANAGEMENT

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Introduction

Scar ectopic is defined as abnormal implantation of embryo within myometrium and fibrous tissue in previous scar on uterus .There has been an increase in the incidence in recent years due to increased incidence of cesarean sections , contributing to 6.1 percent of all ectopic pregnancies.

Case Report

We are presenting the case of a 32 yr old G7P3L2A3 female with previous 2 vaginal deliveries , two first trimester abortions followed by cesarean section 4 yrs ago. No h/o curretage in any of the abortions . Cesarean was done for?arrest of labor/?fetal distress at private hospital . No h/o fever or wound sepsis in postpartum period. In the current pregnancy, patient took MTP pill from a chemist shop at 2 months amenorrhea . There is h/O BPV for 10 days. No h/o passage of clots or POC's . TVS was done, that showed 6+5weeks GSAC with CA at scar site. Serum beta hcg was 12500. Patient was counselled regarding the risk of scar ectopic and offered medical management. Injection methotrexate(50mg) was injected into the GSAC. Patient was then followed with serial serum beta hcg, which was 6358 on D8 and negative by 3 weeks after injection.

Clinical Relevance

Scar ectopic is usually diagnosed at 5 to 12 weeks of gestation and within 6 months to 12 years after cesarean section. The pathophysiology remains uncertain, however it has been stated that scar defects in the form of micro tubular tracts , which arise due to poor healing .The gestational sac is completely surrounded by fibrosis tissue of the scar and separated from endometrial cavity. They usually present as painless vaginal bleeding. The management options include Conservative, with either local or Systemic methotrexate or KCl , as well surgical like Hysteroscopy, laparoscopy, laparotomy and uterine artery embolisation. Scar ectopic pregnancy is rarest of all ectopic pregnancies and a life threatening condition which can cause massive haemorrage and risk of Uterine rupture if misdiagnosed or if not managed timely.

P 1.7

AUTOLOGOUS PLATELET RICH PLASMA: A NOVEL PROMISING OPTION FOR WOUND HEALING

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Background & Objectives

Autologous PRP (APRP) is recently emerging as a promising treatment modality in the field of regenerative medicine. PRP provides damaged tissue with various growth factors, cytokines, and other bioactive mediators that enhance wound healing.

Materials & Methods

We present 2 cases where APRP has been used successfully for wound management in post caesarean patients. APRP therapy was used in wound management of post caesarean patients with non-healing stitch-line.

Results

Complete healing was achieved in these patients after APRP therapy

Conclusion

APRP is a novel promising option for wound healing in post-operative patients.

P 1.8

MEDICAL MANAGEMENT OF CESAREAN SCAR ECTOPIC PREGNANCY USING INTRAMUSCULAR METHOTREXATE INJECTION

Ruby Siddiqui

Introduction

With the increase in the incidence of cesarean section, any subsequent risks of placenta previa, placenta accreta, and ectopic pregnancy have increased. Though rare, cesarean ectopic pregnancy has also increased in parallel with increase in cesarean rates. Cesarean scar ectopic pregnancy is defined as implantation into the myometrial defect in the previous uterine incision.

Case Report

The aim was medical management of caesarean scar ectopic pregnancy using intramuscular methotrexate injection. Two patients with a diagnosis of caesarean scar ectopic pregnancy were offered intramuscular methotrexate injection. Methotrexate is a folic acid antagonist and has been widely used to treat ectopic pregnancies. In the absence of any contraindications, the protocol recommendation for medical treatment of ectopic pregnancy is a single intramuscular injection of methotrexate at a dosage of 1 mg per KG or 50 mg/m^2.

Clinical Relevance

A single dose intramuscular methotrexate injection was given and serial beta HCG levels were monitored, the levels came to normal limits for the first case in 3 weeks and for the second case in 2 weeks. No second dose was required; no surgical intervention was required.

P 1.9

CRANIOPHARYNGIOMA: A RARE CAUSE OF PRIMARY AMENORRHEA

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Introduction

Primary amenorrhea affects 5-10% of adolescent girls. The common causes are turners syndrome, mullerian anomalies and pituitary and hypothalamic dysfunction. primary amenorrhea may be due to brain tumors. We describe a case of craniopharyngioma which presented with primary amenorrhea.

Case Report

A 14-year-old girl presented to gynaecologic endocrinology clinic, LNH Hospital with complaints of delayed menarche and short stature. She was second child of non-consanguineous parents. Delayed growth was observed by her parents at age of 13 years. On examination, her height was 137 cm, weight 35 kg, BMI was 18.7 kg/m2.Breast development was Tanner stage 1, and pubic and axillary hair development was Tanner stage 1. Hormonal profile indicated hypogonadotropic hypogonadism (FSH-0.216mIU/ml, LH-0.66mIU/ml, E2 : 31pg/ml). On further evaluation prolactin 280 mU/L

Clinical Relevance

Craniopharyngiomas accounts for 5-10% of all intracranial tumors in children and adolescents . The combination of headache and growth failure (18%) was the most frequently reported symptom, followed by headache and neurological deficits (15%) but very rarely may manifest as primary amenorrhea. MRI is essential component for work up. Team approach involving gynaecologist, neurosurgeon, geneticist, psychologist andendocrinologist needed. This case highlights importance of intracranial imaging in a case of hypogonadotrophic hypogonadism. timely management of intracranial tumours if detected, helps in pubertal growth.

P 1.10

LIVE PREGNANCY IN NONCOMMUNICATING RUDIMENTARY HORN OF UNICORNUATE UTERUS: A RARE CASE REPORT

Nikita Saxena

Introduction

We report a case of 24 year old gravida 5 para 2 live 2 abortion 2 with a live 12 weeks pregnancy in the rudimentary horn of a unicornuate uterus. Unicornuate uterus is a rare Mullerian anomaly which occurs in 0.1% of the population. The rudimentary horn can be communicating or noncommunicating depending on its fusion with the larger horn. Rudimentary horn pregnancy is a life threatening condition having a high uterine rupture rate of 50%.

Case Report

The patient presented with multiple episodes of vomiting and giddiness.She was hypotensive and tachycardic with a low volume pulse. After initial resuscitaion, an urgent ultrasound showed a geastational-sac with live fetus in the left adenexa with a crown-rump-length of 12+3 weeks with moderate free fluid in the pelvis with echoes and septations suggestive of hemoperitoneum. An emergency laparotomy was done which revealed 1 litre of hemoperitoneum and an enlarged left rudimentary horn with a defect in the anterolateral wall through which the gestational sac was bulging out. Resection of the rudimentary horn with bilateral tubal ligation was done. The horn contained a live fetus of 3 months' gestation along with placenta. Intraabdominal drain was placed after securing hemostasis. She received 3 units' blood transfusion. The post-operative period was uneventful

Clinical Relevance

Awareness about pregnancy in this rare uterine anomaly is crucial as early diagnosis and swift management can be lifesaving and prevent catastrophic maternal outcomes.

P 2.1

A RARE CASE OF LYMPHOMA OF CERVIX

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Introduction

Primary lymphomas of the female genital tract are a quite rare entity, accounting for 0.2%–1.1% of all cases of extra-nodal lymphoma. The most common site in the female genital tract is the ovary, cervix being the second most frequent location. The pathology is likely to be mistaken with other types of malignant neoplasms or inflammatory processes.

Case Report

A 46 year P2L2 presented with white discharge and spotting pervaginum, lower abdomen pain, dysuria with poor stream and increased frequency of micturition for one month. Vaginal examination revealed pulled up cervix with hard growth over the entire cervix extending predominantly over posterior two third and both lateral vaginal walls, not bleeding on touch. A working diagnosis of Ca Cervix stage 4 was made clinic-radiologically. USG showed minimal HUN of left kidney due to compression of distal ureter by pelvic mass and MRI revealed neoplastic lesion involving entire cervix and infiltrating into lower 1/3rd of uterus and upper 2/3 rd of vaginal with poster urinary bladder involvement with iliac nodes and liver involvment. Cystoscope showed normal mucosa with indentation in posterior bladder wall. Cervical punch biopsy was reported as Non Hodgkin lymphoma Diffuse Large B cell Lymphoma of Cervix and was managed with palliative chemotherapy with R-CHOP regimen

Clinical Relevance

Cervical uterine lymphomas may be one of the differential diagnosis in case of a cervical mass, particularly in women with previous normal Pap smear, rapidly growing tumor and initially non-contributory biopsies. Treatment is R-CHOP based chemotherapy to avoid increased morbidity of combined treatments with surgery or radiotherapy.

P 2.2

PRIMARY ADENOCARCINOMA OF FALLOPIAN TUBE-MASQUERADING AS OVARIAN TUMOR

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Introduction

Primary fallopian tube carcinoma is an uncommon tumor accounting for approximately 0.14 -1.8% of all female genital malignancies. The typical presenting symptoms include pelvic pain,vaginal bleeding frequently associated with a watery vaginal discharge.It is often mistaken for benign pelvic disease or ovarian cancer.

Case Report

Hereby presenting a case of 40 years P2L2A1 female with right adnexal mass with complain of pain lower abdomen and discharge per vaginum for the last one year. On per abdominal examination abdomen was soft, non tense and non tender. On per vaginal examination uterus was normal in size and a mass of 6 by 6 centimetres was felt in right adnexa close to the uterus predominantly cystic. All ovarian tumor markers were found negative.MRI done was suggestive of Right complex ovarian cystic mass with predominantly solid component.Patient underwent Staging Laparotomy in view of Right complex ovarian cystic mass. Intraoperatively Right fallopian tube was found edematous, solid cystic in consistency with bilateral ovaries grossly normal.Right salpingectomy was done and specimen was sent for scrape cytology as it revealed a solid mass on cut specimen.Scrape cytology report came out to be suggestive of Adenocarcinoma of fallopian tube. Surgery was then further proceeded with Total abdominal hysterectomy with bilateral salpingoophrectomy with infracolic omentectomy

Clinical Relevance

Primary Fallopian tube carcinoma is a rare tumor and should be kept as an important differential diagnosis for an ovarian mass

P 2.3

INVASIVE MOLE

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Introduction

Gestational trophoblastic diseases are composed of a spectrum of abnormal trophoblastic proliferation ranging from the benign mole to malignant choriocarcinoma

Case Report

A 25-year-old woman with a history of one previous live single pregnancy with 2 spontaneous abortions and no significant medical and Surgical history presented with complain of mild vaginal bleeding and pain lower abdomen @ 2.5 mA on 8th July 2022 , in emergency room of another hospital for which she underwent suction and evacuation in Bihar. Still her bleeding per vaginal continued for which she was referred to Delhi. Patient came to Safdarjung Hospital on 28 November 2022 from where she was admitted. At admission she was oriented and afebrile with a pulse rate of 94 beats/minute and blood pressure of 105/65 mm hg, the abdomen was soft non tense and non tender, P/V exam- cervix soft uterus anteverted doughy ,4cm*4cm mass felt in anterior right fornix, left fornix free Investigation- hemoglobin was 10.6 g/dl, plt -1.13 lakh and B-HCG was 3168 mIU/ml. A pelvis ultrasound showed an anterverted, bulky uterus(11cm*10cm), uterus shows multiple cystic areas in posterior myometrium reaching upto serosal surface ,endo-myometrial junction appears indistinct in lower part . myometrium taking gross vascularity on Doppler. MRI scan confirmed the suspect of invasive mole and showed evidence of multiple tortuous contrast opacified vascular channels in right parametrium closely abutting right lateral uterine wall. Features suggestive of invasive mole (FIGO stage 2). Modified WHO prognostic scoring system was performed and the score identified a low risk patient. After a comprehensive counselling uterine artery emobisation and single agent chemotherapy regime of methotrexate plus folinic acid was started 3 cycles were given after which no significant decline in B Hcg was seen. Thus multiagent chemotherapy was started with EMA/CO regimen (etoposide, methotrexate, ActinomycinD, cyclophosphamide, vincristine) for 7 cycles. After three Cycles of EMA/CO a consistent decrease of BHCG was observed and after 7 cycles consistent values of BHCG

Clinical Relevance

Invasive mole can be successfully treated with chemotherapy after timely investigations and follow up and reduce the need for surgical intervention thus preserving fertility in young females.

P 2.4

BILATERAL MULTIPLE MATURE CYSTIC TERATOMA: CASE REPORT OF AN UNUSUAL FINDING

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Introduction

Mature cystic teratoma, also known as dermoid cyst, is a benign germ cell tumour, comprising 10-25% of all ovarian neoplasms with a peak incidence in the age 25-45years, with bilaterality in 12% cases. Despite the frequency of this neoplasm, the appearance of multiple synchronous ovarian teratomas within the same ovary is rare occurrence and only 9 cases have been reported in literature. They commonly present with lower abdominal pain in 44-47% of cases with an incidence of 3-21% of ovarian torsion, especially in the size 5-15cm.

Case Report

20year unmarried nulliparous woman presented with spasmodic abdominal pain for 2days; with no history of vomiting, fever, menstrual irregularities. On clinical examination: tenderness was present on right iliac fossa, with no guarding/rigidity. Rest of gynecological examination was normal. UPT was negative. On USG: 7x4cm right adnexal cyst with mixed echogenic content and decreased vascularity in stalk, possibility of torsion. On exploratory laparatomy, right ovary underwent torsion with two turns, with 2 large 7x5cm dermoids, left ovary enlarged with 5 cysts. Bilateral cystectomy with bilateral ovarian reconstruction was done. Cut section: cheesy material with hair. Histopathology confirmed the diagnosis and post-operative period was uneventful: discharged on post-operative day 6.

Clinical Relevance

Bilateral multiple mature cystic teratomas in young, nulliparous women are rare and come with the challenge of preserving considerable ovarian stroma to maintain menstrual function and preserve future fertility. The development of complications can rapidly turn it into a life-threatening condition with high morbidity and mortality. Therefore, early diagnosis and appropriate management can ensure optimal outcomes.

P 2.5

LOW GRADE ENDOMETRIAL STROMAL SARCOMA : A DIAGNOSTIC DILEMMA

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Introduction

Uterine sarcomas are rare malignant tumors , according to 2014 WHO classification has four categories: endometrial stromal nodule, low-grade endometrial stromal sarcoma (ESS), high-grade ESS and undifferentiated uterine sarcoma. Incidence: of 1–2 per 100 000 women. ESS typically develop in premenopausal and perimenopausal women with a mean age of 46 (range 18–83 years). ESS represent nearly 0.2% of all uterine malignancies, but represent approximately 7–25% of uterine sarcomas. 90% of women present with abnormal uterine bleeding and 70% with uterine enlargement

Case Report

History: A 32 yrs female, P2L2 got admitted with complains of heavy menstrual bleeding, difficulty in micturition, dysmenorrhea, fatigue and generalised weakness for 5 months Examination: P/A: mass of 16 wk size of gravid uterus, firm, non-tender, freely mobile with irregular margins, P/V: uterus was anteverted, irregularly enlarged to 16-18wk size of gravid uterus, firm, mobile, non-tender. B/L adnexa NAD Investigations: USG pelvis: uterus ~15x10x6cm with multiple intrauterine fibroid; largest measuring(8x8.5cm) in posterior wall; fundal fibroid(3.75x3cm) with an ET of 0.7cm and normal B/L adnexa. MRI Pelvis showed bulky uterus~10.4x8.5x11.5cm with multiple fibroid with posterior displacement of endometrium with mild fluid in POD, largest fibroid measuring 7.7 x 8.7 x 7.8 cm.

Clinical Relevance

The patient's history and investigation pointed towards leiomyoma, patient was managed surgically after failed medical management and underwent Total abdominal hysterectomy; On gross examination ,well circumscribed ,yellow-tan coloured nodules were seen ,which raised a suspicion of sarcoma , the definitive diagnosis was made by HPE. ESS is mostly a postoperative diagnosis; Ultrasound finding may mislead to adenomyosis and leiomyoma; MRI, however, can be used as preoperative diagnostic tool with some accuracy.

P 2.6

ANGIOSARCOMA OF OVARY: A CASE REPORT AND REVIEW OF LITERATURE

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Introduction

Primary angiosarcoma of the ovary is an extremely rare tumor and the diagnosis is still a challenge for clinician as it has no specific clinical symptoms and can be easily confused with other malignant neoplasms in morphology. Herein, we described a case of primary ovarian angiosarcoma with the review of the literature. A 34-year-old woman presented with a rapid increase in size of the left ovarian mass. With a working diagnosis of malignant epithelial ovarian tumor, a staging laparotomy with total abdominal hysterectomy, bilateral salpingo-ophorectomy, infracolic omentectomy, pelvic lymphadnectomy and appendectomy was done. On cut section, small cystic spaces along with hemorrhagic areas, multiple papillary projections and solid-cystic areas were present. Microscopic examination showed anastomosing vascular spaces interspersed with solid areas. Immunohistochemistry revealed tumor cells being positive for CD31 and FLI1 with negative immunostaining for SMA, S-100 and calponin. After surgery, the patient further received radiotherapy and chemotherapy and has been tumor free till date.

Case Report

A 34 year old, P2L2 presented to tertiary care hospital in Delhi, India with a sudden onset abdominal pain and distention since 1 month with no history of weight loss or appetite. Her ECOG performance score was good. On examination, a large well defined, smooth mass of around 14 weeks' size uterus was noted in the lower abdomen. All preoperative investigations were normal. Her tumour markers i.e., CEA, CA19.9, LDH, AFP & B-HCG were normal except CA 125 which was slightly raised (54.8mIU/dl). Cervical cancer cytology screening was normal. On Ultrasonography, a large heterogenous solid cystic lesion of size 10x4.7x5.3 cm seen in left adnexa. On CECT abdomen, a large 8.3cm x7.5cm sized predominantly cystic lesion with enhancing septations and solid components was noted in pelvic region, supero-lateral to the uterus and closely abutting it. A working diagnosis of malignant ovarian tumour most likely epithelial was made. A staging laparotomy with total abdominal hysterectomy, bilateral salpingo-ophorectomy, infracolic omentectomy, pelvic lymphadnectomy and appendectomy was done. Intraoperativerly, hemorraghic fluid of around 100 cc was noted and a mass of 9x8 cm arising from the left ovary was seen. On gross examination, multiple haemorrhagic areas were noted in the ovarian mass. Right ovary and bilateral fallopian tubes were normal. On histopathology, a diagnosis of malignant mesenchymal tumour of left ovary was made. IHC panel was done to further classify the variety of mesenchymal tumor in which FLI-1 and CD -31 positivity was noted. Final diagnosis of primary ovarian angiosarcoma was made. The patient was referred to the medical oncologist, she has received 4 cycles of post-operative adjuvant chemotherapy (Mesna, Adriamycin and ifosfamide). This patient is on regular follow up till date (1 year since diagnosis) is apparently well and has no sign and symptoms of tumour recurrence. FDG PET-CT was done post chemotherapy and showed no evidence of uptake.

Clinical Relevance

Angiosarcoma is a rare malignant tumour which accounts for approximately 1–2% of soft tissue sarcomas . Amongst sarcomas, female reproductive tract angiosarcomas are even rarer and ovarian angiosarcoma contributes to less than 1%. Very few cases of primary ovarian angiosarcomas are documented in literature till now. Mostly these tumors present as primary tumors while a few cases have been diagnosed along side ovarian teratomas and epithelial ovarian tumour. Majorly, the tumor belongs to the reproductive age group, though can develop in the paediatric as well as post menopausal age group. Diagnosis is a challenge as women present with non specific clinical symptoms. Diagnostic histopathology along with positive CD31 & CD34 immunohistochemistry is definitive6. The diagnosis is associated with poor prognosis as the tumor is highly malignant with rapid progression. The overall 5-year survival for non-metastatic disease is less than 30% and for metastatic disease mortality is almost certain within one year of diagnosis.

P 2.7

BILATERAL LEYDIG CELL TUMOURS OF OVARY PRESENTING AS PRIMARY AMENORRHOEA: A RARE CASE REPORT

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Introduction

Leydig cell tumor of the ovary is very rare subtype among the sex cord gonadal cell tumor which constitutes less than 0.5% of ovarian tumours. The disease mostly affects perimenopausal women, often very small and unilateral. We describe a very rare case of large, bilateral Leydig cell tumours in a 25-year-old lady with with primary amenorrhoea and virilisation.

Case Report

25-year-old nulliparous female presented with primary amenorrhoea, increased hair growth and hoarseness of voice for 19 years of age. The secondary sexual characters were normal and on per vaginal examination, hard masses were palpable in bilateral fornix. Investigations showed increased testosterone levels and LDH with a normal karyotype. MRI showed ovaries replaced by hard calcific masses of 7x7 cm and 5x5 cm with normal adrenal glands. Bilateral salpingoopherectomy with infracolic omentectomy with uterine preservation was done with sampling of peritoneal fluid and peritoneal biopsies. Histopathology revealed Leydig cell tumor of the ovary.

Clinical Relevance

Virilizing tumors of the ovary are rare but important causes of primary amenorrhea and this differential should always be kept. These tumours often are multifocal, most commonly seen as stage IA (85.4%) and IC. Very few cases have bilateral involvement. Despite being benign, surgery remains the mainstay of treatment, due to lack of pharmacological therapy. Most patients present with secondary amenorrhea and virilization and this was a rare presentation with primary amenorrhea. Diagnosis is clinched by rapidly progressive symptoms and elevated testosterone, aided by imaging techniques. The type and extent of surgery depends on the age of the patient, desire for future fertility and stage of the tumor.

P 2.8

ENDOMETRIAL POLYP

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Introduction

Endometrial polyp are overgrowth of endometrial glands that typically protude into the uterine cavity.

Case Report

A 43 year old female presented with complain of urinary retention since 15 days, continous bleeding per vaginum with foul smelling discharge since 1.5yrs with lump in abdomen since 3 yrs. On examination, pateint had large abdominal lump approx 24weeks size. On bimanual examination, 7×8cm mass felt filling up the whole vagina, necrosed, sloughed. Imaging revealed 21.4×8.65×8cm mass suggestive of large endometrial polyp.

Clinical Relevance

After preop workup, she was planned for hysterectomy where necrosed foul smelling large polyp was removed with whole of uterus. Histopathological examination confirmed leiomyoma with infarct type necrosis.

P 2.9

VULVAR GRANULAR CELL TUMOUR: A RARE ENTITY MASQUERADING VULVAL CANCER

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Introduction

Granular cell tumor is rare tumor arising from the Schwann cells of the peripheral nerves is which predominately benign (95 %) and rarely malignant (5%). It accounts less than 2% of all vulvar tumors and has variable presentations ranging from solitary, painless nodule to small plaque or a diffuse infiltrative lesion often confused with vulvar carcinoma or Bartholin gland cyst. It possesses diagnostic dilemma until proven by histopathological. Wide local excision of growth is typically curative; recurrence though rare and potential for malignant change deems long-term follow-up necessary.

Case Report

85-year postmenopausal multiparous women reported with painless growth at lower vulva and perineal region with overlying ulceration and repeated bleeding episodes (postmenopausal bleeding) for 3 years. Clinical examination revealed a 10*8 cm exophytic ulcerative growth with wide base arising from fourchette and extending till perineum. Rest of gynaecological examination was normal. On MRI- a well-defined solid masses (hypointense) lesion arising from the vulva suggestive of ? mitotic growth. Tru-Cut biopsy reported it as benign granular cell tumor. Wide local excision of tumor and reconstruction of perineum and vulva was done; histopathology confirm the diagnosis and skin margins free of tumor. The post op period was uneventful.

Clinical Relevance

These tumours are rare with low risk for malignant transformation but cause significant morbidity if left untreated. It is important to accurately diagnose and manage these tumour as they can be mistaken for more aggressive malignancies (melanoma/ squamous cell carcinoma). Histopathology is diagnostic and wide surgical excision is the treatment of choice; early diagnosis and management prevents complication and ensures optimal outcome. It Can occur in women with all ages and ethnicities; therefore, raising awareness of this condition among healthcare aid in timely diagnosis and management for better outcome.

P 2.10

THYROID STORM: A RARE PRESENTATION IN MOLAR PREGNANCY

Harsha Jodwal

Introduction

Molar pregnancy affects 1 in 200 pregnancies in India. Clinically evident hyperthyroidism is observed in 7% of molar pregnancy however thyroid storm is rare, mainly caused by very high levels of βHCG. It manifests as hyperthermia, delirium, convulsion, tachycardia, high output cardiac failure or cardiovascular collapse. Diagnosis can be confirmed by elevated free T3 and T4 levels and decreased TSH level. Overall mortality in thyroid storm is 10-30%, posing a challenge in timely management of such cases.

Case Report

A 24 year old G3P1L1A1 presented at 2 month amenorrhea with complaint of excessive bleeding and passage of grape like vesicles per vaginum. She had PR 160/min, BP 150/90mmHg, SpO2 70%. Patient develop respiratory distress and was intubated due to suspected thyroid storm. Subsequent investigation showed βHCG level was 54,106 and serum TSH-0.01uIU/ml, FT4-297.1nmol/L, FT3-2.81nmol/L thus diagnosis of Thyroid storm confirmed. Suction and evacuation done under general anaesthesia. Her chest X-Ray had multiple sub-centimetric nodular opacities and HRCT Chest was suggestive of ARDS. She was started on medical treatment for thyroid storm. She was extubated after 7days. Following evacuation, her symptoms started to resolve and her thyroid function tests became normal after 2 weeks. On follow up, her βHCG levels showed rising trend and diagnosed as FIGO stage 1 Gestational trophoblastic neoplasia. Currently she received 6 cycle of chemotherapy and doing well. This case is presented because of its rarity and complex management.

Clinical Relevance

GTD induced thyroid storm is a rare but potentially life threatening condition. Early recognition and comprehensive management of the thyroid storm and underlying etiology with a multidisciplinary team of endocrinologists, gynecologist, and critical care physicians are vital for a successful outcome as was done in our case.

P 3.1

ENDOMETRIAL STROMAL SARCOMA: A RARE PRESENTATION

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Introduction

Endometrial stromal sarcoma is a rare uterine malignant tumor accounting 0.2% of all uterine malignancies, affecting women between 40 and 60 years of age. It arises from connective tissue of the endometrium, resembling normal endometrial stroma in proliferative phase. Imaging mainly MRI is powerful in managing these tumors, along with histopathological examination and IHC markers. Diagnosis is challenging because of rarity and symptoms overlapping with benign conditions. Treatment is surgical excision. Prognosis is good but recurrence is seen in many cases.

Case Report

A 60 year old postmenopausal female presented with bleeding and discharge per vaginum since 4-5 months, insidious in onset, non foul smelling, gradually progressive associated with pain abdomen. MRI pelvis showed a large T1 hypointense and T2 heterogenously hyperintense mass lesion in endometrium markedly compressing the inner and outer myometrium approx 90*78*68mm extending upto the internal os. Serosa normal. Mass lesion shows restricted diffusion with reduced ADA values. Endometrial biopsy showed features of high grade endometrial stromal sarcoma positive for cyclin D1 and CD10. Staging laparotomy was done. TAH with BSO performed.

Clinical Relevance

Endometrial stromal sarcomas are rare and poses diagnostic challenges due to diverse clinical and histopathological presentations. Therefore, timely diagnosis is important for early intervention and good prognosis.

P 3.2

DIAGNOSTIC DILEMMA IN A RARE CASE OF TUBERCULAR CERVICITIS

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Introduction

In developing countries like India tuberculosis is a major socioeconomic burden affecting fourteen million people. The rising trend is due to lack of rapid diagnostic tests, effective immunisation, low income, and immunosuppresive disorders. Tuberculosis accounts for 5% to 10% cases of female genital tract and tubercular cervicitis constitutes 0.10%to 0.65%.

Case Report

A 36 years old female P3L3 came with chief complaints of bleeding per vaginum with passage of clots on and off since six months. She also presented with pain in lower abdomen, fever off and on, generalised weakness and malaise. On general examination her vitals were normal with mild tachycardia. She had pallor with haemoglobin clinically 7-8 gm%. Oral candidiasis was present. Per abdomen was soft with mild tenderness in lower abdomen. On per speculum examination, cauliflower shaped ulcerating growth of size 4×4 cm seen which was bleeding on touch. History of dirty foul smelling discharge present. On per vaginal examination, uterus was bulky and retroverted, cervix was hypertrophied and irregular, no adnexal mass present and bilateral fornices free. On per rectal examination, rectal mucosa was smooth and freely mobile. Colposcopy examination showed increased vascularity, acetowhite areas present and lugol's iodine deficient uptake in cervix. Colposcopy directed cervical biopsy from four quadrants was taken under antibiotic cover and hemostatic agents. Chest X-ray was normal, antibody test for HIV and VDRL were negative. Mantoux test was 12mm induration. Sputum test was negative for acid-fast bacilli. Histopathological examination showed lymphocytic infiltrates with granuloma and CIN 1. Tubercular cervicitis was considered as the most probable diagnosis. Patient started on antitubercular treatment.

Clinical Relevance

Our case emphasis that tuberculosis of cervix should form an important differential diagnosis of cancer cervix where cauliflower like growth mimiks malignancy. The need for hystrectomy can be reevaluated as tubercular cervicitis can be managed medically and restoration of cervix to normal state has been observed in cases treated with antitubercular therapy.

P 3.3

A 10-YEAR OLD WITH GERM CELL TUMOR

Bhanvi Pandey

Introduction

Endodermal Sinus Tumours (EST) also called as yolk sac tumour. They are third most frequent malignant germ cell tumor of the ovary. EST occurs with the median age of 16 to 18 years. About one third of the patients are pre menarchial at the time of diagnosis. Abdominal and pelvic pain is the most frequent initial symptom occurring in about 75% of the patients. EST is unilateral in 100% of the cases. Treatment consists of the surgical exploration, unilateral salphingo- oorphrectomy, frozen section for diagnosis and either adjuvant

Case Report

A 10 year old presented with ~15 cm solid mass palpated till umbilicus. Mass was mobile and non tender with regular borders. Mass was first noticed 1.5 years back. Tumor markers shower AFP >30,000 , CEA > 1000, CA -125 > 112.4. USG suggestive of heterogeneous solid cystic abdomin pelvic mass volume 929 cc. MRI pelvis suggestive of complex pelvico abdominal solid cystic mass showing intense enhancement in posterior contrast imaging in solid components. CECT suggestive of large abdomino pelvic predominately cystic mass in left adnexa. Therefore, on based on tumor markers and radiology a diagnosis of germ cell tumor was made. On staging laparotomy a 12* 15 cm left ovarian solid cyst was seen, left saphingo - oopherectomy was done. Histopathological examination confirmed diagnosis of yolk sac tumor. Patient was put on chemotherapy.

Clinical Relevance

EST are third most frequent malignant germ cell tumor of the ovary. It is unilateral in 100% of cases, thus biopsy of opposite ovary is contraindicated. The treatment of EST consists of surgical exploration, unilateral salpingo - oopherectomy with either adjuvant or therapeutic chemotherapy. Cisplatin containing combination chemotherapy with 3 or 4 cycles of BEP should be used as primary chemotherapy.

P 3.4

OVARIAN TUMOR IN CHILDHOOD PERIOD: A DIAGNOSTIC DILEMMA

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Introduction

Ovarian tumors are very rare in premenarchal age, most of them being functional cyst only 10% being malignant. So whenever a premenarchal girl presents with ovarian tumor, diagnosis is a challenge.

Case Report

A 11 yr old premenarchal girl presented to the emergency department with abdominal pain since 3-4 days with sudden increase in intensity of pain for the last 1 day. The pain was associated with vomiting. An abdominal examination revealed tenderness in the lower abdomen with guarding and rigidity and a firm palpable mass [10x8cm] occupying the midline of the abdomen. Her Ultasonography (abdomen) report revealed a large hypoechoic mass approximately 99*56*92mm in the right adnexa, ,with suggestive findings of ovarian torsion. Her contrast MRI (abdomen) findings were suggestive of right ovarian torsion. After that patient underwent exploratory laprotomy with right salpingo-oophrectomy with left oophropexy. Her histopathological report was suggestive of Dysgerminoma.

Clinical Relevance

Ovarian tumors in pediatric patients are most of the time benign but sometimes we get malignant cases. The diagnosis, the intervention, and the therapeutic plan must be based on the symptoms, pelvic USG and potential serum markers.

P 3.5

SYNCHRONOUS PRIMARY MALIGNANCIES AT TWO SITES: A RARE CASE PRESENTATION

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Abstract

The diagnosis of multiple primary malignancy (MPM) is not uncommon. Nevertheless, synchronous MPM involving endometrium and lungs is an extremely unusual event.

We report a case of 54 years old female patient who presented with abnormal uterine bleeding and was diagnosed as a case of fibroid uterus. She was incidentally found to have a nodular mass in left lung in chest x-ray. Magnetic Resonance Imaging (CEMRI) and Whole body 18F-fluro deoxy glucose positron emission tomography- computed tomography (18 F-FDG PET-CT) revealed two distinct lesions- one in endometrium and another in left lung. Immunohistochemistry and biopsy from the endometrium and lung lesion were suggestive of endometrioid carcinoma and adenocarcinaoma respectively.

Hence, the existence of two malignancies having different histopathologies at anatomically distinct sites suggests the diagnosis of dual primary malignancy involving the endometrium and the lung, which being a rare combination, prompted us to report the case.

Hence, the possibility of multiple primary malignancies existence should always be considered during pre-treatment evaluation.

P 3.6

A RARE CASE OF HUGE BROAD LIGAMENT FIBROID WITH PARACERVICAL EXTENSION: SAFE APPROACH BY SAME SETTING MYOMECTOMY BEFORE HYSTERECTOMY

Pallabi Mandal

Introduction

The broad ligament is the most common extrauterine site for leiomyoma with an overall incidence of less than 1%.Excision of it may lead to dreadful intraoperative (bleeding ,ureteric injury) and postoperative (pelvic hematoma and infection) complications owing the surgeon to immense challenge.

Case Report

A 59 years old women , P4+1, presented at G&O OPD , CNMCH with 3 years history of persistent pelvic pain and gradually increasing heaviness in lower abdomen.There was no h/o abnormal bleeding per vaginally.Abdominal examination revealed a firm mobile mass arising from the pelvis corresponding to 26 weeks size.Cervix was deviated to the right side but felt seperable from the mass during prevaginal examination . Ultrasonography showed large 18X16 cm hypoechoic solid mass in the left adnexa with uterus 6X4X4 cm in dimension. On laparotomy, the uterus was elevated up and deviated to the right side by the mass. An 18 to 20 cm large bosselated true broad ligament fibroid was noted at the right mesometrium of broad ligament extending upto umbilicus. Myomectomy was done initially to decompress the mass and to avoid ureteric injury. Hysterectomy with bilateral salpingoophorectomy was done. Post operative period was uneventful.2 unit PRBC was transfused. patient was discharged on postoperative D8.

Clinical Relevance

It is reported as it is a rare case with enormous surgical challenges.

P 3.7

GIANT BENIGN MUCINOUS CYSTADENOMA: A CASE REPORT

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Introduction

Tumors in the ovary are not uncommon. Ovarian tumkrs are termed " giant " if they are bigger than 20cm and are rare these days. Mucinous cystadenoma makes up 15-20% of all ovarian tumor. 80% are benign, 10% are borderline and 10% are malignant.

Case Report

A 26yrs old P2L2 female presented to emergency department with epigastric pain since 7 days & progressive distension of abdomen over 2 years. On examination, she was pale and afebrile with a BP of 100/60 mmhg , pulse rate of 94bpm , respiratory rate 20 beats per minute and spo2 of 96% at room air . On inspection, the abdomeb was grossly distended. On palpation there was firm pelvic mads extending to xiphisternum measuring 36 weeks per abdomen. An ultrasound was done which revealed a huge ovarian cyst (30 x20 cm), side of origin not known. A CT imaging done shows large ovarian tumor (30x 20cm) with multiple thin internal septation . Her CA125 is within normal range. Her beta -hcg & AFB were within limit. After All the investigation it appear to be benign origin and patient was posted for expolratory laprotomy , left ovarian cystectomy with left salphingo-ophorectomy was done. Grossly the cyst measured 29x 21x 14 cm measuring 6.5kg. On histopathology shows Benign Mucinous Cystadenoma of ovary.

Clinical Relevance

In the modern era of medicine huge mucinous tumors have become rare in the current medical practice . As most cases are diagnosed early during routine gynaecological examination or incidental finding on ultrasound examination of pelvic and abdomen.

P 3.8

OVARIAN TORSION IN PREGNANCY

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Introduction

Ovarian torsion is common during pregnancy usually occurring in the 3rd trimester. Ovarian torsion in first trimester is rare. The most common cause is the growth of corpus luteal cyst, which usually regresses by 2nd trimester. The reason that ovarian torsion is thought to occur more commonly on the right side rather than the left is because it is believed that the sigmoid colon limits the mobility of the left ovary.

Case Report

A 24 years old female G2P1L1A0 with 8 weeks +/- 2 days period of gestation, came to Emergency with complaint of pain left lower abdomen~ 2 days & vomiting~2 days. She was admitted, on general physical examination patient was conscious, oriented, her vitals were stable. On per abdominal examination, abdomen was soft, tenderness over left lower abdomen, on per vaginal examination, uterus found to be 8-10 weeks, OS closed/parous, mass in left adnexa, no cervical motion tenderness. Patient was investigated further- blood sample were sent, Ultrasonography whole abdomen done S/O Single live intra uterine foetus of 7+/- 6 weeks, with mild subchorionic bleed, left ovarian simple cyst with internal septations measuring~8.1X5.9 cm, Right ovary normal. Surgical management- Emergency Laparotomy Done

Clinical Relevance

The Ovarian torsion is common during pregnancy usually occurring in 3rd trimester, but in this case it occurred in 1st trimester & Right sided torsion is more common but left sided in this case, on histopathology report it was simple serous cyst adenoma with features of torsion. Pregnancy continued till term @38 weeks POG/term she delivered healthy baby through normal vaginal delivery.

P 3.9

A GIANT CERVICAL FIBROID

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Introduction

Uterine leiomyomas are the most common tumors, usually presented in the reproductive age group. Cervical fibroid are uncommon

Case Report

We report a case of 38 year old woman presented with complain of retention of urine on and off since 2-3 months . She was diagnosed with cervical fibroid and underwent total abdominal hysterectomy.

Clinical Relevance

Cervical fibroid can be located anteriorly causing urinary retention, or posteriorly causing defecatory problems. Treatment is surgical but we need proper peri -operative evaluation and knowledge of anatomical structures to perform myomectomy or hysterectomy.

P 3.10

MASSIVE DEGENRATED LEIOMYOMA MASQUERADING AS OVARIAN MALIGNANCY

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Introduction

Leiomyoma of the uterus is the most common tumor of the female pelvis arising from uterine smooth muscle, prevalence increases after 35 years of age and decreases after menopause. The size of myoma ranges from microscopic to giant myoma, and can be associated with degenerative change.

Case Report

Mrs X 37-year-old P2L2, presented to outpatient department with chief complaints of abdominal distension for 1.5 years and dyspepsia for 6 months, associated with generalized weakness, early satiety and loss of appetite, no history of weight loss. She had normal menstrual cycle. She was average built with moderate pallor (Hemoglobin-8.9 gm%) and had no lymphadenopathy. On abdominal examination an abdominopelvic mass of size 32 weeks, cystic in consistency, non-tender, regular margin with restricted mobile mass. On PV examination, cervix felt high up behind the pubic symphysis uterus pushed anteriorly normal size, a large cystic to firm mass felt of around 30*20cm with the mass occupying all the fornix and felt below the cervix non mobile, rectal mucosa free. USG revealed a normal uterus and ET, with a 21.3*10.9cm lesion in the right adnexa. CT scans showed an abdominopelvic mass on either side of the midline, with multiple internal septa. Tumor markers for ovarian malignancy were negative. Exploratory laparotomy revealed a cystic mass 30*30 cm from the cervix, suggesting cervical fibroid. Uterus was visible over the mass anteriorly, and bilateral fallopian tubes and ovaries were normal. Postoperative course was uneventful. No malignant cells were detected on peritoneal fluid cytology, but histopathology showed leiomyoma with degeneration, hyalinization, and cystic changes.

Clinical Relevance

Although fibroids typically have a characteristic USG appearance, degenerating fibroids can have variable patterns and pose diagnostic challenges. Fibroids masquerading as ovarian tumors can be challenging for both the radiologists and the surgeons. A multidisciplinary approach involving the oncology team is preferred in such cases to achieve optimal results.

P 4.1

MULLERIAN AGENESIS DISGUISING AS SECONDARY AMENORRHEA-A CASE REPORT

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Introduction

Mullerian agenesis also called Mayer-Rokitansky-Kuster-Hauser syndrome (MRKH), is a congenital malformation of Mullerian Ducts resulting in an absent uterus and variable degrees of hypoplasia of fallopian tubes, cervix and first two-thirds of vagina. It is the most common cause of primary amenorrhea affecting approximately 1 in 5000 females and a cause of primary infertility.

Case Report

25 yr old married nulligravida came with complaint of postcoital bleeding since 2hrs. According to history given by patient, she was married since 7 months. her last menstrual period was 23/04/23. Her cycles were regular of 30 days and lasting for 4-5days with heavy flow. Menarche achieved around 16 years of age. On examination-vitally stable, systemic examination WNL. P/a findings: soft No guarding tenderness rigidity. P/s examination-anterior vaginal wall tear present. cervical os not seen. P/v examination -soft mass felt, cervix and uterus not felt. Investigation- Routine investigations done. MRI pelvis done. final diagnosis made by diagnostic laparoscopy.

Clinical Relevance

To diagnose and give treatment options to a female for increasing the chances of her having a complete family without disrupting her sexual lifestyle. She and her family were counselled on further management (both psychological and clinical) for the condition.

P 4.2

PLACENTA INCRETA IN FIRST TRIMESTER-A RARE CASE REPORT

Leena Sharma

Introduction

Placenta acreta spectrum is a rare complication normally diagnosed during 2 nd and 3 rd trimester of pregnancy,placenta increta in early pregnancy is rare and only few cases are documented.we report a case of placenta increta at 13 weeks of pregnancy which was an incidental finding during hysterotomy,placental vessels were invading the myometrium till uterine serosa , termination of pregnancy was done with hysterectomy .The diagnosis of placenta acreta spectrum in early pregnancy must be considered specially in previous caesarean cases to prevent patient from considerable morbidity and mortality

Case Report

A 26 year old gravida 2 para1 live 1 with previous caesarean section,3 years back was presented in emergency with complaint of bleeding per vaginum since last 2 hour USG - shows fetal parameters of 12 weeks of gestation with placenta in the uterine segment completely covering the internal os ,as bleeding was continuous ,decision for hysterotomy was taken after proper consent ,intra operatively - intra operatively we found placental vessels invading the myometrium but uterine serosa was intact and bladder was adhered with previous scar ,bladder was separated, minor bladder injuries were sutured in 2 layers , hysterectomy was performed after proper consent and councelling,4 units of blood transfusion was done intraoperatively , patients post operative period was uneventful. Examination findings - GC -fair Vitals stable at time of examination Vaginal fresh bleeding was present Per abdomen -uterus 12-week size. Relevant investigations -post hysterectomy specimen was send for histopathology which confirmed diagnosis as placenta increta.

Clinical Relevance

clinical relevance of placenta accreta spectrum lies in its complications. All cases of previous cesarean section with low lying placenta must be screened for placenta acreta spectrum. Undiagnosed or underdiagnosed cases may land up in hazardous complications during its course of treatment, which may strongly affect the reproductive life of female and may leads to significant mortality and morbidity. Hence placenta acreta spectrum must be ruled out in first trimester also to prevent hazards later

P 4.3

ARTERIO-VENOUS MALFORMATIONS MIMICKING AS INCOMPLETE ABORTION - A RARE CASE REPORT!

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Introduction

Arterio-venous malformation (AVM) are rare(0.1%) vascular abnormalities characterised by abnormal direct communication between arterial and venous systems without an intervening capillary bed. It can cause abnormal and potentially life threatening vaginal bleeding.

Case Report

A 31 year old female presented to OPD with complaints of heavy bleeding per vaginum and abdominal pain since 3 months.Pregnancy test was positive. She gave history of 3 D&Es done in private hospitals; each D&E done at an interval of one month i/v/o ultrasound findings suggestive of incomplete abortion. Vitals stable. Pallor present (clinically Hb 8g/dl). USG showed small cystic area of size 19×15×57mm in anterior myometrium showing mixed arterial venous flow and spectral tracing (suggestive of arteriovenous malformation) with avascular retained products of conception of 4×2 cm. Diagnosis was confirmed on MRI. Patient was planned for ultrasound guided evacuation of intrauterine contents on 4/7/23. Only suction was done, avoiding the site of AV malformation. No curettage done. Around 50 cc of altered colored blood was evacuated. Patient discharged on oral progesterone. On follow up, patient has no complaints of abnormal bleeding per vaginum now and has normal menstrual cycles. Histopathological examination revealed features of proliferative endometrium with no evidence of products of conception.

Clinical Relevance

This is a rare case of AV malformation which mimicked as incomplete abortion in its clinical presentation and management. This highlights the importance of considering uterine arteriovenous malformations in the differential diagnosis of persistent vaginal bleeding following incomplete abortion and repeated Dilatation and evacuation.

P 4.4

RECURRENT HEMATOMETRA OF UNKNOWN ETIOLOGY- A CASE REPORT

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Introduction

Hematometra is an uncommon disorer that can be caused by congenital mullerian defects or acquired structural obstruction of the cervix due to iatrogenic traumas. Sequelae of genital tuberculosis which includes cervical stenosis, narrow uterine cavity, endometrial bands and synechia, may lead to hematometra.

Case Report

A 35-year-old woman, P1L1, cesarean section 12-years back, HIV positive with history of Tubercular meningitis presented with intermittent severe abdominal pain and secondary amenorrhea since 1-year after completion of ATT. On per-abdomen, an enlarged cystic to firm consistency irregularly defined mass was felt, size ~16cm*18cm corresponding to fundal height of 16-weeks. On per-speculum, vagina was cicatrised at the upper end, cervix could not be visualised. On per-vaginum, cervix not felt and uterus enlarged to 14-16weeks size was palpated. Vaginal scrapping taken was negative for Acid fast bacillus. MRI pelvis- hematometra measuring 17*11*15cm, volume of ~900cc and cervical stenosis. Ultrasound-guided drainage of hematometra done followed by monthly injections of gonadotropin-releasing hormone (GnRH) analogue for 6-months. Symptoms recurred after 7-8months. With consent for hysterectomy, patient was taken in OT for hematometra drainage. Approx.100cc altered chocolate colour blood aspirated with difficulty. As hematometra could not be drained further, hysterectomy done. Uterus was 14-16week size. Cervix was not visualised in the gross specimen.

Clinical Relevance

Evaluation of a patient with lower abdomen pain and secondary amenorrhea with history of tuberculosis, the diagnosis of hematometra due to acquired cervical stenosis should be considered. Genital tuberculosis may be implicated in such cases. Management includes simple cervical dilation, transvaginal drainage, use of GnRH analogues, and insertion of intrauterine Foley's catheter to ensure continuous drainage. However, if these methods fail, hysterectomy may be needed. Management can be complicated by a high rate of recurrent stenosis. Early recognition of this condition and treatment prevents severe complications like uterine rupture, infertility and endometriosis.

P 4.5

SEPTIC ABORTION - THE DEATH DEALING

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Introduction

Septic abortion refers to any abortion, spontaneous or induced, that is complicated by uterine infection, including endometritis. While rare in developed countries, septic abortion is typically associated with unsafe abortion practices that could even be life threatening. Diagnosis is made clinically and confirmed by ultrasound, computed tomography or magnetic resonance imaging

Case Report

A 26-year-old female presented with bleeding per vagina, lower abdomen pian, recurrent fever spikes and decrease urine output. 6 days back she had taken MTP pills for unwanted pregnancy and underwent dilatation and curettage by an untrained worker. Pelvic examination revealed scant blood with malodorous discharge, ultrasound revealed thick localized POD collection, abscess and signs of myometrial injury, CT confirmed the findings. Over the course of ICU stay, she was treated with broad spectrum antibiotics, underwent hemodialysis and anemia correction followed by exploratory laparotomy. Frank pus in POD and transverse perforation (approx. 3cm) in uterus at fundus noted and thus decision for hysterectomy taken.

Clinical Relevance

Septic abortion is a life-threatening infection associated with unsafe abortion practices that require immediate intervention to prevent further complications. This can be prevented by expanding family planning acceptance to prevent unwanted pregnancy, to take aseptic precautions while internal examination or any instrumentation and encouraging abortion in legally practicing institutes only. Treatment consists of broad-spectrum antibiotics, prompt removal of infected tissue and hysterectomy in severe refractory cases.

P 4.6

RHABDOMYOSARCOMA OF UTERUS-A RARE CAUSE OF POSTMENOPAUSAL BLEEDING (PMB)

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Introduction

Rhabdomyosarcoma (RMS) of uterus in postmenopausal women is a malignant neoplasm originating from undifferentiated primitive muscle cells. It most commonly arises from the cervix in postmenopausal female and carries a poor prognosis. Here we present a case of RMS arising from uterine corpus. Of all the patients presenting with Post Menopausal Bleeding (PMB) only 35 cases of uterine RMS have been reported worldwide.

Case Report

A 76 years old P2L2 lady, postmenopausal for 25 years with known case of hypertension and hypothyroidism presented with complaints of PMB since one month. She had no significant past medical, surgical or family history. On pelvic examination uterus was 12-14 weeks' size. On ultrasound a heteroechoeic lesion of 8x7x7 cm obscuring the endometrial cavity. Hysteroscopic biopsy revealed the mass to be rhabdomyosarcoma which was confirmed with immunohistochemistry. MRI and PET-CT showed heterogeneously enhancing solid cystic lesion measuring 8.4x7.2x7.7 cm in endometrium invading into myometrium. Staging laparotomy with total abdominal hysterectomy with bilateral salpingo-oopherectomy with bilateral pelvic lymph node dissection with peritoneal biopsy with omental biopsy was performed. Grossly, uterus was 14-16 weeks' size with normal tubes and ovaries. On cut section 8*9 cm tan brown mass obscuring the endometrial cavity. Her histopathology and IHC report suggested rhabdomyosarcoma of uterus. Patient is currently fine on one month of follow up and is being planned for radio-chemotherapy.

Clinical Relevance

Rhabdomyosarcoma is a rare and aggressive tumor with a poor prognosis and hence multidisciplinary approach is required for early diagnosis and treatment. Immunohistochemistry positive for Myogenin, Myo-D1 and (PAX-7) help differentiating from other uterine sarcomas. Surgery followed by chemotherapy or radiotherapy with or without neo-adjuvant chemotherapy is standard of treatment. Close follow up for every 3 months in first year is essential.

Key words: Rhabdomyosarcoma, postmenopausal bleeding, immunohistochemistry

P 4.7

MIXED GERM CELL TUMOR WITH CO-EXISTING TUBERCULOSIS IN A YOUNG GIRL-A CASE REPORT

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Introduction

Genital tuberculosis (TB) in women is a chronic disease with low-grade symptoms and up to 11% of women with genital TB may be asymptomatic. Germ cell tumors represent only 20% to 25% of all benign and malignant ovarian neoplasms.

Case Report

Here we report a case of a 21year old unmarried girl who presented with a huge 35 x 15 cm mass in abdomen with raised values of CA-125, hCG, AFP (alpha-feto protein) and LDH (lactate dehydrogenase) with complain of pain lower abdomen with low grade fever and vomiting. After admission patient had multiple episodes of high grade fever and anti tubercular treatment was started. She underwent laparotomy followed by unilateral salpingoopherectomy and infracolic omentectomy. Histopathology report revealed mixed germ cell tumor comprising of 90% dysgerminoma and 10% of yolk sac tumor. Post operatively patient continued with anti tubercular treatment and her fever resolved.

Clinical Relevance

Germ cell tumors originate from the primitive germ cells. They represent up to 15% of ovarian cancers in Asian and African American societies. In the first two decades of life, almost 70% of ovarian tumors are of germ cell origin, and one-third of these are malignant. The symptoms of chronic pelvic pain, abdominal mass, and weight loss along with the formation of adnexal mass with or without ascites can be present in both pelvic tuberculosis and ovarian carcinoma. Immune suppression due to malignancy could be the cause of flare up of latent tuberculosis. There is paucity of literature on relation between tuberculosis and carcinogenesis.

P 4.8

AMBIGUOUS GENITALIA: A RARE CASE REPORT

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Introduction

Ambiguous genitalia is a rare condition in which the child's genitalia do not clearly appear to be either male or female. It is not a disease but a manifestation of disordered sexual development (DSD).

Case Report

A 12-year old child who was reared as a female presented to gynaecology OPD with clitoromegaly (3cm), hypospadium and only perineal pouch with a narrow opening. There was no adrenarche, pubarche and thelarche. The height and weight were less than 5th percentile for age with a BMI of 16.5. There was no skin pigmentation, labio-scrotal fusion or palpable gonads. Evaluation: MRI showed hypoplastic uterus with right streak ovary, left ovotestes and rudimentary vagina. Karyotype report was 45 XO, XY. Serum FSH=53.6 IU/ml; LH=5.14IU/ml, Testosterone 56.2 ng/ml; 17-OH Progesterone 0.36ng/dL. Provisional diagnosis was mixed gonadal dysgenesis with Turner mosaic. Management: Diagnostic laparascopy with right streak gonadectomy with left gonadal biopsy was done in Paediatric surgery department in December,2022. Left gonadal biopsy was suggestive of testes. A second surgery clitoral reduction with left gonadectomy with removal of labial adhesions was performed in February,2023. On hysteroscopy vaginal canal was present with rudimentary cervical lips. Follow Up: Hormone replacement therapy was started and the child was rehabilitated to lead her life as a girl.

Clinical Relevance

Complete evaluation, management, follow up and maintaining the privacy of the patient can enable the child to live a well adjusted , acceptable and functional life in society

P 4.9

ISOLATED TUBAL TORSION PRESENTING AS ACUTE ABDOMINAL PAIN IN A PERIMENOPAUSAL WOMAN- A RARE CASE REPORT

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Introduction

Introduction- Isolated tubal torsion (ITT) is a rare

Case Report

Case report- A 43 years old peri-menopausal female, P2L2A2 , with previous 2 LSCS, ligated, presented with complaints of acute lower abdominal pain associated with mild nausea and vomiting for 1 week. Vitals stable. Lower abdominal tenderness present and no mass palpable. On per vaginal examination, uterus normal size, anteverted, 5*5 cm mass felt in right fornix, tender, left fornix free and non tender. On imaging studies, USG reported uterus size normal with ET- 1.7mm, right ovarian complex cyst of 4.8*3.9cm (ORADS 2) with bulky echogenic edematous vascular pedicle adjacent to cyst with mild surrounding fluid. MRI reported large right adenaxal cystic lesion with thickened coiled up fallopian tube likely hematosalpinx with tubal torsion(Type II). Exploratory laparotomy revealed right side 5*5cm hematosalpinx along with tubal torsion(3twists) with right ovary being normal. Detorsion done. On left side, hematosalpinx seen adherent to ovary. Bilateral salpingectomy done, sparing both ovaries. Post-operative period uneventful. Histopathology report shows right hematosalpinx and left tube with unremarkable histology.

Clinical Relevance

Tubal Torsion is a rare entity and should be considered as a cause of acute abdominal pain along with ovarian torsion

P 4.10

COMPLETE HEART BLOCK IN PREGNANCY: A MULTIDISCIPLINARY TEAM APPROACH

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Introduction

Pregnancy with a complete heart block is rare

Case

A total of three cases were reviewed over a period of one year. First case: 25 years old, primigravida, diagnosed incidentally with Congenital complete heart block on routine examination and a minimum HR of 30 beats/min on Holter monitoring. The patient refused pacemaker insertion asymptomatic. The Antenatal period was uneventful. The patient underwent elective LSCS at 39 weeks POG in view of CDMR using a slow epidural, with a temporary transcutaneous pacemaker and ICU backup during caesarean. Second case: 27 years old primigravida, with Known case of acquired CHB. She underwent surgical repair for Ebsteins anomaly three years back following which she had acquired CHB and a permanent pacemaker was applied. Patient was asymptomatic with regular pulse rate of 98 beats/min during pregnancy. Patient underwent elective LSCS with epidural at term for failed induction. Intraoperatively, pacemaker settings were changed to asynchronous mode. Third case: 22 years old woman with asymptomatic congenital CHB. Antenatal period was uneventful and pacemaker was not inserted. Patient had a spontaneous preterm vaginal delivery at 30 weeks POG. Patient had no cardiac complications and did not require any temporary pacing or medications during delivery.

Clinical Relevance

CHB in pregnancy is rare and it is mostly congenital. One of the common investigations ECG can diagnose CHB. CHB are asymptomatic but women may present first time during pregnancy due to hemodynamic changes Management of such a grave condition need a multidisciplinary team approach. Vaginal delivery is preferred and LSCS is reserved for obstetric indications.

P 5.1

OVARIAN FIBROTHECOMA

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Introduction

Ovarian fibrothecoma are uncommon tumors of gonadal stromal cell origin .they account for 3-4 %of all ovarian tumors in 90 %of cases are unilateral .

Case Report

He we report a case of 24 yr unmarried female with right ovarian fibrothecoma .

Clinical Relevance

C/o Right flank and lower abdomen pain for 5 month with irregular menstrual cycle for 3 yr MRI finding Right ovary shows a large well defined rounded smoothly marginated homogenous solid neoplastic lesion of size 8*6cm appearing isointence on T1 iso to hypointence on T2.Right ovary show claw sign around lesion . Frozen section report suggestive of benign spindle cell tumor. HPE is awaited

P 5.2

RARE AGGRESSIVE VARIANT OF CERVICAL CANCER: CASE SERIES

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Introduction

Cervical cancer is the fourth most common cancer after breast, colorectal, and lung cancer. Neuroendocrine cancer is an aggressive histological variant of cervical cancer accounting for about 1%–1.5% of all cervical cancers

Case Report

1. 70 year old postmenopausal para 4 lady presented with spotting and discharge per vaginum for 3–4 months , associated with loss of appetite and weight. Functional status – ECOG 2. General examination was unremarkable. On per speculum examination, the cervix was replaced by, nodular fungating mass of size ~4 cm × 5 cm associated with bleeding on touch, brownish foul smelling discharge. Upon combined recto vaginal examination, a friable hard nodular mass of same dimensions was felt replacing the cervix, anterior upper 3rd of vagina was involved, posterior vagina was free and bilateral parametrium were felt to be fully involved while rectal mucosa was free. A clinical stage of FIGO IIB was made. Histopathology report showed high grade neuroendocrine carcinoma. IHC showed tumor cells are positive for NSE, p16, and CD56 (focally positive). Tumor cells are negative for p 63, chromogranin, and synaptophysin.

2. 62 year old postmenopausal para 3 lady presented bleeding. General and systemic examinations were unremarkable. On per speculum examination, an irregular cauliflower like growth about 3 cm × 3 cm replacing cervix was seen, associated with bleeding on touch. On rectovaginal examination, rectal mucosa was free, the same growth was felt, it was hard and friable, upper 1/3rd of vagina was free and a separate satellite nodule, 1 cm × 1 cm firm in consistency was felt in the lower vagina while the bilateral parametria was also free. Biopsy from the cervical mass and the vaginal nodule was taken and revealed poorly differentiated neuroendocrine tumor small cell type with IHC showing immunoreactivity for p16, Carcinoembryonic antigen, synaptophysin, and CD56

Clinical Relevance

Neuroendocrine tumors of the cervix are rare and aggressive with 5 year survival rate of patients as 14% in advanced stages. Multimodality treatment with radical surgery and neoadjuvant/adjuvant chemotherapy with cisplatin and etoposide with or without radiotherapy is the mainstay of management for early stage disease, while chemotherapy with cisplatin and etoposide or topotecan, paclitaxel, and bevacizumab is for locally advanced or recurrent NECC.

P 5.3

UTERINE LEIOMYOSARCOMA - A RARE UTERINE MALIGNANCY

Surbhi Bhugra

Introduction

Uterine leiomyosarcoma -a rare uterine malignancy arising from smooth muscle layer of uterus , mostly unassociated with leiomyoma

Case Report

58-year-old, nulliparous female came with complain of pain abdomen of moderate intensity, localized to lower abdomen, persistent throughout day since 10 days , pain was not associated with GI AND GU symptoms P/A- large mass felt which was globular in shape, smooth surface, corresponding to 20–24 week size of uterus, hard in consistency, immobile, lower border not felt. P/V- cervix not felt, mass corresponding to 20–24-week size of uterus, hard, immobile. Ovarian markers- Beta HCG , CA-125 , CEA, CBC, RFT, LFT, THYROID PROFILE all within normal limit USG pelvis & abdomen Uterus is post-menopausal, senile, Large heterogenous hypoechoic mass lesion measuring 186x97x156 mm posterior to uterus? Arising from it, with mild internal vascularity? Neoplastic mass? NC & CECT abdomen & pelvis Large well defined, lobulated heterogeneously enhancing mass measuring about 115x230x165 mm in lower abdomen and pelvis in midline inseparable from uterus, likely fibroid, causing mass effect over urinary bladder and bilateral ureter

Clinical Relevance

Management- tumor was large in size with pushing borders, extending beyond uterus. FIGO staging —stage IIB . same removed at surgery TAH with BSO and cyto reductive surgery done. HPE- section from SPECIMEN shows anaplastic cells, which are spindle shaped smooth muscle cells, likely myometrium origin, with increased N/C ratio , high mitotic activiy and pleomorphism , concluding it as leiomyosarcoma immunohistochemistry test- positive for SMA, DESMIN (smooth muscle marker), few cells positive for H-Caldesmon ,CD10 ER, PR - focal weak positive Ki67– proliferation index – 18-20%, cyclin D1- negative Patient further had cycles of doxorubicin based chemotherapy, follow up was done by CT abdomen and thorax

Conclusion - uterine leiomyosarcoma- diagnosed postoperatively, by biopsy report and confirmed by immunohistochemistry report

P 5.4

SYNCHRONOUS PRIMARY MALIGNANT NEOPLASMS OF THE CERVIX AND ENDOMETRIUM

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Introduction

Synchronous multiple malignant neoplasms of the uterus are uncommon, particularly those involving uterus and cervix. Here, we report the case of a patient who developed primary endometroid adenocarcinoma of the uterus and large cell keratinizing squamous cell carcinoma of the cervix at the same time and discuss the diagnosis, treatment and prognosis.

Case Report

The 70-year-old woman presented with postmenopausal bleeding for 6 months. Endocervical curettage and endometrial aspiration unveiled presence of primary endometrial and cervical malignant components. Patient underwent radical hysterectomy with pelvic lymph node dissection as primary mode of management. The presence of coexisting primary separate Mullerian neoplasms was confirmed by histopathological analysis. The final staging was Endometrial cancer stage IIC with LVSI (FIGO 2023) and cervical carcinoma stage IB1 with LVSI. Based on postoperative FIGO staging, adjuvant Radiotherapy was indicated.

Clinical Relevance

Synchronous genital tract neoplasms are clinically complex and pose a challenge in differentiating primary from metastatic tumour. The prognosis in these patients is more favourable when compared to metastatic lesions of individual tumours. There is sparse literature regarding management of such malignancies. An interdisciplinary collaboration of Gynaecologists and Oncologists is necessary for the optimum management of such rare malignancies.

P 5.5

COEXISTING PAPILLARY CARCINOMA WITH EXTENSIVE GENITAL TUBERCULOSIS IN POST MENOPAUSAL FEMALE: A CASE STUDY

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Introduction

The coexistence of papillary endometrial (PEC)and tuberculosis (TB)is extremely rare which posses diagnostic challenges due to overlapping clinical and histopathological feature, requiring a comprehensive understanding of both diseases for accurate diagnosis and appropriate management. Papillary Carcinoma accounts for half of the death attributed to uterine carcinoma.

Case Report

72 year old post menopausal female presented in Gynae OPD with chief complaints of foul smelling discharge per vaginum initially watery in consistency which has now gradually became thick white and spotting per vaginum associated with supra pubic pain x1m. On examination abdomen was found to be soft, non tender. On per speculum examination a 1x1cm hemorrhagic and necrotic growth was seen arising from post lip of cervix that bleed on touch. On per vaginum examination uterus wa normal in size with bilateral fornices free and non tender. Her endometrial biopsy showed papillary adenocarcinoma endocervix with cervical growth. PAP smear showed free benign squamous cell with mod inflammation with foci of squamous metaplasia Patient underwent Staging laparotomy with TAH with BSO with B/L LN dissection. Intraop uterus at 6wk size, B/L tubes dilated. On left 6x7cm large solid adnexal mass seen attached to ovaries reaching upto broad ligament on right side 3x3cm mass in adnexa attached to ovaries On cut section: Rt adnexal mass with caseous material oozing from mass with growth arising from fundal region, endocervical canal normal. Her histopath report was high grade serous carcinoma along with extensive necrotising granulomatous inflammation in uterine endometrium, cervix and B/L tubes s/o ? tuberulosis. Uterine cervix had evidence of surface implant; peritoneal and omental involvement: negative regional LN were found to be negative IHC showed overexpression of p53. Patient is currently not in follow up and was referred to Delhi cancer institute for further mangment

Clinical Relevance

PEC and TB co-existing together is an rare occurrence and due to similar clinical and histopath features diagnosing them can be complicated which may lead to delay in appropriate management

P 5.6

CARDIAC ENZYMES MISLEAD THE OVARIAN PATHOLOGY

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Introduction:

Mucinous neoplasm of ovary represent 10-15% of ovarian neoplasm and affects women of age group between 20-40's. These tumours can become very large and cause pressure symptoms and fill entire abdominopelvic cavity.

Case presentation:

A 23 year old P2L2 woman presented with 3 months abdominal distention, loss of weight and appetite for 1 month and pain abdomen assosciated with vomiting, weakness and breathlessness for 1 day. Patient vitals were unstable with PR 123bpm and BP 80/60mmhg, RR 32/min.Started on inotropes supportives and emergency investigations sent and Ecg were done s/o T wave inversion in lead v1-v3. Cardiac enzymes were raised.

Examination: P/A distention and fluid thrill present, mass of size of gravid uterus around 20-22 weeks of solid cystic mass, irregular arising from pelvis, smooth surface and restricted mobility; P/S cervix and vagina nad; P/V fullness present in all fornices(cystic) and tender, uterus not felt separately; P/R rectal mucosa free. Paracentesis shows LDH 1150 IU/ml with cytology showing mesothelial cells. UPT negative and serum Bhcg less than 2. Tumour markers were raised s/o ovarian malignancy.

Ultasound & CECT scan s/o 20*8.7*16.3 cm solid cystic multiloculated lesion arising from left ovary with septa with gross ascites s/o mucinous cystadenoma, yolk sac tumour, granulosa tumour. On day 3 inotropes were off and maintaining vitals so planned for staging laparotomy for semi emergency reveals 2.5L of mucinous cyst fluid aspirated send for cytology,18*20cm cystic mass in left adnexa left tube stretched over it with 1cm capsule rupture, uterus normal size, right tube and ovary normal hence total abdominal hysterectomy with bilateral salpingo opherectomy with supracolic omentectomy with appendicectomy done. Postoperative course uneventful. Cytology was negative for malignancy and HPE report s/o benign cystadenoma.

Clinical relevance:

A large cystic mass with ascites and high risk of malignancy with cardiac markers raised suggestive of myocardial infarction and masquerade and delays the management. Thus clinically and radiologically evidence were different from each other.

P5.7

SMALL CELL CARCINOMA OF VAGINA

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Introduction

Small cell carcinoma of vagina is a very rare & aggressive tumour. It comprises only around 1-2 % of all gynaecological malignancies. The survival rate of patients treated in early stages is 2years.Most commonly these tumours are pulmonary and only 5percent are extrapulmonary. SmCC are high grade neuroendocrine tumours that emerge from neuroendocrine cells as a result of de-differentiation of an aggressive non-neuroendocrine tumour.

Case Report

CASE HISTORY & EXAMINATION-48yr old P3L3(L3) presented to IGMC KNH OPD with chief complaints of discharge PV for 2 months.-white watery consistency and non-foul smelling. On doing per-vaginum & per-speculum examinations, there was evidence of a whitish lesion around 1*2cm which bleeds on touch in the posterior fornix. Patient was subjected to PAP-smear and its report was inconclusive. Patient subjected to vaginal biopsy and HPE-FSO SMALL CELL CARCINOMA of vagina. There were characteristic fragments lined by stratified squamous cells with high grade dysplasia with neutrophilic exocytosis ,high N:C ratio, round to oval hyperchromatic nuclei. Atypical mitotic figures and hemorraghic areas were also seen.Patient further investigated and evaluated. Tumour markers namely synaptophysin and chromogranin and Ki67(80-90%) all were positive. MRI pelvis showed exophytic mass around 1.7*2.5*4.4cm in relation to posterior fornix cranial upto uterocervical junction and caudal uptil external os with involvement of adjacent parametrium. Patient subjected to further PET-CT and it ruled off any distant dissemination. Patient gives no family history of any cancers ,no history of associated co-morbidties like diabetes ,HTN, Asthma, Tuberculosis ,epilepsy or thyroid related disorders. Patient is non-smoker ,non-alcoholic with normal bowel & bladder habbits.

Clinical Relevance

Patient subjected to radiotherapy and subjected onto concurrent EBRT with 50grays and weekly cisplatin & etoposide on days 1-3 every 3 weeks. Currently undergoing CTRT 4th week. Local therapy alone in small cell carcinoma is associated with poor prognosis. It requires combination of both chemotherapy and radiotherapy. Because of prevalence of this cancer is extremely rare with poor prognosis-this cancer requires an imminent follow up of cases necessitating further accumulation of cases and discussions.

P 5.8

SEX CORD-STROMAL TUMORS OF THE OVARY- A CASE SERIES

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Introduction

Sex cord-stromal tumors of the ovary are rare tumor comprising 5-8% of all ovarian malignancies. These tumors are clinically significant heterogenous tumors that include several pathologic types. These tumors are often found in adolescent and young adults and can present with hormonal manifestations as well as signs and symptoms of a pelvic mass.

Case Report

Here presenting three cases of sex cord-stromal tumors in different age group (reproductive & postmenopausal) but presenting with similar features of pain lower abdomen with menstrual irregularity or postmenopausal bleed. Provisional diagnosis was made by imaging. All three were planned for surgical management and histopathology report confirmed the diagnosis of sex cord stromal tumor which were granulosa cell tumor, Sertoli cell tumor and sclerosing stromal tumor.

Clinical Relevance

The rarity of sex cord-stromal tumors contributes to a low index of suspicion; therefore, a thorough knowledge of the clinicopathologic and radiologic findings of these tumors is important. Surgical management remains the most effective therapeutic approach for the management of both primary and relapsed tumor while adjuvant chemotherapy maybe used only for advanced or unresectable tumors.

P 5.9

AN UNUSUAL CASE OF CERVICAL ECTOPIC PREGNANCY

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Background: Cervical ectopic pregnancy (CP) account for less than 0.1% of all pregnancies with an estimated incidence of one is 18,000 pregnancies. Cervical ectopic pregnancy is usually associated with a painless bleeding in 90% of women & the risk factors include ART & prior uterine curettage or LSCS, IUDs etc.

Case Report : A 35 year old G5P4L1 with previous 4 full-term LSCS with 1.5 months of amenorrhea presented with complaint of Bleeding PV with soakage of 3-4 pads since 3 days associated with mild lower abdominal pain. Vitally stable, on examination, the os was closed, glove stained bleeding and fullness of the bilateral fornices present. Trans vaginal USG revealed a gestational sac of 7+5 weeks in the cervical canal with fetal pole & no fetal cardiac activity with a subchorionic collection of size 2.4 x 1.5 cm. B-hCG – 6379 mIU/ml. Repeat TVS revealed apparent spontaneous expulsion. Patient was managed by Mifepristone followed by D&E as she did not expel spontaneously.

Clinical Relevance : Cervical ectopic pregnancy is a life-threatening condition which usually requires expedited treatment in the form of medical management with methotrexate / suction & evacuation / hysterectomy. Medical management usually includes methotrexate in hemodynamically stable women. Uterine artery embolization may be considered to reduce the risk of perioperative and post-operative bleeding.

6.1

POST ABORTAL RETENTION OF BONE IN UTERO

Renu Kumari Gupta

Introduction: Abortion related deaths which accounts for 47 % of total maternal mortality in the world results primarily from the sepsis and are widespread in developing countries where it is illegal. In our institute we came across 3 such scenarios where bony fragments were found out in post abortal women and removed hysteroscopically. The presence of intrauterine bone fragments is rare. Hysteroscopy is required for confirmatory diagnosis and treatment. Intrauterine bone fragments may result from retained fetal bones or osseous metaplasia or both.

Case Report : Patient X 31yr old para2 living2 abortion 1 with previous 1 C-section.The patient presented to Gyne OPD with Discharge P/V. The discharge was greyish,foul smelling and associated with pain in abdomen since 20 days. The patient delivered via C section 4.5 yrs back and vaginally 2.5 years back.The patient informed of a D&E 1 month back at 4 months amenorrhea, following spontaneous bleeding. There was no complain of bleeding P/v .She had no complain of fever or any previous medical or surgical history.On presentation pulse rate was 82/min and BP was 110/70 mmHg .On examination per abdomen was soft and non tender, per speculum showed no discharge and on per vaginum external os was open-Uterus was around 12 week size was ascertained. A suspicion of retained products was made. The patient was admitted ,routine investigations sent and collected. The hemoglobin was found to be 9.4 g/dl and TLC count was 17850. Urine R/M showed 4-5 pus cells. Blood sugars were raised and liver and renal functions were within normal range. Ultrasound suggested endometrial thickness of 7-8 mm and dense linear echogenic contents casting posterior shadowing within endometrial cavity(approx 36*18 mm)RPOCs ? fetal bones were found and patient was planned for diagnostic hysteroscopy after achieving antibiotic cover for 3 days. In hysteroscopy,multiple bony fragments were found to be present in the cavity some fragments removed partially and some completely(? Tibia ? Ribs). Dense adhesions were present in the cavity and adhesiolysis done simultaneously .All tissues were sent for HPE.An endometrial polyp was found and removed and finally endometrial curettage was done and obtained endometrium sent for histopathology.

Clinical Relevance : Prolonged retention can prove to be a recognized cause of secondary infertility. Bony pieces may act as intrauterine synechia or as an IUD increasing PG F2alpha release from the endometrium. They might cause reactive endometritis that interferes with blastocyst implantation. These patients may present with dysmenorrhea, discharge PV chronic pelvic pain or menorrhagia.It is thought that for endochondral ossification to occur the fetus should atleast have crossed 12 weeks of gestation. Hysteroscopy alone is invaluable in achieving a cure for these patients. GnRH analogues are newly being used and studies have shown improved results with a smaller corpus, reduced uterine volume and an atrophic endometrium. Studies have shown retained bones to be more common in cases of uterine anomalies, thereby it is essential to rule out such anomalies before instrumentation. he Menstrual blood volume and total prostaglandin E2 concentrations were found to decrease by 50% post bone removal.Trans vaginal sonography is an excellent tool for accurate and complete diagnosis of retained bony pieces and any uterine anomaly that may have been missed previously. A diagnostic hysteroscopy followed by removal of the bony entity via wire loop resectoscope or ovum forceps or grasper. It is however also essential to recheck via hysteroscopy if the cavity is clear and our bone removal is complete. Restoration of fertility is expected post removal, though prolonged retention of bone may have lead to endometrial inflammatory damage and might even cause IVF failure.

P 6. 2

HYSTERECTOMY IN YOUNG UNMARRIED FEMALES : SOCIAL, ETHICAL & MEDICO-LEGAL DILEMMAS

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Introduction

The decision for hysterectomy in unmarried, young females, especially those with disabilities, is laden with many social, ethical and medico-legal dilemmas. Our case series unfolds these dilemmas in therapeutic and non therapeutic hysterectomies.

Case Report

In our index case, the mother of a 17 yrs old, unmarried girl with spastic cerebral palsy and irregular menses was denied the request for hysterectomy by a medical board for menstrual hygiene. In the second case, the parents of a 23 yrs old, unmarried girl with primary amenorrhea with transverse vaginal septum with severe intellectual disability (IQ 28) with DM type II, insisted on hysterectomy which was done after due approval from medical board. Lastly, a 26 yrs old, unmarried woman with cortical blindness with cicatrisation of earlier treated transverse vaginal septum with recurrent hematocolpos with endometrioma underwent hysterectomy after self consent in view of poor quality of life.

Clinical Relevance

Universal declaration of human rights 2015 and The Rights of Persons with Disabilities Act 2016, guarantee various rights to people with disabilities including right to reproduce and protection against cruel, inhuman treatment. Various guidelines have been laid out in this matter by courts & various governments. However, there is a lack of comprehensive medicolegal framework in our country to guide management in such cases. This is an attempt to highlight the lacunae in the existing body of knowledge and to emphasize the need for specialized laws and medical board.

PP 6.3

LYMPHANGITIC CARCINOMATOSIS: A RARE CASE OF POSTPARTUM BREATHLESSNESS

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Introduction

Breast cancer is the most common cancer in Indian women, incidence 25.8/100,000 and a mortality of 12.7/100,000 women. Early-onset breast cancer is more aggressive, higher stage and grade at presentation with more estrogen receptor negative or triple-negative subtype PABC is the breast cancer diagnosed during pregnancy or within 1 year of delivery (5-10 years after delivery)and the incidence being 0.2-3.8%.Dual effect of pregnancy on breast cancer risk i.e Transiently increased risk in the early postpartum period and long term risk reduction in premenopausal.

Case Report

A21 year old, P1L1A3 presented to Gynae casualty at postnatal day 26 of preterm vaginal delivery with C/o gradual onset breathlessness on exertion, generalized body ache(mainly upper back) for 15-20 days andcough with sputum with occasional hemoptysis for 4-5 days. Her antenatal period was uneventful and she was referred at 35 weeks with preterm labor and had PTVD, was breast feeding and discharged on Day 3. On Examination- Patient was Tachypneic with B/L chest clear. On Gynecological examination B/L adnexal masses firm, mobile, nontender Rt-8x8 cm, Lt-4x4 cm felt. Ultrasound abdomen/pelvis - uterus normal, Rt- 8x8 cm solid ovarian, Lt- 4x4 cm solid-cystic mass ovarian mass. Chest X ray- reported as Miliary mottling with confluence, possibility of tuberculosis- started on ATT. Suspicion of Tuberculosis with? Krukenberg tumor? Germ cell tumor kept. Tumor markers for germ cell tumor- normal. Sputum for AFB came negative.Patient was put on oxygen support, however, her condition deterioratedrapidlyrequiring Noninvasive ventilation. CECT chest, abdomen and pelvis was suggestive of solid ovarian masses with multiple bony metastasis, Large IVC thrombus, Lymphangitic carcinomatosis in lungs. Also, B/l Breasts showed suspicious lesions for which FNAC was done which suggested malignancy. Trucut biopsy from ovarian masses revealedmetastatic adenocarcinoma. On reexamining breasts- multiple small firm nodule felt in B/L breast. Final diagnosis was Stage IV breast cancer with ovarian metastatsis with Lymphangitic carcinomatosis with Venous thrombosis. Patient was started on palliative care after oncology opinion.

Clinical Relevance

Conclusion: Pregnancy associated breast cancer is a distinct clinical entity and has poorer outcome as it is often detected in advanced stages. All pregnant and postpartum women should be educated about self breast awareness and clinical breast examination should be an essential part of examination. Pulmonary Lymphangitic carcinomatosis is a form of pulmonary metastasis most commonly seen with breast cancer and represents end stage malignancy.

P 6.4

A CASE REPORT ON HETEROTOPIC PREGNANCY

Yashaswi Bhusari

Introduction

Heterotopic pregnancy refers to simultaneous presence of intrauterine and extrauterine pregnancy. Its incidence is 1 in 30,000 births.We came across an interesting case in our centre

Case Report

Patient presented at 2 months amenorrhea with pain in abdomen and giddiness.Outside USGs reflected presence of ruptured ectopic alongside intrauterine pregnancy. She was tachycardic and hypotensive , per abdomen showed mild distention ,tenderness and guarding. Culdocentesis was positive. Emergency laparotomy was done and IUP was undisturbed. Patient was followed up till term

Clinical Relevance

Sonologists should be aware of this entity and if its overlooked it can lead to rupture uterus and maternal shock and mortality

P 6 .5

PLACENTAL CHORIOANGIOSIS IN PLACENTA PREVIA, WITH MATERNAL NEAR MISS. A RARE CASE.

Kartika Pandey

MMIMSR, Mullana, Haryana

Introduction

The normal chorionic villi contain about 2- 6 vascular channels per terminal villus. The term chorioangiosis was introduced by Altshuler in 1984 ,which is characterised by villous hypervascularity. The diagnostic criteria of Chorangiosis was established as the presence of a minimum of 10 villi, each with 10 or more vascular channels, in 10 or more areas of 3 or more random, non infarcted placental areas .1 Its etiology is still not clearly identified, but it is considered to result from chronic low grade hypoxia in the placental tissue. Suzuki K et al proposed that a low transfer of oxygen to the fetal circulation in the villi will lead to an increased oxygen saturation of maternal blood in intervillous spaces and low oxygenation in capillaries of villi, resulting in chorioangiosis.2 Chorioangiosis has been suggested as an important sign of placental injury, associated with hypoxia in utero .Its presence shows correlation with neonatal morbidity and congenital malformations as high as 39% and 42%, respectively. Chorioangiosis is frequently associated with maternal conditions such as gestational diabetes, preeclampsia/eclampsia and placental infection.1

Case Report

A 34 years G3P1L1A1;G1 hysterotomy at 4 months gestation 4 years back,G2-LSCS at term for breech 3 years back, came to the OPD on 28/08/2020 at 36 weeks 6 days of gestation with central placenta previa and labour pains . The patient had an uneventful first and second trimester, but she did not undergo level 2 CMF scan . A large defect of size 3.1 cm in occipital region with herniation of brain tissue suggestive of encephalocele with placenta completely covering the cervical os(no evidence of placenta accreta) was demonstrated in scan at 32 weeks. On examination; patient's general condition was good, with PR of 110/min, BP- 110/70mmHg, Temp- 98.6,RR-18/min. The GPE and systemic examination was normal. On P/A examination; uterus was 34 weeks with fetus in transverse lie, uterine contractions were present but there was no scar tenderness and the FHS was138bpm. The patient was taken up for Emergency Caesarean Section in view of placenta previa with labour pains .On Gross appearance; the placental bulge was seen over the previous uterine scar site suggestive of placenta accreta. A vertical incision on the uterus given and an alive male baby delivered as breech with birth weight-2.802 Kgand APGAR- 7/9 at 1 and 5 minutes respectively. Placenta did not separate, and excessive bleeding ensued, patient had hypotension requiring inotrope support. Placenta was left insitu, a decision for hysterectomy taken in view of deteriorating patient's condition and

retained placenta. A total hysterectomy performed, right fallopian tube and urinary bladder were densely adherent to uterine wall. A bladder injury of 1×1 cm occurred while dissecting bladder from the uterus, same repaired in two layers. The blood loss was 3 L, 3 PRBC with 2 Fresh frozen plasma given intraoperatively and 2 PRBC with 1 FFP given immediate postoperatively. Patient was shifted to ICU on ventilator and inotrope support Post operative vitals were; PR-158/min, BP-110/70 mmHg, Temp- 98.6, RR-20/min, Spo2-98% The patient was successfully extubated on post operative Day 1 and Hb was 8.6g% .The inotropic support was tapered off completely on POD-3 and patient shifted to Ward. Patient was discharged on post op day 6 under stable condition with catheter insitu, which was removed on day 21 and sutures were removed on day 8 of hysterectomy.Patient had normal bladder voiding.A successful corrective surgery was performed for new born. Gross Examination: observation made of placenta encroaching the serosal aspect of lower uterine segment. On Microscopic Examination: Placenta demonstrated focal areas of diffuse villous hypervascularity with increased number of vascular lumina(10 villi having more than 10 vascular lumina, in more than 10 different microscopic field), impression-chorangiosis. No evidence of viral cytopathic effect/ gestational trophoblastic disease and no evidence of placenta accreta on microscopy.

Clinical Relevance

The villous capillary lesions of placenta, namely chorioangioma(CA),chorioangiomatosis(CM) and chorioangiosis(CH) are related entities, but distinct in their presentation and microscopic features . The CA can be nodular or multinodular, with villous capillary lesions located mostly under the chorionic plate and at the placental margins. The CM can be focal, segmental or diffuse multi-focal, with capillary proliferation involving stem villi surrounding the central core, along with permeation of normal villous structure.Histologically, capillary proliferations in CH involve terminal villi sparing the stem villi and vice versa in CM. The CH is devoid of the continuous perivascular layer of muscle-specific actin (MSA)-positive pericytes and the multifibrillar lattice-like reticulin pattern, seen in both CA and CM. CA and CM are observed to co-occur and share associations with toxemia of pregnancy, multiple gestation, as well as preterm delivery at 32 to 26 weeks .On the other hand, CH shows association with gestational diabetes, placentomegaly, chronic villitis and its incidence is not increased in placentas with CA or CM. CH are more frequent at greater than 37 weeks.3 Chorioangiosis in not an uncommon finding but is infrequently diagnosed.The incidence reported in literature is primarily from examination of placentas with abnormal maternal or perinataloutcome,and it ranges from 5% to 7%.1,4Even though the etiology of chorioangiosis is not fully understood ,a long standing low grade hypoxia is put forth as possible cause.2It is observed in smokers,obese,woman living at high altitudes.An interaction of maternal, placental, and fetal factors with increased oxidative stress and angiogenesis may possibly contribute to this arising pathologic change. Chorioangiosis has clinical association with many maternal as well as placental conditions and is associated with poor perinatal outcome. It is observed commonly in hypertensive disorder of pregnancy, gestational diabetes and placental infection.1There are increased chances of cesarean section in pregnancies with chorioangiosis.4 The mother had major obstetric hemorrhage in present report resulting in maternal near miss. The neonatal outcome is poor in chorioangiosis and it can be considered an important indicator of placental injury associated with hypoxia in utero.4An increased incidence of prematurity, neonatal death, IUGR, NICU admission ,poor APGAR score is observed in pregnancies with chorioangiosis.4 A big encephalocele was present in fetus in our case ,the incidence of major congenital anomalies is reported to be as high as 42% in severe chorioangiosis. Chorioangiosis was seen with placenta previa in the case, the common placental lesions seen along with chorioangiosis include intervillous hemorrhage, placentomegaly , umbilical cord knots , chorioamnionitis/villitis , ischaemic placental changes ,fetal vascular thrombi, diffuse villous fibrosis and umbilical vein dilatation . Chorioangiosis is mentioned to be associated with abruptio placentae and placenta previa as well. We found case reports of chorioangiosis with abruption in literature search, but none with placenta previa. Even though ample evidence is available in literature to support the association of chorioangiosis with poor perinatal outcome and certain maternal conditions, it still remains under reported and under studied. Moreover ,a major maternal complication and intra operative clinical appearance mimicking a placenta accreta observed was a novel finding, with reference to placental chorioangiosis. We suggest that, further studies focusing on this pathological entity can better improve our understanding of etiology and delineate the spectrum of associated fetomaternal conditions.

P 6.6

PREGNANCY OUTCOME IN NCPF WITH MASSIVE SPLEENOMEGALY

Namita Batra

G2A1 with 38 weeks with massive spleenomegaly with NCPF with oesophageal varices

P 6.7

MIRRORING REALITY: UNVEILING THE SHARED CLINICAL PRESENTATION OF DIFFERENT VAGINAL WALL CYSTS

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Introduction

*Dr Objective:*To describe the clinical presentation and understand the diagnostic and management challenges encountered in varied presentation of anterior vaginal wall cystic masses,in absence of diagnostic criteria and rarity of such cases in literature. Methods: In this case series,we describe different cases of anterior vaginal masses which include gartner duct cyst, paraurethral cyst, degenerative cystic leiomyoma, in patients who presented with similar spectrum of urogynecological symptoms.

Case Report

Results: By analyzing our data we found prevalence of anterior vaginal wall cystic masses , 26 out of 770 which is 3% of patients who came to Urogynecology OPD from December 21 to june 23,belongs to mean age group of 40 years.

Clinical Relevance

Conclusion: By considering prevalence among woman belongs to 35-45 years coming with complaints of something coming out of vagina with similar urogynecologial symptoms need not be prolapse always.

P 6.8

SYMPTOMATIC ADNEXAL CYST IN PREGNANCY-LAPAROSCOPIC MANAGEMENT WITH A SURPRISE REVELATION

Ritambhara Ratnapriya

Introduction

Large cystic masses are rare in pregnancy.Cystic masses are usually ovarian cysts.Surgical removal of the cyst can be performed electively in the second trimester,or at any time if acute symptoms are present.

Case Report

30 year old patient G4P3L3 at 12 wks period of gestation presented to our emergency department with complaint of pain abdomen for 2 days.Pain was acute,gradual in onset,which aggravated on doing physical activity and relieved after taking rest.On per abdomen,a soft, 12x12 cm tender cystic mass was palpable in right iliac fossa and right lumbar region.On PV examination,uterus was 10-12 week size,fullness was present in right fornix,same mass felt high up tipped through the right fornix.Surgical termination of pregnancy and complete excision of the cyst was done after dividing the pedicle and cyst wall removed after aspiration.

Clinical Relevance

Mesentric cysts are rare in adults.It should be considerd as a differential diagnosis in cystic adnexal masses and all gynaecologists shouls be aware of this entity.Once diagnosed it can be dealt with by open as well as laproscopic surgical excision safely.

P 7.1

LAPAROSCOPIC INGUINAL GONADECTOMY IN CASE OF PARTIAL ANDROGEN INSENSITIVITY SYNDROME-PAIS

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Introduction

Androgen insensitivity syndrome (AIS) is a disorder of sex development with resistance of androgen receptor which may be complete or partial. PAIS is characterized by primary amenorrhea, female phenotype with well developed breast, presence of testes and XY karyotype. They have an almost 5-10% increase risk of testicular germ cell tumor due to cryptorchidism in adults. Here, we are presenting a case of PAIS who was managed by laparoscopic inguinal gonadectomy with bilateral deep inguinal ring repair.

Case Report

23-year-old female, came in OPD with the chief complaints of primary amenorrhea. On examination, she had hirsutism, secondary sexual characteristics were well developed with clitoromegaly and blind vagina. Investigations showed XY karyotype, high LH, FSH, free testosterone and absent uterus with bilateral gonads in the inguinal canal on ultrasound and MRI pelvis. Final diagnosis of PAIS was made, and patient underwent laparoscopic inguinal gonadectomy with deep inguinal ring repair. Post operative period was uneventful and HPE report showed bilateral gonads as testes. Patient was started on estradiol valerate 1 mg/day.

Clinical Relevance

Laparoscopy has gained wide acceptance in paediatric urology. Laparoscopy is also reported to be a useful tool for diagnosing and treating DSD because of its minimal invasiveness and favourable cosmetic outcome. However, reports of evaluation and management using laparoscopy for large numbers of DSD patients are limited and debate is still open about indications and timing of gonadectomy. CONCLUSION: AIS is an important cause of amenorrhea. Gonadectomy should be considered after development of secondary sexual characteristics in partial AIS but can be delayed in CAIS. Laparoscopy is emerging as a minimally invasive route for gonadectomy, and complete removal of gonads should be ensured.

P 7.2

POST-HYSTERECTOMY SCAR ENDOMETRIOSIS: WHO WAS A CULPRIT?

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Introduction

Scar endometriosis is a relatively uncommon condition, characterized by the presence of endometrial tissue in abdominal surgical scars. This report highlights the importance of considering scar endometriosis as a potential differential diagnosis in patients presenting with cyclic abdominal pain and a palpable mass at or near previous surgical scars.

Case Report

We report a case of a 28-year-old multi-parous female with a surgical history of uncomplicated two cesarean sections followed by total abdominal hysterectomy for AUB-L, presented with complaints of lower abdominal pain with painful micturition and swelling over the stitch line. On examination, a well-healed Pfannenstiel incision scar with a lump in the midline with tenderness was present. An ultrasound showed evidence of a well-defined hypo-echoic lesion posterior to the abdominal wall scar site with posterior acoustic enhancement and multiple fine septations. A diagnosis of scar endometriosis was made. The patient underwent laparotomy and the scar site cyst infused with rectus abdominis muscle was excised. The tissue was sent for histopathology which confirmed the diagnosis of endometriosis.

Clinical Relevance

Scar endometriosis should be considered as a potential diagnosis in patients with a history of previous cesarean sections, gynecological surgeries, or any abdominal surgical procedure presenting with cyclic abdominal pain and a palpable mass at or near the surgical scar. Prompt recognition and appropriate management, including complete surgical excision, can alleviate symptoms.

P 7.3

ASSOCIATION OF APOLIPOPROTEIN E GENE POLYMORPHISM WITH DYSLIPIDEMIA IN PREECLAMPSIA – A CASE CONTROL STUDY

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OBJECTIVE: Pathological dyslipidemia causing obstetric vasculopathy may be a common pathway through which Apolipoprotein E (Apo E) gene responsible for reverse transport cholesterol system acts to result in preeclampsia (PE). This study aims to evaluate association of ApoE gene polymorphism with lipid profile in preeclampsia.

METHODS: Case control study on 180 subjects; group I PE(n=90) and group II(n=90) normotensive controls. 4ml venous blood was collected- 1ml used for ApoE gene polymorphism by PCR, 3ml for lipid profile by Synchron Lx® system.

RESULTS: Incidence of PE was 11.4% in our study population. Low socioeconomic status and Muslim religion were significantly associated with preeclampsia. Dyslipidemia prevalence was 82% in PE cases compared to 59% in control. Total cholesterol, LDL, triglycerides were increased by 1.19,1.29 and 1.39 folds respectively and HDL decreased by 0.9 folds of normal pregnancy levels in preeclampsia. Apo E genotype ε3/ε4 was most prevalent in preeclampsia group and had no correlation with degree of dyslipidemia. The most prevalent genotype ε2/ε3 in normal pregnancies was associated with high levels of HDL.

CONCLUSIONS: Dyslipidemia acts as independent risk factor for Preeclampsia. Genotype ε3/ε4 predisposes to PE and has significant association with preeclampsia. No correlation of this genotype with dyslipidemia suggests independent pathways of action of these two risk factors in development of disease.

P 7.4

DOUBLE HIT AND A MIRACULOUS SAVE: EVANS SYNDROME IN PREGNANCY

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Introduction

Evans syndrome is a rare autoimmune disorder and is very rare in pregnancy. It usually has a benign course and responds to conventional treatment. We present a case of Evans syndrome in pregnancy which was a diagnostic challenge with a turbulent pregnancy course and posed a therapeutic challenge by being refractory to conventional treatment, yet with a successful outcome.

Case Report

22-year-old, primigravida presented at 23 weeks with bleeding from gums, petechial rashes all over body, shortness of breath, bilateral crepts, hematuria with bicytopenia (Hb 9.2, Platelet 7000). She required ventilatory support and multiple blood products transfusion due to diffuse alveolar hemorrhage. A differential diagnosis of ITP with DAH, tropical infection, systemic autoimmune rheumatic disease, acute leukemia was considered and was investigated for the same. Direct Coombs test and ANA were positive however others were negative (dsDNA, ANCA, APLA, PNH, viral markers, scrub typhus) and Evan's syndrome was diagnosed. She was started on IV Dexamethasone to target both hematologic and pulmonary manifestations, later on IVIG as no improvement in platelet count.

Clinical Relevance

Evans syndrome is a rare condition which can pose a diagnostic and therapeutic challenge in pregnancy due to close overlapping clinical features and laboratory parameters with limited options for treatment without any defined protocol in pregnancy. A multi-disciplinary approach, persistence of team with strict maternal fetal monitoring, judicious and timely transfusions with use of novel second line drugs can result in successful pregnancy outcome even in pregnant women with life threatening complications due to Evans syndrome.

P 7.5

EARLY VERSUS LATE ARM

Swati Rathore, Shravani

CMC VELLORE

Background & Objectives:

To assess role of early or late ARM in low risk

Materials & Methods

Prospective study

Results

Late ARM is beneficial

Conclusion

Early arm will relenquished

P 7.6

MALINGERERS OF MALIGNANCY

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Introduction

Certain medical conditions can malinger as malignancy and delay definitive diagnosis unless looked for specifically.

Case Report

Mrs. S, 46 years, African descent, came with complaints of abdominal distension and elevated serum immunoglobulin. Detailed evaluation and workup for suspected malignancy revealed bulky ovaries with cystic lesions in the ovary, gross ascites, omental thickening and thickening of peritoneal reflections. Her tumor markers were CA125 – 324, CEA – normal, LDH – 215, Serum IgG - 2898 (raised), Serum IgA – 310 & Serum IgM – 88. She underwent ascitic tapping (therapeutic) to relieve her symptoms as well as to make a diagnosis of the underlying etiology. Ascitic tap was negative for malignant cells, AFB staining and Gene Expert for TB. ADA was raised. Her blood Quantiferon gold was negative and other tests normal. Due to lack of conclusive tissue diagnosis of cancer, chemotherapy could not be started even though the clinical picture was highly suggestive. She underwent assessment laparoscopy (which in the presence of gross ascites is a challenge), to assess feasibility for debulking surgery and obtain tissue diagnosis. Intra-operatively there was large volume ascites, innumerable nodular deposits (0.5cm) over all intra-abdominal organs and peritoneal surfaces, clumping of the bowels and omentum. Biopsies were taken from accessible organs (ovary, endometrium, omentum) and peritoneal reflections of various and sent for frozen section. None of the samples showed conclusive evidence of malignancy, however, biopsy from the ovary revealed a solitary epithelioid cell granuloma. Final biopsy report of all sites showed several Langhan's type of giant cells within granulomas, with central caseous necrosis. Final diagnosis was granulomatous oophoritis & granulomatous inflammation. With this she was started on definitive treatment and made uneventful recovery.

Clinical Relevance

This case highlights the awareness of diagnoses which can mimic malignancy - clinically, biochemically and radiologically.

P 7.7

VISION IS COMFORT: TIME TO EMBRACE LAPAROSCOPIC BURSCH COLPOSUSPENSION

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HIMSR, Jamia Hamdard

Introduction

Bursch Colposuspension has become the surgery of gold standard for Stress urinary incontinence due to multiple mesh related complications. Laparoscopic Bursch Colposuspension (LBC) is associated with reduced blood loss and faster recovery. This video presentation attempts to highlight a few tricks for easing this laparoscopic surgery.

Case Report

A 62 year old, hysterectomised woman presented to the OPD with debilitating genuine SUI since the last 2 years. After ruling out urge incontinence, urinary infections and prolapse, she was planned for a LBC. The principle is to dissect the Avascular space of Retzius till the urethral level and then suspend the paraurethral vaginal tissue to the Coopers ligaments bilaterally. Versatile endosuturing, harmonic scalpel and an experienced assistant are required. Good cephalic traction, harmonic dissection will expose the whitish Arcus tendinous fascia pelvis (ATFP), bladder neck and then the whitish, soft paraurethral vaginal tissue. A pair of Ethibond no 2-0 sutures pass through the vaginal tissue and on the Coopers ligaments with a gap of 1 cm. Tightening should be just enough to pull the vaginal tissue till the level of the ATFP.

Clinical Relevance

In comparison to the open surgery, a skilled endosurgeon can achieve a faster and clearer vision of the Space of Retzius. Fear of blood loss is minimized with the correct technique of harmonic dissection. The efficacy is comparable to the open surgery and should be adopted by endoscopists for relieving this silent loss of dignity for women with genuine SUI.

P 7.8

VAGINAL DELIVERY FOLLOWING UTERINE RUPTURE: A COMPLEX OBSTETRIC CHALLENGE

Bijaya Shalini

Background & Objectives:

Childbirth is a miraculous and complex process, during which a woman's body undergoes significant changes to bring a new life into the world. While vaginal delivery is the preferred mode of childbirth, certain complications can arise, posing risks to both the mother and the baby. One such complication is uterine rupture, which refers to the tearing of the uterine wall during pregnancy or labor. In cases of uterine rupture, the subsequent delivery presents a unique set of challenges and requires careful management.

Materials & Methods

Key Considerations for Vaginal Delivery: When vaginal delivery is considered following uterine rupture, several important factors must be considered. A thorough assessment of maternal and fetal stability is crucial before proceeding with this mode of delivery. Continuous electronic fetal monitoring is essential to detect signs of fetal distress or hypoxia. The availability of an experienced obstetrician, anesthesiologist, and neonatal resuscitation team should be ensured to address any emergent situations that may arise. It is important to note that the decision for vaginal delivery should be made on a case-by-case basis, weighing the risks and benefits for both the mother and the fetus

Results

The prognosis following vaginal delivery following uterine rupture depends on various factors, including the severity of rupture, the gestational age at the time of rupture, the promptness of intervention, and the availability of timely medical care. Maternal complications may include hemorrhage, infection, and organ injury, while fetal complications may range from birth asphyxia to neonatal death.

Conclusion

Vaginal delivery following uterine rupture is a challenging obstetric scenario that requires prompt recognition, careful management, and multidisciplinary collaboration. The primary goal in such cases is to ensure the safety and well-being of the mother and the fetus. Timely intervention, including immediate resuscitation, appropriate monitoring, and access to surgical expertise, plays a crucial role in optimizing outcomes. Preventive strategies and individualized management plans for subsequent pregnancies are vital to minimize the risks associated with uterine rupture. By understanding the causes, diagnosis, and management of uterine rupture, healthcare providers can provide the best possible care for women experiencing this complex obstetric emergency.

P 7.9

VAGINAL DELIVERY OF LOCKED TWINS – IS THIS POSSIBLE?

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The incidence of locked twins is about 1 in every 1000 twin births. It is one of the most fatal foetal complications of twin pregnancy.

Here we present a case of a 28-year-old female, gravida 2, para 1, live 0 pregnancy with severe anaemia with severe preeclampsia with twin pregnancy with first fetus, breech with intrauterine foetal demise and second fetus cephalic with oligohydramnios. The head of the dead fetus was locked to the chin of second fetus(alive) at top of pubic symphysis. The legs and back of first twin were extended to the pubic symphysis. The head of the second baby was visualized below the neck of the first baby. Episiotomy was given and head of second baby was delivered which released the head of first baby and both were delivered vaginally. The second baby was 1.3 Kg and cried immediately. However, leading twin breech and second twin cephalic raises suspicion of potential locked twin and a timed cesarean would avoid foetal death.

Vaginal delivery of both twins may be possible if the foetuses are small, the pelvis is roomy and congenital foetal anomalies are absent. The Kimball–Rand manoeuvre of hyperextension and traction of the first twin and flexion and traction of the second head, using Piper forceps, may result in the simultaneous delivery of both heads; otherwise, delivery of the second twin past the first by forceps may be performed. In our case, manual manoeuvre was tried to resolve the interlocking and because of small sizes of the foetuses, simultaneous delivery of both the foetal heads was achieved

P 7.10

CERVICAL CHORIOCARCINOMA- A UNIQUE PRESENTATION

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Introduction

Gestational choriocarcinoma also known as chorioepithelioma is a malignant rare trophoblastic tumour. Although choriocarcinoma is highly metastatic and often wide spread at the time of diagnosis, it is curable in over 98% of cases. The premalignant or benign forms of GTN are partial and complete mole and atypical placental site nodules. The malignant forms include highly metastatic choriocarcinoma, placental site trophoblastic tumour (PSTT), invasive mole (chorioadenoma destruens), and epithelioid trophoblastic tumour (ETT). Malignant tumours usually develop after molar pregnancies and their incidence after full-term pregnancies is extremely rare, so also is its presence in extra-uterine sites such as cervical canal.

Case Report

A 40-year old P2L2 woman presented with a 3-month history of vaginal bleeding, but without documented antecedent pregnancy (LCB-9 years back). Her D & C histopathology reported- Gestational choriocarcinoma. She presented to casualty with heavy bleeding PV. Patient was stabilised & one dose of methotrexate was given .She underwent emergency exploratory laparotomy with TAH with B/ L Salpingectomy + B/L ovarian transposition(preservation) in view of - gestational choriocarcinoma with life threatening vaginal bleeding. Intra-op on cut section revealed a large mass in the middle 1/3rd of cervical canal. Post-op course was uneventful & she was discharged on 4 th day. Post op HPE was evident of gestational choriocarcinoma, NOS involving isthmus & cervix , stage- pT1, FIGO STAGE I, On IHC: Tumor cells are positive for BHCG, GATA3, MUC, focally positive for SALL4 and negative for P63. Ki67 ~ 95% . She was started on single agent methotrexate / Leucovorin protocol, tolerated well, She received 4 cycles methotrexate postoperatively, although b-HCG normalised only after 1 cycle.2 weeks post treatment completion : PET CT scan: no definite evidence of metabolically active disease. She is put on follow up , as of now there is no evidence of disease.

Clinical Relevance

Choriocarcinoma , non-gestational or gestational with antecedent pregnancy may present with intractable vaginal bleeding as an emergency & early total hysterectomy with preservation of bilateral ovaries may not only be life saving but also improves oncological outcomes by reducing tumor burden & improving response to chemotherapy with possibly less drugs &/or reduced numbers of cycles required to induce & maintain disease/beta-HCG remission.

P 7.11

PGT-M: A CONTRASTING TALE OF 2 EMBRYOS

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Introduction

Preimplantation genetic testing for monogenic disorders (PGT-M) can help patients end the cycle of inheritable genetic illness and welcome a healthy baby. It is recommended as part of an IVF cycle when both partners carry a genetic illness.

Case Report

Case1: 38 years female P1L0 with 1st spontaneous conception. The girl child had thalassemia major; and on investigations both partners were found to be thalassemia minor. The child underwent bone marrow transplant; expired at the age of 7 years. The Couple under went IVF with PGT-M for thalassemia. Out of the 4 embryos formed and biopsied, only 2 were normal on PGT testing. Frozen embryo transfer (FET)was done with 1 embryoand the patient conceived and delivered a healthy baby. Case2: 32 years female P0L0A5 with previous three 2nd trimester MTP in view osteogenesis imperfecta. On karyotyping of both partners, both were found to be autosomal recessive for osteogenesis imperfecta. IVF with PGT-M for osteogenesis imperfecta was performed. Out of 8 embryos formed, 4 were biopsied for PGTM and only 1 was found to be normal (heterozygous). FET was done with the one embryo and the patient conceived. However, at level 2 scan the fetus had features of Pierre-Robin Syndrome and underwent 2nd trimester MTP.

Clinical Relevance

PGT-M is used to describe single-gene PGD. PGT-M is used to help individuals or couples reduce their risk to have a child with a known inherited disorder caused by mutations in a single gene. While we test for theknown single gene in the embryo to avoid the risk of its transmission; there are many other gene disorders which are not tested as parents are not known carriers. This rare untoward incident can lead to disheartening outcome.

P 7.12

SUCCESSFUL OUTCOME OF CONCEPTION IMMEDIATELY AFTER BARIATRIC SURGERY

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Introduction

After bariatric surgery, a woman should wait 12 to 24 months before conceiving so that the fetus is not affected by rapid maternal weight loss and so that the patient can achieve her weight-loss goals. Pregnancy before this recommended time frame is a challenge for the obstetrician. Still more challenging is the management of a patient who conceives within a month post-bariatric surgery.

Case Report

A 33-years-old primigravida was referred to us within a month after she underwent sleeve gastrectomy in the 4th week of her last menstrual period. Initially there was dilemma regarding continuing pregnancy in the phase of rapid weight loss; and later there were concerns of meeting nutritional demands and optimizing pregnancy outcomes. To add to the inherent risks of obesity and bariatric surgery, patient was detected with short cervix for which cerclage was put at 16 weeks, then she had spotting per vaginum at 29 weeks which was expectantly managed. Cerclage was removed at 37 weeks. Patient was induced at 39 weeks and she delivered a 3250 g female baby. The postnatal period was uneventful and patient was discharged on postpartum day-3.

Clinical Relevance

Successful pregnancy outcome is possible with close maternal fetal surveillance even in conceptions immediately after bariatric surgery.

P 8.1

MALIGNANT MIXED GERM CELL TUMOUR OF OVARY IN AN ADOLESCENT GIRL: A CASE REPORT OF AN UNUSUAL COMBINATION

Dhruthi Shivakumar

Introduction

Ovarian tumors and especially mixed germ cell tumors are rare, estimated-only about 1/4th of all ovarian tumors in females

Case Report

Patient was a 15 years old girl, presented with abdomen pain, distension and dyspnea since past 1 week, with huge abdominopelvic mass which was well defined solid, non-tender, non-mobile measuring (~13x15x13cm) extending up to xiphisternum. The mass effect also led to massive right sided pleural effusion requiring tapping and Intercostal chest drain insertion. Ultrasound and CECT scan revealed large well defined heterogeneously enhancing right ovarian mass of ~13x22x30 cm with areas of vascularity and mass effect on all intraabdominal organs and vessels with mild ascites. AFP was grossly elevated (>50000IU/ml), LDH (691U/L), CA-125(751U/ml). We performed Fertility Sparing Surgery. Intra operative findings showed a huge right ovarian mass ~30x25x20cm bosselated, solid mass with irregular margin. Intra-op capsule rupture was seen. Right salphingo-oophorectomy with infra-colic omentectomy, multiple peritoneal biopsies, peritoneal fluid sampling, omental lymph node biopsy were carried out. Postoperative phase was uneventful. Based on Histopathological report diagnosis of Malignant mixed germ cell tumor consisting of Yolk sac tumor with Embryonal carcinoma was made. Peritoneal, omental LN biopsies and peritoneal fluid sample were found clear from malignancy. Patient was staged FIGO Stage 1C1 and planned for 4 cycles of adjuvant chemotherapy with BEP (bleomycin, etoposide, cisplatin) regimen.

Clinical Relevance

Malignant mixed germ cell tumors of ovary are highly aggressive neoplasm and early intervention and fertility sparing surgery is required for any adolescent girl presenting with rapidly enlarging pelvic mass.

P 8.2

Giant Haemorrhagic Ovarian Cyst Torsion- A Case Report.

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Introduction:

Giant ovarian tumours are rare nowadays due to early recognition of these tumours in clinical practice. Management of these tumours depends on age of the patient, size of the mass and its histopathology. We are reporting a case of torsion of haemorrhagic ovarian cyst presented to us with acute abdomen.

Case Report:

36 years old female, married for 7 years, P1L1 with previous 1 LSCS came to our emergency department with complaints of lower abdominal pain for 5 days. Patient was apparently normal before 5 days after which she developed lower abdominal pain which was spasmodic in nature, more on the right side. The abdominal pain was progressive, non-radiating and aggravated on lying down, relieved on sitting and bending forwards. Patient also had history of fever since 3 days. Highest recorded temperature was 101 F, not associated with chills and rigor. She also had 2 episodes of vomiting since 1 day prior to admission. Abdominal examination showed distension, with mass felt in epigastric region, arising from right iliac region. Tenderness was felt in epigastric and right iliac region. Ultrasound pelvis was suggestive of ill-defined heteroechoic predominantly hyperechoic lesion with minimal internal vascularity arising from the right adnexa with a cystic structure arising and extending in the midline reaching uptil the epigastric region at the xiphoid process. With clinical suspicion of torsion, MRI pelvis was done, which confirmed the torsion of cyst.Patient was then posted for emergency laparotomy proceed right ovariotomy. Large right ovarian cyst, measuring 16 cm x 12 cm present on the right side with site of rupture, massive haemorrhage and necrosis. Another cyst below this arising from right adnexa measuring 8cm x 5 cm, with connecting stalk seen between the cysts was visualized and removed and sent for histopathological examination. Patient recovered and discharged on fourth post-operative day.

Key words: Ovarian Cyst, Ovarian torsion, Haemorrhagic Cyst

P 8.3

INVASIVE MOLE: A CASE REPORT

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Introduction

Invasive mole is a rare type of gestational trophoblastic neoplasia which can have variable clinical presentation. We describe one such case.

Case Report

A 28-year-old lady presented with complaint of heavy vaginal bleed for 15 days. She had history of suction and evacuation for molar pregnancy at a private hospital. The histopathology report was suggestive of partial mole with retained p57 expression in villous stromal cells and cytotrophoblasts. A repeat evacuation was done in view of bleeding per vaginum in our hospital. Post evacuation, serial beta HCG monitoring showed a rising trend. WHO prognostic score was 6, accordingly a single agent chemotherapy with methotrexate was started. MRI pelvis revealed a bulky uterus with large ill-defined mass centered in anterior myometrium reaching till serosa and projecting into endometrium with multiple flow voids in parametrium suggestive of invasive mole. Even after receiving methotrexate, beta HCG showed a rising trend. Hence, EMACO regimen started for the patient, after which beta HCG value showed a falling trend.

Clinical Relevance

Invasive mole may arise after molar pregnancy. Although definite diagnosis of invasive mole is based on pathology, radiological findings are fairly suggestive. The best treatment option is chemotherapy (according to WHO prognostic score, with single or multiple agent). Under close supervision, patient can be managed with chemotherapy avoiding the need for hysterectomy.

P 8.4

LAPAROSCOPICALLY CONFIRMED GENITAL TUBERCULOSIS AS A CAUSE OF PUBERTY MENORRHAGIA

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Introduction

Female genital tuberculosis (FGTB) is characterised by chronic inflammation and scarring of genital organs leading to grave consequences. Confirming FGTB especially in pubertal girls is challenging due to vague symptomatology and lack of sensitive diagnostic tools.

Case Report

A 13-year-old presented with complains of continuous heavy menstrual bleeding (HMB) since 2 months. History and physical examination were unremarkable. Haematological and biochemical investigations were within normal limits. There was no history of bleeding diathesis. Ultrasound revealed right-sided pyo-/haematosalpinx. MRI showed bilateral pyosalpinx of size 3.6*2.7*3.7cm along with multiple enlarged right iliac and obturator lymph nodes. Mantoux test, chest X-ray and menstrual fluid were negative for tuberculosis. Considering pyosalpinx, diagnostic laparoscopy was done which revealed nodules on the surface of the pelvic organs with adhesions involving fallopian tubes and omentum; caseous material was drained from fallopian tube which was positive on TB-CBNAAT and histopathological examination of the biopsies taken from nodules showed granulomatous inflammation. Anti-tubercular treatment was initiated as per DOTS guidelines. A follow-up scan after one month showed decrease in the size of tubo-ovarian mass and resolved symptoms.

Clinical Relevance

This report highlights the need for considering FGTB as a differential in puberty menorrhagia. Laparoscopy can play a crucial role in the diagnosis of FGTB in the patients where there is strong suspicion, allowing direct visualization of the pelvic organs and obtaining biopsy samples. Early detection and treatment can reduce damage and preserve future fertility in these girls. Key words: Genital tuberculosis, laparoscopy, AUB

P 8.5

CHRONIC UTERINE INVERSION: A RARE COMPLICATION OF MISMANAGED LABOUR

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Introduction

Uterine inversion is an Abnormal protrusion of internal surface of relaxed uterus through the vaginal orifice. Its cause can be broadly classified as puerperal and non-puerperal with puerperal uterine inversion more common them non puerperal inversion. Acute inversions occurring immediately or within 24 hours post partum are the most common type. chronic uterine Inversions occurring more then four weeks after the delivery are rare identities. There differential diagnosis includes prolapsed fibroids and endometrial polyp. Chronic nature of these inversions makes the restoration of the Normal position of the Uterus per vaginal difficult contrary to Acute liversions which can be reposited more easily. we hereby Present a case of 28 year-old lady who presented with Intermittent Bleeding per vaging at 6 year post partum. She was diagnosed as a case of chronic uterine Inversion base on clinical and Sonographic examination.Inverted uterus was successfully restored through per Abdominal approach by haultain operation. In This case presentation of chronic uterine Inversion as Abnormal uterine bleeding at delayed post-partum period is rare and therefore reported.

Case Report

28-year-old P2L2 female six year post-partum presented to us with complaints of intermittent bleeding per vagina over a period of 6 year. Patient had no abdominal complaints and had regular menstrual cycles with normal flow. Patient delivered a healthy male baby with birth weight 3.5 kg at home six year back. According to the patient, delivery was conducted by traditional birth attendant and removed the placenta immediately by cord traction after the delivery of baby. She denied any eventful antenatal course. After delivery patient has excessive bleeding per vaginally. For further management patient referred to tertiary hospital.Since last six year patient's has intermittent uterine bleeding. On sonogram patient diagnosed with chronic uterine Inversion. On local examination, she had normal external genitalia. On per speculum examination a 5cm x 6cm globular mass with smooth margins pinkish-red in colour was seen. Mass bleed on touch.Huntington's method was tried by giving traction upward over the ring but failed. Finally Haultain's method was done by giving vertical incision posteriorly in the uterine wall over the ringand replacement of uterus was done successfully.

Clinical Relevance

Uterine inversion is a rare complication of vaginal delivery, and an obstetric emergency. If not promptly recognized and treated, it can lead to severe hemorrhage and shock, resulting in maternal death.

P 8.6

PARAOVARION CYST WITH TUBAL TORSION: DOES DOPPLER DIAGNOSE IT?

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Introduction

Paraovarian 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 Report

A 19year old girl presented with acute abdominal pain, non-responsive to analgesics and vomiting. Pelvic ultrasound showed a left paraovarian cyst of size 6.7cm X 5 cm with a left ovarian hemorrhagic cyst of 3 cm with preserved ovarian blood flow. routine microscopy and USG KUB were normal. Laparotomy advised by anesthetist in view of T wave inversion on ECG. Intraoperatively a paraovarian cyst of 5 X 6cm was lying in the POD with the left tube having undergone 2 and a half twists. The tube was long,congested and edematous.The left ovary was bulky 4x4 cm with a hemorrhagic and long ovarian ligament. Detorsion of the tube was done with paraovarian cystectomy and plication of ovarian ligament. A similar case, wherein a 20yr old girl presented with acute abdominal pain, non-responsive to analgesics. USG findings showed a right adnexal complex mass of size 5×4 cm with normal Doppler study .MRI showed similar findings. Tumor markers were negative. On laparoscopy right tube had undergone 2 and a half twist along with the right para ovarian cyst . Untwisting of the tube and cyst followed by paraovarian cystectomy was performed.

Clinical Relevance

When torsion is strongly suspected clinically despite normal Doppler study, torsion of paraovarian cyst with the tube is an important differential diagnosis, and early diagnostic laparoscopy and tubal preservation are strongly advocated.

P 8.7

MYOMECTOMY OF LARGE CERVICAL FIBROID THROUGH VAGINAL ROUTE

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Introduction

Cervical leiomyomas are a rare benign myomas and accounts for 0.6% of all uterine fibroids. Cervical myomectomies by abdominal route are challenging due to difficult surgical dissection through the cervical stroma as well as proximity to the cervical canal and other vital pelvic structures including bowel, bladder, uterine vessels, and ureter. Here we present a case of a lady presenting with urinary symptoms and large cervical fibroid in which myomectomy by vaginal route obviated the need for a difficult hysterectomy.

Case Report

A 49-year-old peri-menopausal lady with previous two vaginal births, presented to the gynaecology outpatient department with complaints of intermenstrual bleeding (not associated with dysmenorrhoea or dyspareunia for 5 years); along with difficulty in passing urine. General physical, systemic and per abdomen examinations were normal. On per speculum examination, a large mass occupying the vagina was visualized. Cervical lips were not seen. On bi-manual examination, a large, smooth, globular mass, firm in consistency with restricted mobility was felt arising from posterior lip of cervix. Cervix was pushed behind symphysis pubis. The uterus could not be felt separately and bilateral adnexa were free. A provisional diagnosis of large cervical fibroid was made based on clinical examination. Ultrasound findings- uterus was anteverted, normal size, with an endometrial thickness of 6 mm, a well-defined rounded hypoechoic lesion of 85*81*85 mm, vol- 306 cc in cervical region. Lt ovary showed a simple cyst 31*31 mm with no e/o calcification. Right adnexa appeared normal. After pre-anaesthetic workup, the patient was taken up for cervical myomectomy. A transverse nick was given on the posterior aspect of the myoma, 2-3 cm away from the posterior lip. Plane of dissection created between the myoma and the pseudo-capsule and myomectomy performed after which the incision on posterior lip sutured. The following hysteroscopy suggested an unremarkable uterine activity and intact cervical canal. Histopathological examination confirmed cervical fibroid with hyalinization. The patient is symptom free at one month follow up.

Clinical Relevance

Cervical myomas are rare. In view of the lack of menstrual symptoms, they grow to large sizes before detection. Cervical myomectomy is a surgical approach through a natural orifice that obviates the need for a total hysterectomy and offers quicker recovery.

P 8.8

CASE SERIES ON PREGNANCY WITH CONGENITAL HEART DISEASE

Peuly Das

Introduction

Woman with congenital heart disease can have a successful pregnancy, but it requires careful planning & discussion with multidisciplinary team. Pregnancy has its risks even in healthy women but there may be greater risk for women with CHD and their baby. For some women, the risk is high enough that pragnancy is not recommened.The risk for pregnant women with congenital heart disease of having adverse cardiovascular events—such as symptomatic arrhythmia, stroke, pulmonary oedema, overt heart failure, or death—is determined by the ability of their cardiovascular system to adapt to the physiological changes of pregnancy. Different congenital conditions carry specific risks based on their morphological features, previous operations, and current haemodynamic status.The risk of patient with CHD having a baby with CHD is 3-5%, this can rise up to 50% depending on the patient's type of CHD.

Case Report

We present 4 cases of congenital heart disease in pregnancy. Our first case 24 year primi with acyanotic congenital heart disease large patent ductus arteriosus with moderate anemia presented with false labour pain at 36 week.she had episode of palpitation, ghabrahat and tab lasix & metoprolol started according to cardiology referral. Patient goes in spontaneous labour at 38 week. Epidural analgesia given at active stage of first stage labour & cut of second stage labor done by doing forceps vaginal delivery. She was closely monitored postpartum and was stable on discharge. The second case was a 28 year old primi with congenital cyanotic heart disease tetralogy of Fallot with fetal growth retardation, presented at 35 week with dyspnea. patient was admitted in icu , was started tab lasix and propranolol 2o mg tds. Patient goes in spontaneous labour & second stage of labor cut short by vacum delivery. patient was monitored post partum & stable on discharge. Our third case was 32 year primi large VSD with severe PAH with subvalvular AS with NYHA 3, presented at 34 week with bleeding placenta previa. Patient was undergone emergency lscs under general anaethesia . She was closely monitored & discharged on stable condition with her baby. But 3 months later she died because of cardiac arrest. The last case was 19 years primi with eisenmenger heart disease with large VSD presented at 16 weeks period of gestation for medical termination of pregnancy. The pregnancy was terminated & she recovered well.

Clinical Relevance

Cardiac disease is one of the leading cause of maternal death and most affected women have congenital heart disease. The number of such cardiac patients at risk is expected to grow.Timely pre-pregnancy counselling should be offered to all women with congenital heart disease to prevent avoidable pregnancy-related risks and crisis management and allow patients to plan their lives.Adequate care during pregnancy, delivery, and the postpartum period requires a multidisciplinary team approach with cardiologists, obstetricians, and anaesthetists. Successful pregnancy is feasible for most women with congenital heart disease at relatively low risk when appropriate counselling and optimal care are provided.

P 8.9

TORSION OF PEDUNCULATED FIBROID: A RARE DIFFERENTIAL DIAGNOSIS OF ACUTE ABDOMEN

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Introduction

Torsion of a subserous fibroid is incredibly rare. We are reporting a case of known subserosal fibroid under follow-up who presented as acute abdomen and was suspected as fibroid torsion. She was subsequently diagnosed as torsion of fibroid along with omentum.

Case Report

A 32 year old P1L0 female, known case of rheumatic heart disease on anticoagulants and chronic kidney disease presented with acute lower abdominal pain since 5 days. On examination, her vitals were stable. Per abdominal examination revealed 18 weeks size irregular abdominopelvic mass, which was mobile and tender on palpation. Ultrasound showed large fibroid 14x10 cm from posterior myometrium with subserosal extension with mild free fluid in right iliac fossa and bilateral ovaries seemed normal. She was taken up for surgery, intraoperatively there was a 15x10cm pedunculated subserosal fundal fibroid with torsion at its pedicle. Omentum along with the pedicle had undergone torsion 8 times at its attachment. After detorsion, myomectomy was done. Tubes and ovaries were normal. She was discharged uneventfully after switching over to oral anticoagulant.

Clinical Relevance

Though rare, pedunculated fibroid torsion can present as acute abdomen. This differential should always be kept in mind in patients with pedunculated fibroid, presenting with acute abdomen.

P 9.1

THE GREAT MASQUARADER

Nibedita Chakraborty

Introduction

Interstitial pregnancy is a rare type of ectopic pregnancy in which the embryo implants at the junction of fallopian tube with uterus. Most common site of ectopic pregnancy is ampullary region of fallopian tube. Interstitial pregnancy though rare is more dangerous than other sites of ectopic pregnancy as it can lead to catastrophic haemorrhages, shock, uterine rupture with mortality ranging from 2-2.5%

Case Report

26 yrs G2P1 brought to district hospital OPD with history of amenorrhea for 14 wks and pain abdomen for 12 hours in a state of shock with severe pallor. On Examination PR 138/min, BP 80/60 mmHg, per abdominal examination reveals tense and distended abdomen. Urine for pregnancy test was positive. Abdominal paracentesis showed hemoperotoneum. Provisional diagnosis of ruptured ectopic pregnancy was made. However ultrasonography showed intrauterine pregnancy with CRL corresponding to 12 weeks 6 days gestation with hemoperitoneum with multiple uterine fibroid. After fluid resuscitation and arranging blood she was taken up for urgent lapatotomy with due consent and explaining all the possible risk and complications. Abdomen was opened by longitudinal paramedian incision and massive hemoperitoneum seen. Fetus with G sac of size 8*10 cm seen along rent in left cornu of uterus with multiple uterine fibroids. Site of bleeding was clamped and repair was done. Post operative period was uneventful.

Clinical Relevance

Early diagnosis of Interstitial ectopic pregnancy can be challenging as it may mimic eccentrically implanted intrauterine pregnancy, Pregnancy associated with fibroids, pregnancy in bicornuate uterus and angular pregnancy. Interstitial ectopic pregnancy though rare, delayed diagnosis and risk of torrential haemorrhage can lead to catastrophy. Early diagnosis using TVS and serum beta HCG titre though challenging can be life saving.

P 9.2

A RARE FORM OF MAYER-ROKITANSKY-KUSTER-HAUSER SYNDROME WITH A FUNCTIONAL RUDIMENTERY HORN: A CASE REPORT

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Introduction

MRKH syndrome, second most common cause of primary amenorrhea is a congenital malformation affecting the uterus and upper two third of the vagina with normal secondary sexual characters and karyotype. Women may suffer cyclical abdominal pain that could be attributed to the presence of active mullerian remnants. We report a rare form of MRKHS presenting with right ovarian endometrioma.

Case Report

A 27 years old woman presented to the outpatient department complaining of primary amenorrhoea with monthly cyclical abdominal pain. The general physical examination including external genitalia were unremarkable. Breasts development, pubic and axillary hair corresponded with Tanner stage V. Her hormonal profile was normal. Ultrasound and MRI Pelvis was suggestive of absent uterine cavity, cervix and upper two-third of vagina with the presence of rudimentary horn on right side along with a large, well defined cystic lesion of 7.6*9.2*9.8 cm in the location of right ovary suggesting endometriotic cyst. An exploratory laparotomy was performed. The rudimentary horn along with hypoplastic uterus and the right endometrioma observed and resected. The left ovary was also diseased forming tube-ovarian complex mass with endometriotic deposits hence was resected. The histopathological examination confirmed the presence of active uterine endometrium and ovarian endometriosis. Her postoperative period was uneventful.

Clinical Relevance

An active endometrial remnants should be suspected when women with mullerian agenesis present with symptoms of endometriosis. Appropriate management of endometriosis is crucial for optimizing the post operative outcome as well as to reduce the risk of ovarian cancer and endometriosis recurrence.

P 9.3

UTERINE HYPOPLASIA WITH CERVICAL AGENESIS AND PROXIMAL VAGINAL AGENESIS: A RARE MULLERIAN DUCT ANOMALY

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Introduction

Uterine hypoplasia with Cervical agenesis and proximal Vaginal agenesis is a very rare congenital anomaly. The patients usually present with primary amenorrhea, primary infertility and left sided Bartholin cyst with well developed secondary sexual characteristic.

Case Report

A 27 year old female came with history of primary amenorrhea with primary infertility with pain and swelling over perineum. On examination she had Tanner stage 3 breast, axillary and pubic hair development present. On per vaginal examination blind vaginal pouch of 5cm with left sided Bartholin cyst seen. Her sonography revealed hypoplastic uterus with cervical dysgenesis and proximal vaginal agenesis. Her contrast MRI findings suggestive of uterine hypoplasia with presence of uterine fundus and upper segment showing functional endometrium ,lower uterine segment, cervix and upper vagina was hypoplastic. Right tuboovarian mass approx 5.2x4.3x5.7 cm was also present. After that she underwent exploratory laprotomy . On naked eye examination right side mullerian duct developed only but lower uterine segment not found with presence of right haemorrhagic ovarian cyst nearby 8.0x7.0 cm. left side ovary healthy and left side mullerian duct was not developed. Decision of Hysterectomy with right salpingo-oophrectomy with left salpingectomy and bartholin cyst drainage with marsupulization taken and done.

Clinical Relevance

Uterine hypoplasia with Cervical agenesis and proximal Vaginal agenesis a rare congenital anomaly and requires a patient centered multidisciplinary approach in careful dialogue with the patient addressing all together gynecological, sexual, psychological and in fertility issues.

P 9.4

A CASE OF CONGENITAL CYANOTIC HEART DISEASE IN A 3RD GRAVIDA DUE TO UNCORRECTED PENTALOGY OF FALLOT

Arimpa Saha

Introduction

Pentalogy of fallot is a cyanotic heart disease that has guarded the prognosis without surgical intervention in infancy. It comprises of right ventricular outflow tract obstruction, right ventricular hypertrophy, over riding of aorta, ventricular septal defect and atrial septal defect. This condition is rare and more complex. Adverse maternal event associated with magnitude of right to left shunting that accentuate arterial hypoxaemia.

Case Report

A 30 yr old pt,3rd gravida with history of two spontaneous abortion (@ 3 and 3.5 month ,1.5 and 1 yr back respectively),housewife by occupation, married for 2 yr,no h/o infertility admitted from emergency with complain of pain abdomen for 24 hrs associated with respiratory distress for last 5 hrs. She was an non booked case, with only 2 antenatal check up. Her antenatal period was uneventful except occasional shortness of breath in going upstairs in 3rd trimester. with more questioning it was revealed that she had recurrent episode of shortness of breath since childhood,which was precipitated by running, weight lifting, going upstairs that was subsided on taking rest. o/e, bp 120/70 mmhg,PR 130/min,spo2 56% in room air. grade 3 clubbing, pedal odema present, b/l clear. She delivered a baby boy by assisted breech delivery. There was continuous oozing from episiotomy site, EUA done, on OT table spo2 36% intubation done. Extubation done after 2 days at spo2 66% CXR reveals oligemic lung field, cour-en-saboot appearance. ECG showed right ventricular hypertrophy and right axis deviation. ECHO reveals non restrictive VSD with Right to left shunt, overriding of aorta, RV restricted, ostium secondum ASD, stenosed pulmonary artery.

Clinical Relevance

Pregnancy with uncorrected tetralogy of fallot comes under class III of the modified WHO classification of maternal cardiovascular risk, There is high risk of maternal and foetal complications so obstetric and cardiac monitoring should be done throughout the pregnancy, intrapartum and postpartum period .This case emphasizes importance of multidisciplinary team, especially the obstetricians with expertise high risk pregnancy, cardiologist and anasthesiologist.

P 9.5

AN INTERESTING CASE ON MULTIPLE FIBROIDS

Suman Adhikari

Introduction

Uterine leiomyomas are the most common type of a benign tumor that arises from the female pelvis. Uterine leiomyoma is a smooth muscle tumor. Its prevalence is more in reproductive age group and decreases after menopause. They are rare in adolescents. In reproductive age group, the preferred mode of management of fibroid is myomectomy. Though most women with fibroids are asymptomatic, approximately 30% of them will present with severe symptoms which can include abnormal uterine bleeding, anemia, pelvic pain and pressure, back pain, urinary frequency, constipation, or infertility, and will require intervention. Furthermore, fibroids have been associated with poor obstetrical outcomes. The current options for symptomatic fibroid treatment include expectant, medical, and surgical management, and interventional radiology procedures.

Case Report

Patient cane with complaints of pain in abdomen and swelling of lower abdomen. In per abdomen findings: lump was seen m/a 10*8 cm extending upto umbilicus, elongated transversely , non tender, fixed mobility. All the required investigations were sent. CRCT w/a showed : Uterine and cervical intramural and subserousal leiomyomas with calcifications and cystic degeneration .mild splenomegaly and retroperitoneal lymphadenopathy.

Clinical Relevance

Multiple fibroids are routinely encountered and myomectomy is done in order to retain fertility for nulliparous women. Complications with myomectomy are also low and symptoms were relieved to a large extent.

P 9.6

ASTONISHING MIRACLES OF GYNECOLOGICAL DEVELOPMENT- A RARE INTERESTING CASE OF A LARGE GARTNER CYST

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Introduction

Female embryological development begins with Mullerian and Wolffian ducts with persistence of previous one and evanescence of the latter. In rare scenarios wolffian duct persists to form Gartner duct cysts. Majority of these are small and asymptomatic but rarely grow to significant extents to cause complaints like dyspareunia, visible swelling in vagina, urinary retention or urgency. These can also be associated with other urinary tract malformations like urethral diverticulum, ipsilateral renal agenesis or ectopic ureters

Case Report

Mrs. X was a 44 year old lady P5L5 who presented to AIIMS gynecology opd with chief complaint of progressively increasing mass per vaginum and incomplete bladder emptying since last 15 days. Local examination revealed a large 20*15 cm cystic mass bulging out of introitus. Initial examination provided an image of pelvic organ prolapse which on further examination and imaging came out to be a large gartner cyst with bilateral hydroureteronephrosis. Bladder complaints resolved with per urethral catheterisation and urinary sepsis managed with broad spectrum antibiotics and vasopressors under multidisciplinary supervision. Definitive surgical management done in form of cyst excision. Patient was discharged in stable condition.

Clinical Relevance

Large symptomatic gartner cysts are rare clinical entity. They usually present as vaginal swelling of anterolateral wall but can sometime present unusually like in this case. Sound knowledge about such entities only, can avail timely treatment and save woman from permanent renal damage and other complications.

P 9.7

USE OF PANICKER'S UNIVERSAL LIGATION FORCEPS (PUL FORCEPS) IN A SUCCESSFUL CERVICAL CERCLAGE IN SECOND TRIMESTER- A CASE REPORT

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Introduction

Objective: To determine the feasibility of use Panicker's universal ligation forceps (pul forceps) over conventional needle holder in second trimester cervical cerclage. Introduction: Cervical insufficiency leading to recurrent abortions and preterm birth is seen to occur in about 1 % of obstetric population and causes both economic burden on the society and psychological burden on the family. We present a case a 30 year old G3P2L1 planned for history indicated cervical cerclage at 15 weeks and is subsequently continuing her pregnancy

Case Report

Methodology: A 30 year old G3P2L1 with history of second trimester abortion in previous pregnancy was planned for history indicated cervical cerclage. The PUL forceps with No 4 mersilene suture was used in the procedure after pushing the bladder up. One end of the silk was held in the needle and brought anteroposteriorly by piercing with the needle at the level of internal os near the uterosacrals close to the cervix. Similar procedure was repeated on the other side. Knot was then tied as high as possible posteriorly. The procedure was very easy and accomplished with minimal force. Tissue handling was also lesser. The special shape of the instrument made penetrating the paracervical tissue very easy.

Clinical Relevance

Results: The patient was comfortable post procedure and is presently 32 weeks gestation and doing well. Conclusions: Mac Donald and Shirodkar's techniques are the two common techniques of transvaginal cervical circlage using a needle holder. Use of Panicker needle for the same was found to be equally effective without any undue trauma. However more cases need to be done to enable a better practice and understanding of this instrument.

P 9.8

APPLICATION OF POSTERIOR ARM SLING TRACTION IN IMPACTED SHOULDER DYSTOCIA: A CASE REPORT

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Introduction

Incidence of shoulder dystocia is 0.3-0.5%. Various manoeuvres are being used in current practice which include, but are not limited to, supra pubic pressure, McRoberts, woods cork screw and Rubin's manoeuvre. Post arm sling traction is also an effective method; however, it is not routinely used.

Case Report

Method:- A 35-year-old G5A4 with 40 weeks period of gestation with overt diabetes with anencephaly in baby was admitted in the labour room for termination of pregnancy. During delivery, intra uterine foetal demise was diagnosed. Episiotomy resulted in delivery of the face and scalp of the baby. The foetal posterior shoulder was however high up and Mc Roberts, supra pubic pressure and rotational methods failed. The Posterior shoulder was dislocated thereby decreasing the bisacromial diameter. A foleys catheter was guided through the posterior axilla and a sling was made. Traction was put which resulted in delivery of posterior shoulder. Anterior shoulder was rotated posteriorly and delivered similarly. Result:- IUD anencephaly Baby Boy of weight 3.07Kg was delivered

Clinical Relevance

Conclusion:- Posterior arm sling traction can be used as an effective method in delivery of impacted shoulder dystocia. However, more studies are needed.

P 10.1

COMPLEX HETEROTAXY SYNDROME IN MONOAMNIOTIC MONO CHORIONIC TWIN : PRENATAL DIAGNOSIS AND AUTOPSY CORRELATION

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Background & Objectives:

Introduction : Heterotaxy syndrome or Isomerism is a rare condition (1 in 10,000 live births) where the internal thoraco- abdominal organs demonstrate abnormal arrangement across the left -right axis of the body. It is associated with high mortality rates with male preponderance at a ratio of 2:1. The syndrome can be accurately diagnosed in the prenatal period on Obstetric ultrasound and fetal echocardiography. Fetal autopsy is an important adjunct to confirm the abnormality if pregnancy is terminated.

Materials & Methods

A 28 yrs old G2P1L1with mono amniotic mono chorionic twin@15 wks of gestation was diagnosed with situs inversus in TwinB.An anomaly scan done @ 20 wks confirmed Twin A to have no anomaly and Twin B with right isomerism and heterotaxy with pulmonary and tricuspid atresia. Couple counselled regarding poor prognosis and prenatal exome sequencing for single gene disorder was offered, options of affected fetal reduction or expectant management as one twin was normal.However the couple opted for termination and autopsy was performed in both the twins which confirmed heterotaxy in Twin B with mono ventricular heart .Twin A had no anomaly.

Results

Autopsy confirmed heterotaxy in Twin B with mono ventricular heart. Twin A had no anomaly.

Conclusion

This is a case of heterotaxy syndrome with cardiac anomaly in one fetus in mono amniotic mono chorionic twin, which is a discordant anomaly on prenatal ultrasound confirmed by fetal autopsy .This rare syndrome can be accurately diagnosed in pre-natal period and appropriate counseling and genetic tests can be offered.

P 10.2

STUDY OF ENDOMETRIAL PATHOLOGIES IN PATIENTS UNDERGOING ENDOMETRIAL BIOPSIES

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Background & Objectives:

To study the association of endometrial histopathologies in patients undergoing endometrial biopsies with different gynaecological complaints. INTRODUCTION- Endometrial biopsy is an office procedure that serves as a helpful tool in diagnosing various uterine abnormalities. When clinically indicated, endometrial biopsy is a safe, efficient, and cost-effective way to evaluate the uterine endometrium. In this study, we aim at evaluating the association of histopathology of endometrium as seen on endometrial biopsy with gynaecological complaints of the patients.

Materials & Methods

The histopathological reports of endometrial biopsies of 375 patients who underwent the procedure at our hospital over the last 5 months (2022, Dec-2023,April) were evaluated and correlated with different gynaecological complaints of patients.

Results

Out of the 375 patients evaluated, 50.48% had abnormal uterine bleeding, 34.05% had infertility, 12.27 % had post menopausal bleeding, 3.2% had secondary amenorrhea. Among the patients diagnosed with abnormal uterine bleeding, proliferative endometrium (45.53%) was found to be the most common finding, signifying that anovulation is an important cause of abnormal uterine bleeding. In patients having Infertility, although majority of the patients had endometrium in secretory (37.62%) or proliferative phase (34.04%), in a few patients (6.7%) granuloma were also seen, implying that endometritis also plays an important role in infertility. In post menopausal bleeding, while majority were reported as atrophic endometrium (52.2%), about 19.9% patients had malignant changes on endometrial biopsy histopathology. Twelve patients presented with secondary amenorrhea, most of them had either atrophic endometrium (4 patients) or showed report as inadequate for opinion (4 patients), suggesting the deficiency of estrogen in such patients.

Conclusion

Endometrial biopsies are a valuable source of information and have contributed significantly to our current understanding of many gynaecological disorders. It helps in screening for abnormal cells in endometrium. Being an office procedure, it is both cost effective and easy to perform, and provides reliable results. Thus, it remains an important screening and diagnostic tool for various gynaecologic pathologies.

P10.3

STUDY OF SURGICALLY MANAGED FIBROID UTERUS IN UNMARRIED FEMALES

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Background & Objectives:

The objective of this study is to know about various characteristics of fibroid in unmarried females, indication for surgical management and post operative course.

Materials & Methods

This was a retrospective study of 20 women who were operated at Dr RML Hospital in past 03 years. Their presentation, investigations, intra-op and postoperative course was noted.

Results

Eighty five percent of the patients presented with chief complaint of heavy menstrual bleeding followed by pain abdomen, dysmenorrhea, pressure symptoms, lump per abdomen. Sixty percent of the fibroids were intramural, thirty percent were submucosal and rest were of mixed origin . Majority of the fibroids were single fibroids. Fifty five percent of the patients required intra op blood transfusion , thirty percent required post op blood transfusion . Average size of the uterus per abdomen was 18-20 weeks. Preoperative mean haemoglobin of the patients was 9.5 and postoperative mean haemoglobin of the patients was 9.7. Postoperative course was uneventful in majority of the patients.

P 10.4

ANEMIA MUKT BHARAT: WHERE DO WE STAND?

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Lady Hardinge Medical College

Background & Objectives:

Anemia continues to a major public health problem in developing nations like India, especially in reproductive age women. The prevalence in women of reproductive age (15-49 yrs) has been estimated to be 57% as per the latest demographic report of the country. The Government of India is striving hard to mitigate anemia and improve the quality of life of its population through various health programs latest being the "Anemia Mukt Bharat Abhiyan". The innumerable healthcare workers (HCWs) in the public health sector of India, which is one of the largest in the world, are pivotal for the implementation of this program. It is an irony that despite having such a robust healthcare structure, India is still grappling with anemia control. One of the primary contributing factors may be the lack of sensitization among HCWs involved with the implementation of the eradication programs

Materials & Methods

A cross sectional study was conducted amongst the healthcare workers (HCWs) including nursing officers, doctors and medical students of a tertiary healthcare facility of Delhi, where their demographic profile was noted and spot hemoglobin was done to diagnose anemia.

Results

Analysis of the data revealed that out of the 305 HCWs screened,67.1% were found to be anemic. Amongst them, 52.3% attendees were mildly anemic (Hb 10-11.9 gm/dl), 46.7% had moderate anemia(Hb 7.1-9.9 gm/dl) and 0.8% had severe anemia (Hb

Conclusion

It is often said that we cannot build a strong structure on a weak foundation. It is obvious that India first needs to work on raising the health status of its HCWs before It can bring about a positive change in the health of the general population

P 10.5

PRE-TERM LABOR - AN OVERVIEW

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Background & Objectives:

Preterm birth (PB) is a leading cause of neonatal mortality and is associated with long-term neurologic and developmental problems. Identifying risk factors and predicting preterm labor can help in the management and treatment of pregnant women at risk of preterm birth.

Materials & Methods

The study reviews various tools and biomarkers that can be used to predict preterm labor. It discusses risk factors such as maternal characteristics, reproductive history, and current pregnancy characteristics. The study also explores ultrasound markers including cervical length and consistency, as well as newer tools like uterocervical angle, uterine artery pulsatility index, placental strain ratio, and fetal adrenal gland measurement. Biomarkers discussed include fetal fibronectin, interleukin-6 (IL-6), interleukin-8 (IL-8), and cervical fluid.

Results

Cervical length measured by transvaginal ultrasound is a good predictor of preterm birth risk. A cervical length d"15 mm was reported as the most optimal cut-off for predicting true preterm labor. Other ultrasound markers and newer tools have also shown promise in predicting preterm birth. Fetal fibronectin testing has varying accuracy but can be useful in predicting preterm birth within 7-10 days after testing. IL-6 and IL-8 levels in cervicovaginal fluid have shown association with preterm birth within 7 days.

Conclusion

Accurately predicting and preventing preterm labor and birth remains a crucial challenge in obstetrics. Identifying women at highest risk of preterm birth can help tailor interventions and treatments to improve maternal and fetal outcomes. Genomic, proteomic, and metabolomic approaches may provide further insights into the physiology of labor and pathophysiology of preterm birth. Different groups of biomarkers may be needed to distinguish pregnancies experiencing different types of preterm labor.

P 10.6

OVULATION INDUCTION

Ranjeeta Gupta

Background & Objectives:

Ovulatory disorders contribute to a significant portion of female infertility cases. This article aims to discuss the physiology of ovulation, the infertility workup process, the classification of ovulatory dysfunction according to the World Health Organization (WHO), and the various medications and treatments used for ovulation induction (OI) in infertility.

Materials & Methods

The article provides information on the general physiology of ovulation and the importance of a comprehensive infertility workup to identify underlying causes. It discusses the classification of ovulatory dysfunction according to gonadotropin and estrogen levels. The medications and treatments used for OI, including Clomiphene Citrate (CC), other selective estrogen receptor modulators (SERMs) like tamoxifen and raloxifene, aromatase inhibitors (AIs) such as letrozole, metformin, and gonadotropins, are also explained in detail.

Results

The article describes the mechanisms of action, clinical outcomes, administration protocols, and dosing guidelines for each medication used in OI. It highlights the importance of monitoring hormone levels and follicular growth during treatment. The risks and considerations associated with each treatment option, such as multiple gestations and ovarian hyperstimulation syndrome (OHSS), are discussed. Laparoscopic ovarian drilling (LOD) as a surgical option for anovulatory infertility is also mentioned, along with its mechanism, indications, and potential risks.

Conclusion

The article concludes that OI medications and treatments are effective in inducing ovulation in individuals with ovulatory dysfunction. Each medication has its specific mechanism of action and administration protocol. While OI medications are generally considered safer and more common, LOD may be considered as a second-line therapy for CC-resistant cases. Further research is needed to fully understand the long-term effects and risks associated with OI medications and surgical interventions like LOD. Proper monitoring and individualized treatment approaches are essential to optimize outcomes in OI for infertility.

P 10.7

AN EVOLVING ERA OF AESTHETIC GYNAECOLOGY

Vandana Babbar

Background & Objectives:

Aesthetic gynaecology is a rapidly growing subspecialty that focuses on procedures to improve the appearance and function of the vaginal and vulva regions. The objective of this lecture is to discuss the techniques, procedures, indications, potential risks, and benefits of aesthetic gynaecology.

Materials & Methods

The lecture explores various surgical and non-surgical treatments in aesthetic gynaecology, including labiaplasty, vaginoplasty, hymenoplasty, clitoral hoodectomy, labia majora augmentation, O-spot, and G-spot amplification. Surgical solutions involve the use of energy-based instruments, lasers, radiofrequency devices, high-intensity focused ultrasound, and more. Non-surgical solutions involve platelet-rich plasma, plasma gel, and hyaluronic acid fillers. The lecture also addresses the problems commonly addressed by these interventions, such as stress urinary incontinence, vaginal tightening, post-menopause indications, post-delivery rehabilitation, and vaginal dryness.

Results

The lecture highlights the reasons why women seek aesthetic gynaecology, including concerns about the appearance of their genitalia, desire for improved sexual function and satisfaction, and psychological factors such as shame and low self-esteem. However, it acknowledges that there is a lack of long-term safety and efficacy evidence for these procedures. It also mentions the importance of proper training for gynaecologists to identify women with sexual dysfunction and psychological disorders.

Conclusion

Aesthetic gynaecology has a significant impact on women's sexual quality of life. Despite concerns about long-term safety and efficacy, the benefits and importance of aesthetic gynaecology procedures are emphasized. However, further research is needed to establish standard nomenclature and protocols in the field.

P 10.8

MANAGEMENT OF STILL BIRTH

Anjuli Dixit

Background & Objectives:

Stillbirth-Baby delivered with no signs of life non to died after 20 weeks of pregnancy. IUF Intra uterine fotel death-Baby with no sign life in uterus. The world health organization uses the ICD-10 definitions and recommends that any baby born without sings of life at greater than oe equal to 28 completed weeks' gestation be classified as a stillbirth. The WHO uses the ICD-10 definitions of "late fetal deaths" as their definition of stillbirth.

Materials & Methods

Sonography-Earliest diagnosis is possible with sonography. The evidences are: (a) Lack of all fetal motions (including cardiac) during a 10 10 minute period of careful observation with a real-time sonar is a strong presumptive evidence of fetal death. (b) Gradually, obligohydramnios and collapsed cranial bones are evident.

Results

It's important not to miss any of your antenatal appointments. Some of the tests and measurements that can identify potential problems have to be done at specific times. Go to all your antenatal appointments and scans. These are designed to spot problems early so that anything that is spotted can be treated early before. Go to all your antenatal appointments and scans so midwives can check your baby's growth and development. They'll also test for signs of conditions that can effect mums, such as pre-eclampsia, which have been associated with stillbirth. Start taking folic acid before conception to reduce the chance of spina bifida. This should be continued for the first trimester. Vitamin D supplements are recommended for the whole duration of your pregnancy. Your midwife or obstetrician can advise on the specific dose based on your individual needs.

Conclusion

Before 28 weeks of pregnancy- The use of misoprostol at a dosage of 200 micrograms every 6 hours in women with a previous uterine scar. After 28 weeks of pregnancy- Women with a previous hysteroscopy and fetal demise after 28 weeks of gestation should undergo induction of labor per standard obstetric protocols for trail of labor after caesarean. Waiting a certain amount of time from six months to one year before trying to conceive again.

P 10.9

ASSESSMENT OF THE ASSOCIATION BETWEEN FETOMATERNAL OUTCOME WITH PLACENTAL LOCATION

Kante Durga Mounika

Background & Objectives:

Placenta is the vital organ which connects fetus to the uterine wall. Nutritive, respiratory, metabolic, endocrine and excretory functions of the fetus are carried out through the placenta. Based on location, it can be classified as anterior, posterior, lateral, fundal and low lying. Placental location can be easily determined in the antenatal period using ultrasound.

Materials & Methods

After informed consent, 50 women with singleton pregnancy of e"28 weeks attending antenatal OPD were included in this retrospective study. Women were followed up with ultrasound at 28 weeks and 34 weeks to identify any maternal and fetal adverse effects such as gestational hypertension, preeclampsia, preterm birth and NICU admission.

Results

Among the 50 women, 38% (n=19) of placenta were situated in fundus, 26% (n=13) were anterior, 20% (n=10) were lateral, 10% (n=5) were posterior and 6% (n=3) were low lying. Gestational hypertension was present in 30%, 15.4%, 20% in lateral, anterior and posterior placental location respectively. Preeclampsia was seen in 20% in lateral placental location. Preterm labour, low birth weight were most common in lateral placental location (40% and 50% respectively); NICU admission was highest in posterior placental location (40%).

Conclusion

Statistically significant association was found between placental location and adverse maternal and fetal outcomes. Ultrasound can be utilized as a non-invasive, safe, and cost-effective method to predict unfavourable maternal and fetal outcomes.

P 10.10

ASSESSMENT OF THE USE OF COMBINATION OF VAGINAL DINOPROSTONE GEL (PGE2) AND VAGINAL MISOPROSTOL (PGE1) IN SECOND TRIMESTER TERMINATION OF PREGNANCY

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Background & Objectives:

The failure rate and time interval for induction abortions are decreased when dinoprostone gel (PGE2) is added to the conventional regimen of second trimester abortion using vaginal misoprostol (PGE1). In women who were having second trimester abortions, we assessed the function and effectiveness of vaginal dinoprostone gel in combination with vaginal misoprostol. The purpose of the current study was to evaluate the efficacy and safety of vaginal misoprostol combined with vaginal dinoprostone gel for pregnancy termination in the second trimester.

Materials & Methods

This retrospective study included 50 women with 12-20 weeks gestation requesting termination of pregnancy. In study group 0.5mg dinoprostone gel applied vaginally followed by 400µg misoprostol every four hourly (max 3 doses) after six hours of dinoprostone gel application. The mean age of the women study was 29.6 years and mean gestational age was 19.2 weeks. Efficacy of the treatment to terminate pregnancy was primarily observed at 16 and 20 hours. Induction abortion interval, failure rate and side effects were also evaluated.

Results

Majority of the women (78%) aborted between 12 and 14 hours, while 96% aborted within 16 hours and at 20 hours, the complete abortion rate was 100%. The mean induction abortion interval was 13.73±2.41 hours. There is no significant association was found between gestational age and induction abortion interval (P>0.5). No major drug related side effects were observed in the study population

Conclusion

Misoprostol (PGE1) and vaginal dinoprostone gel (PGE2) combination is a potent, secure, and reliable alternative approach for ending a pregnancy in the second trimester. Compared to other methods of second trimester pregnancy termination, the induction to abortion interval time in this technique is shorter.

P 11.1

DIAGNOSTIC DILEMMA: A CASE REPORT OF OVARIAN LIGAMENT ADENOMYOMA MIMICKING CARCINOMA OVARY

Mrinalini Dhakate

Introduction

Extrauterine adenomyosis is the presence of adenomyotic tissue outside uterus. It is extremely rare condition with less than 100 cases reported. Here we present a case of young woman with a right ovarian ligament adenomyoma. To the best of our knowledge only five cases of ovarian ligament adenomyoma are reported until 2023.

Case Report

A 22-year-old, unmarried female presented in out-patient department with complaints of gradually progressing right lower abdominal pain for past 1 year. Her menstrual cycles were regular but associated with severe dysmenorrhea for last 6 months. Clinical examination revealed a fixed, firm and non-tender abdomino-pelvic mass corresponding to 18 weeks gravid uterus size with smooth surface. Contrast-enhanced computed tomography of abdomen and pelvis showed 12.5x11x9cm multi-loculated solid-cystic mass arising from right adnexa favouring broad ligament fibroid. Tumour markers were within normal biochemical range. After thorough evaluation and discussion, she underwent surgical exploration. Under laparoscopic guidance, 10 x 8cm irregular and highly vascular mass arising from right ovarian ligament was identified. In view of suspicion of malignancy, laparoscopy was converted to laparotomy. She underwent peritoneal wash cytology and right salpingo-oophorectomy. Intra-operative frozen section revealed benign spindle cell tumour. Final histopathology report was adenomyoma. The patient is asymptomatic and without recurrence at the end of 3 years post-surgery.

Clinical Relevance

Possibility of extra-uterine adenomyoma may be kept as differential diagnosis of an adnexal mass. Pre-operative diagnosis is often difficult and definitive diagnosis can be made only after histological examination. Surgery is the main stay of the treatment.

P 11.2

PRESENTATION OF SCAR ECTOPIC PREGNANCY IN TERTIARY CARE CENTER

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Introduction

Scar ectopic pregnancy is a pregnancy that is implanted on or in scar from a prior cesarean scar/hysterotomy scar/myomectomy scar with incidence of 1 in 2000. Patients usually present with vaginal bleeding or abdominal pain, but 33% remain asymptomatic. These pregnancies are usually diagnosed in the first trimester on transvaginal sonography. They mimic cervico-isthmic implantation and expelling abortus. They are seen associated with placenta accreta syndrome (42%), uterine rupture or dehiscence(5%), preterm delivery, hemorrhage, and need for hysterectomy(60%).Management modalities include- expectant, medical and surgical approach .Surgical approach is preferred mostly. Recurrence rate is approximately 4 in 10 .

Case Report

32 year G3P2L2 at 6 weeks 2 days of gestation with previous 2 LSCS presented with complaint of bleeding per vagina. Transvaginal ultrasonography done and it was suggestive of live scar site pregnancy with CRL 6 weeks 1 day at lower uterine segment in anterior segment. Patient was managed successfully by uterine artery embolization followed by suction evacuation.

Clinical Relevance

Early diagnosis and its prompt management ensures good prognosis. Cesarean scar ectopic rates are increasing as the rate of cesarean sections are increasing. It should be done only for indicated cases and it will eventually decrease the rate of cesarean scar ectopic.

P 11.3

DIDELPHYS UTERUS IN PREGNANCY AN UNCOMMON MULLERIAN DUCT ANOMALY

Senaga Umadevi

Introduction

Mullerian duct anomalies are spectrum of congenital defects arising from failure of fusion of mullerian ducts at 12-16 weeks embryologic development. MDA range between 0.5-5% of the general population. DIDELPHYS uterus is rare mullerian abnormality it may associated with congenital abnormalities and pregnancy and non pregnancy related complications

Case Report

21 year old primigravida with 39+6 days POG came with complaint of pain abdomen .20 weeks ultrasound shows didelphys uterus which is incidental finding. Onper speculum examination she has two cervix with vaginal septum. Right Cervix is soft, mid position,4 cm long. left os is noted posterior and high up.

Clinical Relevance

Didelphys uterus is uncommon mullerian ducts anamolies comes under class 3 ASMR classification accounting for approximately 5% cases .It is often asymptomatic or may be associated with pregnancy and non-pregnancy related problems.It may be diagnosed with menarche as dysmenorrhea or onset of sexual activity as dyspareunia .Incidence of vaginal septum association is 70% .Herlyn wunderlich syndrome is another MDA variant characterized by uterine didelphys, obstructing hemivagina, ipsilateral renal agenesis case of pregnancy increased rate of infertility associated with didelphys uterus. Also associated with 33%miscarriage rate and 30% preterm delivery rate also associated with Fetal growth restriction.

P 11.4

FROM PELVIS TO PECULIAR: A RARE ENCOUNTER OF ENDOMETRIOMA AS A CHEST WALL MASS

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Introduction

Hereby we present a rare case of extra pelvic chest wall endometrioma

Case Report

The clinical history and imaging directed towards diagnosis and the final confirmation was done by histopathology

Clinical Relevance

A relevant clinical history and unique nature of this presentation emphasizes to consider this condition while evaluation of masses at atypical location.

P 11.5

UNUSUAL CASE OF PLACENTA PERCRETA IN A SECOND TRIMESTER ABORTION

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AIIMS NEW DELHI

Introduction

A young reproductive age female with continued bleeding per vaginum in the background of amenorrhea can be due to various obstetrical and gynaecological causes. A holistic approach should be used while dealing with such cases. Here we report a rare case of a young female with a similar presentation having placenta accreta syndrome which was initially misdiagnosed as invasive mole.

Case Report

A 26 year old G4P1L1A2 female with previous 1 caesarean section was referred to AIIMS with a presumed diagnosis of an invasive mole on USG . She had history of 4 months amenorrhea followed by on and off spotting per vaginum since 2 months. Serum beta HCG levels at presentation was 1244 mIU/mL. Further imaging along with falling trends of beta HCG suggested a diagnosis of placenta accreta syndrome secondary to a scar ectopic pregnancy. During the course of hospital admission, she complained of acute abdominal pain for which she was taken for emergency hysterectomy with a suspicion of impending uterine rupture. Intraoperatively, placenta at previous LSCS scar site was seen bulging through the serosa and adherent to urinary bladder. This diagnosis was further confirmed on histopathological examination.

Clinical Relevance

Diagnosing second trimester PAS disorders is challenging. A high index of suspicion must be kept based on a relatively lower position of gestational sac in the first trimester and the position of the gestational sac close to uterine scar. In the second trimester, a history of previous caesarean with a low lying placenta should prompt evaluation for PAS.

P 11.6

CO-EXISTING BLADDER DIVERTICULUM WITH CYSTOCELE IN A CASE OF PELVIC ORGAN PROLAPSE - A RARE CASE REPORT

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Introduction

Bladder diverticula are protrusions of bladder urothelium and mucosa through muscularis propria of bladder wall. They are uncommon in females with incidence of 0.2%. We report a rare case of bladder diverticulum co-existing with cystocele in a patient of pelvic organ prolapse.

Case Report

A 56 year old post menopausal female reported to our OPD with pelvic organ prolapse associated with lower urinary tract symptoms. Pelvic examination revealed a POP - Q stage 3 UV descent, 3 + cystocele, 1+ rectocele. USG whole abdomen showed a urinary bladder diverticulum of size 1.9x1.8 cm in right inferior lateral wall. Patient underwent cystoscopy which confirmed 2 bladder diverticula. Uroflowmetry showed pre moderate obstruction. Vaginal hysterectomy with cystocele repair was performed with careful bladder dissection avoiding injury to diverticula. Catheter removal done on Day - 5. Post-operative period went uneventful.

Clinical Relevance

Bladder diverticulum should be differential diagnosis for cystocele. Awareness of this entity can prevent bladder injury during anterior repair in vaginal prolapse .

P 11.7

UNUSUAL CAUSE OF HEAVY MENSTRUAL BLEEDING IN A YOUNG FEMALE

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Introduction

Heavy menstrual bleeding (HMB) is defined as monthly bleeding which lasts more than 7 days or needs changing pad one hourly or the one which disrupts the normal routine. Among the many causes of HMB, fibroids uteri is also a cause. Submucous fibroid polyp are one of the most common causes of intermenstrual bleeding. They involve pressure symptoms also. Cervical fibroid polyp are fibroid with their origin within the cervix and having a stalk. Giant cervical fibroid polyp is described as a polyp greater than 4 cm in size and is rarely seen in clinical practice The size and clinical presentation mimic neoplasia. They are one of the most common causes of intermenstrual vaginal bleeding. They involve pressure symptoms also. The sparse literature available suggests rates of 0.0 – 1.7% malignant change in cervical polyp. The incidence of cervical fibroid polyp is about 4 to 10% of all cervical lesions.

Case Report

We hereby discuss a case of 25 year old (P3L3) multigravida woman with previous Normal vaginal Delivery presented with 9 months history of Abnormal uterine bleeding with difficulty in passing urine. On Bimanual examination the vagina was completely obliterated with a large growth and uterus could not be felt. However ,on Ultrasonography the diagnosis of a large cervical fibroid polyp with small pedicle and a separately seen uterus was made. The patient was managed successfully by vaginal myomectomy

Clinical Relevance

Careful history, Examination and Relevant Investigation can help in accurate diagnosis and successful management in cases of Giant Cervical fibroid polyp.

P 11.8

MANAGEMENT OF TUBAL ECTOPIC WITH HIGH BETA HCG: A CASE REPORT

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Introduction

The incidence of ectopic pregnancies in India is 0.91% out of which tubal ectopic is most common (95%). Ectopic pregnancy is an obstetric emergency. If the diagnosis is missed it can lead to rapid hemodynamic compromise and maternal morbidity and mortality.

Case Report

Mrs. A, a 30 year old G6P1L1A4, lady presented to the emergency department with chief complaints of pain in lower abdomen with spotting per vaginum. Her last menstrual period was 2 months back. She was married for 7 years and had a female child of 5 years delivered vaginally followed by 4 induced abortions. There was no other significant medical or surgical history other than mentioned above. On physical examination, general condition of the patient was fair. Vitals were stable with BP 124/76 and pulse rate 96 beats per minute. Systemic examination revealed no significant abnormality. On abdominal examination there was mild tenderness in the right lower quadrant. Bimanual examination revealed a normal size uterus with ill-defined mass in the right fornix, tender on palpation. There was no cervical motion tenderness. Her hemoglobin was 10gm/dl, liver function tests were within normal limits. Transvaginal sonography revealed a mixed echogenic SOL of 28*28 mm with gestational sac of 5.6*4.1 mm with no cardiac activity in the right adnexa. Both ovaries were normal and there was no fluid in th pouch of Douglas. Serum beta hcg was 27000 mIU. Since the size of the gestational sac was small and there was no cardiac activity, patient was treated with injection methotrexate 50 mg im single dose. D4 and D7 beta hcg values were 22000 mIU and 20000mIU respectively. Since the fall was more than 15% patient was observed for the following week. After 1 week the beta HCG came down to 5000. Within 2 months the beta HCG reached the pre pregnancy value.

Clinical Relevance

The risk factors for ectopic pregnancy include, previous history of ectopic pregnancy, pelvic inflammatory diseases, tubal blockage, infertility, progesterone containing contraceptives, multiple miscarriages, smoking and multiparity. In this case recurrent abortions was a high risk factor. The indications for medical management of ectopic pregnancy include, i) stable patient ii) absence of cardiac activity in g-sac iii) size of g-sac less than 4 cm (no CA), less than 3 cm (if CA +). iv) beta HCG value less than 5000mIU v) no contraindications to methotrexate In this case all the criteria were met except the beta hcg value. Medical management was successful in this case probably because of small g-sac size. Ectopic pregnancy requires high index of suspicion for diagnosis when patients present with triad of symptoms and should be managed promptly under strict monitoring for vitals.

P 11.9

SPONTANEOUS RUPTURE OF BLADDER IN POSTPARTUM PHASE: A CATASTROPHIC LIFE-THREATENING EVENTS

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Introduction

Bladder rupture during labour or postpartum is a very rare condition. Predisposing factors are increased visceral pressure, weakening of the bladder. Presenting symptoms can be suprapubic pain, anuria, and haematuria. Diagnosing bladder rupture is quiet difficult, even by the means of diagnostic modalities such as CT scan. Surgery is the treatment of choice and consists of urine drainage from the peritoneal cavity and closing of the rupture.

Case Report

A 35-year-old woman P3L3 day 09 of Normal vaginal Delivery, presented to the emergency department with the chief complains of pain abdomen, vomiting, non-passage of urine and abdominal distension for 1 week. On examination patient was having tachycardia, and on per abdomen examination there was uniform distension and tenderness. Patient's KFT was deranged, and TLC was raised. On USG there was gross free fluid with echoes within peritoneal cavity. Impression was bladder rupture with urinary peritonitis. Patient underwent laparotomy. Intra-op there was bladder rupture at 2 sites and 7 liters of urine in the abdominal cavity. Rupture was repaired and foleys catheter and retro vesical drain was inserted. Post-operative phase was uneventful.

Clinical Relevance

New onset ascites, oliguria/anuria, deranged KFT in a post-partum patient with uneventful immediate post-partum phase should raise a doubt of bladder rupture. It is a preventable condition. Early diagnosis and surgical treatment is important and reduces morbidity and mortality in such cases.

P 12.1

UNICORNUATE UTERUS WITH FUNCTIONAL RUDIMENTARY HORN: A RARE PRESENTATION

Dimple Yadav

Introduction

Congenital uterine anomalies are an uncommon type of female genital malformation caused by abnormal development of mullerian ducts during embryogenesis. Overall prevalence of congenital uterine anomalies is 5.5% with unicornuate uterus accounting for 0.1%. The clinical spectrum of unicornuate uterus can vary from asymptomatic and incidental finding to complex reproductive pathology often leading to subfertility and miscarriages. Owing to wide variety of presentations, this clinical condition remains an interesting field of study with regard to its diagnosis and management.

Case Report

A 15 years old unmarried female presented with sudden onset severe abdominal pain for 1 day after menses and vague lower abdominal pain for 1 year with similar sudden onset cyclical pain each month after menarche. On abdominal examination, tenderness present on deep palpation. On per rectal examination, uterus deviated to right side, on left side, a mass of 3*4 cm felt with right fornix fullness. Ultrasonography revealed presence of unicornuate uterus with left sided hydrosalpinx and endometrioma with absence of right kidney. Magnetic Resonance Imaging of pelvis confirmed the same findings. Exploratory laparotomy with left rudimentary horn excision and left salpingectomy was done. Intraoperatively, left non communicating horn of 5*5 cm with left fallopian tube was removed. Post-operative period was uneventful .

Clinical Relevance

Congenital uterine anomalies result from failure of fusion, abnormal development or incomplete reabsorption of mullerian ducts. Patients with unicornuate uterus present with hematometra, hematosalpinx, endometriosis, dysmenorrhea, chronic pelvic pain and primary infertility as well as obstetric complications like miscarriages, ectopic pregnancies , rupture of uterus. MRI was performed on this patient. Unicornuate uterus is often associated with renal anomalies occurring in 40% of cases with renal agenesis most common, which was present in our patient. A case of rudimentary uterus is clinically misleading and therefore an appropriate diagnostic method is needed for prompt diagnosis. Ultrasonography and Magnetic Resonance Imaging can provide a definitive diagnosis.

P 12.2

SUCCESSFUL OUTCOME OF UTERINE TORSION WITH FIBROID IN PREGNANCY

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Introduction

Torsion of fibroid is an uncommon and infrequent finding with full term pregnancy but pathological rotation of uterus beyond 45 is a rare finding and could be a life threatening complication of pregnancy in third trimester with adverse maternal and neonatal consequence.

Case Report

A 32 years old, married nulliparous female presented in gynaecology OPD with huge leiomyoma corresponding to 28 weeks gravid uterus planned for myomectomy and diagnosed pregnant incidentally. Ultrasound revealed large heterogeneously hypoechoic lesion of size 14 x13 cm arising from posterior myometrium, and gestational sac could not be localized due to fibroid. The rising trend of beta HCG suggested intrauterine pregnancy. At 28 weeks POG, the size of fibroid increased to 28 x 14cm. At 36 weeks of POG, she had acute pain abdomen. On P/A, the fibroid was felt on the left side and the fetal parts on the right side, transverse lie, FHR 150/min with mild uterine contractions. 0n P/V cervix was closed, soft cervical os with high presenting part. Emergency caesarean section was performed in view of transverse lie in labour under general anaesthesia. Intraoperatively one sided cornual structures were found in the midline. The uterus was torted 180 degrees and a 30 x 20 cm huge fibroid was seen over the right fundoposterior region. Caesarean myomectomy was performed considering chances of re-laparotomy. 25x 15 cm leiomyoma was resected and was confirmed histopathologically.

Clinical Relevance

Myomectomy during caesarean section is debatable procedure because of post partum haemorrhage, bladder injury, anemia, post op risk of thromboembolism and increased risk of perioperative morbidity. The decision to perform a myomectomy during a C-section is made based on the individual circumstances of each case, taking into consideration the size, location, and number of fibroids, as well as the overall health of the mother and the well-being of the baby. Caesarean myomectomy can be done with presence of fully functionalized blood bank center, experienced obstetrician team and availability of multidisciplinary team.

P 12.3

SCHWANNOMA MASQUERADING AS TRUE BROAD LIGAMENT FIBROID

Nikhil Ritolia

Introduction

Schwannomas are benign tumours of the schwann cells of the neural sheath. They have been rarely reported in the retroperitoneum (0.2%). We present a rare case of benign large schwannoma successfully removed laparoscopically as suspected true broad ligament fibroid.

Case Report

Our patient was 32 years parous lady admitted with acute retention of urine and abdominal heaviness since 2-3 months. A large abdominopelvic mass was felt extending from pelvis till just above umbilicus, firm to cystic in consistency, non-tender with restricted mobility. P/V: Uterus was MPS, towards left, with restricted mobility and a large cystic mass was felt in right fornix. CA125 was high (114) . USG & CE-MRI pelvis revealed large fibroid (12*14 cm) with cystic areas, indenting bladder lumen with? myxoid degeneration displacing uterus to left. Differential diagnosis of Rt adnexal mass ? Broad ligament fibroid with degeneration?? Ovarian(benign) neoplasm were made. After adequate counselling and consents, a Laparoscopy was done; a 12 x 15 cm true broad ligament fibroid partially cystic in consistency with degenerative changes was seen extending upto right deep inguinal ring laterally, superiorly till above IP ligament (ligament stretched over it) and inferiorly till cervix obliterating left ovarian fossa . Meticulous enucleation of the mass was done after dissecting in between the leaves of broad ligament (after identifying and separating the ureter). Fibroid was removed in endo-bag and sent for HPE. The patient had an uneventful post operative recovery.

Clinical Relevance

HPE : whorled appearance and spindle cells with nuclear palisading and focal verruca body like arrangement with areas of myxoid change and focal hyalinisation. On IHC it was diffusely positive for desmin and negative for S-100. Conclusion: Some solitary nerve sheath tumours in pelvic retroperitoneum have been infrequently reported. Our case of large benign schwannoma presenting as a true broad ligament fibroid with acute retention of urine and managed well laparoscopically is very rare.

P 12.4

SCAR ENDOMETRIOSIS MISSED DIAGNOSED AS FIBROID UTERUS

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Introduction

Subcutaneous endometriosis near the cesarean delivery scar is rare form of extrapelvic endometriosis.

Case Report

A 38 years old P2L2A1 with H/o hysterotomy done 7 years back came with complaint of pain lower abdomen with dysmenorrhea. She was referred to Chronic Pelvic Pain Clinic with TVS confirmed anterior wall fibroid uterus adherent to the anterior abdominal wall scar. It was only on detailed history taking in the pain clinic she revealed the pain to be aggravating during menses and continuing for 10 days. On examination a transverse lower abdominal wall scar of previous hysterotomy was present. The scar was hypertrophied and puckered with mild tenderness, no mass was identified. On per vaginal examination uterus was anteverted with a tender mass on the anterior wall of the uterus seemed to be arising from the uterus and adherent to the anterior abdominal wall. Bilateral fornices were free. A transabdominal ultrasound showed a 6.7x2.7 cm anterior abdominal wall mass, rectus sheath posterior to mass was intact with a point of breech at midline. She underwent wide local excision of the mass followed by abdominal wall component separation and mesh repair. The post operative period was uneventful and no recurrence occurred in the 4 months follow up period.

Clinical Relevance

Careful history and examination are important for suspecting scar endometriosis. Transabdominal ultrasound should be done before transvaginal ultrasound. Conclusion: Pain at abdominal scar site warrants detailed history and examination. The diagnosis of scar endometriosis can be confirmed by imaging and aspiration cytology/biopsy.

P 12.5

UNUSUAL SURGICAL INTERVENTION IN PREGNANCY

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Introduction

Small bowel obstruction (SBO) in pregnancy is rare entity with an incidence of 0.001–0.003% and it is secondary to adhesions in around 70% of cases. The risk of intestinal torsion is higher in II and III trimester in most cases. The delay in diagnosis is due to non-specific symptoms and disinclination towards carrying out radiologic investigations in pregnancy.

Case Report

A 28years old G2E1 female at 29week of period of gestation presented in SJH gynae casualty with chief complaints of pain abdomen, colicky in nature with multiple episodes of non- projectile, bilious vomiting with non-passage of flatus and stools for 6 days and past history of abdominal surgery. There was no associated history of fever /worms in stools/ pica. On examination, patient was vitally stable with per abdominal tenderness present in upper abdominal region with no guarding and rigidity. Bowel sounds were absent. Uterine fundal height was corresponding to period of gestation with regular fetal heart rate. On digital rectal examination, rectum appeared to-be collapsed. Several investigations and blood workups were carried out. Severe colicky pain did not subside even after antibiotic therapy. Ultrasound revealed multiple dilated small bowel loops with sluggish to and fro peristalsis suggestive of sub-acute small bowel obstruction and s single live fetus. Surgical consultation was done and was taken up for emergency exploratory laparotomy in view of non-resolving acute intestinal obstruction. Per op finding showed constriction band in small bowel with serosal tears and adhesions with parietal peritoneum. Adhesiolysis with bowel loops decompression done along with continuous monitoring of foetus. Patient was kept under observation postoperatively showing slow but steady recovery. Later, patient delivered a healthy baby vaginally at term gestation. Definitive diagnosis of subacute intestinal obstruction (SAIO) was made in this case.

Clinical Relevance

Intestinal obstruction in pregnancy is a rare event, requires a high index of clinical suspicion for diagnosis. Small bowel obstruction may require expeditious surgery as it is associated with significant maternal and fetal mortality

P 12.6

PROPHYLACTIC LAPOROSCOPIC BILATERAL GONADECTOMY IN TURNER FEMALES WITH Y MOSAICISM

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Introduction

Turner syndrome is diagnosed in females based on clinical presentation combined with a genotype consisting of one normal X chromosome and complete or partial absence of the other X chromosome. Women having a Y line in the karyotype differ in their phenotype and risks, vis-à-vis women with a XX/ XO mosaic. We discuss the clinical picture and management of one such young girl with a Y line Turner's mosaic.

Case Report

A 17 years old girl was referred from endocrine OPD with a diagnosis of Turner syndrome (TS). The patient first visited our hospital with short stature {127cm) at 13 years age when she was worked-up and karyotyping showed 45 XO/ 46 XY karyotype. She was started on cyclic E+P and had withdrawal bleeding. Currently, she was 137cm tall and weighed 38.6 kg with a BMI of 20.6. Both breast development and pubic hair were Tanner stage 3. Despite short stature, she did not exhibit any of the classic characteristics of TS such as scoliosis, high palate, webbed neck, shield chest etc. Systemic and abdominal examination were normal and vaginal orifice was present but no clitoromegaly, imperforate hymen or inguinal mass. Estrogen was stopped 1 month prior to planned surgery. USG suggested of small uterus with endometrial thickness 3-4 mm and b/l ovaries were not clearly visualized. Laparoscopic prophylactic b/l gonadectomy was performed. HPE report showed gonadal dysgenesis but no evidence of malignancy. The postoperative course was good and patient was put on hormone replacement therapy after 3-4weeks.

Clinical Relevance

45,XO/46,XY genotype accounts for approximately 10-12% of cases of TS. Women with TS with Y chromosome material have an increased risk of germ cell tumors like gonado-blastoma and dysgerminoma. Being aware of the subtle phenotype and this risk can help clinicians manage these cases better.

P12. 7

DIVERSE PRESENTATION OF OVARIAN TORSION

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Introduction

Ovarian torsion is caused by twisting of the ovary around the infundibulopelvic ligament and/or the utero-ovarian ligament resulting in partial or complete obstruction of its blood supply. Ovarian torsion is an emergency gynecologic condition seen in women of all ages and typically presents with an abrupt onset of pelvic pain but here we are reporting two cases with diverse clinical presentation.

Case Report

Case-1 was a 33-year-old female who presented to GOPD with recurrent lower abdominal pain on and off since 4 years. Pain was acute in onset with moderate intensity and managed on oral analgesic. Her imaging was suggestive of bilateral complete ovarian torsion with edematous ovaries. Laparoscopic ovarian detorsion and utero-ovarian ligament plication was done. Case-2 was a 21-year-old female who presented in emergency with acute pain abdomen since one day. USG was suggestive of left ovarian cyst with no evidence of torsion. Patient was taken for laparoscopy, intraoperatively, left tube and ovary were doubly torted. Detorsion was done, following which changes in colour of ovary was noted. To prevent future risk of torsion, left ovarian ligament plication was done.

Clinical Relevance

Abdominal pain is reported in majority of patients with ovarian torsion, but the characteristic of the pain is variable. The diagnosis of ovarian torsion is challenging as the imaging yields low sensitivity and specificity. Hence decision of surgery should be based on clinical judgement with high index of suspicion.

P12. 8

LOWER UTERINE SEGMENT AND CERVICAL ARTERIOVENOUS MALFORMATION FOLLOWING SURGICAL ABORTIONS COMPLICATING PREGNANCY –A RARE CASE REPORT

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Introduction

Uterine arteriovenous malformations (UAVM) is a rare condition that to asymptomatic presentation in pregnancy is very rare with abnormal connections between uterine arteries and veins, it is a potentially life threatening condition. AVMs are classified as congenital and acquired types. Acquired uterine arteriovenous malformations are usually traumatic, due to dilatation and curettage (D&C), therapeutic abortions, uterine surgeries or direct uterine trauma. There are very few cases reported of AVM in pregnancy. We found only one case of cervical A V malformation in pregnancy. We present one such rare case of lower uterine segment and cervical AVM due to previous surgical abortion with successful outcome.

Case Report

A 35 year old G7P1L1A5 women, with 32 weeks of gestation with previous pre term classical cesarean section due to uterine arteriovenous malformation was admitted from OPD. The patient had history of 4 evacuation and curettage over a span of 5 years from 2013 to 2018, She conceived immediately within 6 months and was incidentally diagnosed with lower uterine segment A V malformation with ultrasound Doppler and she was taken up for elective pre term classical cesarean section at 35 weeks of gestation in July 2019. In current pregnancy, USG Doppler done, cervical and lower uterine segment A V malformation confirmed. And underwent emergency classical pre term cesarean section at 33 weeks of gestation due to previous pre term classical CS with lower segment and cervical AVM in labor. Intra operatively multiple vessels (sinuses) seen in LUS, with no post-operative complications.

Clinical Relevance

Discussion: Most cases of Uterine AVM reported in literature present as secondary PPH in post-partum period post LSCS. Sung mee kim et al in 2013 reported a case about a primi at 32 weeks incidentally diagnosed with cervical AVM following which she was taken for emergency pre term classical cesarean section at 34 weeks of gestation due to bleeding, intra operatively multiple venous sinuses near to endocervix and lower uterine segment seen which were directly ligated with bilateral uterine artery ligation. Our patient had multiple surgical abortions and following which no investigation done and patient became pregnant within 1 year. Patient underwent classical cesarean section twice due to LUS and cervical AVM which seems to be occurred due to surgical abortion. If Doppler would have been done after vaginal bleeding, could have diagnosed LUS and cervical AVM and could have managed accordingly. Conclusion: Lower uterine segment and cervical AVM in pregnancy with asymptomatic presentation is a very rare case and this is the second case reported that we have found in literature. As Doppler ultrasound have advanced more and become common place, cases of AVM are more easily diagnosed and can prevent excessive hemorrhage and potentially life threatening complications due to earlier recognition and management accordingly.

P 12. 9

UTERINE ARTERY EMBOLIZATION IN POST OPERATIVE HEMORRHAGE AFTER MYOMECTOMY

D. Gamana Sri

Introduction

Uterine artery embolization (UAE) is to occlude arterial supply to uterus. It aims to treat the bleeding rapidly without resorting to surgical removal of uterus. UAE can be used in treatment of Uterine intramural fibroid, Adenomyosis ,Heavy menstrual hemorrhage, dysmenorrhoea, uterine AV malformations, ectopic pregnancies like interstitial, cervical, abdominal, scar ectopic pregnancies and Postpartum hemorrhage.

Case Report

A 30 year old P1L1 female presented gynaecology OPD with complaints of Heavy menstrual bleeding from 2 years, associated with soakage of 10 pads per day, no dysmenorrhea. On TAS+TVS: Uterus enlarged, intramural, heterogenous hypoechoic fibroid 66x58 mm in fundo posterior myometrium causing displacement and compression of overlying endometrium, B/L ovaries normal. On MRI Pelvis - Enlarged uterus with large intramural fibroid from fundal wall. Patient is planned for Myomectomy. Myomectomy is done for this patient. Per-operative findings are Uterus corresponding 18 wks size, smooth surface, globular with posterior fibroid. Uterus is opened on posterior surface and intramural fibroid size 7x7 cms removed after dissection from uterine wall by myoma screw. Uterus closed in layers. Abdominal drain inserted. Hemostasis achieved with difficulty. After 24hrs, Abdominal drain output - 650 ml blood. Hemodynamic vitals were stable. Decision was taken for Laparotomy with consent for Hysterectomy. Alternative option is UAE as patient was vitally stable and P1L1.Decision for UAE taken. Opinion taken from Interventional Radiology : Radiologist performed CT Angiogram showed increased vascularity over posterior surface of uterus.No leakage from blood vessel. Mild collection around drain site . UAE done on bilateral uterine arteries.UAE Findings are Vascular blush noted bilaterally . No AV Malformation. .Embolisation done with gel foam. During post procedure, Abdominal drain output-50 ml. Patient discharged on Day 5. On extensive search, many articles are on treatment of fibroid. No article on UAE in post myomectomy complications.

Clinical Relevance

UAE is effective method for treatment of postoperative hemorrhage following myomectomy.

P 12.10

AN INTERESTING CASE OF IVF CONCEIVED UNILATERAL TRIPLE ECTOPIC PREGNANCY

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Introduction

The incidence of ectopic pregnancies have increased after ARTs. Ectopic-pregnancy complicates 2-11% of all pregnancies after IVF- treatment. Only 8 cases of unilateral-ectopic-gestations have been documented . Here we report a rare case of unilateral-triplet-ectopic-gestation which was safely managed surgically.

Case Report

A 28-year-old Primigravida who underwent IVF-Treatment for Primary-infertility presented to our emergency department with lower abdominal pain with a past H/o appendicectomy and ovarian-cystectomy . Early TVS revealed a triple-pregnancy in the left fallopian-tube (Two at interstitial, one at ampullary location) Her B-HCG was 12,416IU. TVS done showed three g-sacs: one in left interstitium ~11mm, one in isthmus of the fallopian-tube ~10mm near the interstitial region with cardiac-activity , and one in ampulla ~9mm near left ovary with cardiac-activity . Color-Doppler revealed peri-trophoblastic blood flow around the g-sacs with live embryos. Due to decrease in HB and every possibility of tubal-rupture, decision for surgery was taken. To prevent high risk due to laparoscopy, laparotomy was performed which revealed a hemoperitoneum~ 500mL, an enlarged interstitial-isthmic part of the left-fallopian-tube, a wider ampullary part adherent to the posterior-wall of the uterus and left ovary due to disturbed anatomy . After adhesiolysis interstitial part was resected and left-salpingectomy done,. HPE revealed left-interstitial and ampullary multiple-EP.

Clinical Relevance

Our approach to this patient with an early diagnosed triplet-ectopic-pregnancy was surgical as cardiac-activity was present. As hemoglobin and hematocrit levels decreased we performed laparotomy with removal of the left tube and cornual part of the uterus. Our case represents a very rare condition, a unilateral-triplet-EP after IVF–ET . So early ultrasound examinations are important to identify EPs at an early stage when medical management is feasible. Strict monitoring is necessary to identify the success of medical intervention or the need for surgery.

P 13.1

TAKAYASU IN PREGNANCY

Anshul Bhartiyam

Introduction

Takayasu arteritis is a large vessel vasculitis usually seen in women with reproductive age group. It is often associated with risk of cardiovascular complications. Here, I am presenting the case of pregnant female who presented with hemiparesis and later diagnosed as takayasu arteritis.

Case Report

A 30y old, G3P2L2, previous 2 LSCS, referred to department of obs and gynae with 8 months of amenorrhea and right sided residual hemiparesis. On examination, pt had right sided weakness with left sided radial and brachial pulses not palpable and difference of more than 20mm Hg in both arms thus scoring 5 as per ACR Criteria and suspicion of takayasu arteritis made but due to pregnancy CT aortogram postponed till after delivery for confirmatory diagnosis. Meanwhile pt was kept on regular BP monitoring and BPP done for fetal wellbeing. After cardio and neurology opinion, elective LSCS done at 38 weeks. In post op period, bilateral CT aortogram done and diagnosis confirmed and started on prednisolone after cardiac consultant.

Clinical Relevance

Takayasu is a chronic inflammatory disease that involves aorta and it's branches with incidence higher in women with reproductive age group and Asians. Symptoms range from mild fever to as severe as stroke, CAD. Pregnancy is usually advised after disease is controlled and BP is stable. It's reported that there are no exacerbating effects of pregnancy on takayasu and multidisciplinary care for pt is important for favourable maternal and fetal outcome.

P 13.2

MANAGEMENT OF LIFE-THREATENING VENTRICULAR FIBRILLATION IN PREGNANCY

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Introduction

Pregnancy complicated with RHD commonly occurs in our population. Complication includes pulmonary edema, heart failure rarely atrial fibrillation as mitral valve is mostly affected. However ventricular arrythmia is rare. We describe one such case and its management.

Case Report

A 28-year primigravida with RHD [NYHA 2] was admitted at 32 weeks of gestation. She was on tab erythromycin, tab metoprolol and tab Lasix. Her PR-86/min, BP 110/66 mm hg, spo2 96%. On auscultation she had pansystolic murmur while chest was clear.2D echo showed Mitral regurgitation and severe pulmonary hypertension. There was IUGR but CTG and doppler were reassuring.23 day after admission, she developed atrial fibrillation with irregularly irregular pulse with rate of 180/min. Patient was started on tab digoxin and injection clexane after which her heart rate settled. In view of deteriorating maternal condition caesarean delivery was done once cardiac parameters were controlled. Seven hours post caesarean patient developed breathlessness, chest pain. Her pulse, BP crashed, saturation falls to 72% and ventricular fibrillation pattern was detected on cardiac monitor. Patient was revived with DC shock of 150 joules followed by amiodarone infusion. Subsequently she was shifted to cardiology department where she was further managed and planned for mitral valve replacement.

Clinical Relevance

Ventricular fibrillation can rarely complicate RHD during pregnancy. Prompt diagnosis and management is crucial for patient survival.

P 13.3

NON - SPECIFIC AORTOARTERITIS WITH BILATERAL RENAL ARTERY STENOSIS IN PREGNANCY: CASE REPORT

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Introduction

Non-specific aortoarteritis with bilateral renal artery stenosis (RAS) is a rare condition. Pregnancy in such women can be very high risk due to physiological changes of pregnancy.

Case Report

23 years old female with G2P1L0 with known case of non-specific aortoarteritis at 33wk 5days with bilateral renal artery stenosis with history of percutaneous transluminal coronary angioplasty (2012) and stenting of left renal artery with aortoplasty with left infrarenal aorta with chronic hypertension with FGR with Doppler changes (CPR-0.69) with moderate to severe MR. Patient was hypertensive since past 10 years on medication. USG obs detected stage 1 FGR, steroid cover given and tab labetalol started at referring hospital. ECG showed LVH and 2D ECHO revealed no RWMA, LVEF 55%, mild concentric LVH, moderate to severe MR, PASP= (20+5) mmHg. BP in left upper arm and right upper arm 182/96mmHg and 188/96 mmHg respectively. It was non recordable in both lower limbs. On referral to Safdarjung hospital severe pre-eclampsia was diagnosed and Magnesium sulphate prophylaxis given. Fundus examination revealed grade 1 hypertensive changes. Patient underwent Emergency LSCS in view of absent end diastolic flow with superimposed severe pre-eclampsia. Multiple sinuses were present over left side of uterus in lower segment preoperatively. Baby apgar score 6,8. After stabilization of the patient postoperatively in HDU patient was shifted to ward and discharged on revised antihypertensives (tab Cilnidipine, tab Metoprolol succinate extended release, tab Torsemide, tab Ecospirin, tab Atorvastatin, tab Dapagliflozin) in a stable condition. Presently patient is under follow-up in cardiology.

Clinical Relevance

Pregnancy with aortoarteritis with bilateral RAS requires multidisciplinary involvement and should be managed in a tertiary care unit.

P 13.4

TWIN PREGNANCY WITH COMPLETE HYDATIDIFORM MOLE AND CO-EXISTING LIVE FETUS: A DIAGNOSTIC AND MANAGEMENT DILEMMA

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Introduction

Twin pregnancy with coexisting live fetus and complete mole (CMCF, complete hydatiform mole and a coexistent fetus) is a rare clinical entity with the reported incidence of 1/22000 to 1/100000 pregnancies. It is commonly complicated with the development of persistent gestational trophoblastic disease and also associated with increased risk of spontaneous miscarriage, hyperthyroidism, preeclampsia, prematurity, intrauterine fetal death, bleeding and uterine rupture.

Case Report

26-year- old, G2P1L1 with previous one caesarean section, incidentally diagnosed with complete hydatidiform mole and a coexistent live fetus, on routine ultrasound at 15th week of period of gestation. Her general physical examination and vital signs were normal. On abdominal examination her fundal height corresponds to 16 weeks. Her antenatal and admission investigations were normal, with Beta Hcg value of 2.25 lakhs mIU/ml. MRI pelvis showed one live fetus with anterior placenta and coexistent molar pregnancy with posterior uterine wall myometrial thinning. On the basis of above radiological findings and after discussion with the patient, decision of termination of pregnancy with hysterotomy was made. Intra-operatively, grape like vesicles followed by fetus with normal placenta was delivered and blood loss was minimal. Histopathological examination confirmed one normal placenta and one complete mole. Post operative period was uneventful and patient was discharged in stable condition. Patient is under follow-up with weekly beta Hcg levels and last beta hCG level was 636 mIU/ml.

Clinical Relevance

Twin pregnancy consisting of one fetus and one complete mole is a rare obstetric finding that presents a challenge to both the treating obstetrician and the patient and requires an open discussion of outcomes when deciding on a treatment strategy. It's a rare entity, thus obstetricians need to be sensitized about this condition to enable the adequate assessment for possible risk factors as well as to plan further management.

P 13.5

A RARE CASE OF CONGENITAL CYSTIC HYGROMA WITH OPTIMAL PERINATAL OUTCOME

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Introduction

Cystic hygroma is a congenital malformation resulting from lymph accumulation in the jugular lymphatic sacs due to obstruction of lymphatic system. The incidence of nuchal cystic hygroma is 1/6000 at birth and 1/750 in spontaneous abortion. The mainstay of management is surgical; however other options include sclerotherapy, drainage and cauterization.

Case Report

A 31years old G2P1L1 presented to Fetal Medicine at 29weeks of gestation with an ultrasound report of cystic swelling behind the neck region of fetus. Anomaly scan at 19weeks was normal, however prenatal aneuploidy screening had not been done. The First child is doing well and three generation pedigree was not significant. The couple was counselled regarding possibility of cystic hygroma. They opted for fetal Karyotype following amniocentesis which was normal. Fetal magnetic resonance imaging done at 32weeks reported the presence of well-defined cystic lesion in the posterior triangle of neck, extending up to the occipital region measuring 1.6x2.8x4.9cms. Few internal septations were present with no communication with underlying cervical spine. She delivered a female baby of 3.1kg at term by elective caesarean section. Postnatal ultrasound depicted benign subcutaneous fluid collection without any internal communication or solid nodule. The neonate was treated with three cycles of sclerosant therapy and is doing well at one and half years age.

Clinical Relevance

Three generation pedigree, ultrasound evaluation, genetic counselling and prenatal testing should be offered when cystic hygroma in fetus presents late in pregnancy. Prognosis can be good in isolated cases with postnatal sclerotherapy.

P 13.6

MANAGEMENT OF IDIOPATHIC NON-IMMUNE HYDROPS FETALIS IN TERTIARY CARE HOSPITAL

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Introduction

Hydrops fetalis is presence of two or more abnormal fluid collections in fetus including fluid in serous cavities and generalized skin edema. It is divided into two types immune and non-immune hydrops fetalis (NIHF). NIHF is the most common type with prevalence ranging from 1 in 1500 to 1 in 4000 births. NIHF occur due to various causes out of which cardiovascular diseases are most common.15 - 40 % cases are idiopathic. traditionally diagnosis was made postnatally. Ultrasound made prenatal diagnosis possible. It is also associated with polyhydraminos and placentomegaly. Prognosis depends on etiology, gestational age at diagnosis and birth and presence of pleural effusion. Overall perinatal mortality is 50-98 % and 43% die within 1year.

Case Report

A 22year old primigravida in a non-consanguineous marriage, presented at 21+2 weeks in fetal medicine OPD with level 2 anomaly scan report showing fetal pleural effusion and subcutaneous edema. Review scan at our centre showed fetal ascites and pleural effusion. The couple was counselled regarding fetal hydrops and its prognosis. Her blood was O positive. Prenatal blood investigations were normal. Amniocentesis for karyotyping and fetal ECHO were also normal. However, the couple opted for termination of pregnancy at 23+1 weeks. The fetus on expulsion was female with 200gm weight and normal gross appearance. On autopsy bilateral pleural effusion and fetal ascites were present, right lung appeared hypoplastic and liver was enlarged.

Clinical Relevance

As this was a case of non-immune hydrops with early 2nd trimester diagnosis with lung hypoplasia, the prognosis of the pregnancy was poor. Hence the patient was counselled for MTP. If patient had refused MTP, postnatal palliative care would be an option.

P 13.7

PHEOCHROMOCYTOMA OF PREGNANCY, A RARE FAÇADE OF HYPERTENSIVE DISORDERS OF PREGNANCY

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Introduction

Pheochromocytoma is a catecholamine producing tumor arising from the chromaffin cells of the adrenal medulla which is uncommon in pregnancy. In pregnancy, it poses diagnostic and management dilemma due to overlapping features with other hypertensive disorders of pregnancy. We report successful management of a rare case of pheochromocytoma diagnosed during pregnancy.

Case Report

A 27-year-old primigravida had persistent high blood pressure records from 10 weeks of gestation with paroxysmal episodes of dizziness and headache despite antihypertensives. On workup, ultrasound showed 4.8x3.6 cm right suprarenal mass and elevated normetanephrines suggestive of diagnosis of pheochromocytoma. Patient was referred to our institute at 36 weeks for uncontrolled blood pressure (despite two antihypertensives), proteinuria and severe headache mimicking pre-eclampsia with severe features. After stabilizing the hypertensive crisis using alpha adrenergic blockers along with calcium channel blockers, a multidisciplinary team comprising of obstetricians, endocrinologists, anaesthetists, urologists and neonatologists was constituted. Patient was taken up for elective caesarean for breech presentation at 37+3 weeks along with laparoscopic right adrenalectomy in the same sitting and delivered a healthy female baby of 3.6 kg. Patient did not need any antihypertensives in the post operative period and was discharged on postoperative day 7.

Clinical Relevance

When a pregnant female presents with hypertension associated with headache, palpations, sweating, abdominal pain, blurring of vision, there should be a high index of suspicion for other medical causes including pheochromocytoma. A multidisciplinary approach is required for successful management of such cases.

P 13.8

THANATOPHORIC SKELETAL DYSPLASIA: NEED FOR CORRECT GENETICS TESTING

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Introduction

Thanatophoric dysplasia is an autosomal dominant, sporadic skeletal dysplasia characterized by short ribs, narrow thorax, macrocephaly, short limbs due to mutation in the FGFR3 gene. Incidence is 1 in 20-50,000 births and recurrence is 2%. This is a rare case emphasizing on the need for genetic testing by gynaecologists and the role of genetic or fetal medicine specialists.

Case Report

A 26 years G2A1 at 20 weeks pregnancy with features of Thanatophoric Dysplasia on Level II Ultrasound- clover-leaf shaped skull, frontal bossing, prominence of intracranial ventricles, small chest, shortening of long bones. NT/NB scans and Dual markers were normal. As per the fetal medicine specialist, fetal Autopsy and Genetic testing was advised by Whole Exome Sequencing (WES). However due to financial reasons they declined further investigation. Second trimester termination done. A fetus with enlarged head, frontal bossing, short limbs and small thorax expelled.

Clinical Relevance

This is a rare, congenital, sporadic and lethal disorder diagnosed on Ultrasonography but confirmation is done by molecular analysis. Hence emphasis must be given to the need for consultation with Fetal medicine specialists to understand the exact genetic sequencing required.

P 13. 9

FETAL MEGACYSTIS: PROGNOSIS, TERMINATION & FUTURE RISK: LEARNING POINTS

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introduction

The incidence of fetal megacystis is 1 in 1500 pregnancies, with a male to female ratio of 8:1. In a first trimester scan (11-14 weeks), megacystis is diagnosed if the longitudinal bladder diameter is more than 7 mm. The cause may be obstructive in 60% of cases (posterior urethral valves, urethral atresia or urethral stenosis, cloacal anomalies), non-obstructive in 30% of cases, mainly syndromic disease (megacystis-microcolon-intestinal hypoperistalsis syndrome, prune belly syndrome), and finally idiopathic or transient (10% of cases)

Case Report

A 25 years old primigravida present at 20 weeks 3 days period of gestation with level -2 ultrasound suggestive of single live intrauterine pregnancy of 16 weeks 4 days with cystic lesion seen in abdomen -4.9x4.5 cm and mild pyelectasis (AP diameter on right 5.8 mm and on left 5.7mm), oligohydramnios (AFI

Clinical Relevance

Awareness among women regarding genetic tests, need of first trimester scan (NT/NB) is still very low. This needs to be addressed to detect such cases at earlier gestation and to complete work up for chances of recurrence.

P 13.10

SUPERFICIAL VENOUS THROMBOSIS IN PREGNANCY: HOW CRITICAL?

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Introduction

Superficial vein thrombosis (SVT) has been considered as benign, self-limiting condition, consequently being out of scope of well conducted epidemiological and clinical studies. If untreated or inadequately treated, SVT can potentially cause deep venous thrombosis or pulmonary embolism.

Case Report

28 years old, Primigravida at 34 weeks 5 days with singleton pregnancy, cephalic presentation, with BMI 21.4kg/m2 presented with chief complaints of cramping pain in the Right Leg which was sudden in onset; gradually progressive, continuous, and sharp in intensity that aggravated on walking. There was no past history of venous thromboembolism. On Examination: Tender cord like structure palpable over anteromedial aspect right thigh till knee noted (around 10cm long) with bluish discoloration. On compression USG Doppler leg: s/o superficial thrombophlebitis of Great Saphenous Vein with no flow on doppler noted. The patient was managed on inj LMWH 40mg BD s/c daily, followed by termination of pregnancy at 37 weeks gestation.

Clinical Relevance

Despite the incidence for SVT being 0·5–0·6 in 1000 during the third trimester, there are no set guidelines for superficial vein thrombosis in pregnancy. Therefore, this case becomes an important to look into the management protocols for the same.

P 14.1

CASE STUDY ON NON IMMUNE HYDROPS FETALIS

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Introduction

Hydrops fetalis is the accumulation of excess fluid in the fetus. Depending on the severity and causes of Hydrops, the cause may be the existence of edema of the fetus and placenta, ascites, pleural effusion, and pericardial effusion. Hydrops fetalis can be secondary to Rh incompatibility or nonimmune origin.

Case Report

A primigravida mother with complaint of contractions and rupture of membranes and with gestational age of 28-30 weeks reported to emergency. Her LMP was not known. Patient was uninvestigated and unbooked and came in emergency with pain lower abdomen and leaking per vaginum. On examination vitals were stable, FHS was absent, uterine contractions were present. On Per vaginum examination, os was fully dilated. She delivered through normal vaginal delivery, a still born baby which was hydropic and had ascites in clinical picture.

Clinical Relevance

Nonimmune hydrops fetalis is a condition that often requires emergency treatment. These cases can be detected by strict ANC examinations and fetal USG. These pregnancies can be terminated in the first or second trimesters and will prevent mental trauma to the mother's who report late in the labour. This signifies timely ANC visit and USG examination.

P 14.2

PRIMARY ABDOMINAL ECTOPIC MASQUERADING AS ASCITIS: A RARE CASE REPORT

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Introduction

Abdominal pregnancy is a rare and life-threatening form of ectopic gestation, accounting for 1% of all ectopic pregnancies. Primary omental pregnancy, specifically, is an uncommon variant of abdominal ectopic pregnancies. Timely and accurate diagnosis is crucial for effective management.

Case Report

Case of a 28-year-old primigravida with a primary abdominal pregnancy at 12+3 weeks of gestation. The patient presented to the medical casualty department with epigastric pain and abdominal distention. Upon evaluation, severe anemia and significant ascites were noted. Ultrasonography revealed septated ascites, which was managed conservatively. Despite multiple blood transfusions, the patient's anemia persisted and went into acute renal failure and her condition deteriorated. Further investigation revealed a history of amenorrhea for three months, a positive pregnancy test, and a subsequent ultrasound confirmed a pseudosac in the uterus and a fetus corresponding to 11+3 weeks in the peritoneal cavity with significant free fluid. The patient was transferred to the gynecology department and underwent an exploratory laparotomy due to her unstable condition. Intraoperatively, three liters of hemoperitoneum were observed. The uterus, bilateral tubes, and ovaries appeared normal without any communication or rent. A 12-week fetus was found in the abdominal cavity, with the placenta attached to the omentum. Partial omentectomy was performed, and the remaining bowel appeared normal. The patient was discharged on the fifth day post-operation with satisfactory recovery.

Clinical Relevance

Heightened clinical suspicion is paramount when encountering reproductive-age patients presenting with symptoms such as anemia, pronounced ascites, and abdominal pain. Employing a urine pregnancy test to rule out ectopic pregnancy is imperative in such cases. Timely surgical intervention optimizes prognosis.

P 14.3

ROLE OF FDG-PET CT IN DETECTING RESIDUAL OVARIAN CANCER OR RECURRENCE IN PATIENTS

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Introduction

18F-FDG positron emission tomography/computed tomography (PET/CT) is a non invasive, highly accurate imaging method both in staging and in follow-up of many cancers including ovarian cancer. FDG-PET CT holds promise in the evaluation of recurrent or residual ovarian cancer when CA125 levels are rising and conventional imaging, such as ultrasound, CT, or MRI, is inconclusive or negative. Since this modality offers whole body imaging, distant metastases could be detected in addition to abdominal and pelvic lesions thus contributing to patient management.

Case Report

21year old unmarried female presented to gynae casualty with complaints of lower abdominal pain for 2 months, abdominal distension for 20 days, loss of appetite for 10 days. CA-125-104 U/ml and CA 19-9-369 U/ml were increased. USG TAS – multiloculated cystic right ovarian lesion with thickened septation showing internal vascularity with mild ascites likely malignant right ovarian neoplasm likely mucinous. CECT abdomen pelvis suggestive of borderline epithelial ovarian neoplasm on right side likely mucinous. Exploratory laparotomy with frozen with right salpingo-oopherectomy done under GA with epidural anaesthesia. Specimen sent for frozen section- findings suggestive of benign epithelial neoplasm likely mucinous. Patient discharged on POD7. Histopathological examination report- suggestive of mucinous carcinoma ovary. Patient readmitted for evaluation and further management. Provisional plan- right pelvic and para-aortic lymphadenopathy .CA-125-25 U/ml and CA19-9-9.40 U/ml are within normal limit. MRI abdomen pelvis done -suggestive of postoperative changes with no evidence of residual disease. Tumor board held for discussion of the case – advised FDG-PET CT and follow up with report. FDG-PET CT done- No definite evidence of abnormal metabolic activity noted in region of body surveyed to suggest residual / metastatic disease. Patient advised to follow up in gynae opd if any symptoms. Therefore FDG-PET CT is more accurate in diagnosing residual ovarian cancer.

Clinical Relevance

18F-FDG PET/CT has a very high sensitivity rate (85-100%) for detection of recurrence or residual ovarian cancer. Therefore it is more accurate in diagnosing residual ovarian cancer. Since this modality offers whole body imaging, distant metastases could be detected in addition to abdominal and pelvic lesions thus contributing to patient management. One of the main advantages of PET/CT is the information about the extent and location of recurrence. Early diagnosis of recurrence and exact localization of metastatic disease are crucial for determination of the best treatment strategy.

P 14.4

MUSCULOSKELETAL PAIN PRESENTING AS CHRONIC PELVIC PAIN

Pooja Preeti Goyari

Introduction

Chronic pelvic pain affects 3.8% women. The cause of chronic pelvic pain can be gynaecological or non-gynaecological. We present a case of musculoskeletal pain presenting as chronic pelvic pain in gynae OPD.

Case Report

A 35year old P3L3 patient came to Gynae OPD of a tertiary care centre with complains of pain in lower abdomen for one year. It was insidious in onset and increased with prolonged sitting posture. She was a tailor by profession and used to tailor for 8-10 hours a day in sitting position. Patient was evaluated in pain clinic with pain scoring as per symptoms. Her general examination was normal. Per abdomen- soft, nontense and nontender. Per speculum examination was normal. Per vaginal examination was done- Single digit test was done & tenderness felt at right sacroiliac joint. She was treated with tab duloxetine and gabapentine for 3 months, but wasn't relieved. Her referral to the orthopedic OPD was done but no orthopedic cause of pain could be identified by orthopedician. Finally she was sent for physiotherapy at where she was asked to change her posture while tailoring. Her pain improved with change of posture from sitting on floor to standing and sitting on chair while tailoring. After 3 months of duloxetine and gabapentin was tapered and stopped. Patient is asymptomatic for 4 months after stopping medication.

Clinical Relevance

Women with Chronic Pelvic Pain are often referred to Gynaecologists. The pain may arise from non-reproductive organs and if woman is not evaluated for these conditions the diagnosis may be delayed and often treatment given is not focusing on the etiology. This leads to multiple outpatient visits. Women presenting with chronic pelvic pain should be carefully evaluated to rule out other non-gynaecological cause of chronic pelvic pain. Pain arising from musculoskeletal structures may require simple non-gynaecological interventions.

P 14.5

VIRILISING OVARIAN FIBROTHECOMA DEVELOPED IN PREGNANCY– A RARE CASE REPORT

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Introduction

Ovarian thecoma, which is classified as a germinal cord interstitial ovarian tumor, is very rare, accounting for about 1% of solid ovarian tumors. The incidence of this tumor is reported to be highest among pre- and postmenopausal women of 50 - 60 years of age. To our knowledge, this is the first case of ovarian thecoma in pregnancy which caused significant virilization and was diagnosed postnatally after patient delivered at 30 weeks of gestation.

Case Report

23 yr. old P1L0 at post-natal day 11 of PTVD [delivered at home] presented with complaint of abdominal distension and diffuse, dull aching pain with increased facial hair growth and hoarseness of voice for 5 months. Patient started noticing facial hair growth and change in voice (since 3rd month amenorrhea) associated with abdominal distension, which she attributed to pregnancy. she went for routine acheck-up at nearby dispensary. She underwent ultrasound at 15 weeks in which no ovarian mass or free fluid was seen. On examination, patient was relatively ill, vitally stable with coarse facial hair and abdominal hair. Abdominal examination revealed generalised distension with fullness of flanks, well defined mass of 15x 10 cm, smooth surface, restricted mobility, lower margin could not be reached, fluid thrill was present. On local examination of external genitalia, clitoromegaly was present. Ultrasound showed 15.1 x 13.8 x 11.4 cm heterogenous solid cystic mass with moderate vascularity in right lumbar region with moderate free fluid in abdominal cavity. Right ovary not seen separately. Likely right ovarian origin. CEA, CA125, Alpha feto protein were in normal range, serum testosterone levels were raised (763 ng/ dl), Inhibin B Levels were also raised (548). Ascitic fluid for malignant cells came out to be negative. Patient was taken up for staging laparotomy, ascitic fluid 2 litres were drained, Uterus bulky (postpartum uterus), right ovarian mass of 15 x10 cm removed, right sided salpingo oophorectomy done, left side ovary normal, omentum thickened, infracolic omentectomy was done. Intra operative frozen section came out to be Sertoli cell /germ cell tumour. On pathological examination, specimen was reported as benign cell sex cord tumour - fibro thecoma.

Clinical Relevance

rare case report with respect to type of ovarian tumour ,age of presentation and associated virilising character

P 14.6

POSTPARTUM PUBIC SYMPHYSIS DIASTASIS: A RARE COMPLICATION OF DIFFICULT LABOR

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Introduction

Pubic symphysis diastasis is defined as abnormal separation of the two pubic bones of more than 10 mm following delivery . It is an uncommon and debilitating complication of difficult labor presenting as severe pelvic pain. The incidence varies from 1 in 300 to 1 in 30000 in different reports . Physiological separation of 4-5 mm may occur during pregnancy as the ligaments become flexible under the influence of relaxin and progesterone.

Case Report

We report a case of 25-year-old ,P3L2 who presented on 3rd postpartum day following home vaginal delivery by local birth attendant with complaints of excruciating pain over the mons pubis, ,difficulty in walking and passing urine . She had history of prolonged labor of >24 hours . On local examination there was hematoma and induration over mons pubic and right labia , no vaginal hematoma. Hemorrhagic urine was drained on catheterization. Surgery and orthopedic referral was sought . X-Ray pelvis was done which revealed pubic bone diastasis . CT Urography revealed a gap of 2.5 cm between the pubic bones with no bladder or urethral injury. She was given analgesics and binder .Weight bearing was slowly allowed and patient gradually started ambulating. Hematoma and pain resolved .The patient was discharged in stable condition with no residual disability. At the time of discharge patient was passing urine comfortably and her weight bearing was normal.

Clinical Relevance

Disproportionately severe pain , immobilty and hematoma over mons pubis : Think of pubic symphysis DIASTASIS .

P 14.7

PUBERTY TRIGGERED TUMULTUOUS JOURNEY OF A BENIGN PATHOLOGY

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Introduction

Disseminated peritoneal leiomyomatosis is a very rare condition characterized by development of multiple smooth muscle like nodules in peritoneal cavity . It is associated with increased levels of gonadal steroids. Usually it is asymptomatic and diagnosed as incidental finding.

Case Report

The present report describes 22 years unmarried female who came to GTBH with complaints of recurrent abdominal lump associated with generalized weakness with no menstrual complaints. Patient had her first visit to GTBH at 15 years of age with lump abdomen and abnormal uterine bleeding. Complaints started 1 year after menarche at 13 yrs of age. Exploratory laparotomy and myomectomy was done and leiomyoma was diagnosed on histopathology. She presented again after 2 years with similar complaints and exploratory laparotomy with tumor resection and partial peritonectomy was performed in view of multiple peritoneal solid tumor and benign leiomyoma was diagnosed in all specimens. Now after 5 years she came with poor general condition and large abdominopelvic mass. Previous slides review raised suspicion of leiomyosarcoma and on imaging mass was very vascular. On Staging Laparotomy Uterus was enlarged with large 15* 20 cm fundo posterior mass which was burrowed in mesentary of sigmoid colon reaching upto sacrum. Right adnexa were buried in the mass. Multiple nodules 1-3 cm on mesentary, gut and pelvic and diaphragmatic peritoneum were found along with -10×12cm nodular mass in sub hepatic region arising from right parietal peritoneum. Total abdominal hysterectomy with bilateral salpingo oophorectomy and complete peritonectomy was performed. On HPE all masses were found to be leiomyoma with ER and PR positive on IHC making the diagnosis of Disseminated Peritoneal leiomyomatosis. Patient is on follow up and disease free.

Clinical Relevance

This case is being presented for very early presentation in reproductive life and aggressive course without any underlying cause.

P 14.8

UPSTAGING OF TUBERCULOSIS DUE TO COVID

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Introduction

Tuberculosis (TB) is a communicable disease that continues to be endemic in several regions of the world and is one of the leading cause of mortality worldwide. According to WHO, an important sequalae of the COVID-19 pandemic is the worsening of tuberculosis epidemic globally. This may have been due to the additional pressures on health care systems by COVID-19 causing weakening of the National TB programmes due to reallocation of resources to Covid-19 care. According to WHO global TB report 2021 about 1.3 million deaths occur due to TB among HIV-negative people in 2020 (up from 1.2 million in 2019) and an additional 214000 among HIV-positive people (up from 209000 in 2019).

Case Report

A total of four patients were diagnosed with genital tuberculosis (Ovarian and Fallopian tube tuberculosis) in the department of Obstetrics and Gynaecology, Dr Baba Saheb Ambedkar Hospital, Delhi during Covid -19 pandemic. Patient present with history of lower abdominal pain in gynaecologic casualty. Detailed medical history of present illness and past medical history was taken. Thorough clinical examination and radiological investigation done in all the cases. Later on, the patient was taken for Exploratory Laparotomy which shows frank pus collections and adhesions. Post operative investigations give impression of tuberculosis and antituberculosis therapy was given.

Clinical Relevance

The decline rate of TB incidences achieved in previous years has slow down and almost come to a halt. The need of the hour is to take proper actions to mitigate and reverse these impacts urgently. The immediate priority is to restore the provision of essential TB services so that the levels of TB case detection and treatment return to at least 2019 levels. We present here a series of cases which presented in a critical condition to the obstetrics and gynae emergency of Dr BSA Medical college. They were all resuscitated and admitted to ICU/HDU and needed prolonged hospitalisation and/or surgical exploration for unstable vitals. All of them were diagnosed with advanced genital or abdominal tuberculosis and responded after institution of ATT.

P 14.9

RARE CASE OF VESICOVAGINAL VISTULA SECONDARY TO VAGINAL FOREIGN BODY UNDER THE MASQUERADE OF RECURRENT VAGINITIS

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Introduction

An impacted long standing foreign body can be enigma to the life of an adolescent and accounts for 4% of gynaecological the manifestations vary depending on the duration and nature of foreign body ranging from recurrent genitourinary infection, unscheduled vaginal bleeding or foul smelling discharge or genitourinary fistulae. Retained vaginal foreign bodies are clinically significant as they act as a nidus for recurrent infection and may also result in bleeding, ulceration and fistula formation. Hereby, we report a case of 18 year old girl with complaint of persistent foul smelling discharge per vaginum which ultimately lead to development of vesico-vaginal fistula (VVF) formation secondary to impacted foreign body in vagina

Case Report

18 year old female presented with complaint of pain abdomen and persistent foul smelling discharge for 6 years. With increasing discharge and foul smelling nature; she had multiple gynaecological consultations without any relief , she finally came to our OPD.on examination and foul smell emanating from her lead to clinical suspicion of impacted foreign body , which was confirmed on CECT scan. After complete workup, she was taken up for examination under anaesthesia (EUA). The EUA revealed impacted foreign body in anterior vaginal wall with surrounding fibrosis. Cervix could not be seen. On removal she the foreign body turned out to be cloth clip with rusted metallic arm. Cystoscopy was also done, which was normal.. On follow up , patient developed Vesico Vaginal Fistula around 2 weeks later.

Clinical Relevance

Evaluations for foreign bodies in the vaginal canal is necessary when pre-pubertal and adolescent females presents with complaints of chronic pelvic pain, recurrent vaginal discharge or unscheduled vaginal bleeding, non-specific urinary or rectal complaints. Diagnosis of foreign body in vagina requires high index of suspicion; detailed clinical examination and supportive imaging .

P 15.1

DISCORDANT TWINS- MANAGEMENT DILEMMAS

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Introduction

Introduction: The management of preterm birth in the presence of fetal anomalies poses intricate ethical considerations. This case report highlights a unique scenario where only isolated soft marker was initially suspicious, followed by negative amniocentesis. However, after delivery, the newborn exhibited ventricular septal defect (VSD), atrial septal defect (ASD), and patent ductus arteriosus (PDA).

Case Report

A 30-year-old G2A1 with dichorionic diamniotic (DCDA) twins presented with twin A having nuchal translucency (NT) measurement above the 95th centile at 13th week scan accompanied by aberrant right subclavian artery (ARSA) and echogenic fetal kidneys. Amniocentesis performed at 16 weeks showed normal karyotype and FISH without evidence of aneuploidy. In the second trimester, the patient had a 41.3% discordancy with a single umbilical artery (SUA) in twin A, along with early-onset fetal growth restriction (FGR) and increased umbilical artery (UA) resistance (absent end-diastolic flow, AEDF). Later in the third trimester, patient presented with severe early-onset FGR, cerebral redistribution of blood flow in the ductus venosus (DV) with normal pulsatility index (PI), oligohydramnios, a growth discordance of 60% with onset of gestational hypertension were observed. Given the aim to avoid iatrogenic preterm delivery of the relatively healthier twin, despite the negative amniocentesis, twin A developed the aforementioned complications. Therefore, we decided to terminate the pregnancy at 35+2 weeks.

Clinical Relevance

Dilemma in Deciding the Timing of Pregnancy Termination: This case presents the ethical dilemma of deciding between terminating the pregnancy at 37 weeks, regardless of the other twin, or terminating at 34 weeks due to the deteriorating Doppler findings of twin A with the aim of giving it a chance to survival.

P 15.2

NAVIGATING COMPLEXITY: A NEAR-MISS OBSTETRIC CASE WITH MULTIMORBIDITY AND SEVERE COMPLICATIONS

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Introduction

Near-miss obstetric cases present significant challenges in maternal and fetal care, requiring a multidisciplinary approach . We present a case of 22 year primigravida at 30 weeks and 2 days of gestation diagnosed with RHD with moderate MS during pregnancy. She developed PE with HELLP, stage II FGR and CKD and could navigate complexities due to multidisciplinary care.

Case Report

Patient presented with sudden-onset shortness of breath and anasarca following an episode of fever. After admission, antenatal corticosteroids were administered, cardiology consultation revealed RHD with severe MS. Emergency cesarean section was performed due to Preeclampsia with severe features and transferred to the ICU.Subsequently, she developed hemoperitoneum, necessitating exploratory laparotomy and blood product transfusions, experienced a prolonged course in the ICU due to recurrent fever and respiratory symptoms. A comprehensive evaluation, including autoimmune, cardiac and renal workup was undertaken. Autoimmune workup was positive for SLE. Hence, she received two doses of injection cyclophosphamide. Renal biopsy revealed membranous glomerulonephritis. Patient was finally discharged with the baby after three months of hospital stay on steroids, antihypertensives, ACE inhibitors, hydroxyquinone along with penicillin prophylaxis 3 weekly.

Clinical Relevance

This case emphasizes role of multidisciplinary care in near-miss obstetric cases. Early recognition, prompt management, and thorough investigation of complications in complex pregnancies can lead to enhanced maternal and fetal well-being.

P 15.3

SUCCESSFUL MANAGEMENT OF PREGNANCY WITH OBSTRUCTIVE UROPATHY

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Introduction

Obstructive uropathy in pregnancy is an important and potentially reversible cause of acute and chronic kidney disease with an incidence of 1.7 per 1000.

Case Report

25 years old, G3P2L2 with previous two caesarean section referred from Urology department to Obstetric & Gynaecology department at 6 months of period of gestation. Patient was a known case of obstructive uropathy post genitourinary tuberculosis on clean intermittent catheterization, chronic kidney disease stage 5, seizure disorder with anemia of chronic disease. Her physical examination and vitals sign were normal. Her renal function tests were worsening. Patient was managed for recurrent urinary tract infection with several antibiotics and for chronic anemia. Materno-fetal monitoring was done for associated complications. Patient was delivered by elective preterm caesarean section at 36+2 weeks for deteriorating renal function test. A healthy male baby of 2.5 kg was delivered.

Clinical Relevance

Women with obstructive uropathy face several challenges in pregnancy due to increased physiological demands on kidney and risk of disease progression, worsening of maternal (high risk of recurrent infections, sepsis, and renal failure, preeclampsia, eclampsia) and fetal conditions (fetal growth restriction, preterm delivery). These challenges necessitate an interdisciplinary team to ensure good maternal and fetal outcome. It's a rare and high-risk entity, thus obstetricians need to be sensitized about this condition to enable the adequate assessment for possible risk factors as well as to plan further management.

P 15.4

PREGNANCY WITH CHRONIC KIDNEY DISEASE: A CASE REPORT

Aakriti Aggarwal

Introduction

CKD is abnormalities of kidney structure or function, with impaired GFR &/or proteinuria present for e" 3 months. It has been associated with poorer pregnancy outcomes with increased risk of preterm delivery, superimposed preeclampsia, fetal growth restriction etc.

Case Report

24 yr old G3P1L0A1 at 30 weeks presented to opd with k/C/o CKD 4 with stage 2 FGR with chronic hypertension with moderate anemia with hydronephrosis with hypocalcemia with history of 2 cycles of dialysis O/E- Pa++/ Pe+++ Bp- 158/110 JVP NR and CVS RS WNL P/A- ut 32 weeks cephalic relaxed Work up for ckd with serial abg and electrolytes monitoring with bp charting Oral calcium added along with T lobet 200 mg TDS for controlling bp High BP spikes led to IUD induced with miso Treatment for ckd continued.

Clinical Relevance

Management of CKD patient needs multidisciplinary team approach with risk stratification and informed decision making. Easily reproducible indicators—creatinine and proteinuria assessment—can be used in pre conceptional consultation and during prenatal care, regardless of the type of kidney disease. Prevention of complications and early detection of complications with delivery of healthy baby should be the aim.

P 15.5

PRES

Anu Bharti

Introduction

Posterior Reversible Encephalopathy Syndrome (PRES) is a clinico-radiological syndrome characterized by symptoms including a headache, seizures, altered consciousness and visual disturbances. Common triggering factors include blood pressure fluctuations, renal failure, eclampsia, exposure to immunosuppressive or cytotoxic agents and autoimmune disorders. Management is mainly symptomatic.

Case Report

A 22 year old female referred from nearby area hospital in view of 18 weeks period of gestation with ?convulsions? poisoning? pulmonary edema? Aspiration pneumonia. Loading dose of Pritchards regimen was given and investigations sent. At presentation, she was primi with 5 months amenorrhea with antepartum eclampsia with IUD. She was in altered sensorium (irritable), semi conscious with GCS 7/15. All investigations sent and IV Hydrocortisone, IV Leviteracetam, IV Lasix given. No signs of abruption on ultrasound. MRI brain revealed possible severe PRES. MRV- No significant abnormality noted. IV Mannitol 20gm IV stat given. Patient was induced with Misoprostol followed by Oxytocin drip. She delivered a dead macerated fetus of 1.1 kgs birth weight. Immediate postpartum, her vitals are stable. Within an hour, she is unconscious, not responding to deep painful stimulation with GCS 6/15. So she was intubated and Inj.Mannitol was continued. Later she was shifted to T-piece and 2 days later emergency extubation done as tube is blocked after confirming patient general condition is stable. After seven days of IV Mannitol, Syp.Glycerol was started. She eventually recovered.

Clinical Relevance

PRES is increasingly recognized due to improvement and availability of brain imaging specifically magnetic resonance imaging (MRI). If treated early, it resolves within a week. A high index of suspicion and prompt treatment can reduce morbidity, mortality and pave the path for early recovery.

P 15.6

A CASE OF RECURRENT SKELETAL DYSPLASIA IN FETUS

Arati Trivedi

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Introduction

A case of a 35 year old pregnant patient with 20 weeks POG with with previous 2 LSCS was referred to our outpatient prenatal clinic due to malformation in her 4rd fetus detected by USG This case is reported because of its rarity, recurrence in the same patient and to increase awareness among health professionals, especially ultrasonologist in our local setting.

Case Report

A 35 year old pregnant female with 20 week of pregnancy with previous 2 LSCS was referred to our outpatient prenatal clinic due to malformation in her 4rd fetus detected by USG. Their 5th pregnancy in year 2023 was uneventful till 20 weeks when a level II ultrasound outside reported short long bone, all bone

Clinical Relevance

This case represents 1 in 750 cases of anomaly scans done within a period of three years at RAAJ Specialist Scan, a private diagnostic center with branches in the Central and Western Regions of Ghana. Both sexes are equally affected, with no racial or ethnic predisposition. Usually the diagnosis of TSD is made by USG during second trimester and further specific type is distinguished on later scans during third trimester with the help of fetal skeletal morphology.10 Further Diagnosis can be confirmed with autopsy and histopathology but unfortunately could not be done in present case as consent was not given by the parents

P 15.7

WAARDENBURG SYNDROME - A CASE REPORT

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Introduction

Waardenburg syndrome is an autosomal dominant disorder associated with mutations in the EDN3, EDNRB, MITF, PAX3, SNAI2, and SOX10 genes. Incidence of Waardenburg syndrome is about 1 in 40000 and may present as constellation of features like sensorineural deafness, pigmentation defects of the skin, hair and iris and various defects of neural crest-derived tissues. It accounts for >2% cases of congenital deafness.

Case Report

A 30 year old G4P2L2A1 known case of Waardenburg syndrome with strong family history of similar condition. On examination, she has heterochromia with white forelock of hair and synorphys with no history of muculoskeletal abnormalities or abnormal bowel habits. In her previous two pregnancies, she had full term vaginal delivery; both children were diagnosed clinically with Waardenburg syndrome postnatally and underwent cochlear implants due to sensorineural hearing defect. In this pregnancy she was evaluated, underwent amniocentesis and CES. Fetus was found to be heterozygous for PAX3 gene but patient decided to continue the pregnancy. She delivered baby boy weighing 2.6 kg with features of telecanthus, heterochromia iridis, white forelock of hair and hypopigmented lesion on ankle. BERA analysis done at 6 months of age revealed left sided hearing loss.

Clinical Relevance

Waardenburg syndrome is a rare condition however strong positive family history warrants a multidisciplinary approach which includes 3 degree pedigree analysis alongwith proper preconceptional genetic counselling. Genetic testing should be offered which can help in patient counselling, recurrence and prognostication

P 15.8

CONSERVATIVE MANAGEMENT OF CAESEREAN SCAR SITE ECTOPIC PREGNANCY WITH MORBIDLY ADHERENT PLACENTA : A CHALLENGING SCENARIO

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LADY HARDINGE MEDICAL COLLEGE AND SSKH

Introduction

Caeserean Scar site ectopic pregnancy is defined as implantation in defect of previous uterine incision. Incidence is increasing due to increasing caesrean sections rate. The prevalence of cesarean ectopic pregnancy is estimated to be one in 2,000 pregnancies, which could be potential viable pregnancies or miscarriages into the scar

Case Report

A 31 Year old lady Gravida 4 Para 3 Live birth 1 with history of previous 3 caesarean section presented with chief complaints of amenorrhea since past 2 months . Physical examination demonstrated stable vital signs while bimanual examination revealed an enlarged uterus with no adnexal masses. Transvaginal ultrasound revealed a single live intrauterine gestational sac was seen occupying the lower segment of uterus (11+2 weeks POG) along with placenta seen in lower part of uterus extending from scar area covering os and going posteriorly which was suggestive of Caesarean scar site ectopic pregnancy with placenta praevia . Decision for MRI (Magnetic resonance imaging) along with beta hcg (ß-subunit of human chorionic gonadotrophin) measurement was done . MRI revealed a single intrauterine fetus with heterogenous placental mass measuring 72*89*81 mm along with focal area of loss of placental myometrial vesical interface with prominent intervening vascular channels with prominent flow voids on T2 weighted image suggestive of vascular nature . Initial beta hcg (ß-subunit of human chorionic gonadotrophin) was 15,000 mIU/mL. Since the patient was asymtomatic and haemodyanamically stable but being high risk for surgical intervention , decision for conservative management was taken. 25mg intracardiac methotrexate was administered (DAY 1) followed by systemic (intramuscular) methotrexate on DAY 4 and DAY 10. Serial monitoring of beta hcg was done . An initial rise of 60 % from baseline value of beta hcg was noticed 2 days after intracardiac methotrexate which was followed by 20%, 50 % and 90% fall from initial values in next 3 weekly measured values. Patient was asked to follow up with weekly beta hcg till value negative and monthly ultrasound imaging or if patient becomes symptomatic . Two month after methotrexate administration review ultrasound and MRI was done for the patient which revealed significant reduction in the size of mass in lower uterine segment from 7.2*8.9*8.1 cm to 6.6*6.4*4.6 cm.

Clinical Relevance

Ceaserean Scar site ectopic pregnancy with previous 3 lower segment caesarean with morbidly adherent placenta is challenging scenario in terms of risk for torrential life threatening haemorrhage, ICU stay , multiple blood transfusion, organ injury and need for mechanical ventilation. Decision for definitive surgery versus conservative surgery needs to be decided taking in account the general condition of patient , haemodyanmic status of the patient as well as taking in account whether patient is willing for long follow up or not . Need for emergency surgery and dangers signs should be explained to be the patient opting for conservative management.

P 15.9

CASE REPORT OF PERIPARTUM CARDIOMYOPATHY

Lavanya Tanguturi

Introduction

Peripartum cardiomyopathy(PPCM) is a rare form of dilated cardiomyopathy which is life threatening in young women. Peripartum cardiomyopathy is diagnosed when heart failure develops in the last month of pregnancy or within 5months after delivery, in the absence of other causes. The disease incidence varies geographically. Diagnostic findings are echocardiography showing left ventricular systolic dysfunction with EF

Case Report

25 yr. old primi gravida with 36weeks gestation age presented to ER with complaints of pain abdomen, retrosternal discomfort and breathing difficulty since one hour prior to presentation. She is conscious & coherent and general physical examination revealed pallor, vitals showed tachycardia (HR–104/min), regular, with hypotension (BP-88/56mmHg), respiratory rate-20/min , maintaining SpO2-96% at room air. On auscultation of chest, bilateral wheeze present. Her fundal height was corresponding to period of gestation with fetal heart rate of 130beats/min. She received intravenous fluid management with crystalloids as per the protocol and was shifted to ICU for further management. 2D-echo was done which showed hypokinetic basal interventricular septum and basal anterior segments, with LVEF=40-45%. Blood investigations showed elevated troponin-I & pro-BNP. PPCM diagnosis was made and inotropic support was started and planned for termination of pregnancy. She delivered a male child with birth weight-2.25kg by emergency LSCS within 12 hours of hospitalisation. Over next 2days she was managed in ICU, where her inotropic support was gradually tapered. Repeat 2D-echo showed improvement in cardiac function and troponin-I was negative. Both mother & child were discharged, on maternal antiplatelet and beta blocker on POD -4.

Clinical Relevance

PPCM is a rare condition of unknown cause and is associated with high mortality. The pathophysiology is still unclear. Prompt knowledge about this condition and appropriate management results in good outcome.

P 15.10

BROAD LIGAMENT PREGNANCY: FACING THE BATTLE UNARMED

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Introduction

Broad ligament pregnancy is a rare type of ectopic pregnancy attributing to just 1% of all the ectopic pregnancies, where the gestational sac grows in the space formed between anterior and posterior peritoneal folds of broad ligament. Its incidence is 1 in 30,000 to 1 in 10,000 as per the previous data reported. Its diagnosis can be missed in antenatal period and we get to face the challenge unarmed directly on OT table.

Case Report

A 30yr old lady G2P1L1 was admitted at 24 weeks of gestation in view of low lying placenta and anhydramnios. Patient was managed conservatively till 28 weeks of gestation after which she had chorioamnionitis and was taken up for Lower segment Caesarean section in view of low lying placenta with chorioamnionitis. The Uterus was found posterior to the sac towards left pelvic wall. The gestational sac was on the right side in between leaves of broad ligament. After incising anterior surface of sac a live female baby of 760gm was delivered followed by extraction of placenta. Sac was sent for histopathological examination which showed chorionic villi interspersed with blood vessels within the sac. Postoperatively patient had an uneventful recovery, however baby expired after 15 mins due to extreme prematurity.

Clinical Relevance

Broad ligament pregnancy can be easily missed during antenatal period and thus is a catastrophic obstetric emergency with a high maternal mortality rate of about 20%. Hence, one should be watchful and have a high clinical suspicion of broad ligament /extrauterine pregnancy in case of cervix deviated to one side with no obvious reasons, early-onset unexplained oligohydramnios, and failed induction of labour. In case any of these is present, one should further evaluate the patient for extrauterine gestation. An early gestational scan preferably a Trans Vaginal Sonography or Magnetic Resonance Imaging can be beneficial in preoperative diagnosis, ultimately improving the feto-maternal outcome.

P 16.1

SAD FETUS SYNDROME- A RARE PRESENTATION OF PARTIAL MOLAR PREGNANCY WITH LIVE FETUS

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Introduction

Incidence of molar pregnancy is 1 in 200 pregnancies. A rare form of gestational trophoblastic disease is a partial mole with a co-existing live fetus; a condition sometimes referred as "sad fetus syndrome" with an incidence of 0.005% to 0.01%.

Case Report

28 year old G2P1L1, 28 weeks with bleeding per vaginum since 2days. She had no aneuploidy screening or anomaly scan. Ultrasound was suggestive of single live intrauterine fetus of 23.4 weeks with multiple cystic areas noted in placenta s/o molar pregnancy. On physical examination, BP of 140/90mmHg and urine albumin 2+; diagnosed with severe preeclampsia without features. Her abdomen was soft, non-tender with a 30-week fundal height. Apart from the signs of anaemia, the remaining findings of physical examination were within normal limits. Her ßHCG - 64,320mIU/ml, TSH - 4.8mIU/ml. Patient went into spontaneous preterm labour and delivered a baby girl of 650gram (FGR with birth weight < 3rd centile) APGAR score of 1,3 who died next day. Placenta on gross examination had multiple vesicles, which was confirmed as molar on histopathological examination. Baby was grossly appearing normal, karyotype was offered but patient refused for further testing.

Clinical Relevance

Molar pregnancy with a coexistent live fetus is a rare and challenging condition due to wide array of complications like hemorrhage, sepsis, thyrotoxicosis and coexistent mole/choriocarcinoma. Ultrasound examination and serial ßHCG level measurement are crucial in tracking clinical progression. Amniocentesis is the diagnostic test of choice and terminating the pregnancy can be offered.

P 16.2

GENETIC TESTING AND FETAL AUTOPSY AN IMPORTANT ADJUNCT IN UNINVESTIGATED PREVIOUS PRENATAL LOSSES

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Introduction

Pregnancies undergoing termination in view of fetal anomalies should be investigated in terms of genetic associations due to risk of recurrence.

Case Report

Case series of three antenatal women who had similar recurrent fetal anomalies for which previous pregnancies were terminated without prenatal tests. Case 1(G2A1),first degree consanguineous marriage, terminated previous pregnancy for fetal encephalocoele and bilateral enlarged multi cystic kidneys. Case 2(G3A2) and Case 3(G2A1) were non consanguineous marriages and terminated pregnancies for recurrent encphalocoele in their foetuses. None of the terminations had any fetal photographs, genetic tests or fetal autopsies.In their current pregnancy a detailed anomaly scan revealed additional features of ventriculomegaly in case1 along with polydactyly in case 2 and 3. Based on previous pregnancy findings and current phenotype of the fetuses on ultrasound and autopsy Clinical exome sequencing(CES) was done in chorionic villus sample of all three women.CES report diagnosed pathogenic variant in case 1 as Meckel Gruber type 6,in case 2 as Meckel Gruber type 5 and in case 3 as Joubert Syndrome. These are autosomal recessive single gene disorders which have 25% recurrence risk. The couples have been advised to undergo carrier testing for confirmation and subsequent need of prenatal invasive test in next pregnancy.

Clinical Relevance

Detailed anomaly scan, Genetic testing and fetal autopsy should be offered to establish the correct diagnosis in couples opting for termination of anomalous fetus.

P 16.3

FROM CHALLENGES TO TRIUMPH: EXPLORING THE INTERSECTION OF SYSTEMIC LUPUS ERYTHEMATOSUS, PREGNANCY, AND CONGENITAL HEART BLOCK

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Introduction

Introduction: Systemic lupus erythematosus (SLE) poses specific challenges in pregnancy as well as for the neonate. In this case report, we describe successful outcome in a fetus with an extremely low heart rate due to congenital complete heart block (CHB) in a mother with SLE.

Case Report

27-year-old primigravida presented with bicytopenia and fetal echocardiography suggesting complete AV block at 27 weeks' period of gestation. Upon evaluation anti-nuclear antibody (ANA) and anti-Ds DNA testing was positive and was diagnosed with SLE. Further workup confirmed presence of anti-Ro and anti-La antibodies. Repeat fetal echocardiogram showed a ventricular rate of 43/minute. In addition to medical therapy for SLE (HCQ, Wysolone) she was administered Tablet Salbutamol (4mg TDS) to improve fetal heart rate and she underwent fetal echocardiography weekly to monitor ventricular rate. At 37 weeks', an elective caesarean was done and a male baby weighing 2560 gm was born with HR of 53/minute and an Apgar score of 8/8. The neonate required percutaneous pericardial pacemaker insertion on day 3 of life due to left ventricular dysfunction and was discharged in stable condition after receiving appropriate care in the neonatal intensive care unit.

Clinical Relevance

Discussion: Neonatal Lupus erythematosus (NLE) is a rare condition caused by autoantibodies targeting the fetal heart, leading to inflammation and fibrosis, resulting in CHB. Aggressive medical management coupled with pacemaker is required for those babies who do not respond to medical therapy alone. Antenatal diagnosis, intensive monitoring with fetal echocardiography, guided transplacental therapy and multidisciplinary approach is the key to success

P 16.4

MULTIDISCIPLINARY APPROACH FOR A CASE OF SEVERE REFRACTORY IHCP WITH BAD OBSTETIC HISTORY

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Introduction

Intrahepatic cholestasis of pregnancy (IHCP) is a condition associated with itching and raised serum bile acids (BA) Severe IHCP is associated with adverse perinatal outcome with increased risk of still birth (3.4 %).

Case Report

31 year, G6P0+2+3+0 with bad obstetric history with history of abruption in previous 2 pregnancies presented at 21 weeks 3 days with itching over palms and soles, diagnosed with IHCP (deranged LFT- OT/PT/ALP – 206/270/456 with serum Bile acid – 68) .Patient was started on Ursodeoxycholic acid 300 mg TDS , later on increased to 450 mg TDS, due to rising levels of BA and LFT; started on Cholestyramine sachet 4g TDS, but was intolerant, hence was started on tab Rifampicin 150 mg OD at 29 weeks, later on increased to 300 mg OD at 31 weeks. Strict daily fetal count monitoring with alternate day biophysical profile was done . Preterm caesarean was done at 34 weeks 2 days in view of severe IHCP and bad obstetric history. She delivered a female baby weighing 2530 grams, APGAR 9/9

Clinical Relevance

Early diagnosis and intensive feto-maternal surveillance in severe IHCP leads to improvement in perinatal outcome. Adding second line drugs like cholestyramine, rifampicin enhances bile acid excretion and is an option for refractory cases.

P 16.5

RECURRENT OLIGOHYDRAMNIOS WITHOUT ANY IDENTIFIABLE CAUSE - A RARE CASE REPORT

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Introduction

Recurrent isolated oligohydramnios in one or more successive pregnancies is a very rarely observed phenomenon, with only 2 cases reported worldwide, and has been linked to higher rates of adverse outcomes.

Case Report

G6P2L1A3 @35+4weeks presented with decreased fetal movement for two days. Previously 2 pregnancies were both complicated by oligohydramnios without any identifiable cause, the first one being a preterm IUD and the second a term normal vaginal delivery with a healthy baby, followed by three miscarriages at 10-12 weeks after cardiac activity appeared. LAC & APLA was negative. The present pregnancy was spontaneously conceived, supervised, and had normal estimated fetal weight and umbilical artery PI on USG, with deranged middle cerebral artery PI, making the cerebroplacental ratio

Clinical Relevance

Another case of recurrent oligohydramnios was reported by Kamath-Rayne et al in Ohio, USA in 2013, implicating an ErbB4 mutation found in the mother as well as the second neonate with fatal pulmonary hypoplasia, pneumothorax, and pulmonary hypertension along with decreased vascularity in placenta.1 A retrospective cohort study in 2022 showed that previous pregnancies complicated by isolated oligohydramnios are associated with an increased risk of placental related disorders in subsequent pregnancy.2 Isolated oligohydramnios may be the first sign of placental insufficiency. Treatment options for oligohydramnios are few, including hydration and amnioinfusion, and require more research such as a study by Maher et al in 2017 that showed Sildenafil citrate therapy to be superior to hydration.3 CONCLUSION: Recurrent oligohydramnios is understudied and underreported, and requires stringent history taking to be diagnosed and managed timely. Large scale trials are needed to identify causes of recurrent oligohydramnios, to come up with plans for management.

P 16.6

SEVERE HYPERTENSION IN PREGNANCY: NOT-GESTATIONAL

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Introduction

Hypertension in pregnancy usually presents as gestational hypertension or pre-eclampsia. However, secondary causes of hypertension may occasionally be detected in pregnancy. We describe a case of hypertension in pregnancy secondary to renal artery stenosis.

Case Report

A 23-year-old, G2P1L1 presented at 21 weeks gestation with BP of 180/110 mmHg, with a difference of more than 20 mmHg between the two upper limbs. Pulse rate was 90 bpm. All peripheral pulses were palpable. On examination, uterus was 18 weeks in size. Ultrasound revealed Intra Uterine Growth Restriction (IUGR), severe oligohydramnios, and bilateral renal artery stenosis in mother. T. Labetalol (400mg QID) and T. Nifedipine (20 mg TDS) were started. MR Angiography of Renal vessels and Aorta revealed possibility of Takayasu Arteritis (TA). Absent cardiac activity was detected on USG at 23 weeks. She delivered a macerated fetus at 24 weeks. CT Angiography was done post-delivery which confirmed the diagnosis of type-V Takayasu arteritis. Hypertension persisted after delivery and was managed with T. Hydrochlorothiazide 12.5 mg OD and T. Carvedilol 6.25 mg BD.

Clinical Relevance

A majority of the population affected by TA are women of childbearing age. They may have stenotic involvement of the renal arteries leading to hypertension during pregnancy. Fetal outcome is compromised due to increased renin activity and uteroplacental insufficiency, leading to IUGR and oligohydramnios. While dealing with pregnant women with severe hypertension, secondary causes like renal artery stenosis and Takayasu arteritis must also be ruled out. Need for advanced radiological imaging to confirm the diagnosis during pregnancy presents a clinical dilemma. While BP can be controlled with appropriate anti-hypertensives, fetal outcome may still remain compromised due to widespread vascular involvement.

P 16.7

SILENT SCAR RUPTURE AFTER VAGINAL BIRTH IN A PREVIOUS CAESAREAN SECTION

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Introduction

Uterine rupture is a relatively rare yet extremely serious complication in obstetrics, carrying an increased risk of maternal and perinatal health issues and even death. Uterine rupture is reported in approximately 0.5%–1% of women attempting vaginal births after a previous caesarean section and the risk further rises when labor is induced. However, there have been only a few documented cases of silent uterine rupture resulting in the delivery of a healthy fetus, particularly after vaginal delivery.

Case Report

In this report, we present one such case. Shortly after the delivery of placenta, omentum was noted to be protruding out of the cervix immediately after the delievery of placenta while the patient's vital signs remained stable (fig1). An Emergency laparotomy was performed and the part of omentum was observed to be strangulated. Partial omentectomy was done followed by repair of uterine scar in double-layer technique. No postoperative complications were encountered whatsoever.

Clinical Relevance

It is possible for spontaneous silent rupture to occur in women without any alarming symptoms. Therefore, maintaining a high index of suspicion is crucial for early detection of uterine rupture in cases with a previous scar, particularly when patients present with vague symptoms. Timely diagnosis can make a critical difference in saving lives.

P 16.8

PREGNANCY IN PATIENT OF EMPTY SELLA SYNDROME

Megha Gupta

Introduction

Empty sella syndrome is a damaged pituitary gland. Either the gland has shrunk or has been crushed and flattened making it look like an empty sella on MRI scan. Partial empty sella is suggestive that some of the pituitary gland is visible on the MRI scan. The reported prevalence of primary empty sella in general population is 8–35 %. The incidence is more in females, the ratio being 5:1.

Case Report

Our case was a 27 yrs old female taking treatment for infertility from LNJP hospital . Empty sella syndrome was diagnosed on MRI imaging during evaluating the cause of hyperprolactinemia. Patient was started on tab bromocriptine. Patient conceived by ovulation induction with IUI. Patient had DADC twin pregnancy. Course of pregnancy was uneventful till 34 weeks of POG when she developed preterm labour pains. Twin baby girls of 2.1 kg and 1.6 kg were delivered vaginally . Postnatal period was uneventful without any major complications. Bromocriptine was withheld postnatally during lactation phase.

Clinical Relevance

Knowing the etiology of various clinical manifestations seen in patients of empty/partial sella syndrome help us manage and prevent them which improves quality of life.

P 16.9

AN UNUSUAL PRESENTATION OF COMPOUND SICKLE CELL SYNDROME IN PREGNANCY

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Introduction

Compound sickle cell syndromes include any heamoglobinopathy in which the sickle mutation is inherited in combination with another globin gene mutation .These syndromes present with a variable clinical severity.In India cases of sickle cell disease are encountered commonly in deccan plateau, central& coastal India. Sickle cell disease increases morbidity and mortality during pregnancy and negatively influences the pregnancy outcome.

Case Report

: A 26 year old unbooked patient G4P2L2A1 with32wk gestation was admitted from gynae casualty of SJH with complaints of fever , breathlessness , jaundice, cough, multiple joint pain s & h/o 2 unit blood transfusions . She was clinically pale,tachypnoeic. On per abdominal examination uterus was 28-30week size, FHS present ,138 beats/min, uterus relaxed; hepatosplenomegaly was present. Her investigations were suggestive of severe hemolytic anaemia with deranged liver enzymes with moderate hepatosplenomegaly on ultrasonography . Heamoglobin electrophoresis (after 3 unit BT)results showed elevated HbS(35%), HbF(15.7%),HbA2(1.3%) ; peripheral smear was normocytic normochromic anaemia with signs of heamolysis(schistocytes and helmet cells were seen),Her dengue NS1 antigen result was positive .She was given multiple transfusions with no significant improvement of hemoglobin levels , needed exchange transfusions ,leucoirradiated blood transfusions .She was planned for elective lscs at 34week.She was watched carefully for sickling crisis in post op period in high dependency unit ,was adequately hydrated ,given thromboprophylaxis and was discharged on post operative day 7 at the best of her health and advised to follow up in hematology department. After three months her Hb electrophoresis turned out to be suggestive of HbS-HbF complex heterozygous sickle cell syndrome.

Clinical Relevance

Sickle cell disease accounts for 14.5% in new born in india ; Increased awareness on the part of obstetricians about the precence of this hemoglobinopathy early diagnosis of patient and partner, appropriate timely management is required in these patients for a better pregnancy outcome.

P 17.1

SUCCESSFUL OUTCOME OF VALVULOPLASTY IN SECOND TRIMESTER OF PREGNANCY

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Introduction

Rheumatic heart disease is the most common acquired cardiac lesion among pregnant females in India. Along with medical therapy, surgical intervention may be necessary in severe cases. Percutaneous Trans -Mitral Commissurotomy (PTMC) is an effective intervention for severe mitral stenosis in pregnant women. This should be considered as the treatment of choice when managing pregnant women with severe mitral stenosis.

Case Report

We have studied two antenatal cases with severe valvular heart disease in pregnancy who underwent valvuloplasty in second trimester of pregnancy and had successful outcome. Case 1: 23 years, G2P1L0 presented at 22 weeks with DADC twin with single intrauterine fetal demise with RHD with severe MS, severe TR, mild MR, mild AR, EF 60%, CARPREG SCORE 5 and WHO class IV with dyspnea at rest (NYHA 4), underwent PTMC at 22+5 weeks. Post PTMC, significant improvement in cardiac function was observed and discharged in satisfactory condition. She was readmitted at 30 weeks with preterm labor pains with transverse lie, LSCS was perfomed. Her post operative period was uneventful & baby was admitted at NICU i/v/o prematurity. Case 2: Similar case of RHD with Severe MS at 23 weeks period of gestation, presented with difficulty in breathing NYHA IV, underwent PTMC and got discharged in satisfactory condition. She readmitted at term in early labor and delivered healthy baby by LSCS. Her post operative period was also uneventful and patient was discharged.

Clinical Relevance

PTMC during pregnancy offers good results in terms of symptomatic relief and hemodynamic improvement leading to successful outcome of pregnancy.

P 17.2

STATUS EPILEPTICUS IN PREGNANCY – A LIFE THREATENING CHALLENGE

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Introduction

Status epilepticus (SE) is defined as a seizure with five minutes or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery between seizures. The overall incidence of status epilepticus is 9.9 to 41/100,000/year. There is 15-30% increase risk of seizure in pregnancy in women who already have epilepsy. Untreated seizures may lead to maternal hypoxia, acidosis and potential fetal distress. We present a case of a pregnant woman who experienced status epilepticus, highlighting the diagnostic and therapeutic management complexities involved.

Case Report

A 35year old primigravida at 32 weeks gestation with stage 1 FGR k/c/o childhood epilepsy for 9 years of age, not on any medications, presented in AIIMS emergency with multiple episodes of GTCS lasting for more than 1 minute without regaining consciousness in between along with up rolling of eyes, frothing from mouth, urinary incontinence with GCS of E4V1M5. She was immediately intubated and levetiracetam was administered followed by midazolam infusion. Her MRI showed frontal gliosis. Gradually she was stabilized on tab. levetiracetam and Perampanel. Maternal and fetal monitoring was done cautiously. At 35 weeks of gestation patient had repeated seizure episode with poor bishop score, borderline oligohydramnios thus, emergency cesarean section was done and delivered a male baby of 1855gms weight. Patients had multiple episodes of seizures in postpartum period probably due to noncompliance. She was again started on injectables and then shifted to tablets gradually.

Clinical Relevance

Differentiating between seizure types and identifying the underlying cause of status epilepticus during pregnancy can be challenging. Pregnancy-related complications, such as eclampsia and cerebral venous thrombosis, must be ruled out. Furthermore, pharmacokinetic changes during pregnancy may affect drug levels, potentially leading to suboptimal seizure control. Pregnancy may worsen the frequency of seizures in known epileptic women due to hormonal changes, water and sodium retention, stress and decreasing levels of antiepileptic medications. Balancing the need for effective seizure control in the mother while minimizing fetal risks requires a multidisciplinary approach. Strict drug compliance is a crux in the prevention of SE in epileptic patients

P 17.3

ATYPICAL MILLER FISCHER SYNDROME VARIANT DURING PREGNANCY: A DIAGNOSTIC DILEMMA

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Introduction

Miller-Fisher syndrome (MFS) is recognized as a variant of Guillain-Barré syndrome (GBS). Here, we describe the clinical features of a pregnant woman in early pregnancy with MFS and successful neurological and obstetric management

Case Report

26 years old G2P1L, presented with double vision, slurring of speech, difficulty in swallowing and weakness in all four limbs at 26 weeks of period of gestation. There was a diagnostic dilemma of MFS variant of GBS Versus Bulbar Myasthenia Gravis (MG). Patient diagnosed to have an atypical variety of Miller Fischer Syndrome (Variant of GBS) after investigations and received 5 cycles of plasmapheresis and IVIG 2g/kg over 5 days. She was started on tab prednisolone and glycopyrrolate and condition was improved on that. Patient was on Ryle's tube feeding for almost 6-8 weeks and she followed on OPD basis. Patient had improvement in vision, swallowing of food and was able to walk with support. Patient developed stage 1 fetal growth restriction (FGR) and gestational diabetes mellitus (GDM) on diet. Patient delivered at 36 weeks period of gestation by emergency LSCS in view of unstable lie in labor and had healthy female baby, 2.1 Kg. Postpartum period was uneventful.

Clinical Relevance

The association between MFS and pregnancy has been reported very rarely in the past. Although uncommon, MFS is an important diagnosis to make since the presenting symptoms of ataxia and opthalmoplegia may confuse the clinician and suggest an upper motor neuron sign or central cause. MFS should be included in the differential diagnosis of anyone presenting with central findings of ataxia, areflexia, and opthalmoplegia. There are very few cases of MFS reported during pregnancy. The impact of the Miller Fisher variant on the normal course of gestation and on long-term perinatal outcomes is unknown. Key to successful management lies in early diagnosis and treatment with IVIg or plasmapheresis. Further studies that look into the diagnosis, treatment and prognosis of this condition are required.

P 17.4

MANAGEMENT IN AN UNRUPTURED HETEROTROPIC PREGNANCY

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Introduction

Spontaneous heterotropic pregnancy is a rare complication of pregnancy where both intrauterine as well as extra-uterine gestation occurs simultaneously and can be life threatening. Reported incidence is 0.6-2.5/10,000 pregnancies.

Case Report

29 years old, G4P2L1A1 with previous cesarean was referred to our hospital at 6weeks gestational age with scan suggestive of heterotropic pregnancy incidentally diagnosed during routine scan. On transabdominal and transvaginal imaging were suggestive of two live gestational sac, one intrauterine towards fundus (normal implantation) and other at scar site suggestive of scar ectopic. Patient was vitally stable. Patient was counselled regarding various method of management and planned with medical management with aspiration and instillation of potassium chloride into gestational sac at scar site.

Clinical Relevance

The medical management for heterotropic pregnancy includes either KCl instillation into gestational sac or local/systemic methotrexate injection as well. However, as patient wanted to continue with pregnancy, hence, injection potassium chloride instillation at scar site ectopic was planned as methotrexate instillation local or parentral would adversely harm the villi of the normally implanted gestational sac as well.

P 17.5

LIPODYSTROPHY- A RARE CAUSE OF DIABETES IN PREGNANCY

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Introduction

The lipodystrophic syndromes are a heterogenous group of congenital or acquired disorders characterized by either complete or partial lack of adipose tissue (lipoatrophy). The extend of fat loss correlates with the severity of the metabolic abnormalities. Clinically, the patients have severe insulin resistance, hyperlipidemia, progressive liver disease and proteinuric kidney disease.

Acquired lipodystrophy develops in previously healthy child or adult over a period of days to weeks. Only few cases have been reported.

Case Report

A 24 years old G2P1L0 with previous LSCS with Type I diabetes on her second visit at 17 weeks, presented with complains of loose stools 3-4 episodes, aggravated on meals. Her RBS was 300 mg/dl and Urine ketones were negative. Her booking weight was 36 kg, BMI- 18 kg/m2, HbA1C was 7.9%, NT/NB scan and rest of the investigations were normal. Patient was admitted, insulin dose was increased to total 3.7 units /kg according to blood sugar charting.

Review of history revealed complains of progressive fat loss. Clinically there was generalized fat loss with acanthosis nigricans on axilla and neck, skin fold thickness-32.2 mm, estimated body fat percentage-19.5%, Nephritic range proteinuria, hyper- triglyceridemia (333), grade 1 fatty liver. Her kidney function test, fundus examination, USG for fetal being was normal. She was admitted at 24 weeks in view of decreased fetal movements. Blood sugar maintained on Regular Insulin 60 Units/day and Injection NPH 62 units/day. She was kept under observation for blood sugar and fetal monitoring.

Elective LSCS was done at 37 weeks, 3.5 kg male baby was born.

Post op endocrinologist opinion was done, patient was discharged on oral hypoglycemic drugs.

Clinical Relevance:

There is no universally accepted objective criteria for diagnosis. Management remains difficult due to underlying severe IR and its manifestations. Clinical trials have been going on therapeutic role of Leptin in Lipodystrophy

P 17.6

MEIG'S SYNDROME MIMICKING MALIGNANCY IN PREGNANCY

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Introduction

Adnexal masses in pregnancy can be a diagnostic dilemma at times especially in cases suspicious of malignancy. We present a case of an ovarian tumor (suspected malignancy) first detected during early pregnancy and dilemmas faced throughout.

Case Report

A 29 years old primigravida presented at 9 weeks gestation to a private hospital with complaints of pain and distension of abdomen and shortness of breath. Ultrasound scan done showed a live intrauterine fetus of 10 weeks with a heterogenous mass with peripheral vascularity measuring 9.4 x 7cm in right adnexa, right ovary not visualized. Ascites and right sided pleural effusion also present. Ca-125 was more than 1000 units/ml. Abdominal paracentesis showed no malignant cells. She presented to Dr RML hospital, in the third trimester at around 29 weeks when she was diagnosed with early onset pre-eclampsia, cholestasis and growth restriction all of which were managed conservatively. She was followed up with serial CA-125 and ultrasound. CA-125 was increasing marginally and ascites was not increasing. So we continued the pregnancy until 34 weeks to achieve a good perinatal outcome. At 34 weeks, looking at the possibility of malignancy which could not have been completely ruled out without histopathology, we decided to terminate this pregnancy after thoroughly counselling the couple. She underwent Caesarean at 34 weeks and 2 days gestation along with right salpingoophorectomy. A right sided solid ovarian mass 8cm x 10cm with a smooth surface and intact capsule was found. This was identified as a fibroma by frozen section and later confirmed by histopathology. The baby girl weighing 1972 grams was discharged from NICU in healthy condition. Patient recovered well after surgery.

Clinical Relevance

Retrospectively, this was a case of Meig's syndrome in pregnancy which had a good outcome after removal of the tumor.

P 17.7

KLIPPEL TRENAUNAY SYNDROME: A RARE CASE REPORT

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Introduction

Klippel Trenaunay Weber syndrome (KTWS) a complex congenital cutaneous vascular malformation syndrome characterized by a triad of capillary and venous malformation and limb hypertrophy with or without lymphatic malformation. The estimated prevalence is 1 in 100,000 with no predilection for gender or ethnicity, and it appears more frequently at birth, childhood or adolescence. The perinatal outcome of KTS is usually favorable, but the quality of life is significantly affected. Thus, a multidisciplinary approach is required for management such as monitoring for limb length discrepancies, gastrointestinal bleeding and anti-thrombotic prophylaxis.

Case Report

A 30 years old G4P1L1A2 at 15 weeks gestation was detected with abnormal fetal right lower limb thickness, hypervascularity in both thighs and multiseptated hypoechoeic areas involving skin and subcutaneous tissue of left shoulder region, axilla, chest wall and lower back region posteriorly on a routine antenatal scan. The lesion was extending into bilateral lower limbs associated with cortical thickening of long bones of lower limb. Significant subcutaneous thickening was present in right foot along with slow flow vascular malformations. The couple did not opt for any prenatal testing. She received routine antenatal care and at 27 weeks of gestation developed polyhydramnios with fetal demise. She delivered a macerated still born baby girl weighing 2.5 kg (>99th centile). Consent obtained for external autopsy, fetal photographs and tissue biopsy. Fetus was grossly macerated with hypertrophied skin and subcutaneous tissue along with bluish discoloration over affected areas. The histopathology of fetal thigh tissue was suggestive of arterio–venous malformation compatible with diagnosis of KTWS.

Clinical Relevance

This condition can be diagnosed on antenatal ultrasound. Couple should be counselled for genetic analysis as its associated with mutation in PIK3CA gene and carriers are at risk of vascular events such as deep vein thrombosis.

P 17.8

A RARE CASE REPORT OF TWIN PREGNANCY WITH COMPLETE: HYDATIDIFORM MOLE AND CO-EXISTING NORMAL LIVE FETUS.

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Maulana Azad Medical College

Introduction

The Incidence of complete hydatidiform mole coexisting with a viable live fetus is 1/22,000–1/100,000 pregnancies worldwide, with only 56 cases resulting in a healthy take-home baby documented in detail in literature.

Case Report

Here we report a case of a 28 years old lady, G3P1L1A1 referred to our hospital with ultrasound suggestive of - molar pregnancy with normal viable fetus, done in view of bleeding per vaginum at 19 weeks period of gestation. Patient was completely worked up and counselling done regarding amniocentesis in which no aneuploidy was detected. Fetal MRI was also done, suggestive of complete hydatiform mole with coexistent fetus with no gross congenital anomaly in viable fetus. Serial beta hcg monitoring done- at 22 weeks- 9,30,759 mlu/ml. The patient is still under safe confinement for her pregnancy and is being monitored for complications of molar pregnancy.

Clinical Relevance

Management of complete hydatidiform mole and co-existing normal live fetus is uncertain, due to paucity of literature and difficult management due to fetal and maternal complications.

P 17.9

SUCCESSFUL OUTCOME OF A CONSERVATIVELY MANAGED CASE OF PLACENTA PERCRETA CAUSING HAEMOPERITONEUM: A RARE CASE REPORT

Nisha, Juhi Bharti, Seema Singhal, K Aparna Sharma, Soniya Dhiman, Neena Malhotra

AIIMS, New Delhi

Introduction

Patients with placenta accreta spectrum can have varied presentations like antepartum hemorrhage, abdominal pain, uterine rupture, hemoperitoneum or urinary symptoms. Definitive surgical management remains the mainstay of therapy. We present a unique case of PAS that presented with hemoperitoneum in mid trimester and posed management dilemma to the treating team.

Case Report

A 29year-old, G2P1L1 with previous LSCS, presented at 16weeks gestation to emergency with history of fall. On presentation, she had severe abdominal pain with hypotension, tachycardia and anemia (Hemoglobin-6.4gm/dl). She already had MRI report of placenta previa and succenturiate placenta with accessory lobe invading the myometrium. Ultrasound revealed single live fetus with hemoperitoneum, making a diagnosis of uterine rupture due to morbidly adherent placenta.

Clinical Relevance

Emergency laparotomy was done which revealed around 800ml of hemoperitoneum with active bleeding from right margin of uterine scar with placental tissue seen at the scar dehiscence site. Hemostatic sutures taken led to control of bleeding. Intraoperative ultrasound showed normal fetal heart rate and a decision of conservative management was taken. The pregnancy continued till 29+3 weeks when she presented again with antepartum hemorrhage and a decision to terminate pregnancy was taken. Emergency uterine artery balloons were placed which were inflated after delivery of a 1.2 kg baby followed by caesarean hysterectomy. Both mother and baby did well and were discharged in satisfactory condition. Conclusion: Hemoperitoneum in pregnancy requires a high index of suspicion and aggressive management of the cause. If not managed well, patients with placenta accreta spectrum may present with obstetric catastrophe.

P 18.1

A RARE CASE OF SPONTANEOUS RUPTURE OF PLACENTA ACCRETA IN SECOND TRIMESTER

Nikita Sharma

Introduction

•Placenta accreta spectrum disorder is characterized by abnormal or pathological adhesion or invasion of the placenta to uterine myometrium, serosa and to adjacent structures. The rapidly rising incidence of PAS and associated high maternal and fetal mortality and morbidity is of serious concern and is drawing significant attention from all concerned scientific communities. The common presenting feature is hemorrhage. Mid trimester spontaneous rupture in PAS is a rare but life-threatening entity.

Case Report

30 years old female with 1 previous cesarean delivery who presented at 22+4 weeks gestational age, with massive hemoperitoneum in hemodynamically unstable condition with a hemoglobin of 4 gm/dl. Prompt diagnosis, emergency hysterectomy with transfusion of multiple blood and blood products saved her life.

Clinical Relevance

• Incidence of PAS has been on global rise due to increased rates of CD • half to two-third cases remain undiagnosed prior to delivery. • Timely and accurate diagnosis of PAS is of utmost importance • Current antenatal diagnosis is based on identification of sonographic findings of 2D grey-scale and color Doppler imaging. • Spontaneous rupture of placenta accreta in early course of pregnancy is very rare but urgent obstetric emergency. • High suspicion index is necessary for prompt diagnosis and management especially in at risk patients

P 18.2

PRENATAL DIAGNOSIS AND SUCCESSFUL OUTCOME OF FETAL CARDIAC RHABDOMYOMA ASSOCIATED WITH TUBEROUS SCLEROSIS

Preethikka RM, Anubhuti Rana, Lamk Kadiyani, Paridhi Gupta, Satya Prakash, Neerja Bhatla

AIIMS, Delhi

Introduction

Fetal cardiac rhabdomyoma is the most common primary cardiac tumour and is associated with tuberous sclerosis (TS) in 50% of cases. Fetal echocardiography can detect these as multifocal, hyperechoic, homogenous myocardial mass. Spontaneous regression is seen in about 50% of cases. However, few cases may require intervention due to mass-related symptoms.

Case Report

32-year-old, G3P1+0+1+1 presented with multiple cardiac rhabdomyomas in fetus at 29 weeks gestation. Fetal echocardiography and fetal MRI revealed multiple rhabdomyomas involving all chambers of heart. Fetal neuro-sonography did not reveal any tubers. Fetal surveillance continued with regular fetal echocardiography to look for increase in size, appearance of new lesions or any valvular obstruction. Emergency caesarean was done at 34 weeks 6 days due to preterm premature rupture of membranes with genital warts, delivering a female baby weighing 2410 gm, Apgar of 9/9. On Day 1, baby developed cyanosis for which oxygen support was given. Baby was started on sirolimus at 1mg/m2 and echocardiography. After 1 week showed slight reduction in the size of the mass. Genetic testing confirmed the diagnosis of Tuberous sclerosis in the baby. Currently, the baby is on sirolimus therapy with 50% reduction in the tumor size.

Clinical Relevance

Sonograhic detection of cardiac rhabdomyoma in fetus can lead to early diagnosis of tuberous sclerosis. A multidisciplinary approach is required in the prenatal diagnosis and management of tuberous sclerosis which can present as cardiac rhabdomyoma as the initial sign in prenatal period. Sirolimus causing rapid regression of rhabdomyomas in early post-natal life is a vital treatment option.

P18.3

INFECTIOUS GRANULOMATOUS DISEASES IN PREGNANCY - A CASE REPORT

Puneet kaur

MAMC , New Delhi

Introduction

Granulomatous infectious diseases like tuberculosis and leprosy have been a heavy burden on health care systems. With introduction of National programmes to tackle the same, their incidence has reduced drastically, but they continue to drain the health resource especially as new atypical forms are drug resistant forms are being seen the society.

Case Report

24 years old female married for 4 years G3P2L1 at 33 weeks period of gestation diagnosed with bone marrow tuberculosis and borderline lepromatous leprosy with T1 leprosy reaction. The patient underwent work up for prolonged febrile illness with was diagnosed as bone marrow tuberculosis on bone marrow aspirate and biopsy report which showed granulomatous reaction with staining positive for AFB. She was started on ATT and discharged. She presented again with erythematous lesions on face and lower limbs. Skin biopsy of nodules showed globi with fragmented leprae bacilli. This confirmed it as borderline leprosy with type 1 leprosy reaction. She was started on multibacillary treatment and responded to it.

Clinical Relevance

It's important to do early diagnosis of and proper management of atypical tuberculosis as tuberculosis is rampant in all forms in our country. With the added burden of leprosy on the patient, it's important to ensure fetal as well as maternal well-being with mother receiving not only anti tubercular but anti leprosy antibiotics also. So, the goal of treatment is to treat the infectious disorders along with ensuring no adverse reaction to combined therapies in both the mother and the fetus, which makes it a slippery rope requiring early detection of adverse events and prompt response to ensure no lasting damage to fetus as well the mother.

P 18.4

A RARE CASE OF FETAL BRAIN TUMOR - CASE REPORT

Rahul Amitabh, Aparajita Gupta

VMMC & Safdarjung Hospital, New Delhi

Introduction

Congenital CNS tumors have incidence of 0.34 per million live birth and are thus rare.1 USG during pregnancy is the main modality to establish an early and correct diagnosis for these lesions.2

Case Report

A 36y old female G2P1L1 came to fetal medicine OPD and was advised dual marker testing which showed intermediate risk of 1:608. Ultrasound was done where fetal cardiac activity was absent, FL~ 18+1 weeks. Fetal skull was grossly enlarged in size. Structure of parenchyma were deformed and gross free fluid seen within.There was herniation of intraparenchymal content [CSF +brain parenchyma] through a posterior defect of 2.2 cm likely encephalocele and was causing deformation of fetal face. Fetal hydrops noted throughout the body (Maximum separation 10 mm), gross pericardial effusion (15 mm) and gross pleural effusion (6 mm). Differential diagnosis – 1) Intraparenchymal brain tumor in fetus with encephalocele. 2) Fetus in fetus (less likely). Patient was planned for MTP and induced with tablet mifepristone. Patient subsequently delivered Abortus weighing- 400g, sex- male. Fetal brain autopsy could not be done due to autolysis of maximum fetal brain. Residual brain tissue was sent for histopathology analysis which showed normal cerebellar tissue with autolytic changes and necrotic materials on cut section.

Clinical Relevance

DISCUSSION: In majority of cases, these tumors result in IUD and prognosis is poor. Most common among these tumors is teratoma.3 In our study the exact diagnosis of the tumor could not be made because of necrosis and liquefaction of brain tissue. CONCLUSION: The diagnosis of fetal brain tumor is challenging in antenatal period. Routine USG scanning during pregnancy should be done to permit early detection.

P 18.5

UNUSUAL CASE OF TRAUMATIC PPH: A CASE REPORT

Ritu Yadav, Abha Sood

Jaipur Golden Hospital, Delhi

Introduction

PPH is the leading cause of maternal mortality and

complicates 2-11% of all deliveries. Most common cause of primary PPH is atonicity of uterus and Retained tissues for secondary PPH.

Objective :- To find Cause of Primary PPH and it's management

Case Report

A 27 years Female P1L1 had normal vaginal delivery with episiotomy, Referred within 5hrs of her delivery with Primary PPH in shock with Severe Anemia. Per Abdominal Examination- uterus was intermittently retracting and relaxing. Per speculum examination- Cervical os - open and intermittent bouts of blood coming from os, episiotomy intact, no hematoma / Vaginal /cervical tear seen or felt, Ultrasound - heterogenous content in the uterine cavity 87cc Extending to the cervical canal. Hb- 6/ TLC- 24,400, Platelet count- 70,000. Resuscitation started with crystalloids and blood products. Uterotonics, Injection Tranexa given. Patient didn't respond and continued to have PPH. Decision for Laprotomy taken, Uterus explored, and adnexa examined. A broad ligament Hematoma around 9 X 10 cm, and 4cm tear on left side of uterus extending into lower segment involving left uterine artery tear. The tissue along the tear was extremely fragile, decision to proceed with hysterectomy taken. Emergency Obstetrics Hysterectomy done along with massive blood transfusion. Patient kept in ICU, blood transfusion continued, but there was fall in Hb- 5.6/ TLC- 14,000, Platelet count- 40,000. Re-exploration with laproscopy done, around 2 litres of blood clots drained, all stumps checked no active bleeding seen. Blood products transfused, patient was discharged after 7 days in healthy state.

Clinical Relevance

Our case represents a rare presentation as patient had normal vaginal delivery without instrumentation or fundal pressure, still had lower uterine segment tear on an unscarred uterus with broad ligament hematoma. Our approach to this patient was Laprotomy and emergency obstetrics hysterectomy followed by strict monitoring.

P 18.6

RUPTURED CORNUAL PREGNANCY WITH ADHERENT PLACENTA: A RARE PRESENTATION

Soumya Kore, Sarita Singh, Aditi Chawla

Introduction

A combination of adherent placenta with cornual implantation is a rare presentation and there are only 2 cases reported till date, ours is the third case. Adherent placenta accounts for 7-10% of maternal mortality cases worldwide.

Case Report

A 24 years old women G2P1L1 at 19 weeks and 2 days gestation came with IUD with previous lscs with corrected anemia. Patient was managed with tablet mifepristone after which she spontaneously expelled fetus with umbilical cord following which placenta was not delivered even after 30 minutes of delivery. Clinically, placenta was found adherent to fundus and anterior uterine wall. Decision for manual removal of placenta was taken. Intraoperatively left cornual adhered placental implantation with rupture was identified. Patient underwent subtotal hysterectomy with adhered placenta in situ (cornual)

Clinical Relevance

A diagnosis of cornual pregnancy remains challenging, and rupture of a cornual pregnancy causes catastrophic consequence due to massive bleeding. An appropriate individual counselling is needed regarding the risk of future pregnancies and the mode of delivery. Adherent placenta should be kept in mind in case of abnormal placentation.

P 18.7

CASE SERIES OF PORTAL HYPERTENSION IN PREGNANCY

Himakshi Boro, Sangeeta Gupta, Reena Rani, Pallavi Gupta, Ishita Aggarwal

Maulana Azad Medical College

Introduction

Objective: Management of Pregnancy in portal hypertension.

Case Report

Case1: 27years, G3P2L0, previous 2 LSCS, known case of non-cirrhotic portal fibrosis with active esophageal varices with splenic artery aneurysm, was booked at 26weeks. Patient was admitted and detailed history and examination done. Gastroenterology opinion taken and endoscopy planned. Endoscopic esophageal variceal band ligation done and patient advised to follow up. Patient was discharged at 29 weeks POG and readmitted at 34 weeks for elective caesarean. Case2: 29y, G2A1 a known case of portal hypertension since childhood was admitted at 38 weeks POG with mild esophageal varices with thrombocytopenia (platelet manual: 30000). 4-unit platelets transfused and patient taken up for elective caesarean at 39 weeks POG.

Clinical Relevance

Pregnancy outcome depends on the disease status and presence of esophageal varices at the time of conception. Pre-conceptional counselling and proper planning of management during pregnancy can decrease the burden of disease and better outcome. There is anticipation of increased intraabdominal pressure during hyperemesis in first trimester and also during labor where there is the risk of variceal bleed and hence a multidisciplinary approach is required with gastroenterology opinion.

P 18.8

GILBERT SYNDROME: COURSE DURING PREGNANCY AND POSTPARTUM

Shamaila Rashid, Pratibha, Arifa Anwar, Supriya

Hamdard institute of medical sciences and research

Introduction

Gilbert syndrome is due to a genetic variant in the UGT1A1 gene which results in decreased activity of the bilirubin uridine diphosphate glucuronosyltransferase enzyme resulting into unconjugated hyperbilirubinemia. It is typically inherited in an autosomal recessive pattern and occasionally in an autosomal dominant pattern depending on the type of variant. Incidence is around 7% in normal population.

Case Report

A Primigravida presented to us at 37weeks 2 days with pain abdomen and jaundice. On examination icterus was present, fundal height was corresponding to period of gestation and fetal heart rate (+). On further investigation, LFT was deranged with Total bilirubin – 3.81, Indirect- 2.05, Direct – 1.1; HAV, HEV and HbsAg were negative. Patient gave the history of recurrent episodes of jaundice precipitated by fasting. A diagnosis of Gilbert Syndrome was made based on the history, examination and investigation. Grade 3 MSL was noted on spontaneous rupture of membrane and patient was taken up for LSCS in view of Grade 3 MSL in latent labor. Mother and baby were kept in hospital for observation and was discharged on postoperative day 4 without any complications.

Clinical Relevance

Gilbert syndrome is an uncommon Autosomal recessive disorder which presents in teenage and early adulthood. The diagnosis can be made on the basis of history, examination and blood investigations. Genetic testing can be done for the confirmation – UGT1A1 gene sequencing is done which could not be done in the present case due to non-affordability of the patient. Conservative management is done with avoidance of triggers precipitating the flare up of the symptoms. This case was presented due to rarity of the disease in general population and how the pregnancy affects course of disease and outcome

AOGD Risk Management Support [ARMS] Group

One of the ways to ensure stress-free work environment and optimal patient care is mutual support among professional colleagues. An advisory group was set up last year so that they can be contacted if any 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. The same group will continue to provide timely advice and is led by

Convener- Dr. Vijay Zutshi- 9818319110

Co convener- Dr. Aruna Nigam- 9868656051

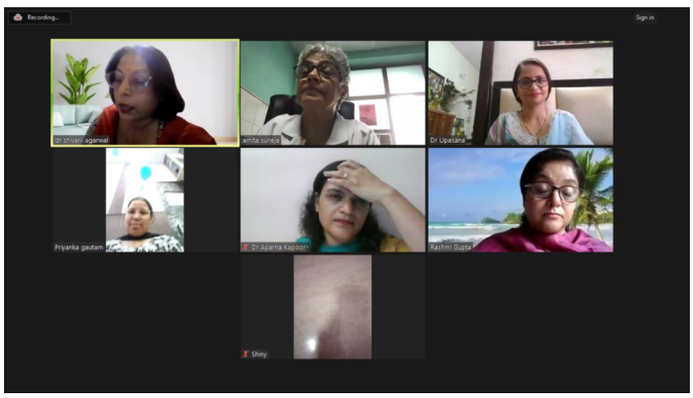
We invite suggestions from all members regarding functioning of this cell which will guide us forming the SOPs. Pl mail to **aogd.ucmsgtbh2023@gmail.com**

Calendar of Virtual Monthly Clinical Meetings 2023-24

Date	Name of Institution
18th -20th August, 2023	AOGD FOGSICON 2023
25th August, 2023	Deen Dayal Upadhyay Hospital
29th September, 2023	ESI hospital, Basaidharapur
27th October, 2023	All India Institute of Medical Sciences
24th November, 2023	MAMC & LNJP Hospital
29th December, 2023	Sir Ganga Ram Hospital
30th January, 2024	Dr RML Hospital
23th February, 2024	VMMC & Safdarjung Hospital
28th, March, 2024	UCMS & Guru Teg Bahadur Hospital
19th April, 2024	LHMC & Smt. Sucheta Kriplani Hospital
31st May, 2024	B L Kapoor Hospital

Events Held

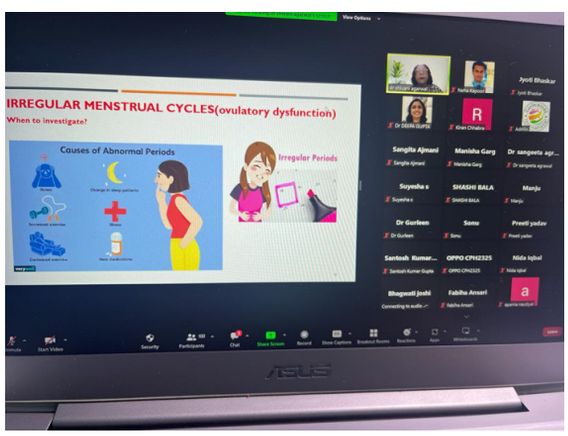
1. A Public Forum webinar was organised by AOGD Subcommittee on Community Health & Public Awareness on 18th July, as a part of WPD Campaign 2023



2. AOGD and Delhi PG Forum organised a Case discussion on "Urinary Incontinence" on 17.7.23 by post graduates of Lady Hardinge Medical College, Delhi.

   Coordinator Delhi PG Forum: Dr. Sunita Malik, Dr Shivani Agarwal

3. Community health and Public awareness committee organised a public forum webinar on 25.7.23 on adolescent PCOS. The event was attended by 170 participants



4. AOGD in association with DGF organised a CME "Conquer PPH by Bundle Approach" on 23rd July at Hotel The Park
5. AOGD monthly clinical meeting was held online on 28th July, 2023, 4-5pm by Army Hospital (Research & Referral), New Delhi
6. An online webinar on the changing perspectives in the management of Ca endometrium with the new staging was organised on 29 th Julyunder aegis of AOGD oncology sub-committee

Forthcoming Events

1. **AOGD and Delhi PG Forum will be organising a case-based discussion on "Acute Dyspnea in Pregnancy" on 21st August 2023 at 7:00 -8:30 pm.**

   Coordinator Delhi PG Forum: Dr. Sunita Malik, Dr Shivani Agarwal

2. **Next AOGD monthly clinical meeting will be held online on 25th August 2023, 4-5pm and will be organised by Deen Dayal Upadhyay Hospital, New Delhi**

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Committee	Chairperson	Contact No	Email id
Adolescent Health Sub-Committee	Dr Jyoti Bhaskar	9711191648	jytbhaskar@yahoo.com
Endometriosis Sub-Committee	Dr Reena Yadav	9868996931	drreenalhmc@gmail.com
Endoscopy Sub-Committee	Dr Swati Agrawal	9810181964/ 9953938995	drswatilhmc@gmail.com
Fetal Medicine & Genetics Sub-Committee	Dr Sangeeta Gupta	8368199481/ 9968604349	drsangeetamamc@gmail.com
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QI Obst & Gynae Practice Sub-Committee	Dr Kiran Aggarwal	9312277346	dr_kiranaggarwal@hotmail.com
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Infertility & Reproductive Endocrinology sub-committee	Dr Manju Khemani	9810611598	dr.manjukhemani@gmail.com
Community Health & Public Awareness sub-committee	Dr Shivani Agarwal	9868249464	dragarwal.shivani@gmail.com
Safe Motherhood sub-Committee	Dr Kiran Guleria	9811142329	kiranguleria@yahoo.co.in

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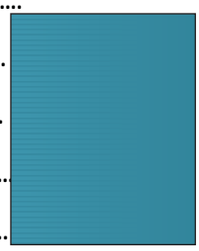

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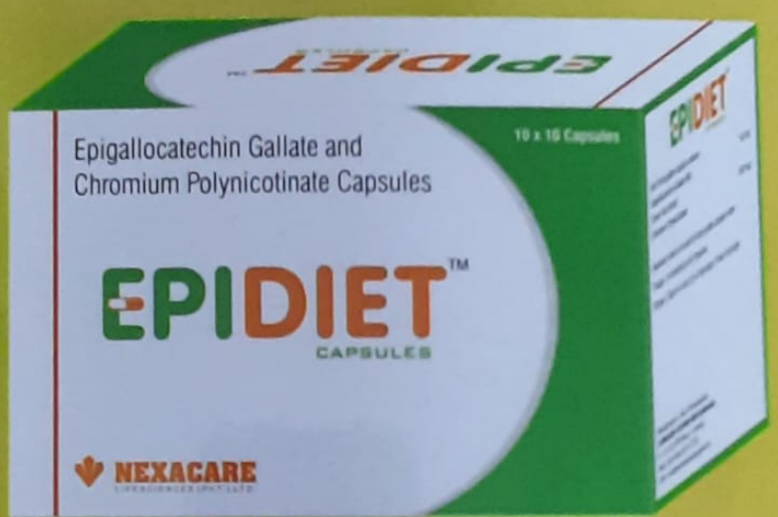

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