AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

VIHAAN

2023 - 2024

APRIL 2023 I VOLUME 1

MOTTO : REDEFINING WOMEN HEALTH

THEME : CATCH THEM YOUNG

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TEAM AOGS MESSAGE

Dr. Mukesh Savaliya
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Respected AOGS Members,

Greetings from team AOGS 2023-24!

We bring with us a vibrant team of enthusiastic members for serving AOGS with their fullest potential.

We hope this bulletin finds you in the best of the health and we wish you all health and happiness in all the fronts of life.

We've chosen 12 ' જ્યોતિર્લિંગ ' as theme of our AOGS Times... We've given the name '**विहान**' - The beginning!

We wish to promote PG activites this year including PG Sessions at the beginning of every CME, as well as we're in process of developing Academic Research wing of AOGS, we wish cooperation and contribution from all of you, as AOGS is very rich society in terms of experts in the field!

Wishing everyone great times!

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Installation Ceremony - Date : 16th April, 2023 Sunday






















Installation Ceremony - Date : 16th April, 2023 Sunday























Installation Ceremony - Date : 16th April, 2023 Sunday

Installation Ceremony - Date : 16th April, 2023 Sunday






















Inaugurate our new Auditorium “THE GLORY” - Date : 15.04.2023, Saturday






















GOLDEN JUBILEE ORATION - Date : 22.04.2023, Saturday

Installation Ceremony - Menopause Society Ahmedabad - Date : 21.04.2023, Friday

ARE POSTMENOPAUSAL WOMEN MORE PRONE FOR INFECTIONS???

DR. PRIYANKUR ROY

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Assistant Professor, Lord Buddha KoshiMedical College & Hospital, Saharsa
Consultant, Infertility & Gynae-Endoscopy, Roy's Clinic & Ramkrishna IVF Centre, Siliguri

INTRODUCTION

Menopause is an estrogen deficiency state. Women in the menopausal age group face both physical and psychological health issues. Yet unfortunately this is the most neglected age group in our society. One of the most common health problem that a postmenopausal woman counters is urinary tract infection. Bacteriuria in the elderly is associated with high mortality rates; however, in most cases, bacteriuria is asymptomatic and not a causal factor of death. Studies have shown, the growth of lactobacillus in the vagina help maintain the vaginal pH and thus is a protective factor for urinary tract infection in females. Postmenopausal women have a relative depletion of vaginal lactobacilli and an increase in vaginal E. coli compared with premenopausal women and hence this is one of the important factor why postmenopausal women are more predisposed to urinary tract infection.

DEMOGRAPHY

To understand the pathogenesis and risk factors for UTI in postmenopausal age group, we again divide this age group into healthy postmenopausal women between the ages of 50 to 70 years who are neither institutionalized nor catheterized, and elderly institutionalized women, who are in many cases catheterized. Bacteriuria is more often seen in the second subgroup of institutionalized elderly women with comorbidities. The majority of elderly women with bacteriuria are asymptomatic and should not be treated with antibiotics. In young to middle-aged women, the prevalence of UTI is $< 5\%$, rising considerably with advancing age. Epidemiologic studies have shown that 15% to 20% of 65-70 year-old women have bacteriuria, compared with 20% to 50% of women > 80 years old. However the risk factors for UTI in elderly women differ a lot much then in young healthy women. A case control study by Foxman et al showed that sexual activity was not associated with acquiring UTI in the age group of 40 to 60 years who are otherwise healthy, whereas a history of UTI during the past year, urine loss, antibiotic use during the previous 2 weeks, and exposure to cold during the previous 2 weeks were positively associated with UTI. In addition, drinking cranberry juice and taking vitamin C were moderately protective.

RISK FACTORS

- ➤ Healthy noninstitutionalized and non-catheterizedwomen
- Urological factors
  - a.Incontinence (41% of case patients vs. 9% control patients; $p < 0.001$)
  - b.Cystocele (19% vs. 0%; $p < 0.001$)
  - c.Post-voiding residual volume (28% vs. 2%; $p < 0.000008$)
  - d.History of UTI before menopause
- Non-secretor status (OR, 2.9; 95% CI, 1.28-6.25; p=0.005)
  - a.Estrogen deficiency
- Diabetic postmenopausal women
- History of kidney stones (hazard ratio, 1.95; 95% CI, 0.9-3.5)
- ➤ Older, institutionalized women
- urine catheterization and functional status deterioration appeared to be the most important risk factors associated with UTI

Major factors predisposing adult women to UTI related to age

Age group (yrs)	*Predisposing factor*
15 - 50	Sexual intercourse, Diaphragm / spermicide, Spermicide, Antimicrobials, Prior UTI, Maternal history of UTI, Childhood history of UTI, Non-secretor status
50 - 70	Lack of estrogen, Urogenital surgery, Incontinence, Cystocele, Post-void residual urine, Non-secretor status, Prior UTI
>70	Catheterization, Incontinence, Urogenital surgery

BACTERIURIA AND MORTALITY

Nordestam et al studied a population of elderly patients and compared their longevity in relation to bacteriuria. There was no increase in mortality related to bacteriuria for otherwise healthy individuals. Bacteriuria per se did not appear to be a risk factor for mortality. In patients with concomitant disease, bacteriuria was associated with increased mortality, but it is not the cause.

THE ROLE OF ESTROGEN

Another important factor in postmenopausal women is the potential role that estrogen deficiency plays in the development of bacteriuria. Postmenopause is characterized by a significant reduction in ovary estrogen secretion, which is often associated with vaginal atrophy. Clinically, it manifests as a syndrome characterized by vaginal dryness, itching, dyspareunia, and urinary incontinence. This may sometimes imitate a UTI. Estrogen stimulates the proliferation of lactobacillus in the vaginal epithelium, reduces pH, and avoids vaginal colonization of Enterobacteriaceae, which are the main pathogens of the urinary tract.In addition, the absence of estrogen decreases the volume of the vaginal muscles, resulting in slackness of the ligaments holding the uteric pelvic floor and the bladder, resulting in the development of prolapse of the internal genitalia.A previous randomized, double-blind, placebo-controlled study demonstrated that vaginal estriol treatment had a dramatic effect on recurrent UTIs in postmenopausal women. The results showed that the incidence of UTI in women who received vaginal estriol was reduced to 0.5 episodes per year compared with 5.9 episodes per year in women who received placebo. In addition, after 1 month of treatment, lactobacillus appeared in 60% of the estrogen- treated group but in none of the placebo group, and the vaginal pH decreased from 5.5±0.7 before treatment to 3.6±1.0 after treatment.

However, contradictory results were found in literature. For example, another study showed that the use of estriol-containing vaginal pessaries was less effective than the use of oral nitrofurantoin macrocrystals in the prevention of bacteriuria in postmenopausal women. This study also showed the failure of the estriol-containing vaginal pessaries to restore vaginal lactobacilli and to reduce vaginal pH in those women. A cochrane review on Oestrogens for preventing recurrent urinary tract infection in postmenopausal women stated In postmenopausal women with RUTI associated with a lack of oestrogens and signs and significant symptoms of vaginal atrophy, vaginal oestrogens are a potentially valid intervention. However, women should be advised that the evidence is based on only a few small studies. Studies comparing vaginal estrogen to antibiotics were inconclusive.

To conclude the efficacy of estrogen in the prevention of UTI in postmenopausal women with recurrent infections remains questionable.The main currently recommended use of estrogen (probably vaginal and not oral) is in postmenopausal women, especially those infected with multidrug-resistant uropathogens, which limits the options and effectiveness of antimicrobial prophylaxis, and in women in whom the symptoms are related to atrophic vaginitis.

TREATMENT

UTI in postmenopausal woman should be properly evaluated. Any complicating factors, such as urinary obstruction, neurogenic bladder disturbances, etc, should be ruled out at initial evaluation.Treatment of acute cystitis and pyelonephritis in otherwise healthy postmenopausal women is similar to that in premenopausal women.

In a double-blind study, including a total of 183 postmenopausal women of at least 65 years of age with acute uncomplicated UTI, similar results were obtained with either a 3-day or a 7-day oral course of ciprofloxacin 250 mg two times daily (bacterial eradication 2 days after treatment 98% vs 93%, p=0.16), but the shorter course was better tolerated. The rate of bacterial eradication in this study was generally high, and the rate of bacterial resistance to ciprofloxacin was low.

Asymptomatic bacteriuria in elderly women should not be treated with antibiotics.The optimal antimicrobials, dosages, and duration of treatment in elderly women appeared to be similar to those recommended for young postmenopausal women. However elderly geriatric population with significant comorbidities, who frequently present with UTI caused by more resistant Gram-negative organisms the treatment duration should be prolonged as in complicated UTI.

Estrogen (especially vaginal) could be administered for prevention of UTI; yet, the results are conflicting.Alternative methods, like cranberry juice and probiotic lactobacillus can contribute to preventing recurrent UTI in postmenopausal women, but more well-conducted studies are required to define their exact role and efficiency. Medical comorbidity like diabetes should be well controlled.

Cesarean scar pregnancy is a precursor of PAS Disorders: A Case report

Dr. Sapana Shah

(Prof), Department of Obs & Gyn, Smt NHL MMC, SVPIMSR, Ahmedabed

As an Obstetrician, our goal is 'safe motherhood and healthy child'. However, the numbers of operative deliveries are proportionately increasing. Amongst them cesarean section is the frontrunner. Rising number of scarred uteri has definitely influenced the increasing number of cesarean scar pregnancy (CSP), PAS(Placenta accreta spectrum) disorders, uterine rupture, intra-peritoneal hemorrhage and obstetric hysterectomy.[1]

Case report:

Mrs. X, aged 28 years, $G_4P_2A_1L_2$, H/O 7 months of amenorrhea, having pain in abdomen and bleeding per vagina since 6 hours and giddiness since 3 hours, was admitted in emergency at our hospital. She had 1stcesarean section delivery 4 years back, 2ndvaginal delivery 2yrs back, one MTP at two and half months before one year, both children alive. Her LMP was 20-07-19.She had only one antenatal visit at one and half month amenorrhea and CSP of 5 weeks gestation was diagnosed (Fig. 1). The patient was advised hospital admission for medical management. Patient refused for the same and came in emergency at 26 weeks of gestation with severe vaginal bleeding and hemorrhagic shock.

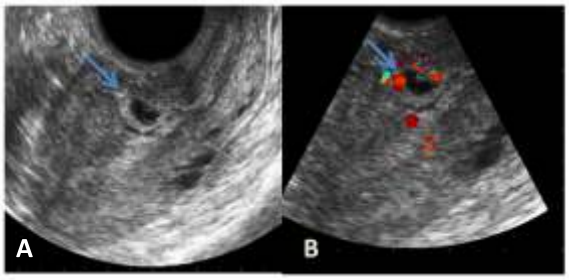


Fig. 1: CSP: (A) Anterior low position of GS (5 weeks) in niche of scar suggestive of scar implantation (arrow), (b) Color Doppler shows presence of peritrophoblastic vascularity (arrow)

On clinical examination, she was very pale, her pulse was 120/bpm, and B.P. was 80/60 mmHg. Abdominal examination revealed a transverse scar of prior cesarean section, uterus 26 weeks size. Per speculum (P/S) examination showed severe bleeding from the cervical canal. Vaginal examination revealed closed external os of cervix.

Her hemoglobin was 7.1g/dl. HerUSG report showed fetal maturity of 26 weeks with absent cardiac activity and central placenta previa with abnormal placental invasion into the myometrium (Fig. 2 A,B). Patient required emergency hysterotomy. Intraoperative findings showed thin vascular distended lower segment due to placental invasion, transverse incision kept above placental insertion site, dead fetus of 26 weeks gestation delivered. Placenta was morbidly adherent (placenta increta), it was not separated and obstetric hysterectomy was performed due to torrential hemorrhage (Fig. 3 A,B). She required multiple transfusions. Postoperative course was uneventful. Patient was discharged on 10th postoperative day.

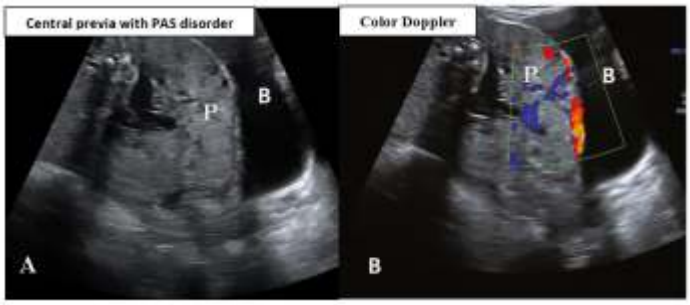


Fig. 2: Morbidly adherent placenta and central previa:

(A) USG image in the second trimester (at 26 weeks) very thin myometrium, loss of retroplacental clear zone, interrupted vesical-uterine interface
(B) hypervascularity at the uterovesical interface on color Doppler, P-placenta, B-bladder

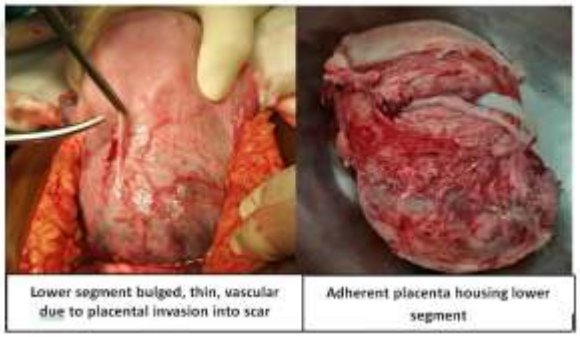
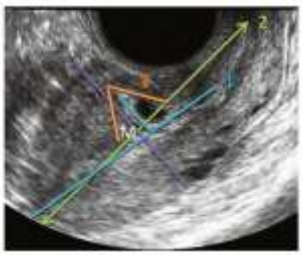


Fig. 3:
(A) Intraoperative findings- lower segment was thin, vascular and the placenta showed myometrial invasion.

(B) Subtotal hysterectomy performed: specimen shows body of uterus- upper segment and lower segment with adherent placenta

Discussion:

The low anterior location of GS between 5 to 7 weeks of gestational age in case of prior cesarean section is definitely associated with the development of PAS disorders.[1] In present case, all the three criteria for prediction of severe PAS disorders were present in the early first trimester scan (Fig. 4):



1. Cross-over 1 (COS-1) sign[2]- Gestational sac (GS) implanted within previous CS scar, and at least two-thirds of the superior-inferior diameter of GS is above the endometrial line, towards the anterior uterine wall
2. Implantation of CSP "in the niche"[3]
3. GS below the uterine mid line[4]

Fig. 4: 1.COS-1 sign present (blue line), 2. "below the uterine midline" (distance between fundus to external os- green double-headed arrow. perpendicular to it - purple line, bisecting point - M point),3. Implantation of CSP "in the niche" (orange line) All the three criteria predicts severe forms of PAS Disorders (placenta increta and percreta) in third trimester.

A recent retrospective study by Cali et al showed that USG at 5 to 7 postmenstrual weeks helps to predict the severity of PAS disorders in the third trimester and, correlation of the first trimester USG findings with that of the second and third trimester can help to determine the surgical risk.[5] COS-1 and implantation "in the niche" and "below the uterine midline" are associated with severe types of PAS disorders in the third trimester of pregnancy.[5] Conversely, COS-2, implantation "on the scar," and "above the uterine midline" are associated with less severe types of PAS disorders.5When combining the three classifications, the **"High-Risk for- PAS Triangle"** is formed by the endometrial line, Cesarean scar, the uterine midline.5If the center of the GS "in the niche", the pregnancy will be at high risk for PAS disorders.[5]

References:

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• Congratulations •

Dr. Sonal Panchal

for obtaining Doctorate of Philosophy **(Ph.D.)**

in **CLINICAL MEDICAL SCIENCES,**
from Sarajevo School of Science and Technology

STUDY OF ADAPTABILITY AND EFFICACY OF MENSTRUAL CUP IN MANAGING MENSTRUAL HEALTH AND HYGIENE

DR. C.R. KAKANI

Senior Gynecologist and Infertility specialist and Laparoscopist.
Ex Dean and Medical Superintendent and Medical administration with more than 35 years of experience in Government and private fields

Menstrual cups have been available for decades, but their use is limited by bulky design and the need for multiple sizes. However, some benefits have been reported like improvement in managing health and hygiene during menstruation, better information on the average menstrual fluid discharged by women during menstruation and attainment of more knowledge bridging the lacuna in knowledge about the adaptability and efficacy of menstrual cup as a better alternative to conventional options. The study is aimed towards assessing the adaptability and the effectiveness of menstrual cup by naïve users who have been using sanitary pads/tampons/cloth as conventional menstrual sanitary protection.

Methods:

The study was conducted at conducted Gujarat Medical Education and Research Society, Medical College and Hospital, Dharpur, Patan, Gujarat, India. Total 158 participants aged between ages of 20 to 50 years with regular menstrual cycle were enrolled in the study. Participants were provided menstrual cups to be used for three consecutive menstrual cycles. They were given detailed explanation/information about its usage. Feedback was obtained after every cycle for three cycles using a structured questionnaire.

Results:

The cup was preferred for comfort, dryness, and less odor. Insertion was easy for 80% participants and 90% participants found removal easy. Problem of leakage was encountered in 3-6%. There were few side effects like rashes, dryness or infection.

Conclusions:

These results demonstrate that this reusable vaginal device has no significant health risks and is acceptable to many women without the need for fitting or other medical services.

CASE STUDY OF PRIMARY AMENORRHOEA – COMPLETE ANDROGEN INSENSITIVITY DISORDER

DR. JAGRUTI SANGHVI

MD (Obstetric and Gynecologist)
Senior Consultant – Sanghvi Hospital, Ahmedabad

Miss XXaged 15 years presented with a complain of not having started menstruation as yetwithout any other complain. (NO MENSTRUTATION WITHOUT ANY OTHER SYMPTOMS)

- **ON EXAMINATION:**

G/E: Height – 5ft7”
Weight – 84 kg
Body built –Muscular but no recession of temporal region
Secondary Sex Characters – Breast development Tanner stage – 4
Axillary &Pubic hair –ABSENT
L/E: No clitomegaly, hymen intact but cleft of vaginal introitus is seen.
P/A: Soft. No mass is palpable in inguinal region or hypogastric region.

- **INVESTIGATION:**

1) USG WHOLE ABDOMEN

a. **Absent uterus & cervix.**
b. Both ovaries are in ovarian fossa anterior to iliac vessel.Right ovary 20 x 11 mm & left ovary measures 24x15mm.
c. Vagina is seen.
d. Both kidneys are normal in size & shape.
e. No abnormal mass orabnormality is seen in abdomen.

2) MRI ABDOMEN

a. Right pelvis shows18x16x17 mm &left pelvis shows 21x32x14 mm size. Suggestive of gonads but uterus & cervix absent.
b. Rest of abdomen is normal.

3) BLOOD INVESTIGATIONS

	a) Hormonal Evaluation	
1)	S. FSH	7.60miuml
2)	S. LH	21.80miu/ml
3)	S. ESTRADIOL	<24 pg/ml
4)	S. AMH	>24.10 ng/ml
5)	S. TSH	2.5uiu/ml
6)	S. PROGESTERONE	<0.5 ng/ml
7)	TOTAL TESTOSTERONE	3.38ng/ml
8)	FREE TESTOSTERONE	4.54ng/ml
9)	S. DHEAS	378.60ng/ml
10)	S. PROLACTIN	10.9ng/ml
11)	RBS	126 mg
	b) *Karyotyping*	
1)	***46 XY***	

- **DIAGNOSIS:COMPLETE ANDROGEN INSENSITIVITY DISORDER**
- **PRE-OPERATIVE DISCUSSION:**

Detailed counselling was provided to the parents & patient regarding Miss XX's choice to live as a female matching with her phenotype.

- **MANAGEMENT:**

As there isa variable possibility, up to 80%, of developing malignant Gonadoblastoma, LAPAROSCOPIC BILAERAL GONADECTOMY was done. Blind pouch of about 5 cm vagina was noted.
Post-operative event was smooth.

- **HISTOPATHOLOGICAL REPORT:**

Specimen shows testes with mainly sertoli cells. Leydig cell hypoplasia was noted.

- **POST-OPERATIVE MANAGEMENT:**

1) Hormone replacement therapy decided in conjunction with an Endocrinologist's opinion. Was prescribed Tab Estradiol valerate 1mg daily at night.
2) Weight reduction advised.
3) Life style modification and dietary changes to increase calcium &Vitamin D uptake to improve bone health.

After 1 month evaluation –

1) Advised investigations:CBC, VitaminD level, Estradiol level, FBS, fasting lipid profile &X-ray of left wrist for bone age.
2) Titrate dose of Estradiol valerate every 6 month till complete development of puberty.
3) Upon puberty,Estradioldose will be fixed which will continue till natural age of menopause.

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DR. DIPAK LIMBACHIYA
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Specialist in Advanced LAP Gynaec Surgeries &
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PRESENTING THE FIRST EVER STUDY FROM INDIA ON CARCINOMA ENDOMETRIUM

SURGICOPATHOLOGICAL OUTCOMES AND SURVIVAL IN CARCINOMA BODY UTERUS: A RETROSPECTIVE ANALYSIS OF CASES MANAGED BY LAPAROSCOPIC STAGING SURGERY IN INDIAN WOMEN

Objectives: The context of this article is based on two main titles those being Gynecologic Oncology and Minimal invasive surgery. **The aim of this study was to report the laparoscopic management of a series of cases of endometrial carcinoma managed by laparoscopic surgical staging in Indian women.**

Materials and Methods: This study was conducted in a private hospital (referral minimally invasive gynecological center). This was a retrospective study (Canadian Task Force Classification II-3). Eighty-eight cases of clinically early-stage endometrial carcinoma staged by laparoscopic surgery and treated as per final surgicopathological staging. All patients underwent laparoscopic surgical staging of endometrial carcinoma, followed by adjuvant therapy when needed. Data were retrieved regarding surgical and pathological outcomes. Recurrence-free and overall survival durations were measured at follow-up. Survival analysis was calculated using Kaplan–Meier survival analysis.

Results: The median age of presentation was 56 years, whereas the median body mass index was 28.3 kg/m2. Endometroid variety was the most commonly diagnosed histopathology. There were no intraoperative complications reported. The median blood loss was 100 cc, and the median intraoperative time was 174 min. There were a total of 5 recurrences (5.6%). The outcome of this study was comparable to studies conducted in Caucasian population. **The predicted 5-year survival rate according to Kaplan–Meier survival analysis is 95.45%, which is comparable to Caucasian studies.**

Conclusion: Laparoscopic management of early-stage endometrial carcinoma is a standard practice worldwide. However, there is still a paucity of data from the Indian subcontinent regarding the outcomes of laparoscopic surgery in endometrial carcinoma. The Asian perspective has been highlighted by a number of studies from China and Japan. **To our knowledge, this study is the first from India to analyze the surgicopathological outcomes following laparoscopic surgery in endometrial carcinoma.** The outcome of this study was comparable to studies conducted in Caucasian population.

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