AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

VIHAAN

2023 - 2024

JUNE 2023 I VOLUME 3

MOTTO : REDEFINING WOMEN HEALTH

THEME : CATCH THEM YOUNG

President
Dr. Mukesh Savaliya
+91 98245 41292
mvsavaliya68@gmail.com

Hon. Secretary
Dr. Mukesh Patel
+91 98253 68346
drmukesh5369@gmail.com

ॐ महाकालेश्वराय नमः ।

2nd Floor, Ahmedabad Medical Association Building, Ashram Road, Ahmedabad - 380009.
Phone : 079 - 26586426 M : +91 78610 11818 E-mail : office@ahmedabadobgyn.org

TEAM AOGS MESSAGE

Dr. Mukesh Savaliya
President

Dr. Mukesh Patel
Hon. Secretary

Dear Friends,

We wish this issue of bulletin finds you in the best of your health.

Monsoon has set in, and we are sure that all of you are enjoying the cool breeze after scorching heat of summer!

We had a very successful PPH conclave last month, and it was well attended by the delegates with a lot of take home message.

We've 2 other conferences lined up, LOGYCON in August first week and AOGS Midterm blast at Goa in First week of September. We are looking forward to participation from all of you!

Let's grow together and make this world beautiful for all of us and our society...

PPH CONCLAVE DATE : 16,17,18, JUNE 2023



















PPH CONCLAVE DATE : 16,17,18, JUNE 2023

PPH CONCLAVE DATE : 16,17,18, JUNE 2023

YOGA DAY DATE : 21st JUNE 2023

YOGA DAY DATE : 21st JUNE 2023

Menopause Society AHMEDABAD

Educational CME

Dr. Vijay Shah
President, MSA

Dr. Janaki Desai
Hon. Secretary, MSA

An Initiative by

Indian Menopause Society
In Association with Menopause Society Ahmedabad
&
Ahmedabad Obstetrics & Gynaecological Society
Invites You to an Educational CME

Dr. Mukesh Savaliya
President, AOGS

Dr. Mukesh Patel
Hon. Secretary, AOGS

Date : 9th July 2023 I Time: 09:30 am onwards
Venue : Welcomhotel By ITC Hotels, Ashram Road, Ahmedabad

Dr. Shobhana Mohandas
Imm. Past President, IMS
Scientific Co-ordinator

Dr. Pushpa Sethi
President, IMS

Dr. Arti Sharma
Secretary General, IMS

Dr. Jyothika Desai
Chairperson
Education Comm., IMS
Scientific Co-ordinator

Dr. Jamuna Devi
Program Co-ordinator

PROGRAMME DETAILS

Time	Topic	Speaker
09:30 am	**Registration and Breakfast**	
10:00 am	Welcome Address	Dr. Vijay Shah
Session 1	**Chairpersons**	Dr. Beena Patel Dr. Bela Patel
10:10 am	**Contraception in Perimenopause**	Dr. Kruti Deliwala
10.30 am	**MHT**	Dr. Janaki Desai
11.00 am	**Pneumococcal Vaccine**	Dr. Monika Patel
11:30 am	**Coffee Break**	
Session 2	**Chairpersons**	Dr. Mukesh Savaliya Dr. Mukesh Patel
12.00 am	**Panel Discussion : Genito-urinary syndrome of Menopause** **Moderator :** Dr. Sonal Kotdawala **Co-Moderator :** Dr. Tejal Patel **Panelists :** Dr. Anjana Chauhan, Dr. Jalpa Bhatt, Dr. Vidya Chauhan Dr. Sumesh Chaudhari, Dr. Kanupriya Singh,	
12:45 pm	Vote of Thanks	Dr. Mukesh Patel
01.00 pm	**Lunch**	

Master of Ceremony : Dr. Nivedita Vaja

This is sponsored by an unrestricted Educational Grant from Pfizer

AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

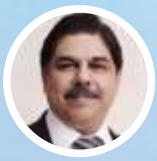
Organises

FOGSI WEST ZONE V. P. CONFERENCE

LOGYCON 2023

4 5 6 AUGUST 2023

Venue : Ahmedabad Management Association (AMA) Ahmedabad, Gujarat.



Dr. Hrishikesh D. Pai
FOGSI President

Dr. Madhuri Patel
FOGSI Secretary General

Chairperson
Dr. Mukesh Savaliya

Chairperson
Dr. Geetendra Sharma

Secretary
Dr. Mukesh Patel

Secretary
Dr. Phagun Shah

ICOG Credit Points and
Gujarat Medical Council Credit Hours
Awaited....

REGISTRATION FEES

Registration Type	Early Bird upto 30th June 2023	Regular upto 15th July 2023	Late upto 30th July 2023
FOGSI Member	☐ 7080	☐ 7670	☐ 8260
Non FOGSI Member	☐ 7670	☐ 8260	☐ 8850
Accompanying Person	☐ 7080	☐ 7670	☐ 8260
PG Student	☐ 3540	☐ 4720	☐ 5900

*Inclusive of 18% GST

BANK DETAILS

Account No.	:	200210210000019
Name of Account	:	LOGYCON-2023
Bank Name	:	Bank of India
Branch	:	Ashram Road, Ahmedabad.
IFSC Code	:	BKID0002002

WORKSHOPS

1. Endoscopy
2. Fetal Medicine
3. Cosmetic Gynecology
4. Sonography
5. Mid Life Management
6. Gynec Infertility, IVF and Andrology
7. PPH
8. PIH

TOPICS TO BE COVERED

OB. - GYN.

- High Risk Obstetrics
- Rare Vaginal Surgeries
- Midlife Crisis Management
- Pearls of Clinical Practice
- Gynecological Malignancies
- Medical Disorders of Pregnancy
- PPH
- Debates

TOPICS TO BE COVERED

MEDICOLEGAL

- Consumer Liability
- Criminal Liability + On Table death + Mob Violence
- Documentation and Consent
- ART Act
- PC-PNDT Act
- MTP and POCSO Act
- Mixed Bag - NMC, CEA, RTH
- Debates

Send Hard copy by Courier to Conference Secretariat :

AOGS I 2nd Floor, AMA Building, Ashram Road, Ahmedabad, Gujarat 380009

Ph.: +91 79 2658 6426 I Mob. : 98252 98762, 98253 68346 I Email : logycon2023@gmail.com I Web : www.ahmedabadobgyn.org

AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

Presents

AOGS MIDTERM BLAST

GOA

1 2 3 SEPTEMBER 2023

ONLY LIMITED SEATS

FIRST COME FIRST BASE

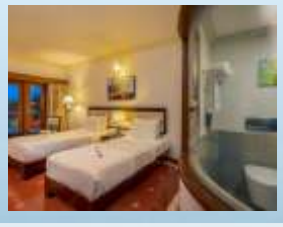
RS. 24,500

(PER PERSON, TWIN SHARING)

Registration after 15 July Package Rs. 27000

INCLUDING CONFERENCE, ACCOMMODATION, FLIGHT

RADISSON HOTEL GOA CANDOLIM

REGISTRATION DETAILS

Kindly Pay Online / Bank Transfer or Favour to Cheque of AOGS

Bank Details

Name	:	AHMEDABAD OBST. & GYANOLOGICAL SOC.
Bank Name	:	BANK OF INDIA
Account No.	:	200210100011484
IFSC Code	:	BKID0002002
Branch	:	ASHRAM ROAD

MORE DETAILS CONTACT : AOGS OFFICE Ph.: 079 - 26586426 I M. : 7861011818

Anovulatory uterine bleeding in adolescents - An evidence based management

Dr. Ankit Rathore
DGO DNB
SR in ObGyn
Dept. GMERS Medical College & Hospital - Vadnagar .

Dr. Chirag Shah
MBBS DGO FMAS (France)
Naritva women's hospital.
Ahmedabad

Dr. Saloni Shah
MBBS 2nd Year
Smt. NHL MEDICAL COLLEGE
AHMEDABAD

INTRODUCTION

Menstrual disorders and abnormal uterine bleeding (AUB) are among the most frequent gynaecologic complaints in adolescents1. AUB may be caused by a number of causes but, the anovulatory uterine bleeding is the primary cause of AUB in adolescents and generally resolves with maturation of the hypothalamic-pituitary-ovarian axis. The management of AUB in otherwise healthy adolescents is the focus of this topic discussion.

SEVERITY CLASSIFICATION[2]

Mild – Longer than normal menses (>7 days) or shortened cycles (<24 days) for ≥2 months, with slightly or moderately increased menstrual flow; haemoglobin is usually normal (≥12 g/dL) but may be mildly decreased (10 to 12 g/dL).

Moderate – Moderately prolonged (eg, >7 days) or frequent menses every one to three weeks, with moderate to heavy menstrual flow and Hb ≥10 g/dL.

Severe – Disruptive menstrual cycles with heavy bleeding that causes a decrease in Hb (to <10 g/dL) and may or may not cause hemodynamic instability.

GENERAL PRINCIPLES

It is important to exclude pregnancy and pelvic infections before initiating treatment. In addition, causes of AUB and anovulatory uterine bleeding other than an immature HPO axis should be evaluated as indicated based upon clinical findings. These patients are at risk for IDA and should be monitored and treated as indicated3. Depending upon the severity of iron deficiency, advice 60 mg of elemental iron once or twice per day.

ACUTE MANAGEMENT OF MILD ANOVULATORY BLEEDING

- Patients with mild anovulatory bleeding, normal Hb, no desire for contraception and good quality of life are reassured and kept under observation.
- Patients with Hb between 10 and 12 g/dL, observation and reassurance or hormonal therapy to stabilize endometrium and promote cyclic shedding are both acceptable options. The hormonal therapy regimens for mild anovulatory uterine bleeding are the same as for moderate anovulatory uterine bleeding. Also recommend iron supplementation for these patients.

ACUTE MANAGEMENT OF MODERATE ANOVULATORY BLEEDING

Manage these patients in the outpatient setting. They may often have mild anemia (Hb 10 to 12 g/dL), which should be treated with iron supplementation.

A- Not currently bleeding — These patients are advised either oral POPs or COCs.

Progestin/progesterone only regimen –

Before initiating the treatment, council the patients that irregular spotting is common initially, but, if heavy vaginal bleeding occurs, immediate see the doctor.

Combined estrogen progestin regimen –

Advise monophasic OCPs with a minimum of 30 mcg ethinyl estradiol (EE) to ensure a sufficient amount of estrogen to prevent breakthrough bleeding[1].

B- Currently bleeding — Suggest them COCs rather than POPs. POPs are reserved for those, who cannot tolerate, dislike, or have a contraindication to estrogen therapy.

Combined estrogen progestin regimen –

COCs with a minimum of 30 mcg ethinyl estradiol (EE) to prevent breakthrough bleeding[1]. Use the following regimen (the pills that do not contain hormones should be discarded):

- One pill every eight hours until the bleeding stops (usually within 48 hours[6]), then
- One pill every 12 hours for 2 days, then
- One pill once per day for a total of at least 21 days

Close follow-up is required. High-dose estrogen therapy can cause nausea, thus add antiemetics like,

promethazine or ondansetron before each COCs. Once anemia gets resolved, allow a menses in a controlled fashion (ie, by discontinuing hormones for at least three days) in order to prevent irregular vaginal bleeding.

Progestin-only regimen –

Norethindrone 5 to 10 mg nightly until the bleeding stops and the anemia is resolved.

Warn patients that irregular spotting is common initially.

Preferred maintenance regimens	
Oral micronized progesterone	200 mg orally nightly for the first 12 days of each calendar month.
Norethindrone acetate (NETA)	5 mg orally nightly for the first 5 to 10 days of each calendar month.
Alternative maintenance regimen	
Medroxyprogesterone acetate (MPA)	10 mg orally nightly for the first 10 days of each calendar month

Tranexamic acid –

The regimen is 500 mg orally up to four to five times per day for the first one to five days of each menstrual cycle. Maximum dose is 4 gm per day.

ACUTE MANAGEMENT OF SEVERE ANOVULATORY BLEEDING

The treatment may involve hormonal therapy, hemostatic agents, and (rarely) surgical intervention. Consider admission if hemodynamic instability, symptomatic anemia, Hb <7 g/dL or <10 g/dL with active heavy bleeding, need for IV conjugated estrogen or surgical intervention.

Combined estrogen progestin regimen –

Following regimen can be used;

- One pill every four to six hours until the bleeding subsides (usually within 24 hours), then
- One pill every eight hours for three days, then
- One pill every 12 hours for up to two weeks, then one pill once per day.

Once the patient is weaned to one pill per day and their anemia has resolved, they should be allowed to have a withdrawal bleed (ie, by discontinuing hormones for at least three days). Discard non-hormonal pills and add antiemetics if required.

Progestin-only pills –

POPs is the alternate in patients in whom estrogen is contraindicated or who refuse to take COCs. Two commonly used tapering regimens are provided below8:

- Norethindrone 5 to 10 mg twice per day for seven days, followed by 5 to 10 mg once per day until maintenance therapy (discussed later) is initiated, or
- Norethindrone 5 to 10 mg three times per day for three days, followed by 5 to 10 mg twice per day for seven days, followed by 5 to 10 mg once per day, until maintenance therapy is initiated.

Intravenous estrogen –

Preferred in those, who are unstable and cannot take oral medications[4]. This preparation is not commonly available in India. Recommended dose is 25 mg every four to six hours until the bleeding stops. No more than six doses should be administered. Bleeding usually subsides within 4 to 24 hours of the initiation of IV estrogen[9]. Add hemostatic agents if, bleeding persists beyond 24 hours and if longer than 48 hours then, add progesterone. Oral progesterone should be discontinued when oral COCs are initiated. After the bleeding subsides, the patient should be switched to a tapering regimen of monophasic COCs. Use COCs that contains at least 50 mcg EE and suggest the following schedule:

- One pill every four to six hours until the bleeding stops
- One pill every eight hours for three days, then
- One pill every 12 hours for two weeks

Addition of hemostatic therapy –

Advise if, severe anovulatory uterine bleeding that continues after 24 hours of hormonal therapy and in patients with platelet dysfunction10. Among these agents, most preferred is tranexamic acid unless the patient has increased risks for thromboembolism.

- Tranexamic acid is administered orally: 500 mg four to five times per day for up to five days.
- Aminocaproic acid is administered 5 g orally during the first hour, followed by a continuous dose of 1 to 1.25 g per hour; treatment is continued for approximately eight hours or until the bleeding has been controlled
- Desmopressin is administered as 0.3 mcg/kg IV over 15 to 30 minutes; the dose may be repeated in 48 hours if there is no response

Refractory uterine bleeding – In the rare cases if, all agents fail, additional evaluation (examination under anesthesia, endometrial sampling) may be necessary to assess causes of AUB other than anovulatory uterine bleeding. D&C also may be used as a therapeutic intervention.

However, therapeutic D&C is rarely required in adolescents with AUB. It should be reserved as a last resort.

LONG TERM MANAGEMENT

Maintenance therapy –

This depends upon the initial hormonal regimen, the patient's desire for contraception, and whether they remain anemic. LNG IUD and DMPA are the options, who desire contraception or are unable to take pills. This approach is based on the observational studies11.

Initial control with estrogen containing regimen –

Hb <10 g/dL– advise monophasic COCs with at least 50 mcg EE once per day continuously (to avoid withdrawal menses) for at least three months (until the Hb is ≥10 g/dL)[4,6].	**Hb ≥10 g/dL** – advise monophasic COCs with at least 30 mcg EE and continue cyclically for three to six months and then discontinue.

Initial control with oral progestin

- **Patients who do not desire contraception –** Following regimes can be used;
- Norethindrone 5 mg orally each night for the first 5 to 10 days of each calendar month, or
- Oral micronized progesterone 200 mg each night for the first 12 days of each calendar month.
- **Patients who desire contraception –**DMPA, progestin implants, and LNG

IUDs are the options here. Continuous POPs may also take in to consideration.

FOLLOW-UP SCHEDULE

Patients with mild anovulatory uterine bleeding who initiated hormonal treatment or iron therapy should be followed three months after the initial episode to assess effectiveness of treatments. Patients with mild anovulatory bleeding who were initially managed with observation and reassurance should follow up in three to six months to assess improvement in menstrual patterns and/or need for hormonal therapy.

Patients with moderate anovulatory uterine bleeding should be seen approximately three months after the initial episode.

Patients with severe anovulatory uterine bleeding who did not require hospitalization should be seen monthly or until Hb is >10 g/dL.

Patients with severe bleeding who required hospitalization should be seen two weeks after discharge and then at least monthly until Hb is >10 g/dL.

If no response to hormonal therapy or heavy bleeding persists despite three months or a normal menstrual pattern is not established after discontinuation of hormonal therapy, an endocrinology evaluation is warranted.

Long-term monitoring – Long-term monitoring and follow-up are necessary to prevent the potential sequelae of anovulatory uterine bleeding (eg, chronic anemia, infertility, endometrial cancer).

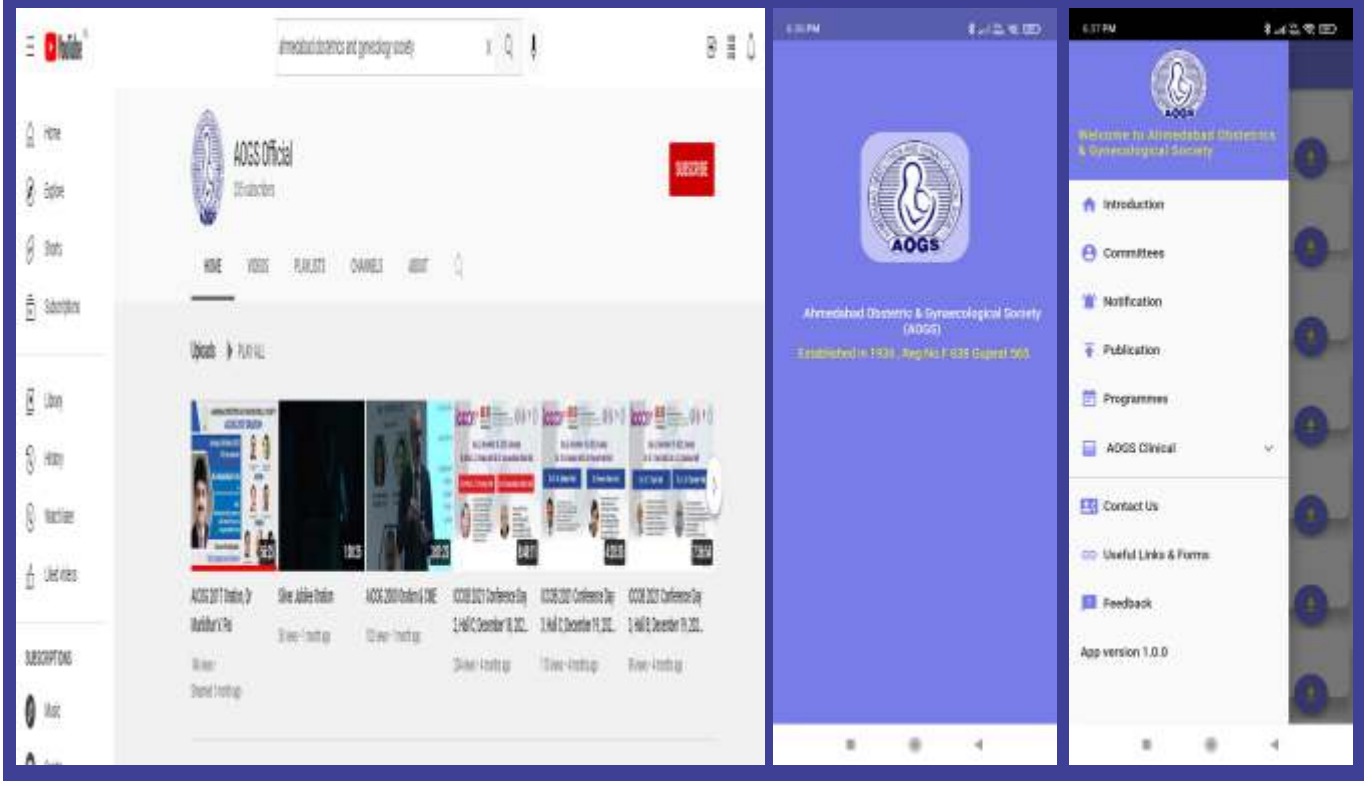
PROGNOSIS

Normal cycle establishes with maturation of the HPO axis. The duration of time that it takes to attain maturity (regular, ovulatory cycles) appears to be related to the age of menarche. In patients who begin menses at <12 years, between 12 and 13 years, and >13 years of age, 50 percent of cycles are ovulatory by one year, three years, and 4.5 years, respectively12. However, normal cycle length is not established until the sixth gynecologic year, at an average age of 19 years[13]. The long-term prognosis for patients with AUB depends upon the underlying cause[6].

REFRENCES:

1. APGO educational series on women's health issues. Clinical management of abnormal uterine bleeding. Association of Professors of Gynecology and Obstetrics, 2006.
2. ADOLESCENT MENSTRUAL DISORDERS: Update Volume 84, Issue 4, 1 July 2000, Pages 851-868
3. Screening and Management of Bleeding Disorders in Adolescents With Heavy Menstrual Bleeding: ACOG COMMITTEE OPINION, Number 785
4. Gray SH, Emans SJ. Abnormal vaginal bleeding in the adolescent. In: Emans, Laufer, Goldstein's Pediatric & Adolescent Gynecology, 6th ed, Emans SJ, Laufer MR (Eds), Lippincott Williams & Wilkins, Philadelphia 2012. p.159.
5. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016
6. Management of abnormal genital bleeding in girls and women B D Cowan , J C Morrison
7. N E J M N Engl J Med 1998; 339:245 253DOI:10.1056/NEJM199807233390407
8. Levonorgestrel-Releasing IUD Use in Female Adolescents with Heavy Menstrual Bleeding and Bleeding Disorders: Single Institution Review
9. Early menarche, a risk factor for breast cancer, indicates early onset of ovulatory cycles D Apter, R Vihko
10. World Health Organization multicenter study on menstrual and ovulatory patterns in adolescent girls. II. Longitudinal study of menstrual patterns in the early postmenarcheal period, duration of bleeding episodes and menstrual cycles. World Health Organization Task Force on Adolescent Reproductive Health.

We request all members to download the AOGS app from play store or apple store to get updates on AOGS events and CME's.
Please also subscribe to our YouTube channel for complete recordings of talks and orations.



AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

SOCIAL SECURITY SCHEME

આપણી સોસાયટીની સોશિયલ સિક્યોરીટી સ્કીમ આશરે છેલ્લા ૧૫ વર્ષથી ચાલે છે.
IMA અને AMA ની જેમ આ આપણી પોતાની ગાયનેક સોસાયટીની
Unique Security Scheme આપણાં મેમ્બર્સ માટે ઉપલબ્ધ છે.
આ સ્કીમ દ્વારા આપણાં પરિવારજનોને હાલની તારીખમાં
રૂા. ૩,૨૫,૦૦૦ જેવી માતબર રકમ મળી શકે છે. જેમ મેમ્બર્સની સંખ્યા વધતી જશે તેમ
આ DFC Amount વધતું જશે.
વધારામાં આ સ્કીમમાં Spouse Membershipની સુવિધા પણ ઉપલબ્ધ છે.
જે AOGS મેમ્બર હજું સુધી આ સ્કીમનાં મેમ્બર ન થયા હોય તેમને સત્વરે મેમ્બર થવાં અનુરોધ.
ફોર્મ અને વિગતો AOGS ઓફિસમાંથી ઉપલબ્ધ છે ઓનલાઈન મેમ્બરશીપનો વિકલ્પ પણ ઉપલબ્ધ છે

AOGS SSS Bank details : Name : AOGS SSS I Branch : Bank of India Ashram Road Branch
AC No. : 200210110002460 I IFSC : BKID0002002

For More Details, Please Contact : Dr. Lata Trivedi Mo. : 79903 08240

AOGS Office : Mo.: +91 78610 11818, Ph.: +91 79 2658 6426

EVA™
Women's Hospital & Endoscopy Centre

DR. DIPAK LIMBACHIYA
M.D., D.G.O., Endoscopy Specialist
Specialist in Advanced LAP Gynaec Surgeries &
LAP Onco Gynaec Surgeries

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.

Eva Endoscopy Training Institute
Block - C, Neelkanth Park-II,
Ghoda Camp Road, Shahibaug,
Ahmedabad-380 004
Ishitamam : 9724011764

QR Code for Entire Article

Eva Women's Hospital & Endoscopy Centre
E : drdipaklimbachya@gmail.com
E : info@evawomenshospital.com
W : www.evawomenshospital.com
P : 079-2268 2217 / 22682075 M : 9825028771

Planet WOMēN™

IVF Center & Advanced Women's Hospital

Our centre **'Planet WOMEN' IVF Centre & Advanced Women's Hospital**, recognized by Times of India as **'Hub for Medical Tourism in IVF'**.

All your Answers at one place:

Female Infertility Clinic	Male Infertility Clinic
3-D, 4-D & Gynaec Sonography	Gynaec Endoscopy Unit
IUI-IVF-ICSI-Egg Donation	PGS / PGD / PGT
PESA / TESA	Surrogacy
Laser Assisted Hatching	Manopausal Clinic

FOGSI recognized training centre for ART (IVF)/Endoscopy/Sonography

Planet WOMēN™
IVF Center & Advanced Women's Hospital

"Planet WOMEN" IVF Centre & Advanced Women's Hospital

Sahajanand College Cross Road, Near Nehrunagar Cross Roads,
Ambawadi, Ahmedabad-380015, Gujarat (INDIA)
Email : planetwomen1@gmail.com Website. : www.planetwomen.in
Helpline Number : 75750 22422, 75750 25422