



AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

VIHAAN

JUNE 2023 | VOLUME 3

MOTTO : REDEFINING WOMEN HEALTH

THEME : CATCH THEM YOUNG

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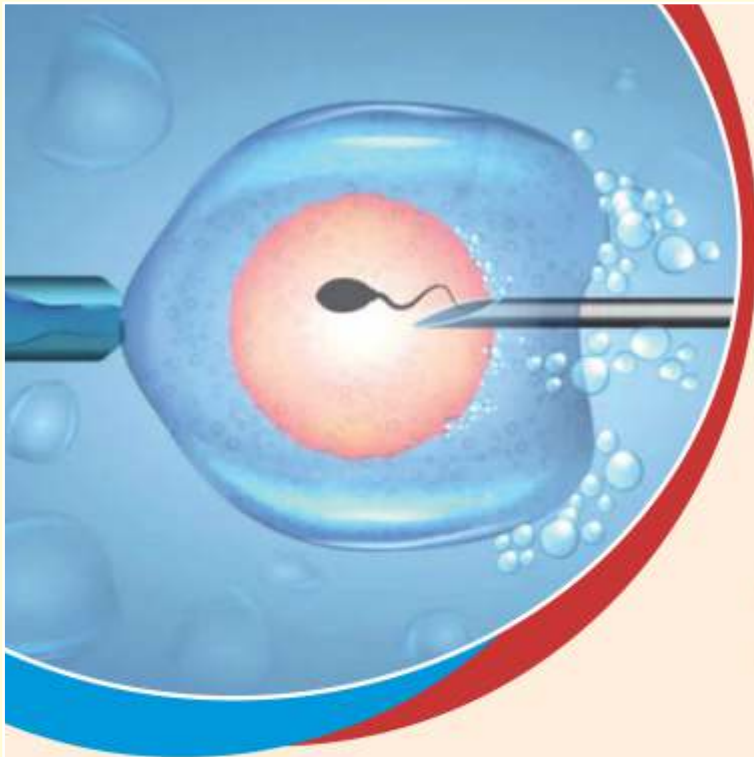
Dr. Azadeh Patel



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TEAM AOGS MESSAGE



Dr. Mukesh Savaliya
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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



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&

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Invites You to an Educational CME

Date : 9th July 2023 | Time: 09:30 am onwards

Venue : Welcomhotel By ITC Hotels, Ashram Road, Ahmedabad



Dr. Vijay Shah
President, MSA



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Hon. Secretary, MSA



Dr. Mukesh Savaliya
President, AOGS



Dr. Mukesh Patel
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Dr. Shobhana Mohandas
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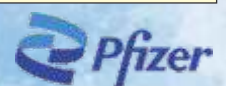
Dr. Jamuna Devi
Program Co-ordinator

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

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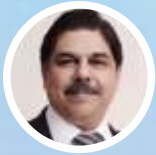


LOGYCON 2023



AUGUST 2023

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



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FOGSI President



Dr. Madhuri Patel
FOGSI Secretary General



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Dr. Mukesh Savaliya



Chairperson
Dr. Geetendra Sharma



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Dr. Mukesh Patel



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Non FOGSI Member	<input type="checkbox"/> 7670	<input type="checkbox"/> 8260	<input type="checkbox"/> 8850
Accompanying Person	<input type="checkbox"/> 7080	<input type="checkbox"/> 7670	<input type="checkbox"/> 8260
PG Student	<input type="checkbox"/> 3540	<input type="checkbox"/> 4720	<input type="checkbox"/> 5900

*Inclusive of 18% GST

BANK DETAILS	Account No.	: 20210210000019
	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 :

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Anovulatory uterine bleeding in adolescents - An evidence based management



Dr. Ankit Rathore

DGO DNB
SR in ObGyn
Dept. GMERS Medical College &
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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 CLASSIFICATION²

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, counsel 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 bleeding¹.

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 bleeding¹. 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 hours⁶), 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 below:

- 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 medications⁴. 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 estrogen⁹. 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 –

<p>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}.</p>	<p>Hb ≥10 g/dL – advise monophasic COCs with at least 30 mcg EE and continue cyclically for three to six months and then discontinue.</p>
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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 years¹³. The long-term prognosis for patients with AUB depends upon the underlying cause⁶.

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8. Levonorgestrel-Releasing IUD Use in Female Adolescents with Heavy Menstrual Bleeding and Bleeding Disorders: Single Institution Review
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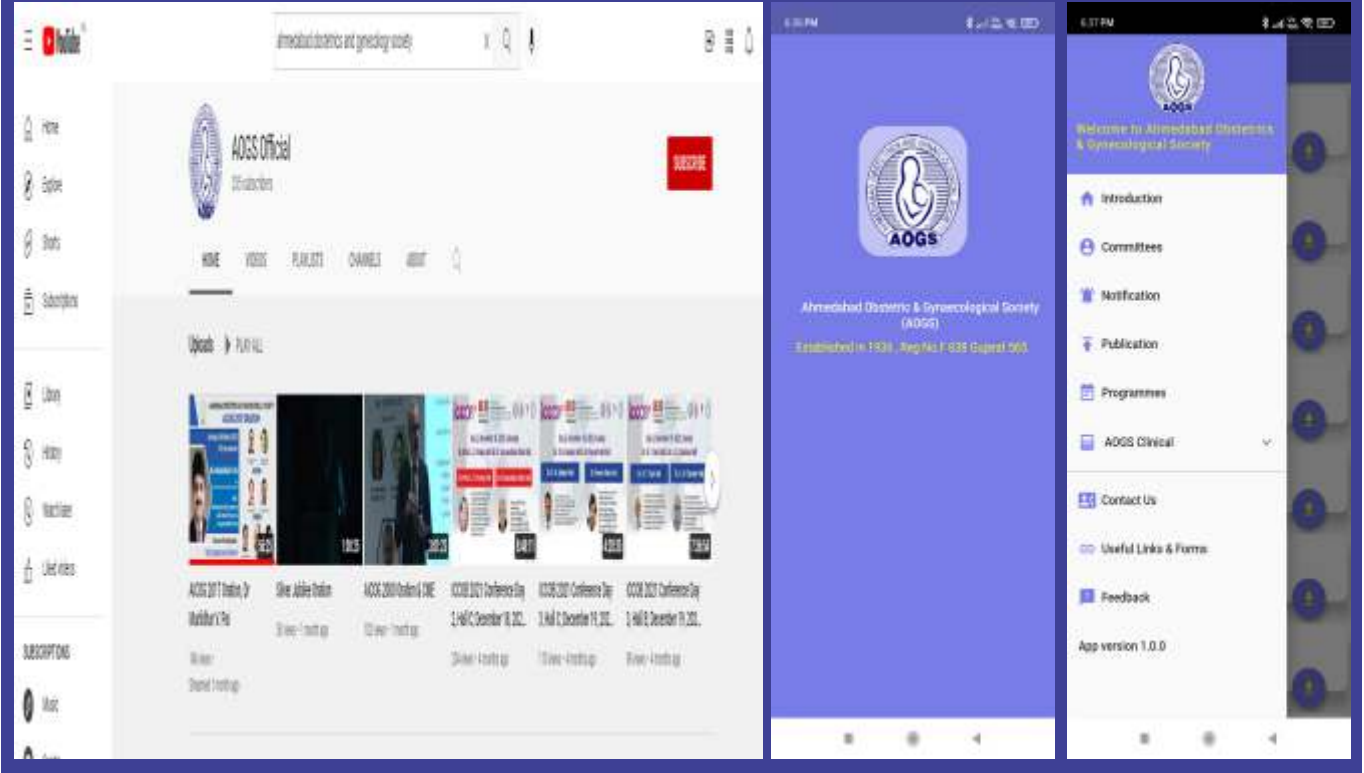
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આપણી સોસાયટીની સોશિયલ સિક્યોરીટી સ્કીમ આશરે છેલ્લા ૧૫ વર્ષથી ચાલે છે.

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- ⊗ Gives platform to observe various testicular biopsy.

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IUI	Basic	Advance
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Directors:

Dr. Shital Punjabi Dr. Anand Patel
Dr. Rajesh Punjabi

Advance Sonography

Course Highlights:

- ⊗ Live demonstrations of ultrasound assessment in pregnancy
- ⊗ Lectures and video presentation on ultrasound in pregnancy and gynaecology and infertility
- ⊗ Live demonstrations of ultrasound in different gynec condition and infertility
- ⊗ Hands on experience in ultrasound in obstetrics and gynaecology
- ⊗ Fellowship training certificate from FOGSI/ motherhood women's and child care hospital

Course Fee:

Basic	Advance	15 Days
8,850/-	29,500/-	17,700/-

Directors:

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Advance Laparoscopy

Course Highlights:

- ⊗ Live Surgeries in OT
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- ⊗ Pre & Post evaluation training by MCQ, Endotrainer, Viva
- ⊗ Fellowship Training Certificate from FOGSI / Motherhood Women's & Child Care Hospital

Course Fee:

Basic	Advance
17,700/-	29,500/-

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AWARDS & ACHIEVEMENT OF SNEH HOSPITAL & DOCTOR TEAM

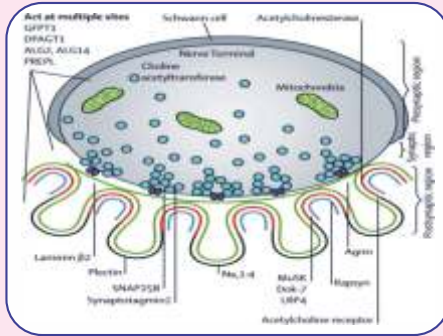
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PRESENTING THE FIRST EVER STUDY FROM INDIA ON CARCINOMA ENDOMETRIUM

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. Endometrioid 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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