



AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

# AOGS TIMES

## VIHAAN

NOVEMBER 2023 | VOLUME 8

MOTTO : REDEFINING WOMEN HEALTH

THEME : CATCH THEM YOUNG

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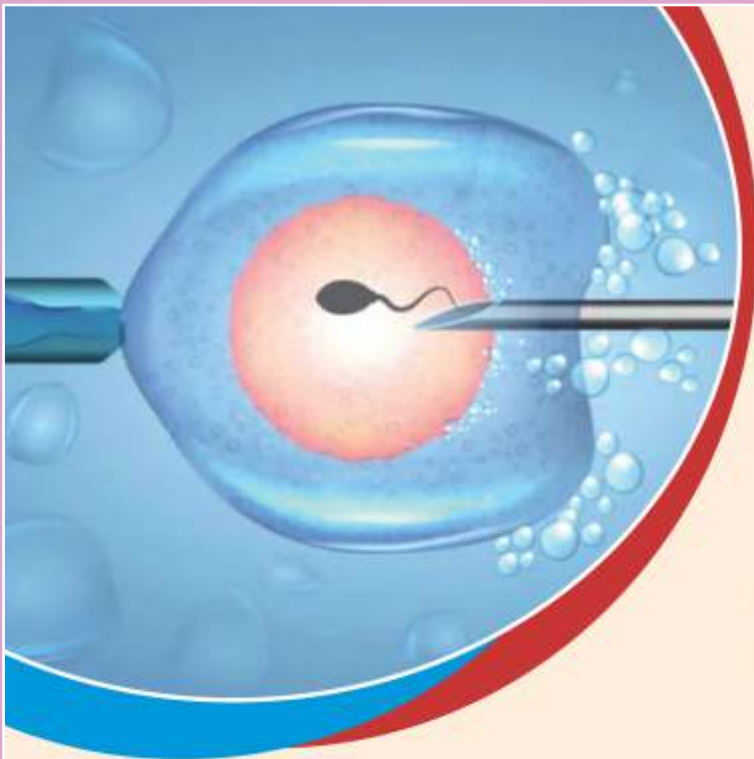
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**Dr. Mukesh Savaliya**  
President

TEAM AOGS  
MESSAGE



**Dr. Mukesh Patel**  
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Dear Members,

We hope all of you had enjoyed Diwali last month. Festivals bring joy and give us an opportunity to infuse joy in monotonous life!

We have our 46th Annual SOGOG conference at Himmatnagar on dates 22nd, 23rd and 24th December, 2023. We encourage you to be a part of this academic extravaganza along with its talent and cultural evenings.

So please hurry and register yourself for the sharing the knowledge and getting input from the stalwarts!

As the winter is approaching, and the city is getting ready for at least one marathon each every month for next 3 months, we wish everyone a fit and healthy life!

EDITORIAL



**Dr. Azadeh Patel**  
Clinical Director & IVF Specialist,  
ART Fertility Clinics



**Dr. Munjal Pandya**  
Associate Professor,  
NMMC, Ahmedabad

# Obesity in Pregnancy



- WHO declared it as Global epidemic (2000)
- NFHS-4 (2015–16): The national prevalence of obesity in pregnancy (12%) and in the postpartum period (13%)

Table 1. Classification of weight status according to BMI<sup>1,2</sup>

BMI (kg/m <sup>2</sup> )	Classification
< 18.5	Underweight
18.5–24.9	Normal/Healthy
25.0–29.9	Overweight
30.0–39.9	Obese I
≥ 40	Obese II

BMI = body mass index

- BMI: According to WHO & NICE; classification is based largely on a s s o c i a t i o n between BMI and

mortality.

- Higher pre-pregnancy BMI is associated with an increased risk of a number of pregnancy complications and adverse pregnancy outcomes
- **Limitations of BMI:**
- Distribution of adipose tissue v/s absolute amount
- Abdominal obesity v/s Accumulation of fat around the hips and thighs
- Waist circumference : Better measure of visceral adiposity and its associated risk (Sattar N, 2001)
- BMI is also unable to distinguish between muscle and fat mass
- Across different populations, a given BMI may not correspond to the same degree of ‘fatness’
- Despite these significant limitations, BMI is still

considered the most useful population level measure of obesity

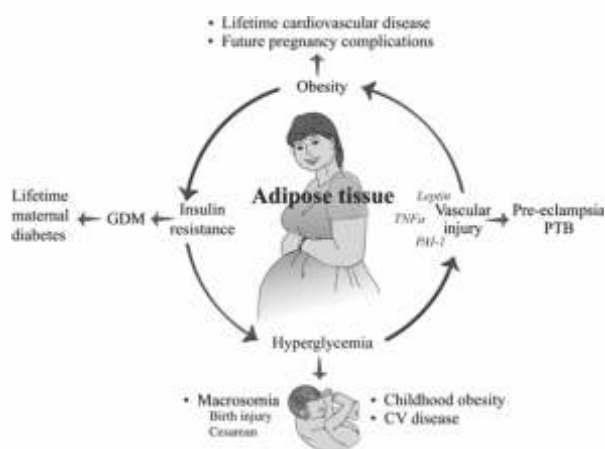
- **Ante-natal**
- Nutritional Deficiency
- 40% deficient in Iron, 24% deficient in Folic Acid, 4% deficient in Vit B12
- Tendency towards straying away from fortified cereals, fruits and vegetables; and eating more of processed foods, high in calories, but low in nutritional value.
- Ideal diet: Healthy mix of fruits and vegetables, lean proteins, good quality carbohydrates
- **Gestational Weight gain (GWG):**
- GWG is composite of products of conception, plasma volume expansion, extracellular fluid, maternal fat deposition, and imprecise estimate of increasing maternal (or fetal) adiposity.
- Excessive wt gain: very high risk of complications, including indicated preterm birth, CS, failed labour induction, LGA infants, infants with hypoglycemia.
- Obese women with less wt gain: reduced risk of pre-eclampsia, CS, instrumental delivery, LGA babies.

IOM (Institute of Medicine)	
Underwt (BMI < 18.5)	12.5-18 kg
Healthy (BMI 18.5-24.9)	11.5-16 kg
Overwt (BMI 25-29.9)	7-11.5 kg
Obese (BMI ≥ 30)	5-8 kg
Optimal wt gain (Cedergren MI, 2007)	
Underwt	4-10 kg
Normal wt	2-10 kg
Overwt	< 9 kg
Obese	< 6 kg

- Conclusion was drawn that overall minimal risk for mother and baby should be taken at point of equal risk of LGA and SGA corresponding with wt gain of 4.5-9 kg for

class 1 (BMI 30-34.9), 0-4 kg for class 2 (BMI 35-39.9) and class 3 (BMI >40)

- **Challenges with diagnostic tests:**
- Excess body fat can make it challenging for USG examination. TVS can be considered in whom transabdominal USG can't conclude NT
- Increased echogenicity of adipose tissue and increased absorption of ultrasonic sound beam by abdominal fat
- BMI > 35 kg/m<sup>2</sup>, are likely to have inaccurate SFH and should be referred for serial assessment of fetal size using USG
- Appropriate cuff size for Blood Pressure Measurement, with its documentation
- Wt and Ht measurement at 1st antenatal appointment and during pregnancy: NICE (2008)
- Antenatal fetal surveillance:
- BMI: 35-39.9- weekly beginning by 37 0/7 weeks



- BMI more than or equal to 40- 34 0/7 weeks
- **Maternal Complications associated with Obesity:**
- HDP, Pre-eclampsia: Direct correlation between maternal BMI and risk of preeclampsia. (O'Brien TE, 2003)
- Pre-pregnancy BMI >35 increased the risk of preeclampsia four-fold compared with women with a pre-pregnancy BMI of 19–27.
- Waist circumference: A non-pregnant waist circumference 80 cm has been associated with an OR for pregnancy-induced hypertension of 1.8 and for preeclampsia of 2.7 in a cohort of over 1000 unselected pregnancies. (Sattar N, 2001)
- GDM: Retrospective UK study of 287,213 pregnancies between 1989 and 1997: women with a BMI >30 were more likely to develop gestational diabetes than women with a BMI of 20.0–24.9 (Sebire NJ, 2001)
- Australian study of 14,230 pregnancies, which showed that the odds of developing gestational diabetes were 2.95 times higher in obese women (BMI 30.01–40.00) compared with normal-weight (BMI 20.01–25.00) women. (Callaway LK, 2006)
- (GDM) increases the long-term risk of developing type 2 diabetes. (Lauenborg J, 2004)

**Obstructive sleep apnea:** Sleep apnea can cause fatigue,

increases risk of HTN, pre-eclampsia, heart and lung problems.

- VTE: 57% of Maternal Deaths from VTE in the **UK** are obese.
- **Denmark:** Retrospective case-control study: A significant association between VTE and obesity (Larsen TB, 2007)
- Associated problems of reduced mobility, co-morbid conditions that predispose to thrombosis, such as preeclampsia, and an increased frequency of operative delivery, higher levels of coagulation factors
- Obesity & "Estrogen"
- An adjusted OR of 1.8 (95% CI 1.3 –2.4) for VTE in pregnant women with a BMI >25, increasing to an adjusted OR of 62.3 (95% CI 11.5–337.6) where BMI and immobility were combined. (Jacobsen AF, 2008)
- RCOG: recommends routine measurement of peak anti Xa activity for women wt > 90 kg, on therapeutic doses of LMWH.
- **Preterm birth:**
- Indicated v/s Spontaneous preterm
- **Respiratory System:**
- Respiratory disease (asthma and obstructive sleep apnea) increases risk of non pulmonary pregnancy complications, such as CS and pre-eclampsia
- Upto 30% experience an exacerbation of their asthma during pregnancy (1.5 times more than non obese).
- Wt loss b/w pregnancies reduces risk of SB, hypertensive complications and fetal macrosomia. Wt loss increases chances of successful VBAC.
- **Fetal complications during pregnancy:**
- Higher incidence of first trimester miscarriage (OR 1.2) (Lashen H, 2004)
- Birth defects: increased risk of heart defects and NTD.
- 3-fold risk of spina bifida, omphalocele and heart defects in babies of obese mothers.
- Increased incidence of neural tube defects in obese women has persisted in populations where flour has been fortified with folic acid. The biological basis for these abnormalities is not clear but may be linked to insulin resistance, diabetes or specific nutritional deficits.
- Confirmed association between maternal obesity and spina bifida, heart defects, anorectal atresia, hypospadias, limb reduction defects, diaphragmatic hernia, omphalocele. (Watkins ML, 2003; Cedergren MI, 2003; Waller DK, 2007)
- Macrosomia: high risk of birth injuries; high chances of CS. Nearly a fifth of women with a BMI >30 had fetal macrosomia; independent of whether the mother also had pre-existing or gestational diabetes. (Jolly MC, 2003)
- Macrosomia is a risk factor for operative delivery, a low Apgar score at one minute and a low umbilical arterial pH level, as well as shoulder dystocia and significant injuries to the baby, including fractures and nerve palsies.

- It is **macrosomia**, rather than maternal obesity that is the main risk factor for shoulder dystocia. The overall morbidity for macrosomic babies is increased to around 8%. (*Robinson H, 2003; Ramsay JE, 2006*)
- **Preterm birth**: Medically indicated preterm birth.
- **SB**: Higher BMI, greater risk of SB. Women with a BMI >30 had a stillbirth rate of 6.9/ 1000 total births compared with 4/1000 total births in women with a BMI of 20 –25 (adjusted OR 1.40)
- **Neonatal Death**



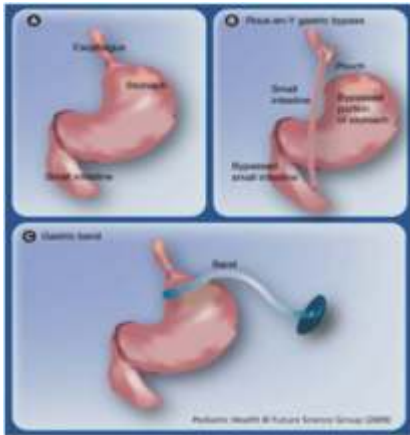
- **Intra-partum:**
- Difficulties with **venous access**
- *Vahratian A, 2004*: Women with a BMI ≥30 were more likely than women with a BMI <26 to have their **labour induced** and to receive **oxytocin**.
- Labour progression from four to 10 cm was **slower** in obese women (7.9 versus 6.2 median hours)
- These data suggest that obesity is associated with **inefficient uterine activity** in labour.
- **Primary emergency caesarean section** rates were higher for obese women compared with women with a healthy BMI (27% versus 19%, P, 0.04), with the majority of the deliveries occurring during the first stage of labour for **failure to progress** in labour and **fetal distress**
- **Anesthesia**: Increased requirements, higher risk of anaesthesia-related morbidity, higher epidural failure rate (*Dresner M, 2006*)
- Increased risk of aspiration under general anaesthesia
- Difficult endotracheal intubation
- Difficulty in achieving regional analgesia/anaesthesia
- Postoperative hypoxaemia and atelectasis
- **Co-morbidities** such as hypertension, ischaemic heart disease and heart failure, adding to the risks associated with anaesthesia
- **C.S.:** Preoperative skin cleansing before CS
- **Vaginal cleansing** using povidone-iodine/Chlorhexidine gluconate before CS in laboring pts and those with ruptured membranes may be considered. (*ACOG, 2018*)
- **Surgical access to uterus** : Transverse v/s Vertical (*RCOG GTG, 2018*)
- **Class 3 obesity** is associated with increased rates of **uterine rupture** during trial of labour and neonatal injury.
- **Emergency CS** is associated with **increased risk of serious maternal morbidity** because of anesthetic and

- operative difficulties
- **Suturing of subcutaneous fat**
- **Post Partum:**
- PPH, Genital tract infection, UTI, wound infection.
- Increased risk of VTE after both CS and ND. **Postpartum infection with obesity** may increase chances of VTE.
- **Breastfeeding:**
- BF rates are poor among obese (*Amir LH, 2007*)
- Possible reasons: difficulty with correct positioning of baby, psychological issues, or endocrine issues such as prolactin response to suckling. (*Rasmussen KM, 2004*)
- **Challenges for BF:** takes longer for the milk to come in, **lower production** (breast size has nothing to do with amount of milk produced). Indicated preterm and admission in **NICU** means prolonged separation of mother from baby. Plus higher rates of **maternal complications** along with CS reduce the rate further.
- BMI > 40 kg/m<sup>2</sup> is a risk factor for developing **pressure sores**; immobility being one more risk factor
- **Mental health problems:** high prevalence of depression symptoms. High antenatal anxiety, postpartum anxiety, eating disorders, antenatal serious mental illness.
- **Long term implications in childhood:** Intra-uterine exposure to obesity is associated with increased risk of developing **obesity and metabolic disorders** in childhood. (*Barker hypothesis, 1990*)



- **Metabolic syndrome:** defined as two or more of the following four components: obesity, hypertension, glucose intolerance and dyslipidaemia. The prevalence of the metabolic syndrome at any time up to 11 years was
- 50% for LGA offspring of mothers with gestational diabetes
- 29% for LGA offspring of non-diabetic mothers (*Boney CM, 2005*)
- HAPO Study: Amongst obese women,
- **Raised maternal blood glucose**
- **Raised tryglyceride and fatty acids**, and **fetal insulin concentrations**, contributing to **fat accretion** in offspring.
- Maternal and cord blood **leptin** conc is elevated, with evidence of low grade inflammatory state in mother with high levels of CRP and IL 6; linked to **insulin resistance**.

- **Management:**
- **Specific recommendations:**
- **Folate Supplementation:** FA 400 microgram daily
- **Wt loss:** loss of 4.5 kg b/w 2 pregnancies reduced risk of developing GDM by upto 40%. (Glazer NL,2004)
- 10% wt loss over 6 months is ideal, safe and possible to sustain in long term.
- Wt loss during first trimester may increase NTD; but prior to pregnancy does not appear to carry this risk. (Carmichael SL, 2003)
- Following Bariatric Surgery: Maternal and perinatal complications were less
- Dumping syndrome: To avoid same, OGTT isn't recommended for women who had bariatric surgery;



- instead, Home based glucose monitoring for at least 1 wk is advisable. (Ukleja A. 2005)
- RCOG GTG, 2018 & ACOG: Min waiting period of 12-18 months after bariatric surgery is recommended before attempting pregnancy
- RCOG GTG (2018): women with more than one moderate risk factor (BMI of 35 kg/m<sup>2</sup> or greater, first pregnancy, maternal age of more than 40 years, F/H of pre-eclampsia and multiple pregnancy) may benefit from taking 150 mg Aspirin daily from 12 wks of gestation until birth of baby.
- Regular Moderate intensity physical activity: RCOG (2006) & Cochrane review suggested regular aerobic exercise during pregnancy improved maternal fitness, beneficial effects of fetal growth. (Kramer M, 2008)
- Anti-obesity or wt loss drugs are **NOT** recommended for use in pregnancy: Orlistat- No major malformation risk. Phentermine/Topiramate- Topiramate during pregnancy- oral clefts; both are excreted in breast milk, and carries unknown risks to infant. (RCOG GTG 2018)
- Metformin: for overwt/obese pts without DM; addition of metformin to diet and lifestyle changes, starting at 10-20 wks **DID NOT** have improved pregnancy/birth outcome. (Dodd JM et al. 2019)
- Type 2 DM steep increase within first 5 years
- Contraception

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- Awarded as **NATIONAL QUALITY ACHIEVEMENT AWARDS 2021** for Best Ivf & Infertility Surrogacy Centre of Gujarat & Ahmedabad.
- Awarded as "Gujarat NU GAURAV" for work in Healthcare sector by the **CHIEF MINISTER of Gujarat Shri. Vijay Rupani**. The felicitation was done considering extensive work of SNEH HOSPITAL in field of Infertility & IVF Treatment across Gujarat we announce proudly that we are the part of "**JOURNEY OF GROWTH & PROSPERITY OF GUJARAT, INDIA**"
- National Healthcare excellence award 2019 held at Delhi in presence of Health Minister of India Best awarded as a best IVF hospital of Gujarat
- Awarded as "**Asia's greatest Brand**" by One of the biggest in the asian subcontinent reviewed by price water house coppers p.l. for the category of asia's greatest 100 brands the year.
- International health care award 2017 & certificate of excellence presented to "**SNEH HOSPITAL & IVF CENTER**" for best upcoming IVF & Women infertility hospital of gujarat
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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/m<sup>2</sup>. 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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