AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

AUGUST 2021 VOLUME 5

THEME : IMPLEMENTATION OF EVIDENCE BASED CLINICAL CARE

MOTTO : SWEAT, SMILE & REPEAT

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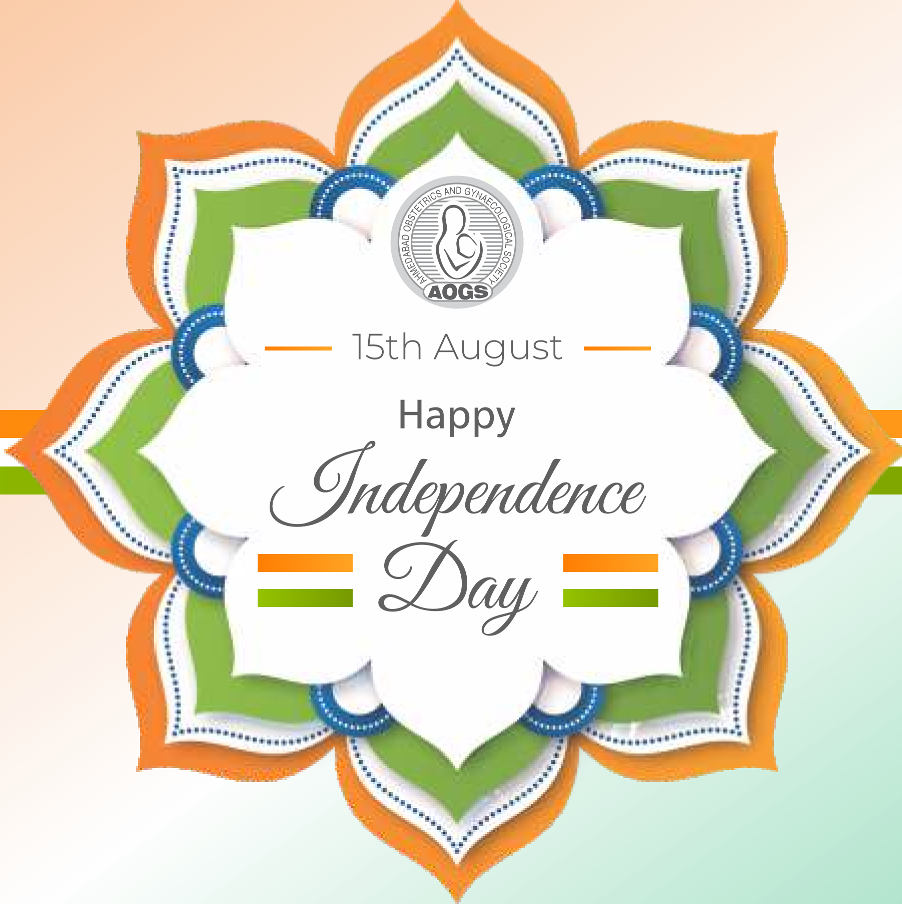

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TEAM AOGS MESSAGE

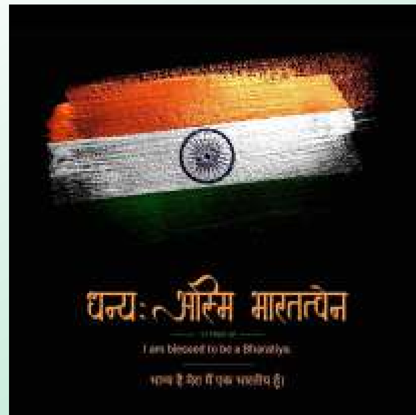
Dr. Jignesh Deliwala
President

Dr. Munjal Pandya
Hon. Secretary

We all know meaning of Independence; we know that historic day when we got freedom from British tyrants. We read a lot about 'Do we really value our independence or do we really deserve it?' Only those, who can't feel the real pain of our Great Freedom Fighters and their families, would speak or think in such a manner. We know the value of freedom, we know the basic principles of humanity, we value every life around us. Needless to say, each one of us has extended helping hand to many, and we continue to do so; that's freedom for us! Many of us nurture seeds, and water them to grow beautiful plants; literally as well as pertaining to human lives as well; and that way we justify our birth or opportunity of being human.

Our country has seen many wars; and specially in last few centuries, our own became puppets in hands of cruel Britishers for Government jobs; beating and capturing our own brave fighters; reflecting lack of unity even at that time. "Unity is Strength" that we learnt; but needs wider implementation for saving our Nation from further damage.

We salute every freedom fighter, we salute all their family members; we salute every soldier and their families; we salute every social worker who has been working hard to set the society right; we salute every person who works in media and has been trying to spread positivity; we salute every little child who thrives hard to become a good citizen; we salute every teacher who carves so many souls; we salute every professional contributing towards the progress of our country; we salute every elderly in the family for keeping the base of family strong; and most importantly, we salute all our doctor friends and their families who standbyed the society in the challenging times of the ongoing pandemic bravely; fighting head on with the invisible, yet deadly virus!



Dr. Jignesh Deliwala
President

आयुर् आरोग्यं सुख्य

Dr. Munjal Pandya
Hon. Secretary

PAST PROGRAMME

AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

14.08.2021 SATURDAY

Dinner : 7.30 pm Onwards

Hybrid CME

Venue : Hyatt Ahmedabad

Next to Ahmedabad One Mall, Vastrapur, Ahmedabad

Coordinator:

Dr. Hetal Patolia

President
Dr. Jignesh Deliwala

Hon. Secretary
Dr. Munjal Pandya

Chairpersons :

Dr. Hemant Bhatt

Dr. Kamini Patel

SPEAKER

Lutal phase support in ART

8:00 pm to 8:25 pm

Dr. C.B.Nagori

Interactive session

8:25 pm to 8:35 pm

Indegenous Dydrogesterone

Dr. P.C. Mahapatra

Dr. Mukund Gurjar

SPEAKER

Selecting the route of hysterectomy for Benign Gynaecological conditions.

Dr. P.C. Mahapatra

8:35 pm to 9:00 pm

VOTE OF THANKS : DR. MUNJAL PANDYA

WEBINAR LINK : http://tcewebinar.com/Emcure/Dydrofem/

From The Makers of

PAST PROGRAMME

AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

AOGS PG SYMPOSIUM

WEBINAR - II

Wednesday, August 18, 2021

7.30 PM to 9.15 PM

President
Dr. Jignesh Deliwala

Secretary
Dr. Munjal Pandya

Co-ordinators
Dr. Akshay Shah
Dr. Shashwat Jani
Dr. Kirtan Vyas

If you are already registered for webinar - 1 than you do not have to register again. Just login on the day of webinar.

Click here For Registration :
http://orangerose.in/connect/

SESSION 1

Shardaben Hospital, Ahmedabad

Obstetrics case :
Previous CS

PG Students:
Dr.Drashti Shah
Dr.Saumya Majmundar
Dr.Heenal Vaghela
Dr.Ruchika Bhabhor

Experts:
Dr. Yamini Trivedi (Ahmedabad)
Dr. Ashwin Vachhani (Surat)
Dr. Rupa Vyas (Ahmedabad)

SESSION 2

Civil Hospital, Ahmedabad

Gynec Case:
Fibroid

PG Students:
Dr. Hemali Nenuji
Dr. Monica Dixit
Dr. Kamlesh Hadiya
Dr. Fenuka Patel

Experts:
Dr. Babu S. Patel (Ahmedabad)
Dr. Megha Patel (Ahmedabad)
Dr. Raxita Patel (Ahmedabad)

PAST PROGRAMME

Photos of Training of 3rd wave - Date : 10th to 13th August, 2021

PAST PROGRAMME

AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

FOGSI Medical Termination of Pregnancy Committee 2021 - 2024

PUBLIC AWARENESS PROGRAM

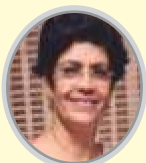
26th, 27th August, 2021

10 am onwards

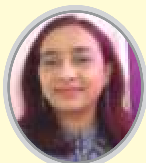
VENUE : Nursing School, V S Hospital Campus , Ellisbridge Ahmedabad.

Dr. Shantha Kumari
FOGSI President

Dr. Madhuri Patel
FOGSI Secretary General



Dr. Archana Verma
FOGSI VP



Dr. Richa Sharma
FOGSI – MTP Committee Chairperson

CHIEF GUEST

DR. DIPESH DHOLAKIYA

DR. M C Patel

GUEST OF HONOUR

DR. HEMANT BHATT

DR. JIGNESH DELIWALA

SECRETARY AOGS

DR. MUNJAL PANDYA

PROGRAM COORDINATORS

DR. AMITA SHAH

DR. KRUTI DELIWALA

26th August, 2021

Program flow is as follows:

1) Welcoming the Chief Guest Dr. Dipesh Dholakiya- Secretary SOGOG, Guest of Honour- Dr. Jignesh Deliwala- President AOGS and Mrs. Rajshree R- Principal, Nursing School
2) Prize distribution for poster competition by Chief Guest
3) Awareness Program for third year nursing students by Dr. Kruti Deliwala
4) Question/Answer session by Dr. Amita Shah
5) Vote of thanks by Dr. Kruti Deliwala

27th August, 2021

Program flow:

1) Welcoming the Chief Guest- Dr. M C Patel - Joint Convenor, SOGOG and Guest of Honour - Dr. Hemant Bhatt- Treasurer, SOGOG
2) Lecture for second year students by Dr. Munjal Pandya - Secretary, AOGS
3) Question answer session by Dr. Amita Shah
4) Vote of thanks by Dr. Kruti Deliwala

With respect and regards,
Dr. Amita Shah and Dr. Kruti Deliwala
Program coordinators- Gujarat chapter

Laparoscopy in pregnancy : Where, when, how and by whom ?

(A quick review of current evidences and recent advances on the subject)

Dr. Sujal Munshi

Consultant Obstetrician – Gynaecologist and Gynaec Endoscopic surgeon

Munshi Hospitals, NOVA IVF Ahmedabad

Approximately 1 in 500 women may require non-obstetrical abdominal surgery during pregnancy. The most common non-obstetrical surgical emergencies complicating pregnancy are acute appendicitis and cholecystitis. Other conditions that may require operations during pregnancy include ovarian cysts, adnexal torsion, heterotopic pregnancy, adrenal tumours, splenic disorders, symptomatic hernias, and other conditions like cervical incompetence.

In recent years that laparoscopy has become an acceptable surgical alternative to open surgery in pregnancy. Over two decades ago, some argued that laparoscopy was contraindicated during pregnancy due to concerns for uterine injury from trocar placement and fetalmalperfusion due to pneumoperitoneum. With more experience and documented outcomes, laparoscopy has become the preferred treatment modality for many surgical diseases in the gravid patient.However, only laparoscopists who have specialist laparoscopic skills and who perform complex laparoscopic surgery regularly should undertake laparoscopy in pregnant women.

Laparoscopic surgery is associated with faster recovery, shorter hospital stay and a trend to lower rate of wound infection for pregnant women. The decision between laparoscopic and open routes of surgery should be based upon the available expertise, infrastructure, background history, gestation and the woman's preference.

Due to enlargement of the uterus and subsequent limitations to visual field and surgical access there is an increased risk of vascular and organ trauma, in particular uterine perforation, although this risk has not been quantified. Counsel women about consequences of uterine perforation, which include subsequent uterine rupture, infections, preterm delivery, and laceration of the fetus or the placenta. There is increased risk of bleeding due to increased vascularity of uterus and adnexae

There should be early involvement of an obstetric anaesthetist. Aspiration prophylaxis should be administered, and a strategy for airway management should be made. General anaesthesia and endotracheal intubation are essential, and the use of a laryngeal mask airway is not recommended.

Creation of the pneumoperitoneum should be gradual, as should alterations in maternal positioning.

Pregnant woman undergoing non-obstetric surgery are at an added risk for venous thromboembolism. Their risk for venous thromboembolism should be stratified and prophylaxis considered. Modern anaesthetic agents, muscle relaxants and opioids are not thought to be teratogenic when used in therapeutic clinical doses and when the maternal physiology is maintained.

Clinicians should ensure the utero-placental blood flow is maintained by avoiding maternal hypotension.In most cases general anaesthesia should be employed.There is limited evidence on the use of regional anaesthesia for laparoscopy in pregnancy. The benefits of general anaesthesia include securing the airway to reduce the risk of aspiration, good muscle relaxation to allow excellent surgical conditions and controlled ventilation to regulate maternal $PaCO_2$. In addition, general anaesthesia can avoid any discomfort that an awake woman may endure, related to either a high neuraxial sensory block level for an adequate pneumoperitoneum, or steep positioning.

Maternal arterial CO_2 should be controlled, avoiding hypo- and hypercapnia, to maintain optimal utero-placental flow and thus avoid fetal acidosis. End-tidal CO_2 ($ETCO_2$) can be used as a surrogate marker for arterial Co_2.

Recent series have shown good maternal and fetal outcomes for laparoscopic appendicectomy, cholecystectomy and adnexal surgery up to 34 weeks gestation, which extends historical recommendation to limit laparoscopic surgery to the second trimester.Though Any surgery in pregnancy is associated with maternal and fetal risks. Non-urgent surgery should be postponed until after pregnancy.

Fetal heart Doppler ultrasound monitoring may be done before and after surgery to confirm fetal wellbeing and reassure the mother. There is no need for routine intraoperative monitoring.If there is a risk of pre-term delivery antenatal corticosteroids for fetal lung maturation and magnesium sulphate for fetal neuro-protection should be administered dependent upon the gestation of the fetus.

Anti-D administration is not deemed necessary according to guidelines since aparoscopic surgery is not included in the list of potentially sensitising events.

Routine tocolysis for women undergoing laparoscopic or open surgery in pregnancy is not recommended because it has not been shown to improve outcomes.

Intrauterine manipulation is contraindicated in pregnancy. Hence collaboration with the anaesthetic team (positioning, tilting) and experienced operating assistance is required. The location of the primary port will depend on the level of the uterine fundus.

The uterine size should be determined by palpation or ultrasound.

Choose the primary port location including umbilical, supra-umbilical / sub-xiphoid and Palmers' point (left upper quadrant in the mid- clavicular line) according to uterine size, location of pathology and operator experience.

In the late second and the third trimesters primary port sites could include 1-2cm below costal margin in the left (Palmers' point) or right mid-clavicular line or 3-6 cm above the umbilicus in the midline.

Insertion of an orogastric tube for gastric decompression maybe helpful when Palmer's point is used for access.Secondary port placement will be dictated by uterine size, pathology and operative approach.

Pre-surgical planning is paramount due to the challenges of accessing the pathology, given the limited degrees of freedom in laparoscopic surgery and the added obstacle of the size of the pregnant uterus. Ipsilateral port placement may circumvent this obstacle.

An intraabdominal pressure of upto20-25 mmHg can be used for gas insufflation before inserting the primary trocar . Current evidence supports operating pressures of 12 mmHg.

The benefits of a smaller 5 mm laparoscope include the need for smaller incisions with better cosmesis and the ability to insert them through secondary ports to gain different views if vision is permissive. Skilful use of a 30-degree laparoscope might improve the visual field in the presence of a large uterus.

Infected and potentially dangerous specimens should be contained in a tissue bag. Power morcellation, should be discouraged in pregnancy due to the risk of uterine trauma. Ultrasound, bipolar and monopolar energy sources are safe to use during laparoscopy in pregnancy. The risk of hernia formation is 1-2% in incisions greater than 10 mm, therefore the fascia should be closed.

Antibiotics should be used if there is an infective process.Good analgesia, adequate rehydration to maintain euvolaemia and measures to prevent postoperative nausea and vomiting should be integrated into maternal postoperative care.

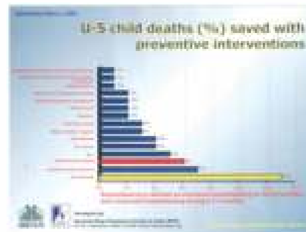
In era of assisted reproduction we often come across many unconventional situations which we have to treat following basic surgical principles on minimal invasive surgery in pregnancy. Attached here with barcode for viewing interesting video of heterotopic pregnancy following assisted conception in patient who had undergone laparoscopic myomectomy and salpingectomy in past. The extrauterine cornual / broad ligament ectopic pregnancy component was safly handled with laparoscopy safeguarding uterine ongoing healthy pregnancy . With proper preoperative , intraoperative and post-operative care intrauterine pregnancy reached near term and foetus was delivered by elective lower segment C Section.

Breastfeeding Primer for the busy Obstetrician

Dr. Shahla Khan
IBCLC
a Lactation Consultant practicing in Mumbai

Dr. Kartikeya Bhagat
MD, FICOG
an Obstetrician running
a Baby Friendly Hospital in Mumbai

1. Breast milk is the best milk for the baby. Breastmilk is species specific and mother's milk is made for human babies. Milk of every mammal has a different composition and the composition of human breastmilk changes with Age in and out of the womb.
2. 19% infant deaths could be prevented just by Exclusive Breastfeeding and proper Complementary foods given to each child. Malnutrition is the underlying cause in 55% of all cases of infant mortality.



3. MoHFW, NIHFW, WHO and UNICEF advocate for every newborn

a. Exclusive Breastfeeding for the first 6 months
b. Proper home-made complementary foods to be introduced after 6 months are complete
c. Continue breastfeeding till 2nd birthday

4. After extensive discussions, UNICEF and WHO came out with a document titled '10 steps to successful Breastfeeding' which summarizes a package of policies that facilities which provide maternity care could implement to support breastfeeding and pointed out the importance of the Maternity Services in promoting Breastfeeding.

5. WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) to motivate facilities providing maternity and new-born care to implement the Ten Steps to Successful Breastfeeding. Implementing each step is important but implementing all the steps has a far greater impact.
6. We now believe:

a. It is the responsibility of the Maternity Service to look after the baby from the time the baby takes its 1st breath/ cry till lactation is established.
b. Duration of the pregnancy is 15 months: 9 months in the womb and 6 months of Exclusive Breastfeeding

7. Three agencies are involved in helping the mother to Breastfeed:
   The Obstetrician-Paediatrician, the facility providing Maternity Care and the Society (Family and the Government). Every mother will exclusively Breastfeed her child only if all the agencies work together to promote Breastfeeding and help the mother.
8. Role of the Obstetrician is pivotal in promoting Breastfeeding.

a. He is the captain of the ship of Maternity Service and is in a position to not only implement baby-friendly changes in the functioning of the unit but also influence the mother in making the right choices for the baby.
b. An Obstetrician will advocate Breastfeeding only when he/ she is convinced about the advantages. Only then will he introduce Baby-friendly practices in the Maternity service and will be able to convince and encourage the mother and the family to Breastfeed

c. Who will convince the Obstetrician? His peer group: baby-friendly colleagues – Obstetricians and/ Paediatricians/ Neonatologists, scientific data/ literature, health agencies and/ workers/ zealots and, of course, the patient/ mother

d. In the Antenatal PeriodThis is the time when the expectant mother is most amenable to suggestions from her treating Physician. S/He is in a position to Educate and Influence not only the mother but the whole family – respecting their varied sensibilities,; keeping in mind their educational background, social and religious customs, expectations, and the feeding preferences

e. In the Intranatal PeriodS/He can adopt Baby friendly practices in the unit

f. In the Postnatal PeriodS/He can make arrangements to provide constant support to the mother for Exclusive Breastfeedingnot only during the hospital stay but also after discharge from the facility

9. The government policies should be Baby Friendly and should be implemented in principle and letter. ‘Ten Steps to Successful Breastfeeding’ and the ‘BFHI’ are two criteria and the ‘IMS Act’ an important legislation to help the cause. Laws to enhance Maternity/ Paternity leave and opening of the ‘Hirkani Kaksha’ (breastfeeding rooms) in public places are welcome steps in this direction.

10. Support from the family and endorsement from the society in the form of cultural practices and rituals go a long way to promote and sustain breastfeeding. Reinforcement from the AV media and the social media adds to the strength.

11. Facilities providing Maternity Care should have a baby friendly atmosphere.

a. It should have a written breastfeeding policy that is routinely communicated to all health care staff. Information about breastfeeding should be displayed in the common area. (Step 1) All health care staff should be well trained in skills necessary to implement the policy (Step 2)

b. Inform all pregnant women about the benefits and management of breastfeeding. (Step 3)

c. Give new-born infants no food or drink other than breast milk, unless medically indicated. (Step 6)

d. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.(Step 9)

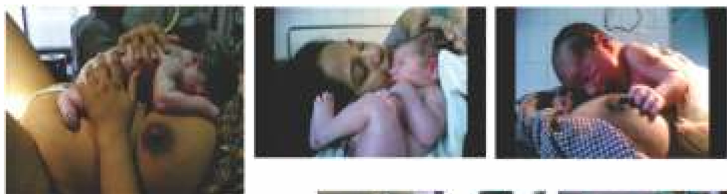
e. Baby Friendly Birthing practices

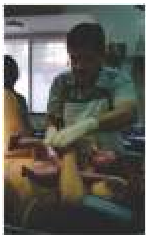
i. Delivering the baby on mother’s abdomen, delayed cord cutting

ii. Immediate cheek-to-cheek and skin-to-skin contact

iii. Breast Crawl

iv. Not breaking the skin-to-skin contact while suturing

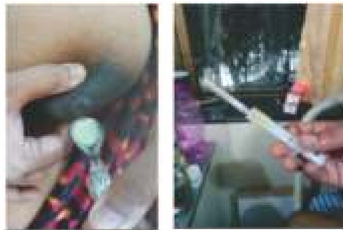




episiotomy and during Caesarean Section

v. Neonatologist can examine the baby on mother's abdomen without breaking the skin-to-skin contact

vi. If the baby cannot be brought to the mother for the 1st breastfeed, colostrum could be expressed, collected and fed to the baby with a sterile spoon or a syringe



vii. Delay Injection Vit K and other routines

viii. No baby bath or oil massage

ix. Help mothers initiate breastfeeding within one hour of birth. (Step 4)

f. Baby Friendly practices in the wards

i. 'Bedding in' rather than 'Rooming in' (Step 7)

ii. Kangaroo care

iii. Proactive frequent feeding initially followed by breastfeeding on demand (Step 8), encourage non-nutritive suckling

iv. Involvement of the husband

v. Minimise visitors: a honeymoon period for the family!

vi. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants. (Step 5)

g. After discharge from the Maternity unit

i. The baby to be followed up to check weight gain, urine output and color (neonatal jaundice) regularly till breasfeeding is established. Neonatology reference as required. Maintain Growth Charts.

ii. To address breastfeeding problems in the mother – reinforce knowledge/ technique for correct position/ attachment of the baby and expression of engorged breast

iii. Take help of Lactation Counsellors and Consultants (bpnimaharashtra.org) and use the shishuposhan app

iv. Introduction to the Mother Support Group

12. Setting up a babyfriendly maternity service is very much possible if the Obstetrician is convinced about the advantages and is helped/ backed by an equally enthusiastic and sincere Paediatrician. The project can't take off without the involvement of the support staff (nurses and ayahbais). Once the staff nurses understand the importance of exclusive breastfeeding, their support is assured.

13. We dream of a world where all maternity services are babyfriendly and every mother will exclusively breastfeed her baby which will help her reach her optimal potential.

14. All we need to do is look at the animal world and learn.

Animals are sensible..........

Are we??????

Congratulations!

Dr. Alpesh Gandhi

Dr. A. P. J. Abdul Kalam
Living Legend Award
16th August 2021

Office Bearers and Members of Delhi Gynaecology Forum

Dr. A.P.J. Abdul Kalam
Living Legend Award

16th August 2021

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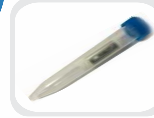
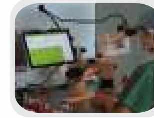


| The blank chip is pre-pasted on the prepared vessels for further identification



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