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THEME : IMPLEMENTATION OF EVIDENCE BASED CLINICAL CARE

MOTTO : SWEAT, SMILE & REPEAT

HAPPY Diwali FESTIVAL OF LIGHTS



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Dr. Jignesh Deliwala
President

TEAM AOGS MESSAGE



Dr. Munjal Pandya
Hon. Secretary

Dear Members,

શુભ દિવાળી !

We had academic feast in form of Annual Destination SOGOG at Tent City, Kutch; Many congratulations to Bhuj Ob Gy Society and Tram SOGOG! Team AOGS 2020-21 has won Best society award jointly with Surat Ob Gy Society during the same. AOGS has won candidature for hosting SOGOG next year as well! Many congratulations to AOGS and all our Members!

We are coming up with ICCOB Dr. Alpesh Gandhi sir's 7th Critical care conference in a row and his Presidential conference of his tenure as FOGSI President; with many esteemed International, National and Our own Gujarat's Faculties to shower upon their views and experiences for the benefit of us- Obstetricians and Gynecologists and Society as a whole! Do get registered for upcoming academic event for getting maximum benefits!

Looking forward to Happier, Healthier and 'sharing of knowledge and skill' times!

Dr. Jignesh Deliwala
President

Dr. Munjal Pandya
Hon. Secretary

PAST PROGRAMME

Endocrinology Committee FOGSI in association with Ahmedabad Obst. & Gyn. Society



ONE ICOG CREDIT POINT



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CONVENOR



Dr. Ananya Das
V.P. FOGSI

Presents

Demystifying Thyroid in Women
EPISODE - 8



11th November, 2021



5:00 pm - 7:00 pm

CHAIRPERSONS SESSION - 1



Dr. Ashish Verma
Associate Endocrinologist
AMU, MPT Medical College, W.P.O. Hospital,
Ahmedabad



Dr. Parag Sinhwale
Vice Chairperson,
ICOG
Topic:
Screening and Management of Hypothyroidism

CHAIRPERSONS SESSION - 2



Dr. Mansuk Shah
Consultant Gynaecologist & Gynecologist
& Medical Specialist,
Lal Bahadur Shastri Hospital, Ahmedabad



Dr. Charvita Ayyappa
Consultant Endocrinology & Department of
ICOG, Endocrinology
Council Member
Topic:
Type 1 thyroiditis

Practice Pearl's - Panel Discussion

Hypothyroidism in Pregnancy

CHAIRPERSONS



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Assistant Professor,
AMU, MPT Medical College,
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MODERATOR



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PAST PROGRAMME



AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

AOGS PG SYMPOSIUM

WEBINAR - VI

Wednesday, October 20, 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**

SESSION 1

GMERS Sola

Obs case: Preterm Labor

PG Students:

Dr. Jil Karia
 Dr. Darshil Prajapati
 Dr. Govind Bhadarka
 Dr. Pinal Pateliya

Experts:

1.) Dr. Akshay Shah
 2.) Dr. Janki Pandya

SESSION 2

LG Hospital

Gynec - Adenexal Mass

PG Students:

Dr. Prakruti Patel
 Dr. Foram Kayasth
 Dr. Naisha Gohel

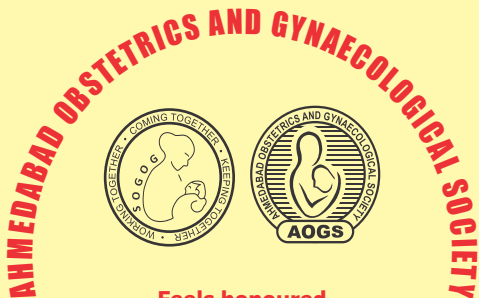
Experts:

1.) Dr. Shashwat Jani
 2.) Dr. Munjal Pandya

If you are already registered for webinar 1 / 2 / 3 / 4 / 5 then you do not have to register again. Just login on the day of webinar.

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AOGS - SOGOG ORATION

for the year 2021-22

to

Dr Prashant Acharya

M.D., FICOG

Date : 20th November 2021, Saturday

Subject :

**Exciting New Era of Imaging
 Science in Antenatal Care in 2021**

Dr Jignesh Deliwala
 President, AOGS

Dr Munjal Pandya
 Hon. Secretary, AOGS

AOGS - SOGOG ORATION - Dr. Prashant Acharya
 Date : 20th November 2021, Saturday



Correlation of Endometrial Length and Thickness by 2D Ultrasound Parameter to the Endometrial Volume Obtained by 3D Ultrasound.



Dr. Ashish Varma

Assistant professor
AMC MET medical college,
LG hospital Ahmedabad.



Dr. Sonal Panchal

Consultant Sonologist at
Dr Nagori's Institute of infertility and IVF,
Jodhpur, Ahmedabad.



Dr. Chaitanya Nagori

Director, Consultant Gynaecologist and
Infertility specialist at
Dr Nagori's Institute of Infertility and IVF,
Jodhpur, Ahmedabad.

Infertility:

In this new era of flooding advancements in the field of reproductive medicine involves both clinical and embryological aspects. Results of these advanced technologies depend on the final step, that is implantation, may it be intrauterine insemination(IUI) or in vitro fertilization(IVF). Implantation is a function of embryo and endometrium. Even in absence of a grade 1 embryo, good receptive endometrium may be a very important contributing factor for conception[1]. Endometrial thickness has been widely used as a parameter for endometrial receptivity assessment. But it has been observed that even with 8mm or thicker endometrium, the cycle often fails. So can we search for other parameters that may be added to assess the endometrium more perfectly? And what are we aiming?

Aim :

To evaluate correlation between the endometrial length and thickness measured on 2d to the endometrial volume calculated by 3d ultrasound VOCAL – virtual organ computer aided analysis.

Introduction :

Endometrial receptivity assessment is essential for every patient undergoing fertility treatment. Generally endometrial thickness is considered as a reliable parameter to judge endometrium growth and maturity. But the dilemma arises in the cases when, endometrium is long and does not grow in thickness or is short but grow well in thickness. Thickness alone therefore may not be an optimum measure to assess the endometrial growth and maturity. This may lead to error in judgment and results will grossly vary in different studies. It is therefore worth measuring other diameters of the endometrium also instead of thickness alone, like length and transverse diameter. Endometrium not being round or ellipse, it is not accurate to calculate its volume from these diameters by ellipse formula. Volume of the endometrium is better calculated by 3D ultrasound using VOCAL software.

How to measure endometrium and what all can we measure for endometrium along with thickness and the newer Modalities by which endometrium can be measured more accurately:

1: Measuring all parameters of endometrium by 2D ultrasound :

After explaining the procedure and taking verbal consent, the patient is asked to empty her bladder and is taken for examination on a gynaecology couch. Scans to be done in lithotomy like position with patients adequately covered to make her comfortable. The privacy in the room is maintained. Now transvaginal probe selection is done from the machine setting and preset for gynaecology scan is selected, the transvaginal volume 5-9 mhz probe is held and ultrasound jelly is applied on its head then it is covered with a sterile condom such that there should not be any air in between. After which again jelly is applied on the condom at the head end, the probe is now held such that the marker on the probe faces the roof and is gently slid through the introitus into the vagina. Once we see uterus in the mid saggital plane from fundus to external os, the 2d image is optimised.

On this image the entire length of the uterus is measured from fundus to external os – **anatomical uterine length (figure 1).**

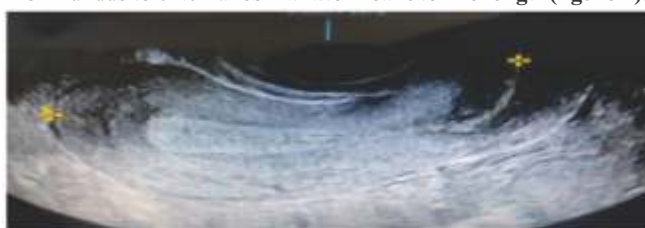


Figure 1 mid saggital plane of the uterus on B mode ultrasound measuring anatomical uterine length

On the same image measure the distance from the fundal end of the endometrium to the internal os – **endometrial length (figure 2).**

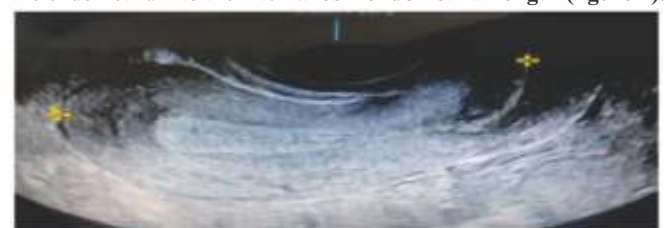


Figure 2 mid saggital plane of uterus on B mode ultrasound measuring endometrial length

In those patients in whom the entire endometrium did not appear triple line due to scar or indistensibility, the length of the endometrium was measured from tip of the endometrium till the lower end of normal morphological endometrium - effective endometrial length (figure 3).



Figure 3 mid saggital plane of uterus on B mode ultrasound measuring effective endometrial length.

Then the fundus is brought in the center of the image and is stored on one of the 2 dual images. Endometrial thickness (figure 4) is measured from the outer margin of the hyperechoic line to the hyperechoic line at the broadest distance perpendicular to the endometrium. Then the probe is rotated 90 degree anticlockwise to get the transverse section and is spanned up and down to find out the broadest diameter, to measure endometrial width.

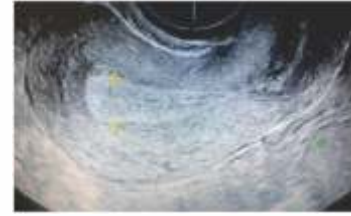


Figure 4 mid saggital plane of uterus on B mode ultrasound measuring endometrial thickness

On the second image the tranverse diameter of endometrium is measured from one end of the endometrium to other end, side to side – endometrial length in transverse section (figure 5) (figure 6).

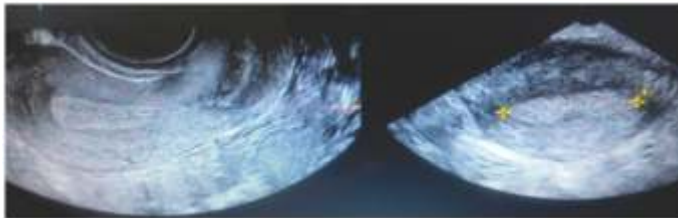


Figure 5 Dual image on B mode ultrasound showing mid saggital plane of uterus in one box and transverse section of uterus measuring endometrial length in transverse section.

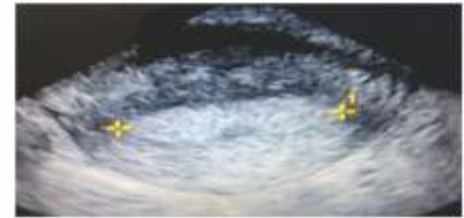


Figure 6 B mode ultrasound showing transverse section of uterus measuring endometrial length in transverse section

2 : Measuring endometrium by 3D VOCAL : Bring the probe back to see the midsagittal plane of the entire uterus and switch on 3d button. Now a box will appear and this is the region of interest. The uterus should be completely in the 3d box with 5-10 mm of extra space all round. Having adjusted the region of interest, angle of acquisition is selected and acquisition is started. The transducer takes an automatic sweep and the acquired volume is displayed on the screen as three images in three orthogonal planes x,y,z. Multiplanar is selected and a walk through is done in each plane to see complete anatomical details of the uterus. Bring the endometrium in midsagittal plane. Select VOCAL for volume calculation of the endometrium. After switching on vocal image “a” is selected which is the sagittal view to work on. When vocal is started a red dashed line will be seen perpendicular to the image a. (image a is the acquired plane, image b is the transverse plane and image c is the coronal plane). The dashed line is kept at maximum thickness of the endometrium. Volume of endometrium is calculated by rotating the entire volume 180 degree with a rotation step of 9 degree. Click start and a circumference is drawn manually around the endometrium at every rotation step and after every rotation you have to click a “>>” button to proceed for next rotation and at the end of 180 degree that is 20 rotation steps, total volume of endometrium is calculated, which is displayed on the screen (figure 7).

Why to measure other parameters for endometrium along with its thickness ?

Any spherical/ovoid structure measured by a single diameter does not accurately judge the size of the same. Therefore a mean of its three longest orthogonal diameters is taken or volume is calculated by $x \times y \times z \times 0.523$. But to measure an irregular structure like endometrium it is not possible to calculate the volume accurately. With 3D ultrasound, we can now measure volume accurately and reliably for any shape^[2-10].



Studies were 3D vocal is used to measure volume of different structures:

Raine-Fenning et al¹² compared the in vitro validity and reliability of different 3D-US methods for assessment of volumes and reported that the multiplanar and VOCAL methods with 3D Ultrasound yielded similar results, although the rotational VOCAL was superior to the multiplanar method for objects with irregular shape. Although these investigators did not observe any significant differences in the measurements obtained using different steps of rotation (VOCAL, 6°, 9°, 15°, and 30°), reliability increased in direct proportion to the number of

planes used i.e. with smaller steps of rotation more accurate calculation of volume.

In a recent publication, Rousian et al¹³ analyzed the accuracy and reproducibility of the VOCAL, inversion mode, ultrasonographic automatic volume calculation, and V-scope methods in vitro (using small- volume phantoms) and in vivo (measuring the yolk sac). According to these authors, VOCAL (15° and 30°) had high intraobserver and interobserver reproducibility and good accuracy.

Another study assessing fetal bladder volumes confirmed that VOCAL with 15° and 30° angles was reproducible and concordant.¹⁴

Barreto et al¹⁵ suggested that the multiplanar (5 mm), VOCAL (30°), and XI VOCAL (5, 10, 15, and 20 planes) methods are reproducible and valid methods for estimating volumes. The XI VOCAL method tended to be superior to the others, especially in the assessment of objects with irregular shape. The measurements obtained using XI VOCAL with 10 planes was closest to the real volumes of the objects.

Ruano R et al conducted a survey of fetuses with congenital diaphragmatic hernia (CDH) and demonstrated that VOCAL is more accurate compared to other methods when employed in the in vivo setting^[16].

A study by Peralta CF et al concluded that, the lungs of CDH fetuses have very irregular external surfaces and this fact could justify the higher accuracy of VOCAL method in measuring this structures. One of the main advantages of this method compared to multiplanar is that the studied structure outline may be modified in each presented plan during measurement, allowing more precise assessment of irregular objects^[17].

Thus there are several studies that have shown superiority of 3D ultrasound and VOCAL for assessment of the volume of irregular shapes.

We have also conducted study which is unique and to our knowledge no similar study is seen where a correlation between 2D measurement and volume calculated by 3D ultrasound is compared. Though complicated, we have been able to derive an equation by which from 2D parameters 3D volume can be calculated fairly accurately. Very interestingly, we have also been able to establish a strong parallel correlation between the volume calculated by 3D ultrasound VOCAL and the predicted volume from the equation^[18].

Equation :

$$\text{Volume} = -2.60426033* + 0.26615925* \text{ Ut length} + 0.31943168* \text{ Effective endo length} + 2.84099633* \text{ Endothickness} + 0.09538773 \text{ Endo length in transverse section}$$

(0.0003)
(0.0115)
(0.0235)
(<0.0001)

(0.3777)

We concluded that endometrial Volume calculated by 2D parameters is 52% similar to volume calculated by VOCAL. We require more 2D parameters to be included in the formula if we want to calculate volume by 2D to make is more accurate. According to these results the most correlating 2D parameters to 3D calculated endometrial volume were endometrial length and endometrial thickness.

This also conveys that when evaluated the endometrium by 2D ultrasound for its receptivity, it is essential to include endometrial length along with endometrial thickness for better prediction or evaluation of endometrial receptivity.

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IUI: Intra Uterine Insemination.



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Consultant IVF specialist (Germany)
Sarvamangal IVF, Ahmedabad.

Mo. : 90999 77077



Dr. Binjal Shah

MB.DipGO



Dr. Ketan Zala

(Fellow ICOG)

What is IUI?

IUI is deliberate introduction of good sperms in the female uterus in order to achieve pregnancy.

First therapeutic step in treatment of infertility.

Non-expensive. Non-invasive.

Simple procedure without substantial complications & can be practiced by all gynecologists at their present facility after simple modifications in their laboratory setup & adding a few equipment.

The rationale is that increasing the density of both eggs and sperms near the site of fertilization will increase the likelihood of pregnancy.

Indications for IUI

- Abnormal male factor: Oligospermia, Asthenospermia, Teratospermia (useful for mild cases only)
- Azoospermia (Donor sperm)
- Mild endometriosis
- Unexplained infertility
- Cervical factor infertility
- Husband is away from wife for long time (work abroad)
- People in same sex relationship
- HIV negative women with processed semen of HIV +ve husband
- The impossibility of vaginal ejaculation
- psychogenic or organic impotence
- severe hypospadias, retrograde ejaculation
- cryopreservation of sperm in cases of cancer treatment

Why it works:

- Cervix is bypassed.
- Better quality and a greater number of sperms enter uterine cavity.
- It is deliberately timed near ovulation.
- Semen washing removed detrimental effect of seminal plasma, WBC and dead sperms.

Pre IUI work Up:

1. Infection profile: HbsAg, HIV, HCV and VDRL of both
2. General Health assessment of both.
3. Hormonal assessment of both: TSH, PRL.
4. Tubal status: HSG or Laparoscopy* (not mandatory). But if it's confirmed blocked than IUI should be refrained.

Complications of IUI:

1. Infection: If done with due care very less chance. Incidence: 0.05-0.2 %
2. Multiple fetal gestation.
3. OHSS: Very less chance.
4. Ectopic pregnancy: 3-5 % due to some tubal pathology causing subfertility.

Ovulation induction for IUI: General guidelines

- Always with Superovulation.
- For normal AFCs and AMH: Tab Clomiphene 50 mg/ Letrozole 2.5 mg for five days from Day 2-6 followed by Inj HMG 75 IU on Day 7,9,11.
- For Low AFCs and Low AMH: Tab Clomiphene 50-100 mg followed by Inj HMG 150 IU on day 7,8,9 and do follow up
- For PCOS: (High AFCs and High AMH): Tab Letroz 2.5 mg from day-2 to 6 followed by Inj FSH or HMG 37.5 to 75 IU on day 7,8,9. You may require to titrate the dose as per the response of the patient.
- There are many other protocols which can be used and modified as per patient.

Optimum ovarian stimulation for IUI

- 2-3 follicles with Ø 18-19 mm.
- Endometrium 9 mm thick & trilaminar.
- IUI between Cycle D13 and D16, 36-40 hrs. from HCG inj.
- Cancellation:
≥ 6 follicles ≥ 15 mm & E2 level > 900 pg/ml

Monitoring:

1. Follicle size and number: 19-21 mm and 2-3
 2. Color doppler: Perifollicular vascularity (Covering 2/3rd), Uterine artery color doppler (PI less than 2.75 -3), Endometrial color flow (reaching up to base). * Not mandatory.
 3. Endometrial thickness minimum 7.5 to 12mm, consistency and color flow
- Follicular monitoring from D10
 - Follicle's size and numbers
 - To time HCG
 - Prevent OHSS
 - S. estradiol levels not always done- but done if large no. of follicles, or in cases of poor responders, or to differentiate cyst from functional follicle

Trigger with HCG

Best to use HCG: 5,000 -10,000 IU or Recombinant HCG: 250 mcg.

Selecting Appropriate Semen preparation method:

Based on the count and motility of the native semen sample:

- Swim-up: for good count & motility
 - Density Gradient: is selected for poor count & motility (15-20 million/CC)
 - Simple wash: For very poor sperm count (<10-15 million/CC with reduced motility and morphology)
- (In all methods seminal plasma containing prostaglandin should be thoroughly removed as this may cause uterine contractions & cramping)

Procedure of sperm preparation:

Semen sample collection:

- Wide mouth pre sterile, nontoxic semen container
- Try not to spill any sample- 1st drop of ejaculate has maximum motile sperms, but don't get stressed for that.
- Sample to be collected ideally in a clean, hygienic room next to laboratory
- Follow all aseptic precautions
- No water droplets on the hand or the container
- Abstinence: 2-5 days ideal

Time before processing:

- Semen sample stored at 37°C
- Start semen processing immediately after liquefaction
- It is critical that the spermatozoa are separated from the seminal plasma within 1 hour of ejaculation, to limit any damage from products of non-sperm cells

Volume of IUI sample:

- Minimal sample (0.3- 0.5 ml) with maximum concentration of rapid linear progressive sperm should be put into the uterus at the time of IUI.
- Excess volume can inflate the uterus causing reflex spasm
- Greater volume (FSP) to be injected very slowly, gently, over longer period of time

Time of IUI

- Single IUI at 36 to 40 hrs after HCG on confirming ovulation
- Double IUI at 24 to 30 hrs followed by another between 44 to 48 hrs after HCG
- No obvious advantage has been reported in literature by doing double IUI

Different and commonly used wash techniques:

1. Simple wash technique: Common steps:

- Mix the semen sample well
- Dilute the entire semen sample 1 + 1 (1:2) with supplemented medium to promote removal of seminal plasma.
- Centrifuge at 1200 rpm for 5–10 minutes.
- Carefully aspirate and discard the supernatants.
- Resuspend the combined sperm pellets in 1 ml of supplemented medium by gentle pipetting.
- Centrifuge again at 1200 rpm for 3–5 minutes.
- Carefully aspirate and discard the supernatant.
- Resuspend the sperm pellet, by gentle pipetting, in a volume of supplemented medium appropriate for final disposition, e.g., insemination, so that concentration and motility can be determined (Who laboratory manual for the examination and processing of human semen 2010)

2. Swim Up technique: common steps.

This technique relies on the ability of spermatozoa to swim out of seminal plasma into culture medium and is suitable for semen with high to moderate motility. This procedure selects spermatozoa for their motility.

The common steps of Swim up are:

- Evaluate the percentage of motile and total number of sperm on a Makler Chamber
- Fill the round-bottom test-tubes with 2 ml Sperm Preparation Medium
- layer 1ml of the liquefied semen underneath the medium
- Incubate the sample in the incubator for 60 min. Placement of tube at 45°
- angle creates a larger surface area for sperms to swim-up.
- Aspirate the medium of the upper part of the test-tubes into new prewarmed round-bottom test-tubes without disturbing the lower layer
- Add 5 ml of the medium to the sample and centrifuge 5 min/1200 rpm
- Aspirate the supernatant but save 0.5 ml of the medium to resuspend the pellet.

- Evaluate the percentage of motile and total number of sperm on a Makler Chamber

3. Double density gradient method:

This method is used to wash poor quality of semen samples.

- Low motility, Poor forward progression, large number of debris, High number of cells, Anti-sperm Antibodies, highly viscous
- Density gradient centrifugation separates cells based on their density.
- Morphologically normal and abnormal spermatozoa have different densities and at the end of centrifugation, they are located accordingly.
- The solutions like colloidal silica, poly-sucrose and others have higher density than semen. Because of that this system can separate the debris, cells, microorganisms and non-motile sperms from the motile ones.
- Centrifugal force enables the motile sperms to swim from a less dense seminal fluid into a denser solution. Cellular debris and non-motile microorganisms are trapped at the interphase between the two solutions.

The common steps of this method are:

- Evaluate the percentage of motile and total number of sperm on a Makler Chamber
- Layer 2 ml of the lower density medium (40%) into conical testtube
- Put the layer of the high-density medium (80%) underneath the upper
- layer (lower layer will raise and a sharp interface is formed)
- Layer 2 ml of the liquefied semen on the top of the gradient
- Centrifuge the sample 15 min/1200 rpm
- Use a new sterile Pasteur pipette to aspirate, in a circular movement from the surface, everything except the pellet and .4-.6 ml of lower phase.
- If no pellet is seen after centrifugation, remove all fluid except the lowest 0.5ml.
- Aspirate the pellet or the lowest 0.5ml liquid. Transfer sperm pellet to new tube and re-suspend pellet in 5ml sperm wash.
- Centrifuge the sample at 1200 RPM for 5 minutes. Do not use the brake.
- Aspirate sperm wash supernatant leaving as little (0.25-0.50ml according to the sperm count and motility) liquid as possible above pellet for swim-up.
- Add 1.5ml of media without disturbing the pellet.
- Incubate the tubes at a 45° angle for 20 – 30 minutes for swim-up in vertical rack in a 37°C incubator.
- Aspirate sperm wash supernatant above pellet and mixed with suitable volume of culture medium to obtain the required sperm concentration.
- Evaluate the percentage of motile and total number of sperm on a Makler Chamber

Comparison

Comparison made for the same volume of liquefied sample prepared

Technique used	Time	Cost	Yield	Quality
Simple wash	low	Low	High	low
Direct swim up	Highest	Low	lowest	Highest
Density gradient	High	Highest	Highest	High

Congratulations



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Dr. PRAKASH PATEL

IVF & Infertility Specialist
Dipl. in Adv. Laparoscopy (France)
Diploma in Sonography (Croatia)



Dr. AJAY PRAJAPATI

MS. Gynec (Infertility & Foetal
Medicine Specialist)

Dr. HEMAXI CHANGELA

Gynecologist
(Fetal Medicine Expert)

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Our Doctors Team



Dr. Anand B. Patel
M.D., D.G.O.

Diploma in Gynec Endoscopy, Diploma in Gynec Endoscopy,
(C.I.C.E. - France),
Diploma in Sonography



Dr. Rajesh Punjabi
M.D., Gynec

(C.I.C.E. - France)



Dr. Shital Punjabi
M.D., D.G.O.

(Gold Medalist)
Art Specialist (USA)



Dr. Prerana Shah
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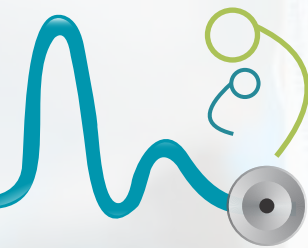
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Workshop

Critical Care in Obstetrics

December 17, 2021; Friday

Venue: Smt. NHL Municipal Medical College, Ellisbridge, Ahmedabad

Time	Scientific Details
08:00 to 09:00	Registration and Breakfast
09:00 to 09:50	Session 1
09:00 to 09:20	Physiological and Haemodynamic changes in pregnancy - Know the difference
09:20 to 09:40	Assessment of critically ill obstetric patient - Warning signs and Triagging
09:40 to 09:50	Interaction
09:50 to 11:00	Session 2
09:50 to 10:10	Basic and advanced life support in Obstetric patient
10:10 to 10:30	Fluid management in Shock & obstetric patients
10:30 to 10:50	ABG- Systemic approach to interpretation in obstetrics
10:50 to 11:00	Interaction
11:00 to 11:15	Inauguration
11:15 to 11:45	Session 3 : Oration
11:15 to 11:45	Obstetric Bundles of Care in Preventing Maternal Deaths
11:45 to 13:15	Session 4
11:45 to 12:05	Sepsis and Septic shock in Obstetrics
12:05 to 12:25	Maternal Echocardiography in obstetrics - When and Interpretations
12:25 to 12:45	Monitoring obstetric patient in OHDU/OICU
12:45 to 13:05	
13:05 to 13:15	Interaction
13:15 to 13:50	Lunch
13:50 to 16:45	Session 5 : Life Savings Skill stations and Hands on training (20 min +5 min)
13:50 to 14:15	CPR & Perimortum Resuscitative CS in obstetric patient
14:15 to 14:40	Endotracheal intubation in ICU
14:40 to 15:05	Oxygen Therapy
15:05 to 15:30	Use of Infusion and Syringe Pump
15:30 to 15:55	Eclampsia Drill
15:55 to 16:20	Assessment of blood loss and PPH drill
16:20 to 16:45	Neonatal resuscitation

Workshop Imaging in Obstetrics

December 17, 2021; Friday

Venue: Smt. NHL Municipal Medical College, Ellisbridge, Ahmedabad

Time	Details
08:00 to 09:00	Registration and Breakfast
09:00 to 10:15	MODULE "A"
09:00 to 09:15	Will it, Won't it?: Pro tips on assessing an early pregnancy and predicting an early miscarriage
09:15 to 09:30	NT in the era of NIPT: How can I keep it relevant to my clinical practice?
09:30 to 09:45	Fast Forward: Can an 18-week anatomical survey be done at 13 weeks?
09:45 to 10:00	Beyond the Heartbeat: Tips and tricks for first trimester echo evaluation
10:00 to 10:15	Screen to Save: Adding value to routine imaging by screening for pregnancy issues – pre-eclampsia, pre- term birth and growth restriction.
10:15 to 11:00	LIVE DEMO FOR FIRST TRIMESTER IMAGING
	- Expert faculty to be allocated each topic. - Optional 5 minutes can be allotted for workshop delegate interaction or question answer session depending on scheduling and response.
11:00 to 11:30	Tea Break
11:30 to 01:30	MODULE "B" : THE SECOND TRIMESTER ASSESSMENT, OPTIMIZING OUR RESULTS
11:30 to 11:45	The Foetal Blueprint: Simplifying protocol-based imaging – resource management in low-risk settings.
11:45 to 12:00	Soft markers – Boon or bane?: Optimize soft marker assessment and understanding its individual and collective relevance.
12:00 to 12:15	Echo like an Expert: Using 4D and AI-assisted imaging to screen for cardiac defects
12:15 to 12:30	3D 4D – not just for the parents' picturebook: Tips to improve image acquisition; clinical relevance of 3D imaging to fetal assessment
12:30 to 12:45	You ask, Experts answer: Interactive session for delegates to clear their concepts and get image acquisition tips from the masters.
12:45 to 13:30	LIVE DEMO FOR SECOND TRIMESTER IMAGING
	- Expert faculty to be allocated each topic. - If the need for a longer demo session is felt, the Q&A session can be merged with live demo
13:30 to 14:30	Lunch
14:30 to 16:30	MODULE "C" : THIRD TRIMESTER – WHERE IMAGING MEETS CLINICAL OBSTETRICS
14:30 to 14:45	The Growth Chart Conundrum – why does it matter?: Assessment of foetal growth, comparison between different charts and expert guidance on choosing the correct chart for clinical use
14:45 to 15:00	The Doppler Pentagram: Dopplers beyond UmbA and MCA – why, when and how to evaluate and interpret Aortic Arch, Ductus Venosus and Uterine Doppler.
15:00 to 15:45	Low Fluid Levels – how alarmed should I be?: Comparison of Amniotic Fluid Index vs. Deepest Pocket, interpretation of values and relevance to clinical decision-making.
15:30 to 15:45	Intrapartum Ultrasound – for the tech savvy: Imaging-guided decisions for progression of labor and assessment of intrapartum fetal wellbeing.
16:00 to 16:45	LIVE DEMO FOR THIRD TRIMESTER IMAGING
	- Expert faculty to be allocated each topic. - Optional 5 minutes can be allotted for workshop delegate interaction or question answer session depending on scheduling and response.
16:45 to 17:00	CLOSING REMARKS

Scientific Sessions

Day : 1 - Saturday - December 18, 2021

Conference Venue: Shree Shakti Convention Centre

Sardar Patel Ring Rd, Near Vaishnodevi Circle, Beside KD Hospital, Ahmedabad, Gujarat 382421

	Time	Dr. RM Nadkarni Hall & Dr. B.S. Ankalesaria Hall	Dr. Praful Munshi Hall & Dr. Sanath Joshi Hall	Dr. Miss S. C. Pandya Hall & Dr. Tanumatiben Shah Hall
Session 1 08:30 to 09:00 Lecture (8 Min + 2 Min)	08:30 to 08:40	MRP Tips and Tricks- When and How?	How to tackle Single fetal demise in Twins?	Vaccination during pregnancy: Preventing the complications
	08:40 to 08:50	Acute Uterine inversion - Managing the crisis	Prediction of Preeclampsia (Including Gestosis score)	Supine Hypotension & shock: Prevention and management
	08:50 to 09:00	CS Myomectomy	Thrombocytopenia in Pregnancy	How to examine a victim of rape?
Session 2 09:00 to 10:30 Lecture (18 Min + 2 Min)	Session	SMFM Session: HDP & complications: The unresolved Mystery	Sepsis: An avoidable scourge	09:00 to 10:00 Panel on Pregnancy with COVID-19: A challenge of the century
	09:00 to 09:20	World wide Maternal mortality and SMFM's Vision	LSCS in Chorioamnionitis	
	09:20 to 09:40	Persistent Hypertension after Preeclampsic pregnancy	Management of Maternal Sepsis	
	09:40 to 10:00	Management of Severe Hypertension	Management of Septic Shock	
	10:00 to 10:20	Neurologic Emergencies in Preeclampsia	Maternal death due to sepsis: Malaysian Experience	10:00 to 11:00 - Gestosis India Session Panel on Nearmiss cases: The unseen base of an Iceberg
10:20 to 10:30	Discussion	Discussion		
Session 3 10:30 to 12:00 Lecture (18 Min + 2 Min)	Session	SAFOG Session: Severe Anaemia: The major killer	AICC-RCOG Session Thrombophilias & Embolic phenomena: The	
	10:30 to 10:50	Screening of Anemia & interpretation of reports	DIC: How to make early diagnosis? How to manage?	
	10:50 to 11:10	Severe Anaemia in Pregnancy: Adds fuel to complication	DVT: How to prevent and Manage?	
	11:10 to 11:30	Making Labuor Safe in Severe Anaemia	SLE: Ensuring safe delivery & MTP	11:00 to 12:00 Panel on Acute abdomen in Pregnancy (Pandora's box precious life)
	11:30 to 11:50	Sickle cell crisis and Management	APLA: How to Prevent and Manage flare up?	
11:50 to 12:00	Discussion	Discussion		
Session 4 12:00 to 13:30 Lecture (18 Min + 2 Min)	Session	PPH: A scare for every obstetrician	Infections in pregnancy: A complete complexity	12:00 to 13:00 Panel on Imaging in High risk pregnancy (FGR, Anaemic Foetus etc)
	12:00 to 12:20	Carbetocin & Tranexamic acid - reduce PPH related admissions to ICU	Recurrent UTI in pregnancy	
	12:20 to 12:40	PPH Bundle - An effective approach	Pregnancy with Malaria, Dengue and Chikungunya	
	12:40 to 13:00	Lower segment uterine bleeding	Pregnancy with H1N1 infection	
	13:00 to 13:20	Placenta accreta syndrome: A Gordian knot	Pregnancy with Chicken Pox	Mob Violence: How to Prevent and Protect
13:20 to 13:30	Discussion	Discussion	Discussion	
Lunch Break	13:30 to 14:00	Lunch Break		
Session 5 14:00 to 15:30 Lecture (18 Min + 2 Min)	Session	Pregnancy & NCD: The Tsunami	Prematurity - The biggest challenge	14:00 to 15:00 Panel on critical complications in MTP: Still a reality (unexpected excessive bleeding during D & E, Unsafe abortion, perforation during MTP, MTP under sono guidance, difficult dilation etc)
	14:00 to 14:20	GDM: Preventing & Managing its' Complications	Prediction and Prevention of Preterm delivery	
	14:20 to 14:40	Diabetic Ketoacidosis in Pregnancy	Management of Preterm delivery	
	14:40 to 15:00	Eeffects of Pollution and Toxins on Pregnancy & future generation	Emergent Cervical Os tightening	
	15:00 to 15:20	Patient's safety in critical care	PPROM	15:00 to 16:00 Panel on Contraception and critical care: The confusion
15:20 to 15:30	Discussion	Discussion		
Session 6 15:30 to 17:00 Lecture (18 Min + 2 Min)	Session	Obst HDU/OICU: The Vital Back up	Obstetric Haemorrhage	
	15:30 to 15:50	Obstetric HDU: Need of an hour	Managing HELLP Syndrome: early diagnosis makes difference	
	15:50 to 16:10	Infection Prevention and control in Obst HDU/OICU	APH : Safeguarding interest of Mother and Foetus	
	16:10 to 16:30	Importance and Interpretation of Laboratory investigations in OHDU	Ectopic Pregnancy with Shock	16:00 to 17:00 Panel on Medico-legal Litigations issues in CCOB: Career Nightmare
	16:30 to 16:50	Role of Critical care in Obstetrics for achieving SDG targets 2030	Obstetric Hysterectomy: When and How?	
16:50 to 17:00	Discussion	Discussion		
Session 7 17:00 to 17:40 Faculty	Session	Panel Discussion	Miscellaneous	17:00 to 17:40 Panel on Pregnancy with STDs and HIV
	17:00 to 17:20	17:00 to 17:40 Panel on Pregnancy with Cancer & Trophoblastic diseases	Compression sutures	
	17:20 to 17:40		Preventing and managing Anal Spincter injury and Fistulas during childbirth	
Coffee Break				
	18:00 to 19:00	Award		
	19:30 onwards	Inauguration		
	20:00 onwards	Gala Dinner with Entertainment Program		

Scientific Sessions

Day : 2 - Sunday - December 19, 2021

Conference Venue: Shree Shakti Convention Centre

Sardar Patel Ring Rd, Near Vaishnodevi Circle, Beside KD Hospital, Ahmedabad, Gujarat 382421

	Time	Dr. RM Nadkarni Hall & Dr. B.S. Ankalesaria Hall	Dr. Praful Munshi Hall & Dr. Sanath Joshi Hall	Dr. Miss S. C. Pandya Hall & Dr. Tanumatiben Shah Hall
Session 8 08:30 to 09:00 Lecture (8 Min + 2 Min)	08:30 to 08:40	How to deal with OHSS?	Role of obstetricians in critical care in obstetrics	Role of teamwork in critical care in obstetrics
	08:40 to 08:50	Resuscitative (Perimortem CS)	Anaphylactic reactions - How to Prevent and manage?	Effects of drugs, smoking and alcohol consumption in pregnancy
	08:50 to 09:00	Laparoscopy in Critical Obstetrics	How to deal with mother with O - ve blood?	Immediate Blood transfusion reactions: Prevention & management
	08:54 to 09:00	Discussion	Discussion	Discussion
Session 9 09:00 to 10:25 Lecture (18 Min + 2 Min)	Session	Critical situations in LR/Obst OT: A dreadful Situation	Critically ill foetus: Be alert. To deliver or not? How?	09:00 to 10:00 Panel on Non assuring NST & CTG case based scenario
	09:00 to 09:20	AFE & PE- When to be alert & What to do?	BF in mother with medical disorders and medications	
	09:20 to 09:40	Pregnancy in adolescent girl	Meconium stained liquor in 2nd stage of labour	
	09:40 to 10:00	Operatives Difficulties in LSCS	Shoulder Dystocia: How to prevent and Manage?	10:00 to 11:00 Panel on RPL : (supported by Abbott) Obstetric Imbroglio
	10:00 to 10:20	Dealing with cord problems (Including cord prolapse)	Difficulty in delivery of a baby in LSCS	
	10:20 to 10:25	Discussion	Discussion	
Session 10 10:25 to 11:50 Lecture (18 Min + 2 Min)	Session	Endocrine problems in Pregnancy: The crisis	UNICEF Session: Still Birth/Neonatal birth injuries: The frustration	11:00 to 12:00 (supported by Emcure) Panel on Critical Care in Infertility
	10:25 to 10:45	Pregnancy with Thyrotoxicosis & Thyroid strom	Prevention & management of neonatal birth injuries	
	10:45 to 11:05	Pregnancy with Obesity	Still Birth: Prevention and Auditing	
	11:05 to 11:25	Post Partum Psychosis	When baby does not cry: What to do?	
	11:25 to 11:45	Pregnancy in Preexisting HT		
11:45 to 11:50	Discussion	Discussion		
Session 11 11:50 to 13:20 Oration (30 Min)	11:50 to 12:20	Topic: Women health crisis in COVID'19 Pandemic		
	Orator			
	12:20 to 12:50	Topic:		
	Orator			
	12:50 to 13:20	Topic: Obstetric risk assessment in IVF pregnancy		
Lunch Break	13:20 to 14:00			
Session 12 14:00 to 15:30 Lecture (18 Min + 2 Min)	Session	Cardio-obstetrics	Blood, Drugs, Nutrition in CCOB: The supportive care	ISOPRAB Session: Pre-conceptual care - Preventing High risk pregnancy
	14:00 to 14:20	Acute Fatty liver of pregnancy	Pain management in critically ill obstetric patients	Preconceptional care: A wondow of opportunities
	14:20 to 14:40	Pregnancy with congenital cardiac diseases	Uterotonics & tocolytics in pregnancy with medical disorders	H/O of genetic diseases: What to do?
	14:40 to 15:00	Post Partum cardiomyopathy	Rational use of blood and its' components in Obstetrics	Thalassemia Major: Prevention & supportive care
	15:00 to 15:20	Pregnancy after cardiac surgery	Fluid selection and Administartion in critically ill obstetric patient	Preconception care and preventing NCDs in future generation
	15:20 to 15:30	Discussion	Discussion	Discussion
Session 13 15:30 to 17:00 Lecture (18 Min + 2 Min)	Session	Medical disorders in Pregnancy: The rising trend	Fluid and electrolytes: Keep the Balance	MMR and NMR auditing
	15:30 to 15:50	Fulminating Jaundice at term	Obesity and Obstetric critical care	Uterine artery embolization
	15:50 to 16:10	Pregnancy with Kochs'	Steroids in Pregnancy	Maternal Mortality Auditing
	16:10 to 16:30	Pregnancy with Severe bronchial asthma	Nutritional care: Plays significant role in critica care in Obstetrics	Neonetal Mortality Auditing
	16:30 to 16:50	ARF in Pregnancy and Post delivery	Electrolytes: It's Significance and maintaining balance	Anesthesia complications (spinal headache, high spinal, Mandleson's syndrome etc)
	16:50 to 17:00	Discussion	Discussion	
	17:00 to 17:30	Miscellaneous: All in one	Miscellaneous: All in one	Miscellaneous: All in one
17:30 to 17:45	Validictory			



Vani

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OUR SERVICES

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- Innovation for Implantation Failure
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- Thin Endometrium
- Recurrent Implantation Failure
- Azoospermia

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Dr. Vinod Joshi



Dr. Kuntal Patel



Dr. Parth Patel

Management Team & Nursing Staff



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