2017-18
AOGS
AHMEDABAD
Aptitude for academics & servitude to the society

AOGS प्रगति

Strong girls - Strong India
BULLETIN
AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY
NEWS LETTER I APRIL 2017

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We don't conduct pre-natal sex determination test. It is a punishable offence.

Ahmedabad | Rajkot | Surat | Udaipur

Dr. Hemant Bhatt
President

PRESIDENT'S MESSAGE

Respected Seniors & Dear Collegues,

Warm regards & rememberance from team AOGS 2017-18.

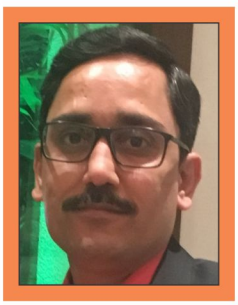
It is truly said that 'well begun is half done'. With your love & affection our installation ceremony saw the presence of more than 450 esteemed guests. The off-academic talks of Shri Tushar Shukla, Shri Bharat Pandya & RJ Dhvanit enthralled the audience with elan. The emotions of our members has compelled me to say proudly, during these hot sunny days : **કસમ ખુદા ની જ્યારે મારા ગળે વૂં લાગે,**
મજાલ શું આ ઉનાળાની કે, મને 'લૂ' લાગે...!

There are lots & lots of noble ideas for our AOGS during this year. Right from creating new audio-video facilities for refering best of academic material at our AOGS bunglow, to purchase of new primises for our AOGS with the facility of our own auditorium. Active participation in all social & healthcare services for millions of needy brothers & sisters of our nation is also our motto. Our theme & motto are depiction of those aims & objectives.

Seving all AOGS membrs with equanimity without prejudice or personal favour & in the best of the interests of our society will be the endevour of team AOGS 2017-18.

We have the rainbow coalition of some of the most enthusiastic, energetic, innovative & assertive senior & young docs as our team members. I consider this year's team as the great transitional phase of AOGS - where baton will be handed over to new generation youngsters. I feel myself extremely lucky to be the link of experienced seniors & bubbly young enthusiasts.

At last, **એવું કે કરીએ કે આપણ એકબીજાને ગમીએ,**
શા માટે રટીયાળી રાતે એકલ એકલ ભમીએ ?.
ભણવા કે ના ભણવાના કોઈ પણ બ્હાને મળીએ,
હળીએ, મનથી ભળીયે, સદાયે એકરૂપ થઈ સંચરીએ... - **With Respect & Regards - Dr. Hemant Bhatt**



Dr. Jignesh Deliwala
President

SECRETARY'S MESSAGE

Respected seniors and dear colleagues

Warm greetings!

At the outset I would take the opportunity to thank all the valued members of AOGS to elect me as Hon. secretary for one of the oldest and prestigious association of the country.

I felt very much overwhelmed with your gracious presence at the installation ceremony held at Pandit Dindayal auditorium. I would also thank our distinguished and honourable guests for their auspicious presence of Mr. Tushar Shukla – famous poet, Mr. Bharat Pandya- spokesperson of BJP and RJ Dhvanit the Best RJ of Gujarat Radio Mirchi fame.

It is rightly said 'THE SOLE MEANING OF LIFE IS TO SERVE HUMANITY'. I will feel proud and privileged to serve this association with my fullest effort and utmost sincerity. As far as academics is concerned let me assure you that all the progress related with academicswill be of highest quality & with latest of inputs in that particular subject. It will always be clinically relevant & will be helping in day to day practice & caring for your queries related with practical obstetrics & Gynaecological & sharing the latest update of emerging fields of fetal medicine, ART & Endoscopy would my endeavour.

Team AOGS 2017-2018 has some of the best hearts & minds of our prestigious organization. Every esteemed member of our team is 'Master Blaster' in his /her field, we do have such a wonderful bonhomie that will user an entirely different saga of fame & glory for our AOGS. As a team 2017-18 we promise to work with great fervers and enthusiasm. At last, I would greatly thank Dr. Hemant Bhatt our president, who has given me this opportunity to serve this society with full freedom. I feel very much honoured to work with him.

Looking forward for a great year with full of zeal and energy to serve you all.

Long live AOGS.

INSTALLATION CEREMONY
DATE : 02.04.2017

HON. SECRETARY'S REPORT
YEAR 2016-2017

MCM	11	
Extra Ord MCM	01	
GBM	05	(GBM, Extra Ord GBM, AGM)
CME	17	1. 10-04-2016: Gynaecologists' perpective of Breast Diseases FOGSI Breast Committee 2. 28-05-2016: Genetic Diagnosis: Prospects& Challenges 3. 10-06-2016:Prevention of Parent to child transmission of HIV GSAC & SAATHI 4. 12-06-2016: Influenza Vaccination in Pregnancy:Need, Effectiveness & Safety 5. 19-06-2016: GCISAR with AOGS 6. 02-07-2016: Aging Oocyte & infertility 7. 03-07-2016: - A Novel concept to induce browning of white fat cells to counter obesity - IT commissioner – IDC scheme 8. 31-07-2016: Infertility 9. 07-08-2016: FOGSI-Gestosis certificate, course HDP 10. 12-08-2016: Online birth registeration with AMC 11. 11-09-2016: Use of Gonadotrophins in IUI 12. 25-09-2016: Endometriosis 13. 02-10-2016: PCOS-infertility & early pregnancy AOGS & PCOS Society 14. 13-11-2016: Infertility 15. 18-12-2016: USG 16.25-12-2016: Male Infertility 17. 19-03-2017: Do We Need Introspection?-Increasing Rate of LSCS
Conferences	03	● National Medico Legal Conference 2-3-4 September 2016 (including 4 workshops) ● AICOG2017 25-29 January 2017 o AICOG Registrations: 10180 (second highest so far) o Workshop Registrations: 3673 (highest so far) (12 workshops) o CME Registrations: 3200 ● Annual AOGS Conference 25-26 March 2017 (attended by 20 committee chairpersons)
Orations	4	● AOGS Oration at SOGOG 16/10/2016 ● Silver Jubilee Oration 25/3/2017 ● AICOG2000 Oration 25/3/2017 ● Golden Jubilee Oration 26/3/2017
PG Exam Review Course	1	20-24 Feb 2107 & 27-28 Feb 2017 (PG students had great learning experience from 70 faculties of various medical colleges across Gujarat)
Social Awareness Programs	19	Lectures on Adolescent Health, Cancer Awareness, Anaemia, Hygiene
AICOG2017 **Social Awareness Programs**		22/1/2017: (HK Arts College) - Poster Exhibition on theme of women empowerment, betibachaao - Launch of theme song of conference - Bhavai on theme of menopause & Prevention of cervical cancer - Lectures on women empowerment &women safety - Rally on conference theme of BetiVadhaao- BetiPadhaao from H K Arts College to Induchachapratima, Nehrubridge corner followed by pledge taking 23/1/2017(GujUni Convention Center) - Lectures on Breast Cancer, Cervical Cancer, Osteoporosis, vaccination, Life after 40, liaison btwn NGO & Medical Organisations, Garbh Sanskar, Sexual Harassment-Kavvali on Menopause 26/1/2017 (River Front&GujUniConvetion Center) - School girls from various cities across Gujarat & participation of various ObGyn Societies: Surat, Mehsana, Junagadh, Ahmedabad - Poster exhibition - Bhavai - Skit on PCOS - Rally & Torch Lighting
Poster Exhibition	2	- 14/2/2017 at SLU college - 15/3/2017 at SCL Hospital
Felicitations	2	- Seniors 13/11/2016 -Seniors& Team AICOG 4/3/2017
Health Programs	2	- YOG, Pranayam, Dhyan 18/5/2016 - 27/1/2017 at AICOG
Outdoor Activities	5	- Bicycle Rally 5/6/2017 -Bird watching trip 26/6/2016 -Ladakh Adventure Trip 7/7/2016 to 17/7/2016 - Dang family & Trekking 8/11/2016 to 11/11/2016
Entertainment Programs	15	- Narrations: PucchineThaayNahiPrem 24/4/2016 -Drama: Waiting Room 5/8/2016 -Drama: Joke Samrat 31/3/2016 - Songs of LataMangeshkar: 25/9/2016 -NavratriCelebrations: 2/10/2016 -Christmas Celebrations: 25/9/2016 - GTG of Organizing committee of AICOG with Dinner & Photo session: 14/9/2016 -HasyaKaviSammelan: 8/2/2017
AICOG2017:		o Folk Dance & Musical Night: 25/1/2017 o Hariharan Night: 26/1/2017 o MohitChauhan Night: 27/2/2017 o Folk Dance & Osman Mir Night: 28/1/2017
AMLCON:		o Faculty Dinner with DJ & Karaoke 2/9/2016 o Entertainment program: 3/9/2016
AOGS Annual Conference:		o Entertainment program: 25/3/2016 Communication o Thru AOGS bulletins oThru SMS oPublished New Directory

CME 2 : CURRENT CONCEPTS ON RPL
DATE : 7th May, 2017, SUNDAY

Venue : Starottel (Hotel Regenta) Vadaj, Ashram Road, Ahmedabad

Chairpersons : Dr. Kashyap Sheth, Dr. Heena Shah, Dr. Mrugesh Shah

Time	Subject	Speaker
09.30 am to 10.00 am	Registration & Breakfast	
10.00 am to 10.20 am	RPL : Risk Factors and Prognosis	Dr. Kirtan Vyas
10.20 am to 10.40 am	Management of Endocrine Abnormalities in RPL	Dr. Kanthi Bansal
10.40 am to 11.00 am	Genetics & RPL	Dr. Jayesh Sheth
11.00 am to 11.20 am	Role of Low-Dose Aspirin & LMWH in RPL	Dr. Girija Wagh
11.20 am to 11.40 am	Uterine factors & RPL	Dr. Sanjay Shah (Ahm.)
11.40 am to 12.00 pm	Cervical Incompetence	Dr. Sapana Shah
12.00 pm to 12.45 pm	Panel Discussion Moderator : Dr. Girija Wagh Topic : Evidence Based Management of RPL (Interesting Cases) Panelists : Dr. Jayesh Sheth, Dr. Suresh Kothari, Dr. Chaitali Bansal, Dr. Nisha Patel, Dr. Kirtan Vyas	

Program Co-ordinators : Dr. Munjal Pandya

IMPORTANT ANNOUNCEMENT

We have created new post of clinical secretary in AOGS Governing body by unanimous approval in GBM held on 21st April, 2017
clinical secretary will be updating academic material for our AOGS members on our website & in our bulletin. Any objection or suggestion in this regard are invited within 15 days to be taken in next GBM.

SOCIAL SECURITY SCHEME

The Benevolent Scheme for Our Dear AOGS Members

Important Announcement :

Now, All Registered AOGS - SSS Members can make their Spouses the official members of the scheme, by providing following documents : (Xerox - Self Attested)

1. Aadhar Card / Pan Card Copy
2. Address Proof
3. Birth Certificate / School Leaving Certificate

Non - Registered AOGS - SSS Members can also Join the Scheme by following above instructions

FEE STRUCTURE

Age	Admission Fee	Membership Fee	AFC	Total Before 31.05.2017	Total
<45 yrs.	1000	100	1500	2600	3600
45-60 yrs.	1500	100	1500	3100	4100
>60 yrs.	2000	100	1500	3600	4600

Please send cheque in favour of 'AOGS SSS' payable at Ahmedabad only to AOGS office or SSS co-ordinators- Dr. Hemant Bhatt, Dr. Dipesh Dholakia, Dr. M.C. Patel, Dr. Geetendra Sharma and Dr. Jignesh Deliwala.
Please mention your Birthdate, Name and contact number on the back side of the cheque.

ATTENTION Admission fee will be increased by Rs. 1000/- in each category after 31.05.2017. so, please hurry up to avail the benefit of concession if you wish to join the scheme.

Premature Closure of Ductus Arteriosus –

Tip of Iceberg in Atlantic Ocean
Case Report
Correspondence : parthpjs@yahoo.com, 9429617556

Dr. Parth Shah MD; DGO, FIGE
Laproscopy Surgeon
Fetal medicine expert
Rajni Fetal medicine center
Reshambai Hospital Shahibag
Akanksha Hospital & research center Anand

Introduction – Ductus Arteriosus act as shunt for shunting blood from placenta bypassing high resistant Pulmonary artery (inactive lung in intrauterine life) to Aorta.Closure of Ductus arteriosus before birth can lead to high backpressure in right camber and cardiac compromise.

Case Report –

Mrs XYZ age 27 yrs.Primigravida non consensus marriage, Spontaneous pregnancy was diagnosed Mono-chorionic Twin from early Gestation. Patient registered to our centre after having co-twin demise at 20 weeks. Risk related to co twin demiseexplained and close follow up was made for study any sequence of Micro thrombi from co twin. Patient presented at 35.2 weeks with Pain in abdomen and decrease fetal movement. After examination False labour Pain wasconfirmed. complete scan with Doppler study done and patient advised observation admission. Scan on Day one shows Dilated Right Atrium and Ventricle **Fig 1.** High velocity Flow in Ductusarteriosus with Normal Doppler in Uterine,Umbilical, MCA and Ductus. **Fig 2.**with Good amount of liquor.On Day 2studyFinding were completely Changed,Further Enlargement of Right Heart Chambers, Non Visualization of Ductus arteriosus with Large Pulmonary Trunk **Fig 3.**Moderate anhydrous as Shown in Graph **Fig 4** , with still Good Doppler in MCA and Umbilical **Fig 5,** Comparing Tricuspid regurgitation of Day 1 and Day 2 **Fig 6.** Relatives and Patient Counselled condition and decision of LSCS taken with consent. Paediatrician with Paediatric cardiologist given call for same. Postnatal Apgar 1 mon 5 min was 9/10 ,9/10. Shifted in NICU postnatal Echo confirm Finding –Pulmonary HT, Right Sided Chamber enlargement with Tachycardia. 3 days course in NICU uneventful discharged on Day 4 on digitalis Prophylactic. Follow up at 1 month was Normal.

Etiology –The ductus arteriosus originates from the 6th branchial arch and represents a muscular artery, whereas the pulmonary and aortic vessels are elastic arteries. Patency of the ductus arteriosus is maintained during gestation by locally produced and circulating prostaglandins. As gestation reaches near term, the ductus becomes less sensitive to dilating prostaglandins and more sensitive to constricting factors such as prostaglandins synthetase inhibitors. Fetal ductus arteriosus closure or constriction is caused by maternal medication of prostaglandin synthetase inhibitor or corticosteroid. Idiopathic or spontaneous ductus arteriosus closure has been also reported 1,2,3.

Pathology – Haemodynamic changes that affected byright ventricular blood directed to high resistant lung vasculature, leading to increase right ventricular afterload and impairing right ventricular function with Tricuspid Regurgitation. After birth conversion of high resistant Lung vasculature to low resistant will help in resolving afterload of right ventricle.

Differential Diagnosis – 1 Premature closure of Foramen ovale-Enlarge Right atrium with Foramen ovale valve touching till Left Atrial Border2 Coarctation of aorta –Show Bidirectional Flow in arch of Aorta 3 Sudden placenta Dysfunction – Doppler will be abnormal.

Prognosis – Delaying delivery can threaten the survival of the fetus. Urgent delivery is associated with an excellent prognosis and is always indicated in a term pregnancy. In the case of a preterm infant, the risks due to prematurity should be carefully weighed against the risks of the fetal cardiac decompensation, Delaying in Diagnosis lead to sudden unexplained IUD4

Discussion –

The Ductus arteriosus patency in the normal fetus is maintained by circulating prostaglandins derived mainly from the placenta and by low oxygen tension normally present in the fetus. Vasodilator prostaglandins, specially PGE2, plays major role. NASIDS, Certain Herbal medicine, "bhasma"from quacks known to be inhibitors of prostaglandin synthesis.

In our case the patient has not taken any NSADIS, likely to be idiopathic. Strong supervision and prompt diagnosis could improve outcome.

In country with free availability of NSAIDS, tendency of self-administration of pain killer, lot of unauthorised quack giving Powder medicine, new era of so called generic medicine. Pathology known as Premature closure of Ductus arteriosus could be a huge in number. Pathology is very underdiagnosed and awareness should be raised about stoppage of usage of NSAIDS, counselling and preventing patient from self-medication. Perinatology Journal autopsy study showing finding of 10% stillbirth having closure of Ductus arteriosus in cases of Unexplained Stillbirth fetus autopsy. That could be major cause and retrograde history can help in judging many unexplained IUD. Proper documentation of history and sono finding could be useful for medicolegal purpose of unexplained IUD .Watchful surveillance of antenatal period and timely pick up can prevent still birth .

Classical triad of decrease fetal movement, history of painkiller, Sonographic sudden Oligo with significant TR > 120 cm/sec with Right sided chamber enlargement could help suspecting and diagnose condition.

So it's your titanic travelling in Atlantic Ocean (Pregnancy) with Conditions like Premature closure of Ductus arteriosus are tip of iceberg, easily missed and collision can occur. Knowledge of condition will help to secure your titanic (Fetus).

(References available at AOGS office)

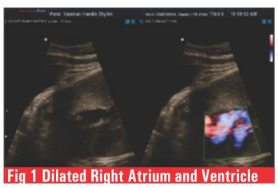


Fig 1 Dilated Right Atrium and Ventricle

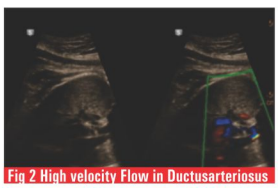


Fig 2 High velocity Flow in Ductusarteriosus

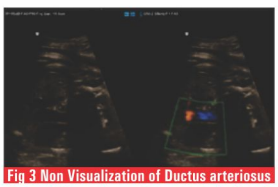


Fig 3 Non Visualization of Ductus arteriosus


Fig 4 Moderate anhydrous


Fig 5 Good Doppler in MCA and Umbilical

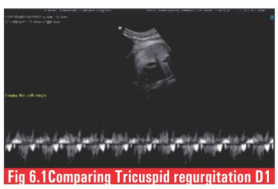


Fig 6.1Comparing Tricuspid regurgitation D1

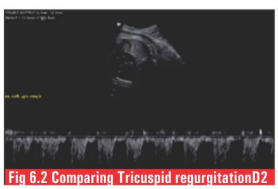


Fig 6.2 Comparing Tricuspid regurgitationD2

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Calcium Citrate Malate 250 mg, Vitamin D3 100 IU, Folic Acid 50 mcg

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More calcium per calcium

For the treatment of Calcium and Vitamin D deficiency state (pregnancy and lactation)

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During long term treatment, follow serum calcium levels and monitor renal function. Reduce dose or discontinue treatment in hypercalcaemia or signs of impaired renal function.

Exercise caution while prescribing CCM in sarcoidosis and in immobilised patients with osteoporosis. Consider the content of Vitamin D in CCM when prescribing other medicinal products containingvitamin D

Crossover study on 12 adolescent subjects; Calcium supplement in form of calcium citrate malate or calcium carbonate with provided with breakfast. Average fractional absorption of calcium citrate malate were 26.4% and 36.2% respectively ($p < 0.03$). # Presentation of values of fractional absorption of calcium sources (calcium carbonate, calcium oxalate, tricalcium phosphate, hydroxyapatite, and calcium citrate malate)obtained in 352 studies in normal adult women under standardized load conditions (200 to 300 mg calcium) in liquid form labeled by addition of a high specific activity radioactive calcium tracer. Solubility values refer to the amount of the substance concerned that can be dissolved in water at neutral pH.

1. Patrick L. Comparative absorption of calcium sources and calcium citrate malate for the prevention of osteoporosis. Alternative Medicine Review 1999;4(2):74-85. **2.** Heaney RP, et al. Absorbability of calcium sources: the limited role of solubility. Calcif Tissue Int 1990; 46:300-4. **3.** Miller JZ, et al. Calcium absorption from calcium carbonate and a new form of calcium (CCM) in healthy male and female adolescents. Am J Clin Nutr.1988;48(5):1291-4. **4.** Prescribing Information of CCM. Version: CCM/PI/IN/2016/01 dated 27 January 2016.

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Abbreviated Prescribing Information of CCM® TABLETS (Calcium Citrate Malate, Vitamin D3 and Folic Acid Tablets)

ACTIVE INGREDIENT: Each film coated tablet contains Calcium citrate malate equivalent to Calcium 250 mg, Colecalciferol concentrate (powder form) BP equivalent to Colecalciferol (vitamin D3) 100 IU, Folic acid IP 50 mcg. INDICATION: Treatment of calcium and vitamin D deficiency state (pregnancy, lactation, growing children). DOSAGE AND ADMINISTRATION: dose for children and adults may be adjusted according to the dietary intake of calcium, vitamin D and folic acid. Adults: 2 tablets twice daily. Children: 2 tablets per day in 1 or 2 divided doses. Consider ability of child to take CCM tablets before prescribing particularly to young children. Additional calcium, vitamin D may be supplemented through diet or other sources to fulfill requirements. In case of Folic acid deficiency, additional supplementation will be required through diet or other sources. Duration of therapy depends on response to therapy. Renal impairment: Not to be used in severe renal impairment. Hepatic impairment: No dose adjustment. CONTRAINDICATIONS: Hypersensitivity to active substances or any of excipients, hypercalcaemia, hypercalciuria, nephrocalcinosis, nephrolithiasis, disease and/or conditions resulting in hypercalcaemia and/or hypercalciuria, (e.g. primary hyperparathyroidism, myeloma, bone metastases), hypervitaminosis D, severe renal impairment and renal failure. SPECIAL WARNINGS AND SPECIAL PRECAUTIONS: During long term treatment, follow serum calcium levels, monitor renal function through measurements of serum creatinine particularly for patients on concomitant treatment with cardiac glycosides or hiazide diuretics and in patients with high tendency to calculus formation. Reduce dose or discontinue treatment in hypercalcaemia or signs of impaired renal function. Reduce therapy or preliminary interrupt if urinary calcium level > 7.5 mmol/24 h (300 mg/24 h). Exercise caution while prescribing CCM in sarcoidosis and monitor serum and urine calcium. Exercise caution while use in immobilised patients with osteoporosis. Risk of soft tissue calcification in patients with impairment of renal function, monitor calcium and phosphate levels. In severe renal insufficiency patients, use other forms of vitamin D as colecalciferol not metabolized normally. Consider the content of Vitamin D in CCM when prescribing other medicinal products containing vitamin D. Close medical supervision and frequent monitoring of serum calcium and urinary calcium excretion while taking additional doses of calcium or vitamin D. Estimate calcium and Vitamin D intake from other sources (food and dietary supplements) before prescribing. Co-administration with tetracyclines or quinolones is usually not recommended, or must be done with precaution. PREGNANCY and LACTATION: To be taken at 2 hour interval from meal due to possible decrease of iron absorption. Pregnancy: Daily intake not to exceed 1,500 mg of calcium, 600 I.U. of vitamin D. Avoid overdosage. Supplement folic acid through diet or other sources to fulfill folic acid requirements. Lactation: calcium, vitamin D, folic acid passes to child through breast milk. ADVERSE EFFECTS: Post marketing data: Uncommon ≥1/1000 to <1/100: hypercalcaemia, hypercalciuria. Rare ≥1/10000 to <1/1000: nausea, diarrhea, abdominal pain, constipation, flatulence, abdominal distension, rash, pruritus, urticaria. Not known (cannot be estimated from the available data): hypersensitivity reactions, laryngeal edema, vomiting, angioedema. OVERDOSAGE: Signs and symptoms: Symptoms of hypercalcaemia may include anorexia, nausea, vomiting, thirst, polydipsia, polyuria, constipation, abdominal pain, muscle weakness, fatigue, mental disturbances, bone pain, nephrocalcinosis, renal calculi and in severe cases cardiac arrythmias. Extreme hypercalcemia may result in coma and death. Persistently high calcium levels may lead to irreversible renal damage and soft tissue calcification. Treatment: stop treatment, fluid deficiency to be balanced. Discontinue treatment with thiazide diuretics, lithium, vitamin A, vitamin D, cardiac glycosides. Rehydration, isolated or combined treatment with loop diuretics, bisphosphonates, calcitonin, corticosteroids to be given. Monitor serum electrolytes, renal function, diuresis, ECG, CVP. API Version: CCM/API/IN/2017/01 v01 dated 22 Feb 2017

Refer to full prescribing information before Prescribing: Full Prescribing Information available on request from GlaxoSmithKline Pharmaceuticals Ltd., Dr. Annie Besant Road, Worli, Mumbai – 400030 (India)

Please report adverse events with any GSK product to the company at **india.pharmacovigilance@gsk.com**

IN/CCM/0014/17

Date of Preparation April 2017

ALL INDIA FERTILITY & IVF SURVEY-2017

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(i3RCinsights Survey)

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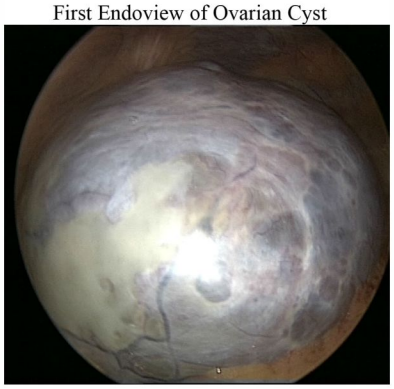
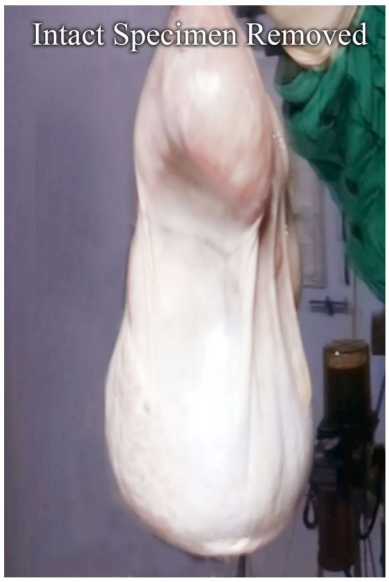


- 75-year-old female with h/o Abdominal Hysterectomy done 30 years back came with c/o severe pain in left iliac region since 5-6 days.
- USG was S/O big septate ovarian cyst of approx 20 x 18 cm size in lower abdomen. LDH was raised, rests of the tumor markers were normal.
- PLAN: **Laproscopic management of suspicious big ovarian mass?malignancy**



- Frozen section report of the ovarian mass sent during operation turned out to be Boderline Mucinous Neoplasm. At the same sitting Lap BSO + Omentectomy + Appendicectomy + Bilateral pelvic lymphadenectomy + Para-aortic lymphadenectomy was carried out.
- Pt was discharged at day 2 post-surgery. Final HPR was Boderline mucinous neoplasm with microscopic foci of invasive mucinous carcinoma.

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