Knowledge is Power,
Unity is Strength

AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

NEWS LETTER I AUGUST 2018

Mata Bhavani's Vaav, Ahmedabad. 1866

OUR HERITAGE CITY OUR PRIDE

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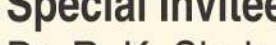

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TEAM AOGS MESSAGE

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" If you don't fight for what you want, don't cry for what you lost"
- Lord Krishna

August being the month of festivals reminds us the essence of love, purity, care and the sense of duty. With the increasing modernity and its entanglement in our lifestyles have made us fashion robots.

Working at the same pace everyday, we compromise with the peace of our soul.
Running for the burgers, we have forgotten the importance of family dinners.
Matching others' expectations, we have taken ourselves for granted.
Supporting the Tag line "Being Human" does not make us humans...

Our Karma makes us a beautiful human being.

Let us try and get our essence back, Let us celebrate our festivals with our families rather than 1020 friends on Facebook.

Wish you all a very Happy Rakshabandhan and Happy, loving Janmashtami.

"Incredible things can be done simply if we are committed to making them happen"

In the month of July, AOGS succeeded in making three CMEs possible. A wonderful initiative by FOGSI President, Dr. Jaydeep Malhotra and team have started a positive wave in the society. Dr. Shubhada Neel and Prof. Girish made us understand the concepts of life. We are proud to share the presence of Dr. Angela Aguilar and her expertise in PCOS: The India Story.

PC-PNDT Date : 29th July 2018

CME : 6 - Adbhut Matrutva - Date : 5th August 2018

Dr. Rajal Thaker received
Unsung Hero Award for her dedicated and selfless services in women's health care in India during
FOGSI GESTOSIS - 2018
conference on 28/07/2018 at Nagpur.

Lecture on Adolescent health
at JN Balika Vidyalaya, Saraspur On
Date : 11.8.2018
attended by 700 girls

Women Health & Wellness Summit 2018 - Date : 5th August 2018

CME : 7 - USG in Infertility - Date : 12th August 2018

CME - 8 - Date : 19th August 2018

Mata Bhavani's Stepwell, Ahmedabad... Since 1866

Mata Bhavani ni vav, or the stepwell of Mata Bhavani, is a well located in the Asarva neighborhood of Ahmedabad, just to the north of the old city center. Its name refers to a small temple dedicated to the Hindu goddess Mata Bhavani built within the well. Based on stylistic grounds, scholars date the well to the eleventh century/fifth century CE with later additions. The temple itself is likely among these later additions.

The plan of the well follows the same structure as many stepwells in Gujarat: a straight stairwell leads from an entrance at surface level down several stories to the level of the well. This stairwell is broken into stages by subterranean pavilions (kuta), that rise in stories supported by pillars to above ground level. The top stories of these vertically-oriented pavilions are covered by canopies. The entrance, located on the west side of the well, is unceremonious. A stairwell descends from this point through three pavilions, dividing the whole into three stages. One interesting feature of this well is that the stairs break into smaller flights that descend at right angles to accommodate for the steepness of the stages. At the bottom of the stairwell just before the deepest pavilion, the stairwell breaks into several cascades at right angles that surround a small square ornamental pool. The deepest pavilion, on the east side of the small square pool, gives access to the well cistern itself.

The decoration of this well is not lavish. The canopies covering the top stories of the subterranean pavilions are ornamented with rampant lions and some images of Hindu deities.

Sources

Burgess, James. The Muhammadan Architecture of Ahmadabad. Part II, 1-3. London: W. Griggs and Sons, 1905.

Jain-Neubauer, Jutta. The Stepwells of Gujarat in Art-Historical Perspective, 35-37. New Delhi: Abhinav, 1981.

CME : 9 - "Recurrent" How to Deal it?

By Indian Fertility Society - Gujarat Chapterin association with
Ahmedabad Obstetrics and Gynecology Society

Date : 9th September, 2018 - Sunday | Venue : Hotel Radisson Blu, Panchvati, Ahmedabad

Programme Coordinators: Dr. Munjal Pandya, Dr. Parth Shah

Time	Topic	Speakers
09:00 - 09:30 am	**Breakfast** **Chairpersons : Dr. Devang Patel, Dr. Shashikala Sahu**	
09:30 - 09:45 am	Lamp lightning & Introduction to IFS	Dr. Jayesh Amin
09:50 - 10:10 am	Recurrent IUI Failure and its optimization	Dr. Sonal Kotdawala
10:15 - 10:40 am	Recurrent Endometriosis How to Deal it?	Dr. Sonia Malik
10:45 - 11:10 am	Recurrent ovulation Induction Failure	Dr. Kamini Rao
11:15 - 11:40 am	Recurrent IVF Failure	Dr. Jayesh Amin
	15 min Tea Break **Chairpersons : Dr. Akshay Shah, Dr. Pawan Dhir**	
11:55 - 12:20 pm	Recurrent Implantation Failure	Dr. K.D. Nayar
12:25 - 12:50 pm	Recurrent Pregnancy Loss	Dr. Sapna Shah
12:55 - 01:10 pm	**Q/A Session**	
01:15 - 02:15 pm	**Panel Discussion** Evidence base Practice in Infertility when to start When to Stop? **Moderator** : Dr. Kamini Patel **Panelists** : Dr. Suresh Kothari, Dr. Jignesh Shah (Vadaj), Dr. Sheetal Punjabi, Dr. Anand Chaudhary ,Dr. Munjal Pandya, Dr. Nisarg Patel	
02:15 pm onwards	**Lunch**	

Mylan
Better Health for a Better World

CME : 10 - Endometriosis

Date : 16th September, 2018 - Sunday | In Association with ISAR - IAGE

Programme Coordinators : Dr. Kamlesh Jagwani, Dr. Heena Shah

Time	Topic	Speakers
09.30 - 10.00 am	**Registration, Tea / Coffee, Snacks**	
Session 1	**Chairpersons : Dr. Tushar Shah, Dr. Jitendra Prajapati**	
10.00 - 10.20 am	Pain Management in Endometriosis	Dr. Kanthi Bansal
10.20 - 10.40 am	Managing Subfertility with Endometriosis	Dr. Raj Boldhane - Aurangabad
10.40 - 11.00 am	Recurrent Endometriosis	Dr. Pragnesh Shah
11.00 - 11.20 am	Ovarian Endometrioma	Dr. Dipak Limbachiya
11.20 - 11.40 am	Diagnostic Modalities	Dr. Archana Baser - Indore
	Tea Break	
Session 2 **12.00 - 01.00 pm**	**Panel Discussion** **Adolescent Endometriosis** Moderator : Dr. Parul Kotdawala Panelists : Dr. R. G. Patel, Dr. Sanjay Shah, Dr. Mahesh Jariwala, Dr. Archana Baser - Indore Dr Jignesh Shah, Dr Meena Amin, Dr Girish Patel	
01:00 pm onwards	**Lunch**	

Sponsored by BAYER Visanne

CME : 11 - Infertility and Ultrasound Update

AOGS & GC ISAR

Date : 23rd September, 2018 - Sunday

Venue : Hotel Crown Plaza, Nr. Shapath 5, S.G. Highway, Ahmedabad

Programme Coordinators: Dr. Tejas Dave, Dr. Kiran Desai

Time	Topic	Speakers
09:00 - 09:30 am	**Registration and Breakfast**	
Session 1	**Chairpersons : Dr. Phagun Shah, Dr. Sheetal Punjabi**	
09:30 - 10:00 am	Clomiphene Citrate : End of the beginning	Dr. Priya Bhave
10.00 - 10.30 am	Fibroids and adenomyosis Role of ultrasound in diagnosis and treatment plan	Dr. Mala Sibal
10.30 - 11:00 am	IUI Current Status	Dr. Abha Majumdar
11.00 - 11.30 am	Ultrasound in male Infertility	Dr. V. Boopathy
11.30 - 12.00 pm	**Coffee Break**	
Session 2	**Chairpersons : Dr Jayprakash Shah, Dr. Janak Desai**	
12.00 - 12.30 pm	IVF for Gynecologist	Dr. Jatin Shah
12.30 - 01.00 pm	Follicle monitoring and its impact on fetal anomalies	Dr. Sonal Panchal
01.00 - 01.30 pm	Understanding the Women	Dr. P.C. Mahapatra
01.30 - 02.30 pm	**LUNCH**	
Session 3	**Chairpersons : Dr. Sunil Shah, Dr. Mukesh Savaliya**	
02.30 - 03.00 pm	Luteal phase support current evidences	Dr. C.B. Nagori
03.00 - 03.30 pm	Hormonal and ultrasound dialogue in PCOS	Dr. Sonal Panchal
03.30 - 04.00 pm	Role of LH in Infertility	Dr. Ramaraju
Session 4		
04.00 - 05.00 pm	**Panel Discussion : Prescriptions in infertility what is the evidence** **Moderators :** Dr. Manish Banker, Dr. Praful Doshi **Panelists :** Dr. Kanthi Bansal, Dr. R.G. Patel, Dr. Jayesh Amin, Dr. Pooja Nadkarni, Dr. Vaibhav Kapadia, Dr. Hitendra Somani, Dr. Darshan Sureja	

Corrections in previous article on Evidence Based Guidelines for Management of Pre Term Birth – Dr. Rajal Thaker

PROLONG (Progestin's Role in Optimizing Neonatal Gestation) trial, which is a multicenter, multinational, placebo-controlled, randomized clinical trial (RCT) **designed to assess the safety and efficacy of Hydroxyprogesteronecaproate injection, 250 mg/mL** in reducing the risk of preterm birth (PTB) and neonatal morbidity/mortality in women pregnant with a singleton gestation who had a previous singleton spontaneous PTB. The total sample size of the RCT will include 1,707 women. The trial has two coprimary outcomes: PTB less than 35 weeks and a composite neonatal morbidity and mortality index. This study sample size will provide 90% power to assess for a 35% reduction in neonatal morbidity and mortality. Secondary outcomes will include 2-year follow-up of infants. The trial is ongoing and targeted to complete recruitment in 2018.

BREASTFEEDING
Dr. Heena Oza - Prof. Civil Hospital

Breastfeeding protects infants against infections, offers an inexpensive supply of adequate nutrition, contributes to mother-infant bonding and provides contraception.

The relationship between lactation and fertility is an important public health issue. A birth interval of two or more years improves infant survival chances and reduces maternal morbidity. In developing countries, breastfeeding provides protection from pregnancy and is important for achieving the two year birth interval that engenders good maternal and infant health.

Giving up breastfeeding was a misguided notion of bygone times. The tradition of wet nursing (the practice of breastfeeding by someone other than the mother) was popular from the time of the Ancient Greece to Medieval Europe. In Ancient Roman societies, breastfeeding was disdained by the elite. In India, breastfeeding by 'Dhav ma' was prevalent among royal families.

A further decline in breastfeeding came with the introduction of bottle feeding. Since the 1930s preparation of infant 'formulas' moved from the home kitchen to commercial production and promotion. Breast milk substitutes, initially developed to meet specific needs (allergies and intolerance to cow milk), eventually came to be viewed as a means to free women from the responsibility of breastfeeding. A downward trend in breastfeeding began in the 1930s and by the 1950s the prevalence of breastfeeding on discharge from the hospital fell to 30%, reaching a nadir (22%) in 1972. Development and modernization also contributed to this trend which, fortunately, has been somewhat reversed.

A higher mortality rate in artificially fed infants was observed in the early 20th century. By the 1940s the difference in mortality between early and late weaned infants was recognized to be due to general care and other conditions. In the developed world with good health supervision, early weaning posed no problem. However, in the developing world with inadequate health supervision, mortality due to early weaning continues to be high.

Breastfeeding is a personal choice, but one influenced by customs, social, and economic circumstances. The resurgence of breastfeeding can be attributed to increasing knowledge regarding its health benefits, both maternal and infant, some of which are:-

1.Breastfeeding has a child spacing effect, which is very important in the developing world as a means of limiting family size and providing good nutrition for infants.

2.Breast milk prevents infections in infants, both by the transmission of immunoglobulins and other immunity bestowing factors and by modifying the bacterial flora of the infant's gastrointestinal tract. This gives some protection to infants against infectious diseases, Sudden Infant Death Syndrome (SIDS) and metabolic diseases. However, avoidance of breastfeeding by HIV-infected women is strongly recommended.

3.Breastfeeding enhances the bonding process between mother and child.

4.Breastfeeding provides a degree of protection to the mother against breast cancer, ovarian cancer, diabetes, hypertension, and heart disease.

Unfortunately, the average duration of breastfeeding remains short- usually under six months, most often only two to three months, perhaps because of more number of working women nowadays- this still provides a significant benefit for the infant.

Clinical management of lactation is a core component of reproductive health care. Enabling women to breastfeed is also a public health priority. Early unwanted cessation of breastfeeding is commonly due to problems like pain, infection, nipple soreness, retraced nipple and low milk output. Obstetric care providers should evaluate and manage aforementioned problems vigilantly. Women who experience breastfeeding difficulties are at a higher risk of postpartum depression (and vice-versa) and should be screened and treated appropriately.

It is very well acknowledged all over the world that in spite of all modern scientific and technological advances, there is no real substitute for breast milk.

Pre eclampsia - Pre empting the disease.....
Dr. Manish Pandya

- The most common medical disorder of pregnancy
- Accounts for ~ 200 000 maternal deaths per year worldwide
- Pre-eclampsia is a multi-system disorder unique to human pregnancy
- Globally hypertensive disorders of pregnancy complicate approximately 5–10 % of pregnancies.
- Incidence of hypertensive disorders in India is found to be 10.08 % as observed through the data collected by the National Eclampsia Registry (NER)
- 76.34 % of the patients were between 21 and 30 years of age
- 81 % of the patients with preeclampsia were primigravid.
- Eclampsia prevalence among registrypatients is 1.9 %.

Disease of Theories!!!!!

- Abnormal trophoblast invasion •Immunological intolerance •Maladaptation to CV changes of pregnancy •Infection agents similar to those involved in atherosclerosis •Dietary deficiency •Genetic abnormality •Combination of the above

  Pre-eclampsia-Pregnancy complicated by significant hypertension and proteinuria in the second half Eclampsia-Occurrence of convulsions in setting of pre-eclampsia

  Pre-existing hypertension with pregnancy- Pregnancy in a woman known to be hypertensive prior to getting pregnant

  Super-added Pre-eclampsia -Appearance of proteinuria and worsening of hypertension in a setting of pre-existing hypertension

The GESTOSIS theory.....

- Many possibilities have been speculated to give rise to preeclampsia.
- But, the novel and unifying theory about the pathophysiology of preeclampsia which is more convincing is the one originally proposed by Feinberg et al. from USA in 2005.
- It is the GESTOSIS theory which states that there is excess of immune complexes produced because of placental antigenicity which are not cleared by maternal immune system.

  Hence, they are deposited in the various endothelial layers causing pro-inflammatory cytokines and oxidative stress. This results in clinical preeclampsia which is inflammatory response of pregnancy

  Diagnosis ....

  Regular BP monitoring, Urine albumin check up, sudden weight gain, pain in epigastrium, blurring of vision etc..

  Investigation - CBC, S. Urea , S . Creatinine, S.LDH, AFP, uE3,PAPA-A, Free bHCG

  USG –Doppler for Uterine artery, DuctusVenosus , MCA , Umbilical Artery

  Treatment – Antihypertensive 1. Labetalol 2. Methyl dopa. 3. Nifedipine

  Management :Eclpamsia means delivary...

Summary of talk "Treatment of endometriosis: a practical approach" by Dr. Parth Bavishi

Endometriosis is the disease characterized by presence of endometrial tissue outside the cavity of womb. It is often an underappreciated because of lack of non-surgical markers. Appearance of chocolate cyst on USG is characteristic , apart from chocolate cyst in endometriosis on ultrasound the fundus of uterus may be pulled backwards: meaning that uterus is anteverted retroflexed. Laparoscopy is the gold standard for diagnosis. The surgical staging remains controversial.The more popular classification by ASRM can give prognosis regarding fertility outcome but it is not correlated well with the pain associated with endometriosis. Adenomyosis is a disease which is commonly associated with endometriosis, on hysteroscopy adenomyosis appears as cavity forming lesions at the fungus or in the lateral walls.

When managing endometriosis importance should be given to the priority of patient; Is it fertility, pain relief or other?

ASRM recommends that the benefit of laparoscopy in minimal to mild endometriosis is insufficient to recommend laparoscopy to solely increase the likelihood of pregnancy. However according to ESHRE guidelines ablation of endometriotic lesions and adhesiolysis to improve fertility in minimal to mild endometriosis is effective compared to Diagnostic laparoscopy alone. Meaning that if the lesions are found they must be treated. Most of the studies have proven that it is better to remove the chocolate cyst rather than aspirate and fulgurate.

For advance cases both laparoscopy and IVF remains the treatment options. the correct option depends on female age, ovarian reserve, male factor or other factors for infertility and the desire to conceive fast.

In patientsof endometriosis undergoing ART chocolate cyst removal is not recommended before ART. Cystectomy give easy access for pick up but may reduce ovarian reserve. New approach of long-term agonist suppression before IVF in patients of severe endometriosis has been tried and the initial results are promising.

Patients who are not willing to conceive Dienogest is a drug that can help in reducing symptoms with better long term safety profile than agonist or Danazol. For symptomatic relief LNG-IUD is also a good option.

World Breast Feeding Week (WBW) 2018 (Compilation by Dr. Rajal Thaker)

Logo of WBW 2018

- 'Triad' of two adults and an infant, which reinforces the importance of working together to protect, promote and support breastfeeding
- Branches, leaves and sprouts represent growth and development
- The line extending from the triad and sprouting into leaves are the links between breastfeeding and nutrition, food security and poverty reduction (Hence, need to prevent malnutrition in all its forms, ensuring food security even in time of crisis – natural disasters, war, famine etc, breaking the cycle of poverty)

BREASTFEEDING
Foundation of Life

OBJECTIVES OF #WBW2018

Management of Preeclampsia – Recent Guidelines - Dr. Shashwat Jani

Hypertensive disorders are common complications of pregnancy, affecting 8% to 10% of all gestations. Approximately 1/3 of hypertensive disorders in pregnancy (HDP) are due to chronic hypertension and 2/3 are due to gestational hypertension–preeclampsia. The spectrum of the disease ranges from mildly elevated blood pressures with minimal clinical significance to severe hypertension and multi organ dysfunction.Hypertensive disorders of pregnancy (HDP) are one of the major causes of maternal morbidity and mortality leading to 10-15% of maternal deaths.

Updated Classification of Hypertensive disorders of pregnancy :

1. Preeclampsia (PE) (BP elevation after 20 weeks of gestation with proteinuria OR any of the severe features of preeclampsia)
2. Chronic hypertension (CHTN, of any cause that predates pregnancy)
3. Chronic hypertension with superimposed preeclampsia (chronic hypertension in association with preeclampsia)
4. Gestational hypertension (GH: BP elevation > 20 weeks of gestation in the absence of proteinuria or any of the severe features of preeclampsia.

Major changes of the new classification are as follows:

(1) HDP is defined as hypertension in pregnancy. (2) Eclampsia was removed from the major classification. (3) Chronic hypertension was added to the major classification. (4) If pregnant women with new onset of hypertension have either maternal organ dysfunction or uteroplacental dysfunction, they should be diagnosed with preeclampsia, even in the absence of proteinuria. (5) The severity classification should be 'severe' when hypertension is severe, or when hypertension is mild but there is maternal organ dysfunction or uterine placental dysfunction. The term 'mild' was excluded from the criteria of HDP because it can be misinterpreted to mean 'not at high risk'. (6) The definition of 'early onset type' is that which appears earlier than 34 weeks gestation, in accordance with international standards.

TREATMENT OBJECTIVES:

- To stabilize the hypertension and to prevent severe pre-eclampsia. • To prevent the complications. • To prevent eclampsia.
- Delivery a healthy baby in optimal time. • Restoration of the health of the mother in Puerperium.

Pre-eclampsia without severe features:

> 37 weeks gestation: deliver < 37 weeks gestation: expectant management until term or maternal/fetal indication for delivery

– Bedrest no longer "suggested" – Serial maternal assessment (BP, symptoms, labs, weight gain)

– Serial fetal assessment (NST/BPP, fetal kick count, serial Us for AFI and growth) – Oral antihypertensives.

Severe Preeclampsia :

> 34 weeks: deliver

33-34 weeks: steroids and deliver after 48 hours if maternal/fetal status allows

22-32 weeks: antihypertensive meds(oral/IV), steroids, extensive counseling, close surveillance deliver for maternal/fetal indications or 34 weeks gestation

< 22 weeks : expectant mgmt not recommended

Start MgSO4 upon diagnosis irrespective of GestestionalAge .

Antihypertensive therapy for Preeclampsia :

Antihypertensive therapy should be started with systolic BP =/> 150 and /or diastolic BP =/> 100 mm Hg.

Aim of therapy should be to lower BP to < 140 mmHg systolic and < 90 mmHg diastolic.

Oral antihypertensive agents to be used are: alpha methyldopa, labetalol, and nifedipine.

Treatment of Mild Preeclampsia :

	Mode of Action	Starting Dose	Maximum Dose	Contra-indications	Breast Feeding
Methyl Dopa	Centrally acting α agonist	250mg bd	1 gram tds	Depression	Yes
Labetolol	α + β antagonist	100mg bd	600mg qid	Asthma	Yes
Nifedipine SR	Ca channel antagonist	10mg bd	40mg bd		Yes
Hydralazine	Vasodilator	25mg tds	75mg qid		Yes

Treatment of Severe Preeclampsia :

Hydralazine
5mg IV or 10mg IM
Repeat 5-10 mg at 20 min intervals as needed
If no response after 20mg IV or 30mg IM, consider other drug

Labetalol
20mg IV as bolus to start
Further 40mg 10 min later if needed
Further 80mg every 10 min if needed for 2 doses
Maximum dose 220mg; switch to other drug if inadequate response

If using Nifedipine
10mg PO to start
Repeat 10mg in 30 min if needed
Do not use short-acting nifedipine

Use Sodium Nitroprusside rare cases*
Start with 0.25 µg/ kg /min to a maximum dose of 5 µg/ kg /min
Fetal cyanide poisoning risk if used for > 4 hrs

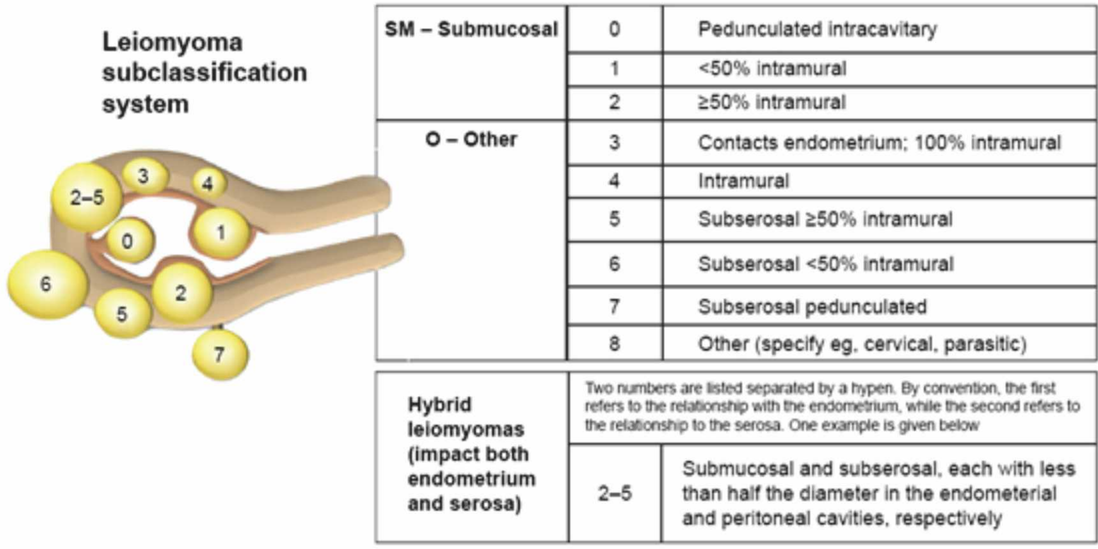
- Lower BP promptly but slowly: AIM for BP < 150/100 mm Hg
- Loading Dose of MgSO4 is Recommended to Prevent Eclampsia in all Severe Preeclampsia.
- Expectant management is done at tertiary centre only if there is no maternal organ involvement there is no immediate danger to fetus to get time to use steroids for fetal lung maturity.

TIMING OF DELIVERY :

- Gestational hypertension can be taken to term.
- Mild preeclampsia should be delivered at 37 weeks.
- Severe preeclampsia should be delivered after 34 weeks.
- Eclampsia should be delivered once stabilized with MgSO4 at any weeks of gestation.
- Corticosteroids are given for fetal lung maturity where appropriate.
- Intramuscular Dexamethasone 6 mg 6 hourly 4 doses or 12 mg 12 hourly 2 doses.
- Cesarean section is done for Obstetric indications only.

·Classifications of fibroids

-It is recommend to follow the figo classifications as per the figure.



SM – Submucosal	0	Pedunculated intracavitary
	1	<50% intramural
	2	≥50% intramural
O – Other	3	Contacts endometrium; 100% intramural
	4	Intramural
	5	Subserosal ≥50% intramural
	6	Subserosal <50% intramural
	7	Subserosal pedunculated
	8	Other (specify eg. cervical, parasitic)
Hybrid leiomyomas (impact both endometrium and serosa)	Two numbers are listed separated by a hypen. By convention, the first refers to the relationship with the endometrium, while the second refers to the relationship to the serosa. One example is given below	
	2–5	Submucosal and subserosal, each with less than half the diameter in the endometerial and peritoneal cavities, respectively

Figure 1 FIGO leiomyoma subclassification system.
Note: Reprinted from *Int J Gynaecol Obstet*. Vol 113(1). Munro MG, Critchley HO, Broder MS, Fraser IS, FIGO Working Group on Menstrual Disorders. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. Pages 3–13. Copyright 2011, with permission from Elsevier.[1]
Abbreviation: FIGO, International Federation of Gynecology and Obstetrics.

- **Treatment goal**
- Treatment goal is decided based on following facts
- Age of the patient
- Peribubertal
- Young
- Fertile age group
  - Pre menopause
  - Post menopause
  - Family completed
  - Willing for child
- **Symptoms of patient**
- No symptoms
- Mild symptoms
- Moderate to severe symptoms
- **General health of the patient**
- Normal mild risk
- Moderate to severe risk
- **Desire of the patient**
- No invasion
- Minimum invasion
- Surgical correction
- **Demand of time**
- Temporary suppression/relief
- Permanent cure
- **Submucous fibroid**
- Should always be removed
- Removal improves fertility outcome
- Fertility outcome submucous fibroid removal still does not match non fibroid patients
- **Subserous fibroids**
- Generally does not required treatment or removal
- Rarely removal for location and size related problems
- **Intramural fibroids**
- Treatment strategy is based on
- Intramural fibroid prior to IVF
- Size

- Number
- location
- Proximity to endometrium
- Ability to access surgically
- Deciding the best surgical procedure
- Choosing the correct route
- Potential complications
- Patient preference
- Removal is debatable
- ≥ 5cm size removal improves fertility outcome

However consensus on this fact & size is not there

- **Treatment options of fibroids**
- **Hysterectomy**
- If the uterus is > 10w size
- Or symptoms that are due to the fibroids
- Rapid growth
- Abdominal or vaginal
- **Myomectomy**
- Young women
- Willing for fertility
- Not willing for hysterectomy
- **Uterine artery embolisation (UAE)**
- **MRI-guided focused ultrasound (MRgFUS)**
- **Medical Management**
- NSAID
- Tranexamic acid
- COC
- SERM
- LNG IUS
- SPRM
- GnRH Agonist
- GnRH antagonist
- Danazol/Gestrinone
- Aromatase inhibitors
- Newer development
- **Progestogens**
- **LNG IUS**

It promotes endometrial atrophy and suppresses gonadotropin secretion,
It does not reduce myomata volume, but may cause amenorrhea
Submucous or intramural myomas distorting the cavity, - risk of expulsion
LNG IUS is more effective
Less adverse effects
Considered for treatment of mild symptoms, especially for women who need contraception.

- **Ulipristal acetate**
- Ulipristal acetate is used for pre-operative treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age in a daily dose of a 5 mg tablet.
- It is a SPRM that inhibits ovulation, but has little impact on serum estradiol levels. The drug is approved for 3 months of preoperative therapy outside USA.
- **GnRH Analogue**
- Hypoestrogenic side effects (Vasomotor symptoms, Trabecular bone loss)
- Cost (High)
- Regrowth of myomas on cessation of therapy.
- Degeneration (some leiomyomas) – causing difficulty in myoma enucleation.
- **Fibroids and pregnancy**
- In most women there is no effect
- 80% remain unchanged in size
- Rarely rapid growth and red degeneration
- Increased risk of bleeding and threatened preterm delivery
- But most deliver at term
- Fibroid in the lower segment can interfere with vaginal birth
- Myomectomy at the time of Caesarean is not wise
- **Conclusion:-**
- Every fibroid does not require treatment, just because it exists. Treatment has to customized for every patient.

1. EVALUATION OF UTERUS

UBP - Uterine Biophysical Profile is for determining Qualities of uterus

- Applebaumdeviced a scoring system dependent upon 7 factors known as :
  Applebaum's uterine scoring system for reproduction (USSR)

PARAMETER	DETERMINATION	SCORE
Endometrial thickness (mm)	< 7 7 – 9 10 – 14 > 14	0 2 3 1
Endometrial layering	No layering Hazy 5-line Distinct 5-line	0 1 3
Endometrial motion(no. of myometrial contraction in 2 min)	< 3 > 3	0 3
Myometrial Echogenicity	Coarse, inhomogenous Relatively homogenous	1 2
Uterine artery doppler flow (PI)	2.99 – 3.0 2.49 <2	0 1 2
Endometrial blood flow in zone 3	Absent Present but sparse Present multifocally	0 2 5
Myometrial blood flow (gray scale)	Absent Present	0 2

2. **Keypoints in Doppler study in infertility**

- ET in IVF is cancelled when uterine artery PI > 3.2
- Spiral artery RI- 0.53 (ovulation group); RI- 0.70 (LPD group)
- Follicular phase: perifollicular vessel RI- 0.54 ± 0.04

2 days prior to ovulation- declines to 0.44 ± 0.04.

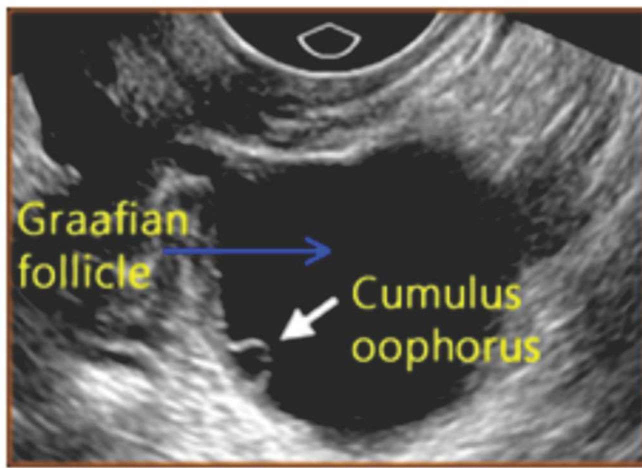
PSV $>$ 10 cm/s predicts higher rates of fertilization

- OVARIAN Stromal PSV: 5-10 cm/sec

AFC > > OV > > ovarian stromal vascularity (sensitivity for prediction of response)

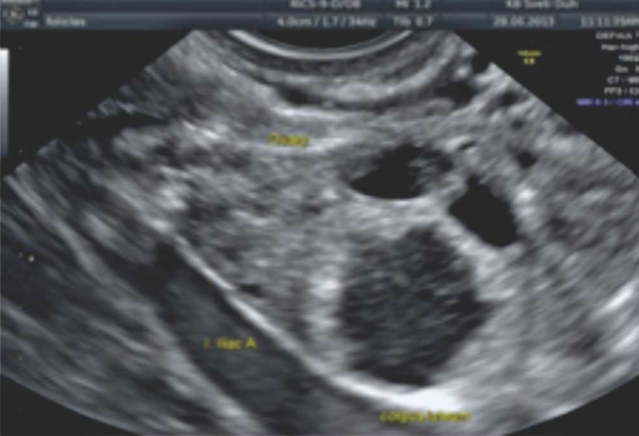
3. **Mature follicle**

- Size approx. 20 to 25 mm in CC induced cycle
- In HMG/FSH cycle 16 to 18 mm size is considered mature
- Double folding of follicle margins(rupture within 24 hrs)
- Cumulus oophorous(rupture within 24-36 hrs)
- Color doppler shows more than 75% circumference flow



4. **USG markers of ovulation**

- Disappearance of or sudden decrease in follicle size (the most frequent sign of ovulation with the sensitivity of 84 %)
- Appearance of ultrasonic echoes in the follicle
- Irregularity of follicle wall
- Free fluid in the pouch of Douglas (in 77 % of cases on the day of ovulation)
- Secretory changes of the endometrium



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Punjiben R. Patel (from Bombay/Katch) age is no worry for miracle mom at 60 (Postmenopausal IVF success)

Shushila P. Pandya (From Katch) Holy mother of God at 58 years (Postmenopausal IVF success)

Shammipal (from Australia) with her husband and miracle baby girl at 62 years (Post menopausal IVF success)

Soniya Gopesh Shah (Baroda) with her miracle baby boy at 50 years age. (she is having Polio Myelitis)

Few of our international patients

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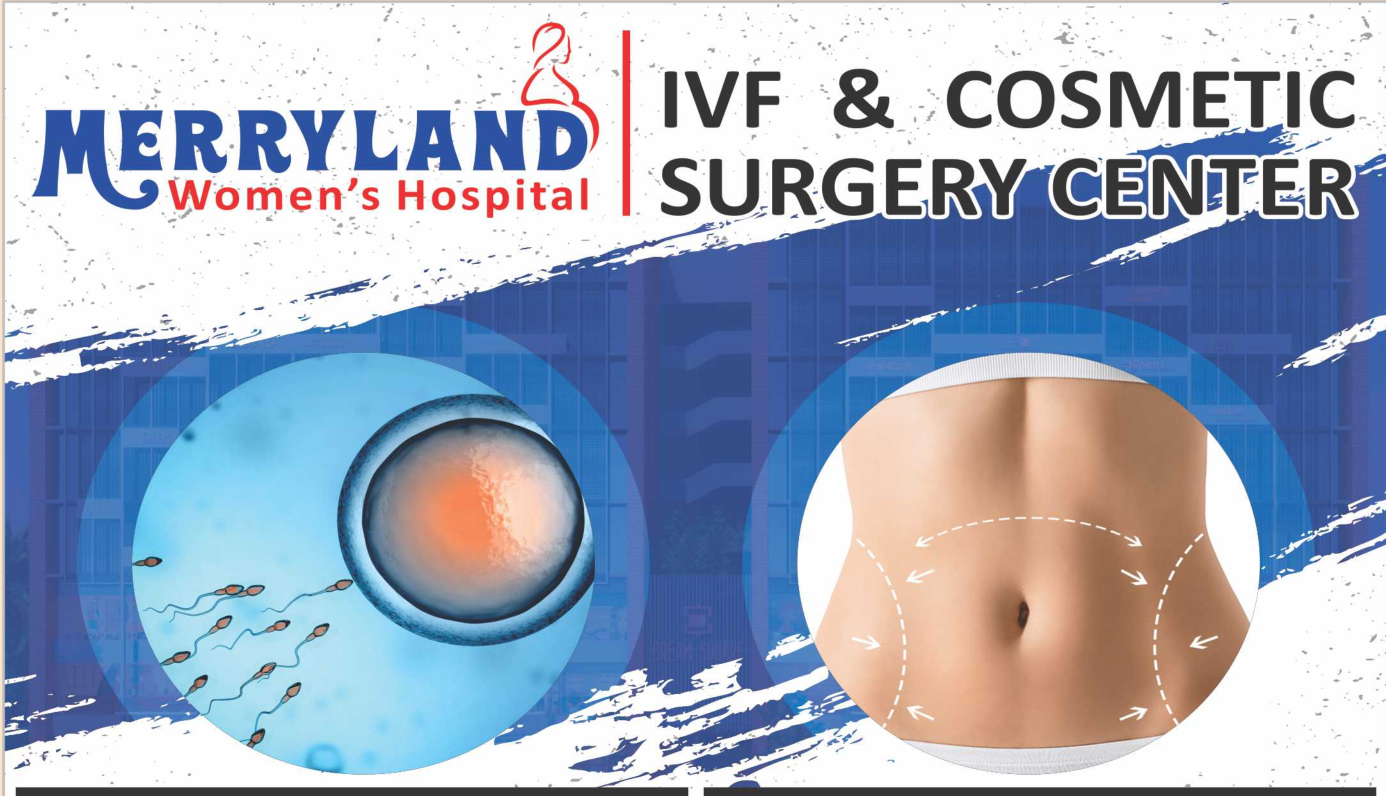

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