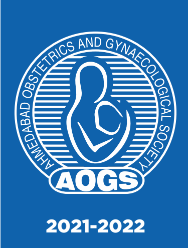

AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

APRIL 2021 VOLUME 1

THEME : IMPLEMENTATION OF EVIDENCE BASED CLINICAL CARE

MOTTO : SWEAT, SMILE & REPEAT

HOPE

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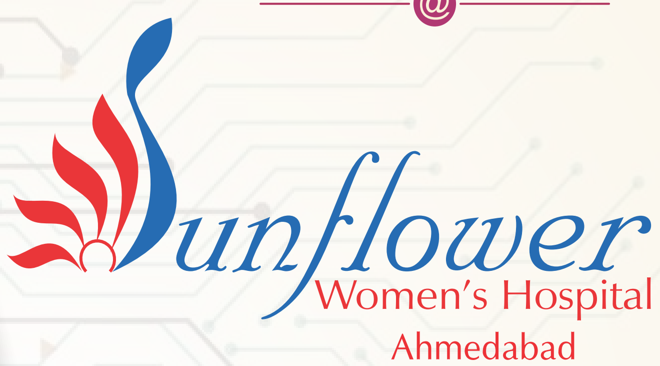

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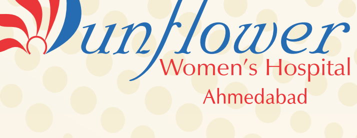

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TEAM AOGS MESSAGE

Dr. Jignesh Deliwala
President

Dr. Munjal Pandya
Hon. Secretary

Dear AOGS Family,

These are challenging times for everyone on the earth. This second wave has been causing much more damage than the first wave. Proper safety precautions, keeping patience and helping one another will be key factors of survival.

This year, we have chosen the motto on the basis of fitness. Let us be optimistic and fight against all odds, and stay healthy, and help everyone stay mentally and physically fit. These are the times to cheer those up who have got sunken into the depths of fear; these are the times when landing a supporting hand is all that is needed for many.

“Hope” is the title chosen for the cover page; we hope better health for everyone; we hope that this pandemic ends soon; we hope that the sufferings finally end; we hope that we see reasons enough to be alive and keep walking on the rightest possible path; we hope that ‘Health’ and ‘Happiness’ prevail; we hope that those elderly and children who have not gone out of their houses for over a year now, can soon get outside in safe and clean atmosphere to feel ‘free’ again; we hope that we all stay united.

We have lost our father figure obstetrician-Gynecolosist Dr. N T Vani sir, our dear colleagues Dr. Rani Morakhiya and Dr. Deepak Naik last month. Our condolences to the family members, and they will stay in our hearts forever.

“AOGS Times” will be published as an ‘e’ version as well as will be dispatched as hard copy. Recent updates and synopsis of webinars will be covered in AOGS Times.

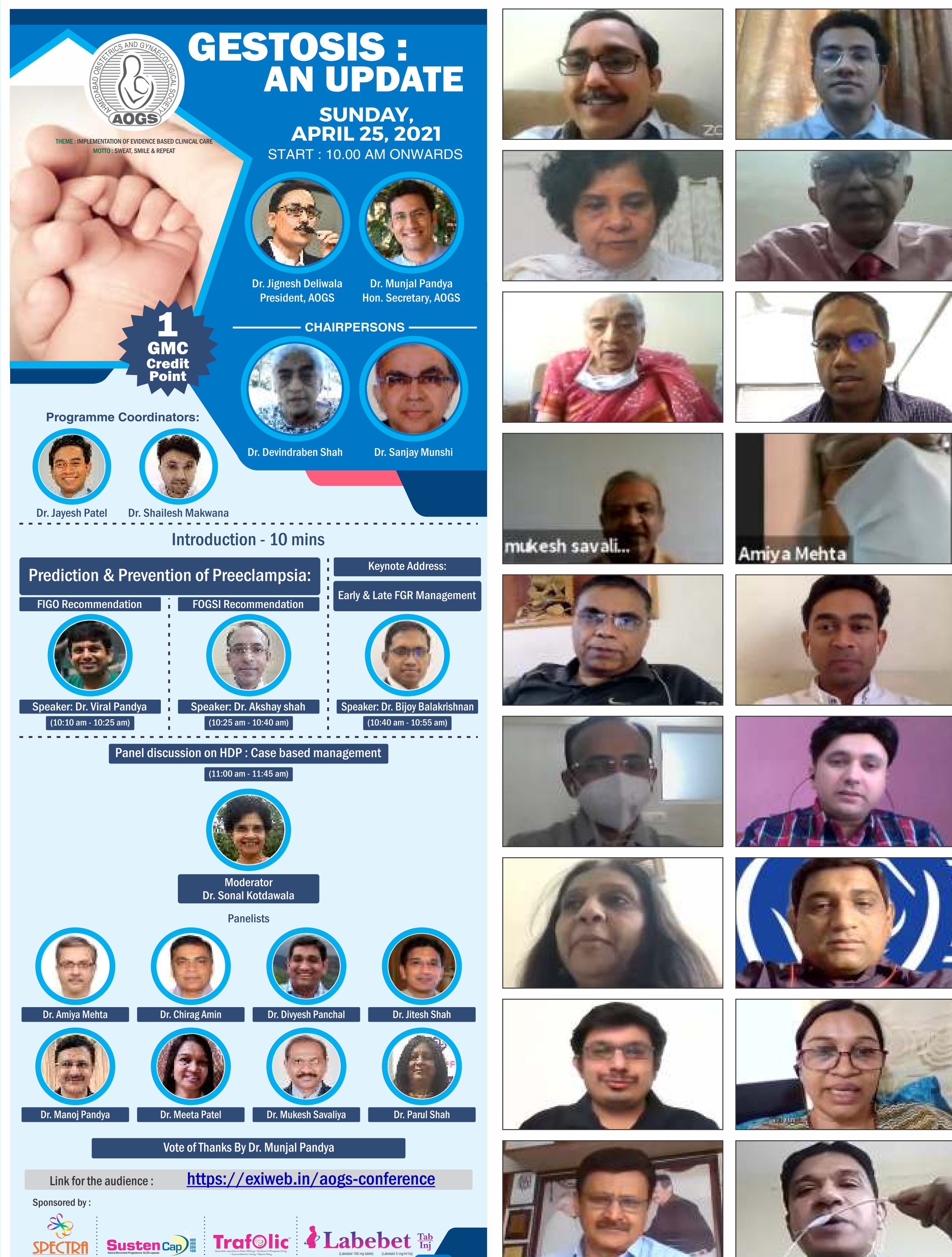
सर्वे भवन्तु सुखिनः सर्वे सन्तु निरामयाः ।
सर्वे भद्राणि पश्यन्तु मा कश्चिद्दुःखभाग् भवेत् ॥

Dr. Jignesh Deliwala
President

Dr. Munjal Pandya
Hon. Secretary

PAST PROGRAMME

GESTOSIS : AN UPDATE - Date : 25.04.2021



OBSTETRIC ANAL SPHINCTER INJURIES (OASIS)

3RD AND 4TH DEGREE PERINEAL TEARS

Dr. Rajnish Patel

Past president Thane Ob/Gyn Society.

OBSTETRICIAN, GYNAECOLOGIST & LAPAROSCOPIC SURGEON

- Double gold medal in M.D. from B.Y.L. Nair Hospital 35th year in pvt. Practice
- Associate. Hon. Prof. at Rajiv.Gandhi.Medical.College. & Chhatrapati Shivaji Maharaj hospital Kalwa since >25years Head of Unit - III
- Recognized Basic Laparoscopy skills course instructor at the Royal College of Surgeons- U.K
- Member -MDR (maternal death review) Committee-Thane Mun Corp.

Visiting consultant Jupiter & Kaushalya hospitals Thane

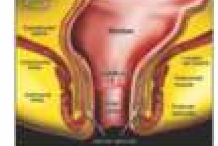
Peer reviewer for the 'Journal Of Surgical Simulation'- JSS

Anal incontinence is defined as the complaint of involuntary loss of flatus and/or faeces affecting quality of life.

60% of women reported symptoms of anal incontinence at 10-year follow-up....after vaginal delivery.

It is one of the biggest reasons for medicolegal claims in obstetrics............(in the west)

(Mous M, Muller SA, de Leeuw JW. Long term effects of anal sphincter rupture during vaginal delivery: fecal incontinence and sexual complaints. BJOG 2008;115:234-8.)



The following **classification** described by **Sultan** has been adopted by the International Consultation on Incontinence and the RCOG:

First-degree tear : Injury to perineal skin and/or vaginal mucosa.

Second-degree tear : Injury to perineum involving perineal muscles but not involving the anal sphincter.

Third-degree tear : Injury to perineum involving the anal sphincter complex:
Grade 3a tear : Less than 50% of external anal sphincter (EAS) thickness torn.
Grade 3b tear : More than 50% of EAS thickness torn.
Grade 3c tear : Both EAS and internal anal sphincter (IAS) torn.

Fourth-degree tear : Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.
Rectal buttonhole tear

Indian women may be more vulnerable to OASIS due to anatomic factors like a short perineal body.

Methodical research has shown the following in recent times:

Perineum distends at crowning (more in the transverse plane (270%)
and less in the vertical plane (140%)

The angle of the episiotomy has been found to be pivotal in causation of OASIS

OASIS is highest in midline episiotomies (10-20%)-
Incidence is reduced to 0.5% with a 45 degree suture angle.

An episiotomy performed at 40 degrees (during crowning) results in a post-delivery angle of 22 degrees

A 600 episiotomy from the centre of the introitus results in a post-delivery angle of 450

OASIS is lowest when the **sutured** episiotomy angle is 40-60 degrees

(in a UK based study , None of the midwives and only 22% of doctors were able to perform a truly mediolateral episiotomy
Only 13% of episiotomies were at a postdelivery angle of 40 degrees or more.)

Resultant suture angle of 40–60 degrees is more important than the incision angle of 45–60 degrees.

Learning point :

Previously it was believed that episiotomies should commence at 6 o'clock in the perineal midline. However, due to perineal distension, this does not seem easily achievable. Recent research shows that episiotomies should be initiated at the 7 o'clock position and angled at 60 degrees

This technique has been shown to reduce the risk of OASIs by 56% for every 4.5mm away from the midline!

(Stedenfeldt M, Pirhonen J, Blix E, Wilsqaard T, Vonen B, Qian P. Episiotomy characteristics and risks for obstetric anal sphincter injury: a case-control study. BJOG 2012; 119:724-30
Fodstad K, Laine K, Staff AC. Different episiotomy techniques, postpartum perineal pain, and blood loss: an observational study. Int Urogynecol J 2013; 24:865-72)

LENGTH DOES MATTER!

A sutured episiotomy length of greater than or equal to 1.7 cm has been shown to be associated with reduced OASIS.

The risk reduces by 75% for every 5.5mm increase in length of episiotomy !!

This is presumably due to shorter episiotomies not unloading the perineum sufficiently, and being associated with extensions zig-zagging back into the anal sphincter muscle complex (ASC).

We estimate the minimum pre delivery length of episiotomy to be 3 cm to achieve this sutured episiotomy length of 1.7cm.

CONCLUSION

1. Off centre (5 or 7 o'clock) mediolateral episiotomies (start epi @ 5-7 o'clock during crowning)
2. Angled at at least 60 degrees to the verical midline. Results in a post delivery epi of 45 degrees)
3. Minimum length of 3cm.

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-29.pdf

(copy paste the above URL) OR scan

Link to article : https://www.dovepress.com/articles.php?article_id=17785

GESTOSIS UPDATE : 25/04/2021 Synopsis by Dr. Shashwat Jani

FIGO RECOMMENDATIONS: SCREENING AND PREVENTION OF PRE-ECLAMPSIA : DR VIRAL PANDYA

1. May 2019, FIGO, in consultation with subject experts, has published evidence-based clinical recommendations for screening and prevention of pre-eclampsia.
2. These guidelines include best practice recommendations as well as suggested pragmatic use modifications for countries with limited resources of maternal healthcare.
3. FIGO strongly recommends multi-modal first trimester screening for pre-eclampsia which includes maternal history, mean arterial pressure measurement, Doppler assessment of uterine artery blood flow and estimation of maternal serum placental growth factor (PIGF) levels.
4. Robust research evidence suggests that the detection rate of this protocol for preterm pre-eclampsia is almost 75%, and the screen positive group can be further managed for prevention of disease.
5. For parts of the world where resources are limited, measurement of biophysical factors – PLGF levels and uterine artery Doppler assessment can be considered optional.
6. FIGO recommends the minimum level of screening to include maternal history and mean arterial pressure measurement.
7. This strategy would be economical but will result in a lower detection rate of almost 50%.
8. Using a contingent screening pathway, screen positive patients of the above screening protocol can be subjected to biophysical measurement testing to further improve screening rates and rationalize healthcare delivery.
9. Data from large randomized controlled trials and meta-analyses have confirmed that aspirin is safe and an effective measure for prevention of pre-term pre-eclampsia.
10. Aspirin, if started at the appropriate time and in the correct dosage in patients at risk, has the potential to prevent 90% of early pre-eclampsia and 65% of pre-term pre-eclampsia.
11. The best results are seen when aspirin is started in a dose of 150mg per day at bedtime, started before 16 completed weeks of gestation.
12. The minimum recommended dose by FIGO is 100mg, and the safety profile of low-dose aspirin has been well established, with extremely low risk of maternal bleeding disorders.
13. Adherence to the aspirin regimen is key to improving outcomes, hence the patient must be educated and made aware regarding the risk and the importance of regular aspirin intake.
14. Other preventive modalities such as calcium supplementation (in women with low calcium intake), heparin, megadose vitamins, magnesium, statins, heparin, metformin etc. are not substitutes for aspirin and should be used only with appropriate clinical judgement and awareness that there is very limited evidence supporting their use for prevention.
15. Inversion of the pyramid of care and making the early first trimester assessment accessible to maximum number of antenatal women, will play a big role in screening and prevention of pre-eclampsia.

PREDICTION & PREVENTION OF HDP FOGSI GUIDELINES : DR AKSHAY SHAH

- HDP occurs in up to 7.5% of pregnancies worldwide (WHO).
- 10-15% of maternal deaths are associated with HDP.
- Screening of HDP has to be an important part of the regular antenatal care.
- Monitoring and therapeutics then can be judiciously planned.
- Antenatal risk assessment is of help
- UAD during 11-13+6 weeks or during 2nd trimester can help in prediction of preterm preeclampsia
- Initiate preventive measures Such as
- Low dose Aspirin @ 12 weeks in high and moderate risk women
- Increase Calcium intake in Low calcium intake group
- LMWH - second line therapy
- The sFLt-1 & PLGF biomarkers have the potential to offer major advances in diagnosis & management of HDP

EARLY & LATE FGR MANAGEMENT : DR BIJOY BALAKRISHNAN

Stage-based classification and management of FGR

Small-for-Gestational Age.

EFW<10percentile, all dopplers are normal:- Fortnightly doppler and growth assessment is required. Labor induction should be recommended at 40 weeks[5].

Stage I Fetal Growth Restriction (Severe Smallness or Mild Placental Insufficiency).

Either UtA, UA or MCA Doppler, or the CPR are abnormal. In the absence of other abnormalities. Weekly monitoring seems reasonable. Labor induction beyond 37 weeks is acceptable, but the risk of intrapartum fetal distress is increased [5].

Stage II Fetal Growth Restriction (Severe Placental Insufficiency).

This stage is defined by UA absent-end diastolic velocity (AEDV) or reverse AoI. Monitoring twice a week is recommended. Delivery should be recommended after 34 weeks[5].

Stage III Fetal Growth Restriction (Advanced Fetal Deterioration,

Low-Suspicion Signs of Fetal Acidosis).

The stage is defined by reverse absent end diastolic velocity (REDV) or DV PI >95th centile. Monitoring every 24–48h is recommended. Delivery should be recommended by cesarean section after 30 weeks[5].

Stage IV Fetal Growth Restriction (High Suspicion of Fetal Acidosis and High Risk of Fetal Death).

This stage is defined by spontaneous FHR decelerations, reduced STV (<3 ms) in the cCTG, or reverse atrial flow in the DV Doppler. Monitoring every 12–24h until delivery is recommended. Deliver after 26 weeks by cesarean section at a tertiary care center under steroid treatment for lung maturation[5].

An interesting case summary of COVID & pregnancy by SVP

Dr. Megha Patel
Professor,
SVP Hospital

Dr. Rina Patel
Associate Professor,
SVP Hospital

Dr. Kruti Deliwala
Assistant Professor,
SVP Hospital

A 25 year old primi female patient with 8 months 11 days of amenorrhoea with complaints of breathing difficulty and cough since 5 days with outside RTPCR positive report on
12/04/2021 & HRCT score 17 out of 25 who is maintaining spo2 below 80 percentage so patient was kept on 15 l O2 with NRBM.

On examination, Temperature was normal; Pulse: 102/min; BP: 122/84 mmHg; RS,CVS: NAD; P/A: 32 weeks, Cephalic floating, FHS +, regular; P/V: os closed, no show, no leak.

So patient was shifted to OT for EMLSCS with indication of maternal distress due to covid positive. On table patient was desaturated so decision for general anaesthesia was taken and patient was intubated.
Male 2.2 kg baby was delivered who was kept in NICU on 0.5 L O2on nasal prongs to rule out covid.

Patient shifted intubated to ICU because she was not maintaing spo2 after lscs.On third day,patient was extubated and put on HFNC MODE. Then oxygen requirement of patient was gradually decreased with help of NRBM to Simple Oxygen Mask. Pateint was maintaining spo2 99% on room air on post op day 8.

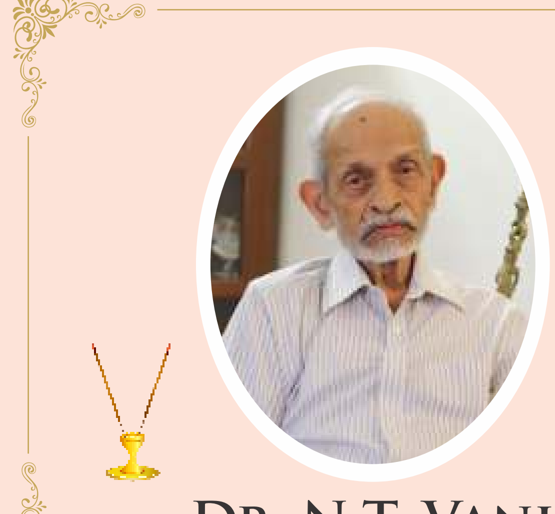
All stitch removal was done on post op day 10 of lscs. Stitch line was healthy. Patient was discharged on post op day 12.on discharge ,patient was healthy.

During hospital stay,Patient was given full dose of Inj Remdecivir,inj Piptaz,inj Metro, inj Dexona,inj LMWH.

Conclusion: A case of moderate to severe COVID infection (HRCT score 17) in pregnancy which was managed by timely intervention by LSCS saved mother & foetus both.

Dr. Mukesh Bavishi

Dr. Mukesh Bavishi
was awarded
'GUJARAT RATNA 2021'
on 61st Gujarat Day



Dr. N.T. Vani

OBITUARY

We have lost our member
Dr. N.T. Vani Sir
We convey sincere condolences
to his family and our prayers
for the departed soul.

Dr. Deepak Naik

OBITUARY

We have lost our member
Dr. Deepak Naik
We convey sincere condolences
to his family and our prayers
for the departed soul.

Dr. Rani Morakhiya

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