AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS E-TIMES

FEBRUARY 2021

Theme : Catch them Young & Teach Them Right

Motto : Beti Bachaao, Beti Padhaao Aur Bete ko bhi Samjhaao

Painting by Dr. Purvi Parikh जुगनू के साथ जंगल में

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Dr. Rajal Thaker
President

President's Message

Dear AOGS Member,

Season's Greetings…

I hope you are enjoying beautiful orange flowers of Kesudo (Flame of forest), Pangaro (E.Indica), Shimlo (Bombax) and Tulip tree (Spathodea) that bloom in this season. Once again Team AOGS is happy to share the E-Times of February 2021, that has a painting by Dr Purvi Parikh on its cover page and painting by Dr Parimal Panchal on its last page.

We are trying our level best to update the contact details of our members. Our office staff has made several phone calls for same. Personal visits have been made by our office staff at the address of those members whose number is unreachable/switched off. But, still there are few memebrs who have shifted to another city/country and their data is not updated. For such members, we are personally making calls to other AOGS members whether they have contact details of these members. In addition, we are trying to find out contact details of such members through social media platforms. I request all our memebrs to update AOGS office, if there is any change in their conatct details.

As per GBM resolutions, you are requested to inform AOGS office about your dual membership (if at all) of AOGS and any other FOGSI society.

Team AOGS 2020-21 is happy to share that, we are going ahead with E election by E Voting. Only "A" category member of AOGS will be able to vote. Registered member will get link to open ballot during election time period, on registered mobile and/or registered email.After opening link, registered member will have to generate One Time Password (OTP) from either registered mobile or registred e-mail.Voting will only be possible with OTP.

We had organised three PG case presentation webinars in February. Large number of PG students across India had attended these webinars and not only PG students but faculties of medical colleges have appreaciated our efforts. We are coninuing these webinars in March as well, in addiiton to AICOG 2000 oration and AICOG 2017 oration. Public awarenss webinar on menstrual hygiene has been organised on International women's day - 8th March in addition to awareness and screening programs for cervical and breast cancer during 6-8 March. Sambharna Series – 4 has been planned for 21st March.

Enjoy reading the E-times.

Dr Rajal Thaker

President

Dr. Sunil Shah
Hon. Secretary

Hon.Secretary's Message

Dear AOGS members,

Respected Seniors and Colleagues,

Season's greetings!

Slowly and steadily we are winning the war against Corona with good actions taken by government and well supported by people of India. Largely vaccine is also putting break on spread of Corona. I urge everyone to take vaccine soon and encourage everyone in your family and staff to take benefit of free vaccine provided by Government.

It's a proud moment for all amdavadi as largest and biggest Cricket stadium "Shri Narendra Modi stadium" with capacity of 1,35,000 people has been inaugurated in Ahmedabad. Hopefully we win(let's **શ્રી ગણેશ**) inaugural match against England.

We are in the final process of data update and streamlining things. We are taking utmost care in updating data by getting information through email, post/courier and repeated calls from office. We would like to reassure each and every person no one will be removed or made associate member (from AOGS) without proper consultation and communication with each person. I request all the members to co-operate activities and data collection process for further progress and digitalization process of AOGS. We have also scrutinized life members, associte members and honorary members. Before we handover charges to new team we want to give new AOGS with I card and E election.

Jay Hind! Long live AOGS!

Dr. Sunil Shah

Hon. Secretary

CONTRACEPTION IN ADOLESCENTS

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India has the highest young population in the world, which is almost one-fourth of the total 1.36 billion. These youngsters are facing significant risks and challenges to their sexual health. As a Gynecologist, shall we advice contraception to the adolescents is a big question. Ideally abstinence is the best contraception for all adolescents. Adolescent age starts from 12 years up to 19 years. Young people between this age make up 50 per cent of all new HIV/AIDS infections in the country while 7.8% girls aged between 15-19 years are becoming pregnant according to latest National Family Health Survey in India. It is all because of lack of awareness of contraceptive majors and its non acceptance in this age group. There are the many barriers to teens for using contraception like :

- Developmental issues ●Teens are spontaneous ●Teens may be ambivalent about pregnancy ●Teens have inadequate access to information and confidential care; lack of awareness ●Inability to pay for services and transport. ● Fear of violence from partner or parents. ● Pressure from in-laws & society to have children. ● Sugar Daddy, sexual crave. ● Poor Negotiation skills. ● Political, religious, cultural hurdles

Early adolescents are less likely to plan ahead, more spontaneous, may be too much shy to ask about condoms availability. Middle adolescents can plan ahead, but may think they won't get pregnant.

As we all know , government of India has implemented a new act to handle the sexual abuse against any person below 18 years which is known as POCSO act 2012 (Protection Of Children from Sexual Offences Act 2012) which says that every person who has knowledge or has apprehension about the sexual abuse or activity against anyone below 18 years shall inform the local police or SJPU immediately. If failed to inform, the person is punishable for imprisonment up to six months. And obviously the person performing or attempting the abuse or activity is also punishable strictly. It means that government is very keen to protect the adolescents below 18 years of age from sexual abuse and sexual activity, even if the sexual act is consented by the girl . So with this situation it is a big controversy about advising as well as providing the contraception to the girls below age of 18. Is it an encouragement for sexual activity, is a personal view for every clinician. But magnitude of the sexual problems in the adolescent age group, is rising day by day to very alarming situation because of lack of knowledge and no use of contraception. It is said that the least age of loss of virginity in metro cities is 14 years in India. The average premature and premarital sexual involvement of girls in India is around 60% presently. Along with the self premature sexual involvement of adolescent girls, the sexual abuse in India is rising day by day to the dangerous levels.

There are many factors pushing the adolescents towards premature or premarital sexual involvement in the current era, like -

1) Social media with easy internet availability. 2) No control on the net usability. 3) Effect of changed Films and Television culture. 4) Peer pressure. 5) Increased substance abuse in youngsters. 6) Wrong idols in youngsters. 7) Effect of western culture 8) Small family norms and nuclear family. 9) Busy parents 10) Miscellaneous reasons.

These are the complications or problems because of unprotected sexual activity which can put the adolescents in extreme danger.

1) STDs 2) HIV 3) PID 4)Teenage pregnancies with complications like HDP, Premature deliveries, APH 5) Teenage unsafe abortions. 6) Teenage deliveries with increased instrumental or surgical deliveries, PPH. 7) Future sub-fertility or infertility because of PID or complications of abortions. 8) Mortality because of teenage abortions, pregnancies and deliveries.

To prescribe the contraceptives to the girls below 18 years may not be parallel to the Law, but it is the need of time to educate as well as to provide the contraception to the girls above as well as below 18 years. Adolescents need to protect themselves from unsafe sex, unwanted pregnancies, early childbearing, unsafe abortion and sexually transmitted diseases. Usually the methods of contraception chosen by Adolescents are based upon use by friends or relatives, accessibility, personal knowledge, media , fear of side effects and physician's recommendation.

Best practices in prescribing contraception :

More holistic approach is needed while prescribing the contraception to the adolescents. While selecting a method for them one should look for the: 1) Nature of his/her sexual relationship whether it is unplanned or sporadic, 2. Sexual behaviors engaged in and sexual history, 3. Frequency of intercourse, 4. Risk of STIS / HIV, 5. Medical eligibility, 6. Efficacy of the method, 7. Ability to tolerate side-effects, 8. Services available, cost, convenience, 9. Religious Beliefs, 10. Partners' attitudes, life style issues, 11. Personal factors influencing compliance, 12. Conformity with prevailing laws of the country. In fact we should provide them the details of each and every method of contraception with their details and ask them to choose according to their circumstances. And no doubt as a health care provider our input or advice is must. Along with this, they should be provided the knowledge about the POCSO ACT 2012.

In this task as a health care provider one may face the challenges like the attitude of adolescent to confidentiality, accessibility and affordability of methods. There can be barriers in communication, as well as geographical difficulties for those in rural and regional areas. The counseling should differ between early, middle and late adolescent females according to their contraceptive needs. If needed both partners should be counseled together, rather it is always beneficial. The final goal of this task is to prevent the adolescent girl from STIs and unwanted pregnancy and its complications.

The options of contraception are-

1) Abstinence 2) Barrier contraception 3) Combined oral contraceptive pill 4) LARC- Long acting reversible contraceptives 5) Emergency contraception 6) Other methods

Abstinence :

Even though it is difficult to explain, advice and force the adolescents for abstinence, one should have holistic approach in this regard. The girl can't talk in this aspect with parents or teachers . But she is comfortable as well as believes in her doctor. She may not be aware of all sides of this act, so proper counseling may divert her thoughts and she may adapt abstinence which is the best, cheapest, most protective and use full contraception in many regards. Also if the girl is below 18 years of age, both the partners should be made aware of POCSO act 2012 in detail.

Barrier contraception :

If the couple is not ready for abstinence then it is the duty of the health care provider to proceed with due respect to their choice. Male condom is the most common , well accepted and effective type of barrier contraception . There are other options like Diaphragm, Cervical cup, Sponge and female condom

too, but it is always wise to advice the male type in this age group. It has many advantages like easy availability, ease to use and affordability. Also it is available in non medical shops and doesn't need prescription of doctor.

Also it has a special advantage of protection against STIs, and HIV which should be the target for adolescent age group . So practically if any girl is using or preferring other contraception , additional use of barrier contraception is always wise. But if the couple is in loyal relationship then should be treated as adult or married couple, provided they are above 18 years of age. The only big problem of the male condom is that the failure rates in adolescents are higher than adults. May be it is due to the difficulty in correct and timely use. This difference may be because of difference in experience as well as size of their bodies. Failure rates can range as high as 13 pregnancies per 100 users. Other disadvantages are complaints of decreased sexual pleasure, itching, irritation on genitalia or sometimes burning micturition. So the advice for the use of emergency contraception should be pass on , after the tear or sleep of condom by adolescent male.

Combined oral contraceptive pill :

For the couple in long term loyal relation , and the girl with the AUB or PCOS ,combined oral contraceptive pill (COCP) is an effective method. It prevent pregnancy through inhibition of ovulation and thickening of cervical mucus. COC also provides multiple gynaecological benefits, in the form of menstrual cycle regulation, reduction of dysmenorrhoea and heavy menstrual bleeding, improving acne and hirsutism. However, the failure rate is high in adolescent age group, due to the compliance challenges associated with daily administration, reporting 6–8 pregnancies per 100 women in the first 12 months of use. There can be discontinuation of contraceptive pills commonly due to irregular bleeding in the first few months of use. Other common side effects are vomiting, headache, nausea and breast tenderness. There are many combinations of the COCP available, with target specific goals such as weight, acne, hirsutism which can be chosen according to the need. In the girls with PCOS the COC with anti-androgen progesteron like Drosperinone, Desogestrel should be preferred.

Long-acting reversible contraceptives :

The examples of LARC are Intra uterine devices (Copper T, Multi load, Levonorgestrel intrauterine system eg: Emily,Mirena), The Implanon implantable device, and The injectable contraception.

The facts about LARC are-

1) > 99% Effective 2) 100 % Reversible 3) < 5% Adolescents on Globe use it 4) < 1 % Risk of complication 5) 10% is rate of discontinuation 6), 1/1000 rate of perforation by IUCD or IUS

IUCD is safe, effective, convenient, reversible, long acting, cost effective and easy to use method for contraception in females. If adolescents are in active sexual practice with a single partner , then this can be a good option for her. It is available as Copper T380, Copper t 220C, The Multiload Copper T 375 and Nova T. There are few contraindications, few side effects and rare complications with IUCD. The major disadvantage is, it doesn't protect from STIs. But the list of advantages is longer than disadvantages. The failure rate is extremely less than barrier or COC.

Levonorgestrel intrauterine system is a very effective form of contraception, releasing levonorgestrel continuously over a period of five years. Contrary to perceptions regarding its use, the IUS is a safe method for adolescents and has a low failure rate of 0.8 pregnancies per 100 women in the first 12 months of use. The IUS can safely be inserted in the small setting, and importantly, in adolescents there is no increased risk of insertion complications, such as uterine perforation. The risk of pelvic infection following insertion is minimal, due to the protective effect of cervical mucus; but it doesn't prevent the STIs. Use of IUS is very less in India as compared to the western countries.

The Implanon implantable device is another type of LARC. It is a flexible plastic rod about the size of 4 cm, inserted in the inner upper arm, which release Progesteron continuously for three years. The failure rate is very low at 0.1 pregnancies per 100 women. Its high effectiveness, action for long duration and easy compliance for the user are the major advantages . One of the major disadvantages, however, is irregular vaginal bleeding, usually within the first 3–6 months following insertion, which can disturb the adolescents from its use and no protection from STIs.

The injectable contraception (Depo-Provera) contains MPA (Medroxy-progesterone acetate) and is given every 3 months. It is an effective form of contraception. It's failure rate varies between 1–8 pregnancies per 100 women due to non-compliance with repeating the injection typically in Adolescent age group. Irregular bleeding pattern is one of the major side effects, which have been reported to be as high as in 30% users. There can also be a delay in the return of fertility from the last injection and loss of bone mineral density with long-term use, which does resolve once discontinued. And doesn't provide protection from STIs.

Emergency contraception :

This should be the choice of contraception in the immediate time period following unprotected sexual intercourse to prevent pregnancy. There are various options available like selective progesterone receptor modulator (Ulipristal acetate), Levonorgestrel , and high-dose combined pill (Yuzpe), as well as the intrauterine Copper device insertion. Ulipristal acetate has proven higher efficacy than the other methods, especially if taken within the first 24 hours of unprotected sexual intercourse, and is effective for up to five days. On the other hand, Levonorgestrel-only regime will prevent 85 per cent of pregnancies up to three days after unprotected sexual intercourse, and Yuzpe will prevent up to 75 per cent. There are few side effects of these methods due to the high dose of hormones in their composition, which can alter the bioavailability of the drug. These effects are only transitory. There is no issues of return of fertility rather the fertility return is immediate and therefore a long-term treatment plan with the adolescent must be initiated. Alternatively, the copper intrauterine device can be inserted up to five days following unprotected sexual intercourse, and has the added advantage of long-term contraception. Access to emergency contraception is just as important as the efficacy of these methods, as the success will decrease with time elapsed from unprotected sexual intercourse. Health care provider should educate the Adolescents about the different methods available and how to source them. Pregnancy status must also be checked 3–4 weeks after initiation to verify success of treatment.

Other options:

There are a variety of other contraceptive methods available like Natural methods. It is classified as :

1) Fertility awareness method

2)Periodic Abstinence method

3) Withdrawal method or coitus interruptus.

Practically these are less suitable to the adolescent group. The failure rate will be very higher in these techniques. Also the protection against the STIs will be zero. And as this age group is not aware of the menstrual physiology and is usually facing the menstrual abnormalities, it's difficult for them to follow the menstrual calendar. Periodic abstinence and withdrawal techniques are very difficult to be followed by adolescent age group.

Conclusion :

Contraception in adolescents is an important and controversial topic to practice upon. We as a clinician are aware of the fact that it is almost impossible to stop the premarital sexual involvement in adolescents. We should think of the disasters happening because of it. Probably the answer for these disasters is the provision of proper contraceptive majors. and as Gynaecologists we must consider the entire clinical picture when approaching each individual to ensure the most suited method for contraception. Once the contraception plan has been established, a follow-up appointment should be made within three months as a responsible health care provider. This practice will help to monitor and ensure correct use of contraception as well as confirming that the adolescent is satisfied with every type of outcomes. And while prescribing contraception to the girl below the age of 18 you should be well aware of POCSO act 2012, which says that **"any person who has knowledge or apprehension about the sexual act performed or likely to be performed with or without consent of a girl below 18 years, should inform the Special Juvenile Police Unit or local police about it without any delay. if fails to do so, you are punishable for the imprisonment for 6 months".**

Mind, Body and Obstetrics

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The most painful aspect of modern medical practice is not whether most

physicians are up to date in their knowledge or in their techniques, but whether too many of them know more about the disease than about the person in whom the disease exists. The overriding issue before medicine today is one not of proficiency but of humanity.

Our body is a complex entity governed by constantly interacting bio-chemical, psychological and cultural forces. Every ailment is a product of organic forces and events as well as a patient's psychosocial profile at a given time. Hence it is obligatory to manage disease with the patient as an active partner in the process. Such a partnership provides clues to a cost effective, successful strategy to achieve healing. The main function of a doctor is to engage to the fullest, the patient's own ability to heal, by strengthening his belief system.

Modern medicine tackles the diseases only at a physical level, ignoring or even being unaware of the influence of mind in the aetiology of illnesses. Behind every physical problem, there is a mental cause; some damaging thought patterns, negative feelings or self-defeating beliefs and even spiritual crisis. Just removing the physical symptoms, without undergoing a psychological or spiritual healing, could result in the spiritual disharmony manifesting in another disease at a later date.

Most reproductive health problems in women operate through the combination of a triad of factors, namely; Biological, Psychological, And Socio-cultural. Copper et al. (1996) analyzed through their study that various measures of poor psychosocial status in pregnancy are associated with spontaneous preterm birth, IUGR, or low birth weight. The articles reviewed by Lederman (1995) examined the relation among the major types of stressors and anxiety, on the one hand, and development of maternal, fetal, and neonatal complications, on the other hand. It showed that the maternal stress, by activating abnormally high levels of adrenocorticotropic hormone and beta endorphin from the hypothalamic-pituitary-adrenal axis, influences fetal growth and neonatal birth outcomes associated with placental insufficiency.

The yogic disciplines such as abdominal breathing, Shavasana, progressive muscle relaxation and meditation admirably bring about a reduction in the sympathetic activity and help achieving improved circulation throughout the body. This phenomenon can be of use in improving placental circulation and restoring the changes of placental insufficiency.

Hypnosis is defined as an altered state of consciousness, characterized by highly focused attention and heightened suggestibility. Various studies over the years have shown effectiveness of clinical hypnosis in antenatal period in conditions such as nausea-vomiting, pruritus, and backache. The usefulness of hypnosis has also been reported in the preparation for childbirth with improvement of birth outcome (Zimmer, Peretz, Eyal, & Fuchs, 1988). Brown and Hammond (2007) reviewed the benefits and effectiveness of hypnosis in obstetrics. Its benefit in cases of preterm labor is noted in a randomized controlled trial and in a meta-analysis.

It was hypothesized that the social, financial, and emotional constraints during pregnancy generate subconscious conflicts and act as stressors for the mother. This is particularly so when the pregnancy is unplanned or unwanted. It is postulated that when stressors affecting pregnancy are addressed and resolved in a state of hypnotic trance, it helps to achieve deep relaxation.

We published a longitudinal prospective study where clinical hypnosis was used as an adjunct to the conventional medical management in pregnancies with documented IUGR and oligohydramnios. The perinatal outcome was compared with the control group wherein hypnosis was not used. The hypnosis group had a significantly lesser preterm delivery rate and fewer incidence of low birth weight babies with significantly reduced operative intervention in terms of lower rate of cesarean section. Hence, the use of clinical hypnosis as a viable adjunct to medical management is suggested to help to prevent neonatal morbidity and fetal loss.

Cloud Bernard, a great medical researcher, wrote more than a century ago, "I feel convinced that there will come a day when physiologists, poets and philosophers will all speak the same language." So, let's work together to achieve our dream of a healthy mother and healthy baby

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POLYHYDRAMNIOS

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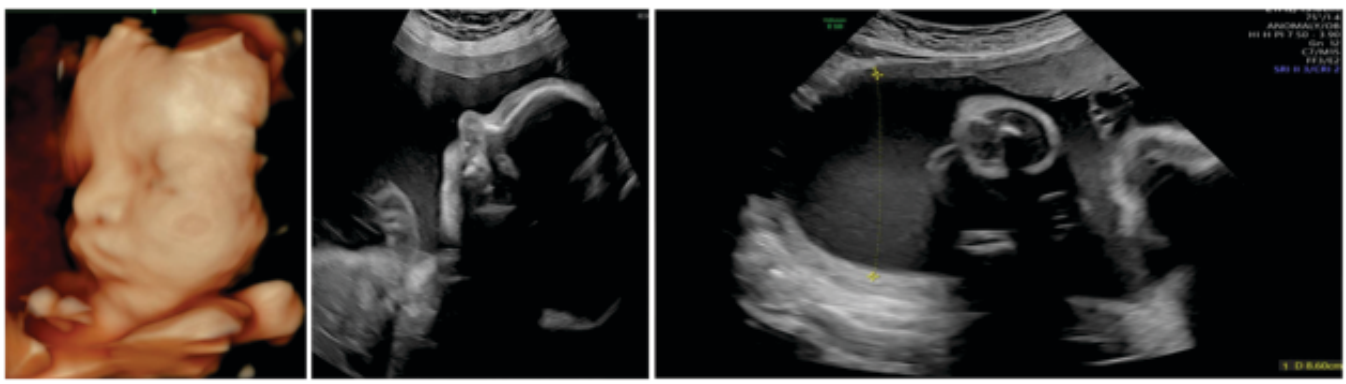
(Dr S. Suresh)

INTRODUCTION:

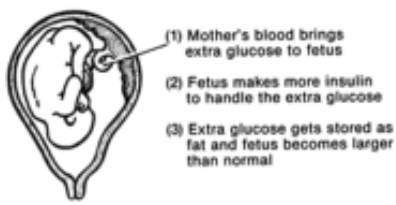
It means presence of an excess amount of amniotic fluid in amniotic sac (2000ml or more) / AFI > 24cm or deepest vertical pool of > 8cm. Usually detected after 20 weeks . Affects 1-4% of all pregnancies . AFI volume in 1st trimester is not criteria for pregnancy failure, abnormal amount of fluid may indicate poor outcome.

Idiopathic polyhydramnios occurs in 50-60% of cases and has been linked to fetal macrosomia and increase in adverse perinatal outcome. Acute polyhydramnios at 16-22 weeks is mainly seen in association with TTTS.



CAUSES:

1. Gestational and Pregestational diabetes (25-30%)
2. Isoimmunization
3. Fetal structural and chromosomal abnormalities (10-20%)
4. Fetal infections
5. Multiple pregnancies with Twin- Twin transfusion syndrome
6. Idiopathic (60-65%)



PATHOPHYSIOLOGY:

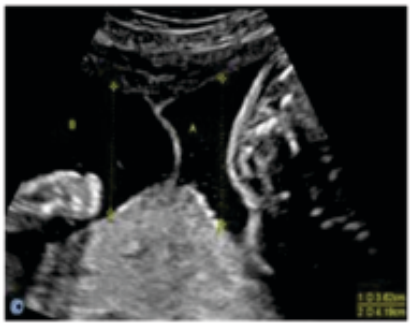
Volume of amniotic fluid increases steadily until 33 weeks of gestation. It plateaus from 33-38 weeks and then declines with volume of amniotic fluid at term (approx. 500ml). It predominantly comprised of fetal urine output with small contributions from placenta and some fetal secretions. Fetus breathes and swallows the amniotic fluid. It gets processed, fills the bladder and is voided and cycle repeats. Fetus close to term will produce between 500-1200ml urine and swallow between 210-760ml of amniotic fluid per day.

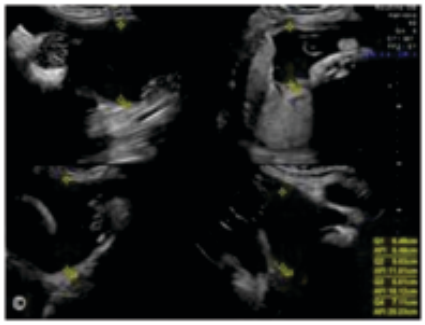
TECHNIQUE:

1. SUBJECTIVE : Normal / Reduced / Increased

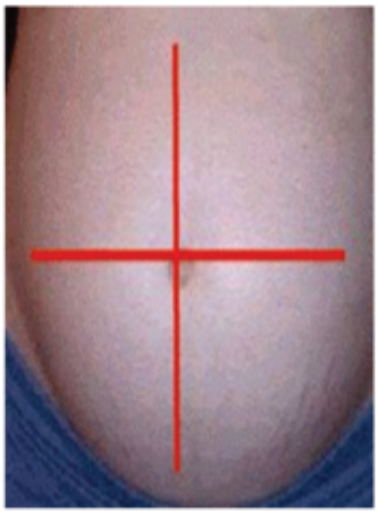
2. OBJECTIVE:

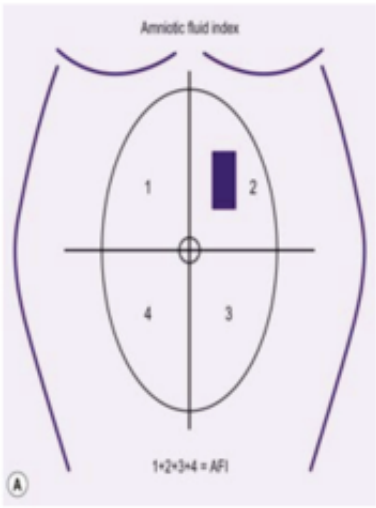
- **Single deepest vertical pocket –** Vertical measurement within largest amniotic fluid pocket, free of umbilical cord and fetal parts. Normal 2-8cm. In multiple gestation, SDP 3-8cm is considered as normal. < 2cm – Oligohydramnios and > 8cm – Polyhydramnios





- **AFI –** Sum of deepest vertical measurements within each quadrant. Uterus divided vertically into two halves by an imaginary line along linea nigra. During measurement transducer is held at right angles to sagittal plane of patient's abdomen. Normal: 7 – 25cm





MILD POLYHYDRAMNIOS	MODERATE	SEVERE
SDP 8-11cm or	12-15cm or	> 16cm or
AFI 25-30cm	30-35cm	> 35

METHODS TO SEE FETAL ANATOMY IN SEVERE POLYHYDRAMNIOS

1.Reduce the amount of liquor by Amnioreduction and then see the anatomy

2.Extreme lateral decubitus or Knee chest position and try to see the anatomy

TEST TO DIAGNOSE POLYHYDRAMNIOS:

1.Detailed Ultrasound - To rule out associated anomalies

2.Glucose Tolerance Test - To rule out maternal Diabetes

3. **RH Iso Immunisation test** - if there is suspicion for fetal anemia and fetal hydrops
4. **TORCH** screening
5. **Amniocentesis + Karyotype** – in presence of fetal malformations
6. **DNA testing** for myotonic dystrophy mutation if there is abnormal posturing of extremities

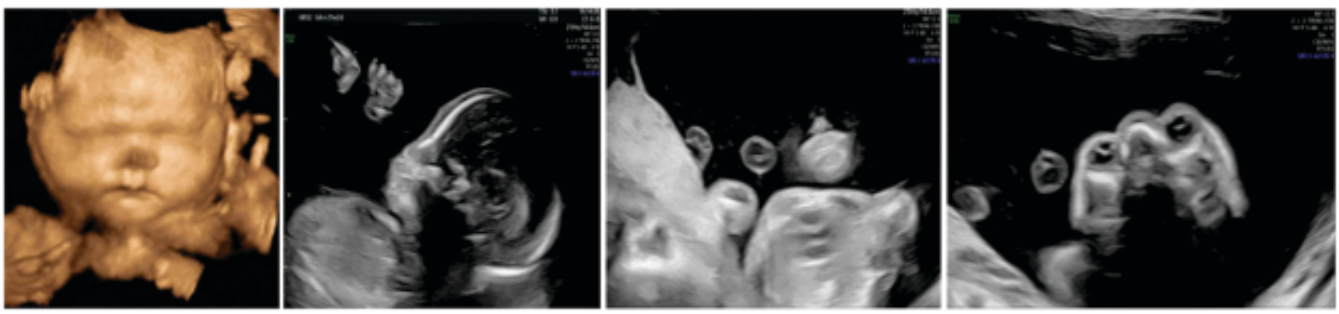
FOLLOW UP – Ultrasound scans every 1-3 weeks to monitor fetal condition and amniotic fluid volume.

PRENATAL THERAPY:

1. Maternal diabetes mellitus – Good glycemic control
2. Hydrops due to dysrhythmias – Antiarrhythmic medication
3. Hydrops due to fetal anemia – Intrauterine blood transfusion
4. Pulmonary cyst / Pleural Effusion – Thoracoamniotic shunting
5. TTTS – Laser occlusion of placental anastomoses
6. Fetal / Placental tumors – Laser occlusion of feeding vessels

PROGNOSIS & RECURRENCE RISK:

1. **MILD IDIOPATHIC** – Excellent Prognosis and no increased risk
2. **IF IDENTIFIED CAUSE** – Depends on the cause, degree of severity and gestational age at delivery
3. Due to common etiology with GDM, it is often associated with fetal macrosomia



DELIVERY:

1. **Standard obstetric care and delivery** in most cases
2. **Fetal abnormalities :** Induction of labor at 38 weeks gestation in a hospital with neonatal ICU and facilities for pediatric surgery
3. **Fetal Tumors :** Consider Cesarean section and EXIT procedure
4. **Severe Polyhydramnios :** Controlled Induction and membrane rupture at 38 weeks to avoid risk of umbilical cord prolapse

CONCLUSION-

Despite normal detailed ultrasound examination , Polyhydramnios is associated with increased rate of fetal malformations, genetic syndromes, neurologic disorders and developmental delay which may be diagnosed only after birth.

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AMH - AntiMullerian Hormone as a Predictor tool for Fertility

Dr. Kamini Patel
IVF Specialist & C.E.O. Vani IVF Centre

AMH is expressed throughout folliculogenesis, from primary follicular stage towards the antral stage. Serum level of AMH represent both quantity and quality of ovarian follicle pool.

AMH is the best marker compared to other marker to measure reproductive age and also useful in menopausal transition.

In IVF cycle, AMH used to predict poor ovarian response and possibly the prognosis.

AMH seems to act in the reproductive organ. The most striking effect of AMH is its capacity to induce regression of Mullerian ducts and the anlage of the female internal reproductive organs.

When AMH not present then Mullerian ducts of both sexes develop into the uterus, the fallopian tubes and the upper part of the vagina.

The inhibitory effect of AMH on primordial to primary follicle transition was confirmed by invitro studies of neonatal ovaries and ovarian cortical strips of various species, including human (Durlingeretal.,2002; Giglietal.,2005; Carlsson et al., 2006; Nilsson et al., 2007).

The second type of human AMH gene (AMHRII) isolate in 1995.it is located on chromosome 12 and is made up of 11 exons spread over more than 8 kbp. The AMHRII messenger is expressed by AMH target organs, namely Mullerian ducts, gonads.

AMHRII is localized to the mesenchyme around the Müllerian duct in the urogenital ridge of both the male and female rat and mouse.

Loss - of - function mutations in the type II receptor as well as the AMH ligand itself are causes of persistent Müllerian duct syndrome in humans.

AMH has developed in to a factor with a wide array of clinical applications, mainly based on its ability to represent the number of antral and pre-antral follicles present in the ovaries.

Many different factors proved variation in AMH. Genetic factors, life style factors, several environmental factors. Genetic factors have been proved to play a major role in determining the variation in menopausal age, in life style factors smoking, BMI, alcohol have been affected on AMH variation.

Some health factors also impact on the AMH level such as chemotherapy, radiotherapy, surgery.

Radiotherapy is also widely recognized to cause ovarian damage even at low doses and women treated with radiotherapy that includes the pelvis (including abdominal pelvic therapy in children or total body irradiation) generally have very low or undetectable AMH concentrations (Lie Fong et al., 2009; Gracia et al., 2012).

AMH level will adjust the predictions that can be based on female age at the moment of AMH sampling, so that women with low age-speci c AMH will have menopause earlier and vice versa (Tehrani et al., 2009; Broeret al., 2011b

Although many aspects of AMH action in the ovary remain to be elucidated, knowledge is emerging. AMH significantly decreases FSH- and LH-induced aromatase expression in granulosa cells as well as reducing the activity of the ovary-specific aromatase promoter II. This results in a significant reduction in E2 production (Pellatt et al., 2011)

Ovarian reserve tests (ORTs) improve the accuracy of female age in identifying those with a close to zero prognosis (Hendriks et al., 2008; Broer et al., 2013).

To study the value of the ORTs in the assessment of the future ovarian reserve status, long-term follow-up studies are required, where several factors assessed at initiation of the follow-up are linked to the final outcome age at menopause

Serum AMH is the best biochemical marker of ovarian function in a large array of clinical situations, both in childhood and adulthood.

Both AMH and AFC have been shown to be useful marker s of the ovarian response to controlled ovarian hyperstimulation.

AFC and serum AMH correlated with each other with different factors such as antral follicle size. AFC size is small (1-2 mm) represent higher serum AMH levels than a patient who has a majority of large antral follicles.

The second factor correlate with serum AMH and AFC that is follicle health as granulosa cell atresia may hinder AMH production.

The rapid decline in AMH expression corresponds with these lections of follicles for dominance, which is characterized by a transition from a low estrogen producing state to one of rapidly increasing estrogen production. E2 is instrumental in this decline through E2 receptor b, which interacts with the AMH promoter region (Grynberge etal.,2012)

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Although many aspects of AMH action in the ovary remain to be elucidated, knowledge is emerging. AMH significantly decreases FSH- and LH-induced aromatase expression in granulosa cells as well as reducing the activity of the ovary-specific aromatase promoter II. This results in a significant reduction in E2 production (Pellatt et al., 2011).

It became apparent that a number of genetic regions and variants involved in several possible pathways underlying timing of a menopause could be identified. Regarding a potential role for AMH or its receptor in modulating the rate of follicle loss from the primordial follicle pool, it has been demonstrated in studies that common variant of the AMHR2 gene modifies the relationship between parity and natural menopause.

On Feminine way

Ela R. Bhatt
Founder, Self Employed Women's Association, (SEWA), Ahmedabad.
Email : bhattela@sewa.org

One of the quietest wisdoms one acquires as one grows older is that every time I say "I", I realize I am a collection of "We's". I am a self-nurtured by several collectivities. When I saw I am feminist, I realize the pluralities of possibilities I am raising. I belong to a trade union tradition which had once no place for women although a woman Anasuya Sarabhai was the Founder of the Union (TLA), there was a nationalist tradition where women played creative roles, a feminist tradition where dissent was creative. And a Gandhian tradition, Gujarat has created its own style of creativeness and dissent. It is home to thousands of NGOs in Gujarat. Gandhi himself established 18. So when I speak of feminism or speak to feminists, I address them from all these backgrounds. However, I realize my feminism has to be reinvented every day from each of these perspectives.

I shall share with you here, today, my Ideas of feminism or rather call it feminine way that is based on a few simple tenets. Firstly, when I locate myself in women's work. Women's work is no longer shadow work. Shadow work was work done at home, the acts of teaching, nursing which had little price and less value in a market. Today woman's work is central to a woman's life. It is not just identity or a job, it marks a life worldwide, a way of life.

Women's work is not just a demand for job, an arid idea of employment. A woman's work relives everydayness, recreates a cosmos and it creates community. The home, the neighbourhood, the locality, the region combine to create envelopes where locality means autonomy. Locality is ecology and women's work is ecological in a variety of senses. However, women's work as WORK is hardly reported in the media.

Women's work sustains diversity. As craft, as cooking, as sowing, as weaving, women's work is a celebration of locality and difference. It does not seek uniformity, or standardization. By allowing difference, it allows thousands of ways of life to survive.

I have found that the concepts of Swadeshi and Swaraj explain feminism best. Women's work is local work. But by sustaining autonomy and locality it protects the small, the marginal and vulnerable. By strengthening the locality, it seeks to defend other vulnerabilities, often marginal like the tribe, the craftsmen, and the scavenger. Women's work recognizes the informal economy as the centre of the democratic world. By strengthening these vulnerabilities, their voice, it produces Swadeshi, the power of the local and the informal. Nature is always the background to women's work. If economists and ecologists do not validate these concepts, I hope, the women journalists for example, will .

Beginning with Swadeshi, feminism moves to Swaraj in spiraling circles. Gandhi called it Oceanic circles. From local vulnerability, it moves in wider circles of care, concern and competence. If Swadeshi is about rights, Swaraj is about responsibility. From women's work, we move to a theory of women's peace. The peace I am talking about is not a national peace, a mere cessation of violence, an agreement of nation-states to behave. Peace goes beyond the absence of militarism. It heals. It cares. It rebuilds many times in war from areas I meet women tired of war, refugee women desperate for normalcy. They always ask for work. Out of women's work, they can forge a women's peace.

Yet as women, we not done enough for women's peace. It needs to begin with a deeper sense of the fate of the woman's body. Her body today has exploded into multiple bodies. One has to think of the tortured body, the raped body, the body of incest, old age, of sexual trafficking, the surrogate body, the destroyed body of foetus, the displaced body, the hungry body. Unless we creates a new mapping of bodies, it might miss many forms of suffering in the world today. To focus merely on desire and consumerism might perpetuate new forms of violence. One has to ask what is a feminist theory of sustainability and suffering? For this, feminism cannot be a standardized language, a global table talk but a huge collection of dialects where local problems and planetary issues intersect. I am reminded of the woman of Bhopal Gas disaster. They did not speak merely of compensation. They wanted their suffering understood. They wanted suffering to create community not division. They asked that the people of the US Carbide plant spend time with them. To understand.To emphasize.To heal.To ethically repair.Because a feminist theory of suffering cannot begin only with a theory of contract and compensation. It is not money, it is fraternity with men we are talking about.

Lastly, feminism has to be clear about desire and consumption. Beauty contests do not exhaust the idea of freedom. Dress does not exhaust individuality. We have to ask where does desire meet reciprocity and responsibility. Otherwise women's desire and feminist sustainability could be at loggerheads. Ironically feminism can become a mere vehicle for middle class consumption. Look at our Ads, we object to obscenity but how many of us as women object to obscenity of consumption? How many of us ask about energy miles? Or demand local produce? A fragmented feminism can be counterproductive. We as women need a clear worldview.

I will argue for a feminist theory of citizenship. Citizenship cannot be standardized. It has to recognize diversity, a diversity of bodies, of time. We have to recognize cycles of time of childhood, old age, of pregnancy each of which has entitlements. Standardized rights are not enough, democracy has to build a sense of diversity at every level. This is because equality is not enough. Equality has to recognize fraternity, difference and think not of equality of uniformity but equality across diversity. This is what I want to urge you a women professionals.

In my experience, women are the key to building a community. When we invest in women's participation, we have an ally who wants a stable community and roots for her family. Each woman is not only a worker, but also a provider, a caretaker, an educator, a networker and a vital forces of bonds in community. Moreover, women's participation brings constructive, creative and sustainable solutions to the community. I consider women's participation and representation an integral part of building stable, peaceful nurturing world. Women need to take themselves seriously, on feminine way.

Ahmedabad Obstetrics and Gynaecological Society (AOGS)

Date: 06/03/2021

Electoral Notification for year 2021-2022

The nominations are invited on prescribed form for the following posts of Ahmedabad Obstetrics and Gynaecological Society for the year 2021- 22.

No	Post	No. of Post
1	President Elect	One
2	Vice President	One
3	Hon. Secretary	One
4	Hon. Jt. Secretary	One
5	Hon. Treasurer	One
6	Clinical Secretary	One
7	Managing Committee Members	Ten

Election Rules:

1. Only "A category" member of Ahmedabad Obstetrics and Gynaecological Society can contest.
2. Any eligible member can contest for managing committee, only after completing one year membership in Ahmedabad Obstetrics and Gynaecological Society, and must have attended at least one GBM (General Body Meeting).
3. An eligible member can contest for the post of office bearer after completing at least one year's tenure as member of managing committee of AOGS.
4. An eligible member can contest for the post of treasurer only after completing at least two years as a member in the managing committee of AOGS.
5. President-Elect will be the president for the year 2022-2023.
6. A member who has served as President of AOGS cannot contest for the post of treasurer.
7. The tenure of each post is for one year.
8. No member shall remain on the same post as managing committee member for more than three (3) consecutive terms.

9. The proposer, seconder and the candidates should be in good standing position without any outstanding fees/dues towards society (AOGS).
10. A member can contest for the one post only.
11. In case of valid nominations for more than one post, all nominations shall be considered invalid.
12. Nominations fees (non refundable) for the post of managing committee member is Rs.1500/- and for the post of office bearer is Rs. 2500/-.
13. Please use prescribed form only.Nomination on and in any other form will be considered invalid.
14. Nomination form will be rejected if nomination form is incomplete or form found with incorrect information.
15. Important dates for election:

a. The nomination forms will be available from (1) AOGS office (during office hours 2pm to 6:30 pm). (2) AOGS Website (3) AOGS SMS link from **6th March, 2021.**

b. The duly filled nomination form with required nomination fees should reach AOGS office before **6 pm, on13th March,2021.**(On working day).

c. Last date for withdrawal is **15th March,2021 by 5:00 pm**

d. Scrutiny of forms by managing committee will be on **15th March, 2021.**

16. Election procedure

a. This year election will be by E Voting(E Election)

b. Only "A" category registered member with Ahmedabad Obstetrics and Gynaecological Society will be able to vote.

c. Registered member will get link to open ballot during election time period, on registered mobile and/or registered email.

d. After opening link, registered member will have to generate One Time Password (OTP) from either registered mobile or registered e-mail.

e. Voting will only be possible with OTP

f. Election will be open from **10:00 am 24th March, 2021 to 5:00 pm 30th March, 2021.**

17. Annual General Body Meeting will be held on Digital platform on **30th March, 2021 at 9:00 pm.**
18. Result of election will be declared in Annual General Body Meeting by President.
19. In case of any kind of dispute, the decision of president would be final.

Dr. Sunil Shah
Hon. Secretary

Ahmedabad Obstetrics and Gynaecological Society (AOGS)
Nomination form for Annual Election for year 2021-2022

No	Post	No. of Post	Put tick mark against post to contest
1	President Elect	One	
2	Vice President	One	
3	Hon. Secretary	One	
4	Hon. Jt. Secretary	One	
5	Hon. Treasurer	One	
6	Clinical Secretary	One	
7	Managing Committee Members	Ten	

- I, Dr._____propose name of Dr._____.for above said post for annual Election Of AOGS for year 2021-22

Signature of Proposer: _____

- I, Dr._____second name of Dr._____for above said post for annual election of AOGS for year 2021-22 .

Signature of Seconder:_____

- I, Dr._____give consent to contest for above said post for annual election of AOGS for year 2021-22 .

Signature of Candidate:_____

.....

- **I hereby declare that I am not life member with voting right of any FOGSI Society other than Ahmedabad Obstetrics and Gynaecological Society.**

Signature of Proposer **Signature of Seconder** **Signature of Candidate**

.....

For office use

Received nomination with requisite fees of Rs.....from Dr._____for annual election of AOGS for year 2021 -22

Dr.Sunil Shah
Hon. Secretary, AOGS

Ahmedabad Obstetrics and Gynaecological Society

Following members have not responded about their status of membership to AOGS despite repeated reminders by different ways. So, they are in 'under-consideration' category. Once, they respond to AOGS office, their category will be revised.

Dr. Urmila Keniya
Dr. Erika Desai
Dr. Roshni Modi
Dr. Praveen Jadav
Dr. Darshana A. Patel
Dr. Shaileshkumar R. Patel
Dr. Meghavini Parmar
Dr. Prakash N. Joshi (Gandhinagar)
Dr. Urvi D. Parikh
Dr. Rohit D. Patel
Dr. Punit Vasa
Dr. Kamlesh N. Parikh
Dr. Dhaval Patel
Dr. Samira Mistri
Dr. Nautamba H. Parmar
Dr. Ira V. Buch

Dr. S.R.Parasar
Dr. Virna Mishra
Dr. Asmita Solanki
Dr. Devabhai Bhalakia
Dr. Praveen Yadav
Dr. Vaishakhi Chaudhari
Dr. Arpana Chaudhari
Dr. Narendra Patel
Dr. Prakash Naik
Dr. Girdhar Patel
Dr Kunal J. Modi
Dr Viralkumar Narayanbhai Patel
Dr Neeta Engineer
Dr Dolar R. Trivedi
Dr Madhukanta Trivedi

Data of following members has not been updated with AOGS office. So, if anyone has contact details of following members, please ask them to contact AOGS office for their data update.

1) Dr Jolly Dey
2) Dr Shaileshkumar R. Patel
3) Dr Daisy J. Shah
4) Dr Ashit N. Bhatt
5) Dr Prakashkumar L. Naik
6) Dr Darshna A. Patel
7) Dr Ingita A. Chadha
8) Dr Raziyabanu M. Girach
9) Dr Suchi R. Jain
10) Dr Purvi Mehul Parekh
11) Dr Mita D. Singare
12) Dr Ajinkya P Kulkarni

OBITUARY

DR. TANUMATIBEN SHAH

We have lost our Senior member
Dr. Tanumatiben Shah
We convey sincere condolences to her
family and our prayers for the departed soul.

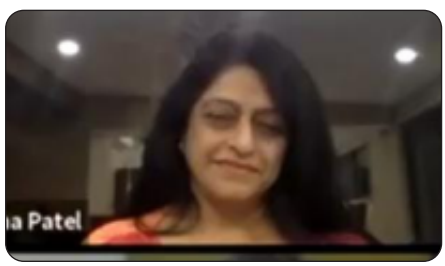
PAST PROGRAMMES

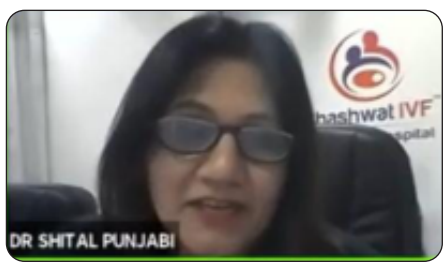
AOGS PG SYMPOSIUM

WEBINAR - I - Date : 06.02.2021

WEBINAR - II - Date : 12.02.2021

PAST PROGRAMMES





PAST PROGRAMMES

Ahmedabad Obstetrics & Gynecological Society

AOGS PG SYMPOSIUM

WEBINAR - 3

Inauguration: 7.30 PM
Welcome Address: **Dr. Rajal Thaker**
Blessings by:
Dr. N T Vani
Dr. Atul Munshi

LIVE WEBINAR

27th Feb 2021, Saturday
7.30 pm to 9.30 pm

SESSION - 1	SESSION - 2
Time: 7.45 - 8.30 pm **Obstetric Case:** Previous CS	Time: 8.30 - 9.15 pm **Gynec Case:** Prolapse
Faculty: **Dr. Ashis Kumar Mukhopadhyay,** CSSMC, Kolkota **Dr. Ajesh Desai,** GMERS, Ahmedabad **Dr. Sushma Shah,** NHLMMC, Ahmedabad **Dr. Shonali Agarwal,** SSGMC, Baroda	**Faculty**: **Dr. Hemant Deshpande,** DYPMC, Pune **Dr. Smruti Vaishnav,** PSMC, Karamsad **Dr. Megha Patel,** NHLMMC, Ahmedabad
Students: GMERS - Sola, Ahmedabad **Dr. Jaydeep Chaudhari** **Dr. Hardi Shukla** **Dr. Bhumika Dobariya** **Dr. Disha Patel**	**Students:** NHLMMC, SVPIMSR, Ahmedabad **Dr. Fiza Saiyad** **Dr. Ronak Bhankhar** **Dr. Raj Mehta** **Dr. Prachi Shelat** **Dr. Bintu Dadhaniya**

Vote of Thanks: **Dr. Sunil Shah**

President
Dr. Rajal Thaker

Honorary Secretary
Dr. Sunil Shah

Co-ordinator
Dr. Munjal Pandya | Dr. Shashwat Jani | Dr. Parth Shah | Dr. Kirtan Vyas

WEBLINK: https://scienceaboveall.com/AOGS/sunpharma/

Educational partner

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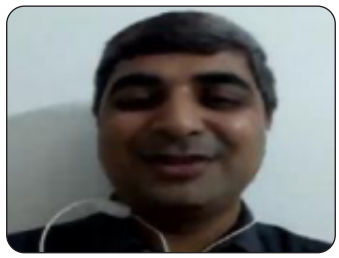
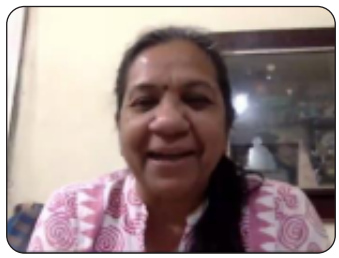
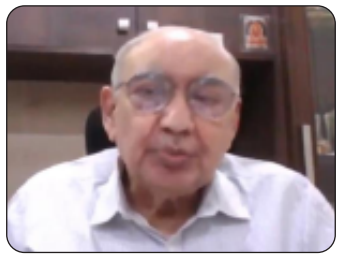

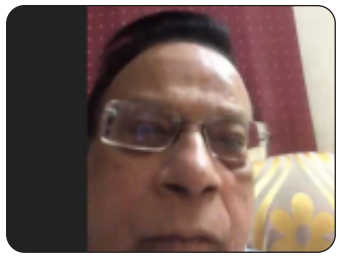






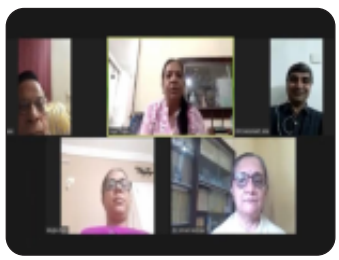

PAST PROGRAMMES

Ahmedabad Obstetrics & Gynecological Society

AOGS PG SYMPOSIUM

WEBINAR - 4

Inauguration: 7.30 PM
Welcome Address: **Dr. Rajal Thaker**
Blessings by:
Dr. Smruti Rawal
Dr. Ajit Rawal

LIVE WEBINAR

1st March 2021, Monday
7.30 pm to 9.30 pm

SESSION - 1	SESSION - 2
Time: 7.45 - 8.30 pm **Obstetric Case:** Multifetal Pregnancy	Time: 8.30 - 9.15 pm **Gynec Case:** Ca Cervix
Faculty: **Dr. Mukul Shah,** GCS, Ahmedabad **Dr. Purvi Patel,** SSGMC, Baroda **Dr. Rekha Wadhwani,** GMC, Bhopal	**Faculty**: **Dr. Pariseema Dave,** GCRI, Ahmedabad **Dr. Priya Ganesh Kumar,** Past HOD Preventive Oncology CRWH, Thane **Dr. Yashodhara Gaur,** GRMC, Gwalior
Students: NHLMMC, SCL, Ahmedabad **Dr. Dimple Gandhi** **Dr. Bhumi Zalawadia** **Dr. Paresh Panchal** **Dr. Farheen Diwan**	**Students:** NHLMMC, SVPIMSR, Ahmedabad **Dr. Dipal Shah** **Dr. Bhavi Shah** **Dr. Aishwarya Gupta** **Dr. Zalak Patel** **Dr. Nidhi Patel**

Vote of Thanks: **Dr. Sunil Shah**

President: **Dr. Rajal Thaker**
Honorary Secretary: **Dr. Sunil Shah**

Program Coordinators
Dr. Munjal Pandya | Dr. Shashwat Jani | Dr. Kirtan Vyas | Dr. Parth Shah

WEBLINK: https://scienceaboveall.com/AOGS/sunpharma/

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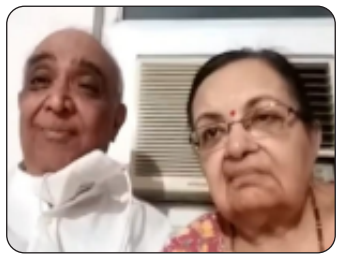


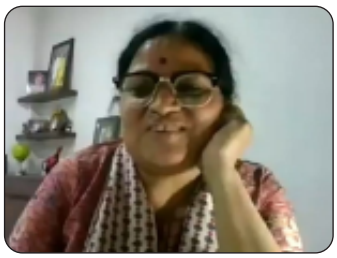
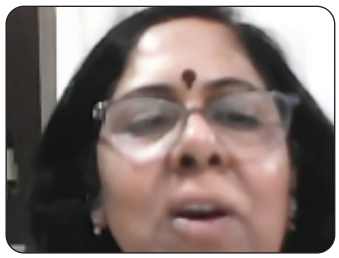
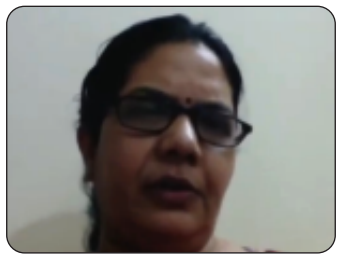


PAST PROGRAMMES

Ahmedabad Obstetrics & Gynaecological Society

AOGS PG SYMPOSIUM

WEBINAR - 5

Inauguration: 7.30 PM

Welcome Address: **Dr. Rajal Thaker**

Blessings by:
Dr. Kalaben Parikh
Dr. Manoranjna Shah

LIVE WEBINAR

4th March 2021, Thursday
7.30 pm to 9.30 pm

SESSION - 1	SESSION - 2
Time: 7.45 - 8.30 pm **Obstetric Case:** Breech	Time: 8.30 - 9.15 pm **Gynaec Case:** Ca Ovary
Faculty: **Dr. Muralidhar Pai,** MAHE, Manipal **Dr. Rohit Jain,** GMERS, Gandhinagar **Dr. Shonali Agarwal,** Medical College, Baroda	**Faculty**: **Dr. Ava Desai,** Gynaec Onco, Ahmedabad **Dr. Nisha Singh,** KGMU, Lucknow **Dr. Bijal Patel,** GCRI, Ahmedabad
Students: LG, AMC, MET, Ahmedabad **Dr. Gira Dabhi** **Dr. Neha Ninama** **Dr. Vibhuti Kotiya** **Dr. Ekta Bariya**	**Students:** B J Medical College, Ahmedabad **Dr. Veeni Kaithwas** **Dr. Janki Shingadia** **Dr. Vedi Shah** **Dr. Sneha Patel** **Dr. Bansi Popat**

Vote of Thanks: **Dr. Sunil Shah**

President: **Dr. Rajal Thaker**

Honorary Secretary: **Dr. Sunil Shah**

Program Coordinators

Dr. Munjal Pandya | Dr. Shashwat Jani | Dr. Kirtan Vyas | Dr. Parth Shah

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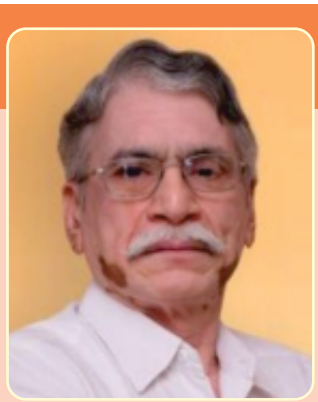
FUTURE PROGRAMMES

14 MARCH, 2021
SOGOG AOGS - WEBINAR

સંભારણા SERIES EPISODE - 4
with Dr R K Shah
Date : 21/3/2021 I 10:30 am onwards

FUTURE PROGRAMMES



AICOG 2000 Oration

Dr M C Patel

Topic : Land mark Judgements those Shaped Clinical Practice

Date : 12.03.2021 I Time : 08.30 pm

- CONSULTANT OBSTETRICIAN ,GYNAECOLOGIST AND MEDICO LEGAL COUNSELLOR
- VICE PRESIDENT,FOGSI 2018
- ORGANIZING SECRETARY,AICOG 2017
- CHAIRPERSON ,ETHICS AND MEDICOLEGAL COMMITTEE FOGSI 2011-2013
- HON.JOINT SECRETARY,STATE ORGANISATION OF GYNAECOLOGIST AND OBSTATRICIAN OF GUJARAT 2019 -21
- ORG.CHAIRPERSON, M M CON 2018
- HON.MEMBER,NATIONAL INSPECTION AND MONITORING COMMITTEE,PNDT ACT GOVT. OF INDIA 2015
- HON. MEMBER, STATE SUPERVISORY BOARD, PNDT COMMITTEE, GUJARAT STATE 2005-09
- PRESIDENT , AHMEDABAD OBST/GYNAEC SOCIETY 2010-11
- HON.MEMBER ,NATIONAL MANAGING BODY,INDIAN RED CROSS SOCIETY (HEAD QUARTER)2019-22
- NATIONAL PRESIDENT,NATIONAL MEDICOS ORGANISATION 2016-18
- PRESIDENT, IMA AHMEDABAD BRANCH 2007-08
- HONARARY SURGEON, INDIAN RED CROSS EYE BANK, COLLECTED MORE THAN 1000 EYE PAIRS
- ORGANISING CHAIRPERSON ,VIVEKANAND NMO CON 2013
- PRESIDENT,LIONS CLUB GHATLODIA, AHMEDABAD 1997-98
- CONVENOR, AHMEDABAD JILLA,BJP DOCTORS' CELL 1995-98

March 14, 2021

Gynaec Onco Update

CIMS Hospital, GMERS, Sola, Ahmedabad,
AOGS and SOGOG jointly organised JIC 2021

(Joint International Conference)

Gynaec Onco Update on March 14, 2021 (Sunday) :
Best of Both Worlds Conference

(At Radisson Blue Ahmedabad)

Be a Part of JIC 2021.

Timing : 9.00 am Onwards.

For Reg. https://cutt.ly/dk1Y271 outtakty and Details Call on :

Mr. Ketan Acharya : +91 9825108257

Mukesh Gohel : +91 9427026374

Note: Only first 100 registration will be allowed

Painting by Dr. Parimal Panchal