स्पंदन AOGS

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BULLETIN

AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

NEWS LETTER I JANUARY 2018

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Ahmedabad | Rajkot | Surat | Udaipur

TEAM AOGS MESSAGE

TEAM AOGS MESSAGE

Dr. Hemant Bhatt
President

Dr. Jignesh Deliwala
Hon. Secretary

અંતમાં આરંભ અને આરંભમાં અંત, પાનખરના હૈયામાં ટહુકે વસંત
સોળ વરસની વય, ક્યાંક કોયલનો લય,
કેસૂડાંનો કોના પર ઊછળે પ્રણય ? ભલે લાગે છે રંક પણ ભીતર શ્રીમંત,
પાનખરના હૈયામાં ટહુકે વસંત
આજે તો વનમાં કોના વિવાહ, એક એક વૃક્ષમાં પ્રકટે દીવા.
આશીર્વાદ આપવા આવે છે સંત, પાનખરના હૈયામાં ટહુકે વસંત.
- નરેન્દ્ર મોદી
(આદરણીય પ્રધાનમંત્રી શ્રી)

Respected Seniors & Dear Collegues,

Rainbow greetings on the colorful festival of Vasant Panchmi - the ever energizing season of spring.

Over the last month, we witnessed the mega show of SOGOG Annual Conference with more than 600 registrations. In shortest time of 15-20 days, we alongwith MOGSO could organise a grand show of Acaedemics & Entertaintement.

A noble program of "Save the Girl Child" & "Beti Vadhavo & Beti Padhavo" campaign on 1st day of conference at Vastrapur lake was attended by more than 500 school & college girls. The inspiring presence of CDHO - Madam Shilpa Yadav & well known social activist Smt.Ruzan Khambhatta was also appreciated by all & sundry. With more than 45 stalls - we could get wonderful support from Pharma industry as well. With great acaedemics, attractive conference kit of trolly bag worth of 3500/- Rs. & memorable entertainment show of versatile singer Shri Osman Mir, everybody got much much more than what they paid for the conference.

The splendid atmosphere of bonhomie & brotherhood between member societies was a great achievement, we accomplished with MOGSO. (Mehsana Gyn. Society)

We hope that our efforts of creating a wonderful begining of more hope & aspirations & cementing further ties with member societies in SOGOG will deliver the fruits to all the members of SOGOG in coming years.

Next month, we are organising PG lecture series, a visit to ISRO & IIM, a heritage walk & our AOGS election. All the details are given in this bulletin, regarding these programs.

ADIOS....

YUVA ISAR IN ASSOCIATION WITH AOGS DONE ON
15TH, 16TH, 17TH DECEMBER,2017

SOGOG WORKSHOP - 5TH JANUARY 2017- 2018

SOGOG CONFERENCE - 6TH & 7TH JANUARY 2017- 2018

SOGOG CONFERENCE - 6TH & 7TH JANUARY 2017- 2018

SOGOG - ENTERTAINMENT PROGRAM ON 6TH JANUARY, 2018 BY VERSATILE SINGER SHRI OSMAN MIR

AOGS - AMA PG LECTURE SERIES 2018

Venue : Jagmohan Parikh Hall, AMA, Ashram Road, Ahmedabad

Date : 01.02.2018 to 08.02.2018

Date	Session 1 7.30 pm - 8.30 pm	Break 15 min.	Session 2 8.45 pm - 9.45 pm
01.02.2018 Thursday	**Male Infertility** Dr. C. B. Nagori		**PCOS** Dr. Manish Banker
02.02.2018 Friday	**Ca Cervix** Dr. Meeta Mankad		**Difficulties in LSCS** Dr. Parul Kotdawala
05.02.2018 Monday	**Gestational Trophoblastic Neoplasia** Dr. Ava Desai		**Diabetes in Pregnancy** Dr. Sanjiv Phatak
06.02.2018 Tuesday	**Ovarian Tumors** Dr. Pariseema Dave		**Endometriosis** Dr. Tejas Dave
07.02.2018 Wednesday	**Ca Endometrium** Dr. Shilpa Patel / Dr. Bijal Patel		**Doppler in FGR** Dr. Girish Patel
08.02.2018 Thursday	**Primary & Secondary Amenorrhoea** Dr. Ajesh Desai		**Multiple Pregnancy** Dr. Mayank Chaudhary

Programe Co-ordinators : Dr. Rajal Thaker, Dr. Pragnesh Shah, Dr. Shashwat Jani

Celebration of The Biggest Festival of Democracy - Election

Ahmedabad Obstetrics and Gynaecological Society

Electoral Notification 2018-19

The nominations are invited on prescribed form for the following posts of Ahmedabad Obstetrics and Gynaecological Society for the year 2018-19.

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	Nine

ELECTION RULES

1. Please use enclosed prescribed form only. Nomination on and in any other form will be considered invalid. Nomination forms will be available from AOGS office.
2. Important dates for election:
1. The duly filled nomination form with required nomination fees should reach AOGS office between **04/02/2018 to 08/02/2018 before 5:00 p.m.** (on working day).
2. Last date for withdrawal is **09-02-2018, by 5:00 p.m.**
3. Scrutiny of forms by managing committee on **09-02-2018, 9:00 p.m.**
4. Election on **16/02/2018, 7:30 p.m. to 10:30 p.m.** with Annual General Body Meeting **at AMA Building, Ashram road, Ahm.**
3. A member can contest for managing committee, only after completing one year membership in Ahmedabad Ob. Gyn. Society and must have attended at least one GBM (General Body Meeting).
4. A member can contest for the post of office bearer after completing at least one year's tenure of the managing committee of AOGS and he must be a life member of AOGS.
5. A member can contest for the post of the Treasurer only after completing at least Two year as a member in the managing committee of AOGS.
6. Any member contesting for the post of President Elect or Vice President must have completed at least one term as Office Bearer.
7. President – Elect will be the president for year 2019-2020.
8. A member who has served as president of AOGS can not contest for the post of Treasurer.
9. The tenure of each post is of one year.
10. No member shall remain on the same post for more than three (3) consecutive terms including the membership of managing committee.
11. Membership subscription and past dues of the proposer, seconder and the candidates if any must be received by the office before 09/02/2018.
(Annual membership fee is 3000/-, Life Membership fees -17000/-, Admission fee for new member is 500/-) + GST
12. A member can contest for the one post only. In case of valid nominations for more than one post all nominations shall be considered invalid.
13. Nomination fees (non refundable) for the post of managing committee member is 1000.00 and for the post of office bearers is 1500.00.
14. No canvassing material of any kind, in any form, in any way is permitted or allowed in election area.
15. Person found with canvassing material will be disqualified for voting.
16. In case of any kind of dispute the decision of a casting vote of president would be final.

Dr. Jignesh Deliwala
Hon. Secretary

AN ARTICLE ON ENDOMETRIOSIS - BY DR. TEJAS DAVE

When endometrial tissue implants and grows outside the uterus, it is called ENDOMETRIOSIS.

Endometriosis can develop anywhere in the body apart from spleen , but they usually occur in the pelvic area.

When found outside the pelvis, it is termed extra genital endometriosis.

Common sites are intestinal, urinary tract, abdominal wall, perineal area (either abdominal scar or episiotomy scar). Other sites rare but includes liver, thorax, pleura, nasal cavity and so on….

Associated theories-

There are many theories for endometriosis; few of them are as follows:

(a).Mesenchymal cells with retained multipotential may undergo metaplasia into endometriosis

(b).Endometrial cells may be transported to ectopic sites forming an endometrioma. When stimulated by estrogen, these cells may proliferate till they become symptomatic.

(c).In case of a Caesarean section the usual cause is the needle passing through the endometrium and transplanting endometrial tissue in the abdominal wall when it is being stitched with the same needle.

A.Bowel Endometriosis—

Incidence 3-34%

It may affect any portion of the gastrointestinal tract and can present with multiple sites of involvement in either a single lesion with small satellite lesions surrounding or as isolated nodules. True multifocal involvement has been observed in 15-35 % cases.

The most frequent site of bowel involvement is the rectum including the rectosigmoid segment, accounting for 70-88% of cases, followed by the sigmoid colon, ileum, appendix and cecum. The small intestine is less frequently involvedInvolvement of the bowel and rectovaginal septum usually occurs in conjunction with deep infiltrating endometriosis (DIE). This severe form of disease almost invariably involves the uterosacral ligaments and may also affect the ureters and bladder.

DIE Implantation of stroma and/or glandular epithelium outside endometrial cavity and uterine musculature, penetrating into retroperitoneal space or the wall of the pelvic organs to a depth of more than 5 mm .

Histopathology & Clinical significance

Endometriosis of the bowel varies in extent of involvement from microscopic foci of disease to large space-occupying lesions. These larger lesions can invade the bowel wall resulting in significant narrowing of its lumen although such extensive disease is fortunately rare.

Endometriosis of the bowel typically involves the serosa and muscularis propria, rarely involving the submucosa or mucosa. Endometrial implants are usually found in the anti-mesenteric edge of the bowel.

Differential diagnosis:

Inflammatory diseases (such as Crohn's),

Diverticulitis; Radiation colitis,

Ischemic colitis and stricture,

Malignancies of the gastrointestinal tract,

Symptoms:

Endometriosis limited to the bowel serosa may be asymptomatic.

Commonly reported symptoms are pelvic pain, dyspareunia and low back pain. It occurs in conjunction with menstrual period.

Other complains are painful defecation, tenesmus, cyclic hematochezia, a change in bowel habits (diarrhea, constipation, hyperperistalsis, flatulence), rectal bleeding. Rectal pain and painful defecation are generally more prevalent when the rectum is involved with disease.

Examination:

Physical findings are variable and depend upon the specific location and size of the implants. The most common finding is Nodularity and Localized tenderness in the cul-de-sac. Adherence of the rectal wall to the cul-d e-sac is possible and often more prominent on bi-digital examination. A recent study has suggested that transvaginal ultrasound is more useful in detecting rectosigmoid endometriosis than vaginal examination

Investigations:

Transvaginal sonography (TVS), Transrectal sonography (TRS), Double contrast barium enema (DCBE) ,Magnetic resonance imaging (MRI) are the modalities to be used to investigate intestinal endometriosis.

Intestinal endometriosis will appear on sonography as an irregular hypoechoic mass, with or without hypoechoic or hyperechoic foci, penetrating into the intestinal wall. The hypoechoic lesion corresponds to a layer of hypertrophic muscularis propria and may be surrounded by a hyperechoic rim corresponding to the mucosa and submucosa.

TVS alone is 91% sensitive and 98% specific for the detection of deep infiltrating endometriosis of the rectosigmoid.

Inability to determine the exact distance of rectal lesions from the anal margin or to determine the precise depth of rectal wall involvement. Lesions above the rectosigmoid junction are beyond the field of view

TRS

TRS has the potential to evaluate the extent of involvement of the muscularis propria of the bowel, the largest diameter of smaller lesions within view, the distance of a lesion from the anus and the infiltration of adjacent pelvic organs. Sensitivity and specificity for detection of intestinal lesions is similar to that of TVS ranging in different studies from 88-96% and 80-100% respectively.

However, as with TVS, examination of the upper part of the colon is not possible. The technique is not as widely used and the quality and predictive value of the images is dependent on the experience of the sonographer.

TVS is cost-effective, familiar and does not require anesthesia. It should be considered as a first line modality for any patient suspected of endometriosis. If bowel involvement is suspected, the requesting physician should take care to inform the radiologist of the particular concern and thus direct imaging accordingly. MRI or Multi Slice Computed Tomography Enteroclysis can be used in selected cases.

MRI

MRI of deeply infiltrating intestinal endometriosis affecting the rectosigmoid can be challenging. The anatomical area in question is relatively small

and includes several thin fibromuscular anatomic structures such as the uterosacral ligaments, as well as the vaginal and rectal walls. The endometriotic lesions are themselves fibromuscular structures and thus have similar MRI signal intensity to the anatomy surrounding them. Various methods can be used to aid in delineation of lesions on MRI including an endoluminal coil positioned in the rectum or insertion of vaginal and rectal contrast

Multislice Computed Tomography Enteroclysis (MSCTe)

Newer imaging techniques are being explored including the use of multislice computed tomography (CT) combined with colon distension by water enteroclysis in determining the presence and depth of bowel endometriotic lesions. A prospective trial involving 98 women established a sensitivity of 98.7% and a specificity of 100% for this method in identifying women with bowel endometriosis. Subsequently, MSCTe was found to have similar accuracy in the diagnosis of rectosigmoid endometriosis when compared to rectal water contrast TVS.

TREATMENT:

Role of medical management is supportive one.

SURGICAL TREATMENT is the choice of treatment depending upon the severity of the disease.

Surgical Treatment Options—

Laser Ablation

Use of the CO2 laser for treatment of deep rectosigmoid colon and rectovaginal septum endometriosis was reported as early as 1992 by Nezhat.

Techniques such as hydrodissection and new technology including a super pulsed laser allow for removal of adherent endometriotic implants without damage to underlying normal tissue. Unfortunately, few gynecologists or general surgeons are trained in the use of CO2 laser despite its obvious benefits in the treatment of endometriosis. Diathermy excision should be used with caution as thermal damage to the bowel may result in a delayed postoperative fistula or other complication.

Shave Excision

Superficial rectovaginal endometriosis can be shaved off the rectal wall while leaving the mucosa intact. The most distal peritoneal attachments of the rectum on both the anterior and lateral aspects are incised to enable access to the extraperitoneal rectovaginal septum. The endometrial implant is then dissected free from the anterior rectal wall and the posterior vaginal wall. The extraperitoneal rectal wall lacks the outer serosal lining and is comprised of mucosa, submucosa, muscularis propria and peri-rectal fat. If the dissection is maintained as superficial then bowel integrity will not be compromised. If Endometriosis is deep, the dissection requires resection of a portion of the muscularis propria, the surgeon should reinforce any defect with laparoscopically placed sutures to diminish the risk of postoperative bowel perforation. Mechanical or thermal damage to the mucosa should be avoided. Visual inspection with proctoscopy after completion of the excision and an air leak test can ensure that no inadvertent proctotomy exists.

Distal Small Bowel, Ileo-Colic and Right Hemicolon Resection

Sigmoid Colon Resection

Anterior and Low Anterior Resection of the Rectum

Appendectomy

B.URINARY TRACT ENDOMETRIOSIS

Presence of functional endometrial tissue within URINARY TRACT is called URINARY TRACT ENDOMETRIOSIS.

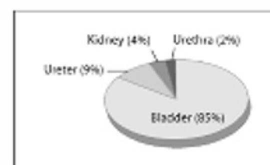


Fig. 1. Relative frequencies of UTE localization.

It occurs in < 2% of all patients with endometriosis. It is seen in post menopausal women receiving exogenous estrogen. It is usually present in the posterior wall of bladder above trigone or at dome

Bladder Endometriosis---Primary, secondary

SYMPTOMS:

The most frequent presenting complaints are: urgency (78%), frequency (71%),suprapubic pain (43%), urge incontinence (21%),dyspareunia (21%).

Symptoms, when present, mimic those of recurrent cystitis,

DIAGNOSIS:

TAS and TVS are the initial investigation of choice in evaluation of suspected bladder endometriosis due to immediate availability and easy access.

adequate in determining the site and size of lesion, the degree of infiltration of detrusor and mucosa, and the relationship with concomitant adenomyosis of the uterus

MRI can be used in selected cases. does not only delineate the morphologic abnormalities of bladder endometriosis but can also potentially identify other common sites, particularly at the uterosacral ligaments, where ultrasound is less reliable

Cystoscopy is useful modality. Cystoscopy is able to visualize the endometriosis foci only when present on bladder mucosal surface, but is unable to define the extent of endometriosis lesion. BLADDER MUCOSA APPEARS BLUE OVER THE DISEASE.

TREATMENT:

Surgical removal of the lesion.

C.ABDOMINAL WALL, PERINEAL AREA ENDOMETRIOSIS(SCAR ENDOMETRIOSIS)

ABDOMINAL WALL ENDOMETRIOSIS

After CS, TL , Hyesterotomy, Hyesterectomy

PERINEAL ENDOMETRIOSIS

After Episiotomy.

Incidence

Abdominal wall endometriosis is rare, with an incidence of 0.03-0.47% following a Caesarean delivery

It is difficult to diagnose as the symptoms may be non-specific.

Presentation

96% of the patients presented with a mass, 87%presented with pain ,57% presented with cyclic symptoms.

Diagnosis

Ultrasonography is usually the first choice, where the mass appears hypoechoic and heterogeneous with scattered internal echoes. Some of the masses appear completely solid on sonography but occasionally some cystic changes may be seen.

CT may be useful

Endometriosis has no pathognomonic findings on CT, as appearances depend on the phase of the menstrual cycle, the proportions of stromal and glandular elements, the amount of bleeding, and the degree of surrounding inflammatory and fibrotic response.

Owing to the relatively vascular nature of these lesions, enhancement often occurs on CT scans when intravenous contrast material is used

FNAC under ultrasound guidance may be able to make pre-operative diagnosis but if it is inconclusive, core biopsy may be done

Differential Diagnosis

Suture granuloma , Incisional hernia, primary or metastatic tumour

Treatment

SURGICAL EXCISION IS THE ONLY TREATMENT.

It has cure rate 95%, Recurrence rate is 4.3%.

Synchronous endometriosis

Synchronous multiple site extragenital endometriosis remains a rarity with only one case described of a patient with both ureteral and pulmonary endometriosis.

31-year-old Gravida 0, Caucasian female presented with complaints of catamennial dysuria of 1-year duration, catamennial pleurisy associated with spontaneous pneumothoraces of 7-month duration and a longstanding history of pelvic pain and endometriosis.

severe dysuria with her menstrual periods, of almost 1-year duration.

7 months prior to presentation and in addition to cyclic dysuria, she suffered the first episode of shortness of breath and pain with inspiration at the onset of her menses

Evaluation at that time in the emergency room including a chest radiogram, revealed a 10% apical pneumothorax on the right lung.

gynecologic history was notable for endometriosis diagnosed and treated laparoscopically approx. 10 years back

Speculum examination however, was notable for a blue-purple lesion at the posterior fornix.

During bimanual and rectovaginal examination, marked uterosacral ligament and rectovaginal septum nodularity and tenderness were noted.

Conclusion:

A VISIT TO PRESTIGIOUS INSTITUTE NID ON 12TH JANUARY, 2018

60 MEMBERS PARTICIPATED WITH THEIR FAMILY & FRIENDS

SOGOG ANNUAL CONFERENCE
SOCIAL PROGRAMME - BETI PADHAO-BETI VADHAO
6TH JANUARY, 2018

PCOS PROGRAMME - 13TH FEBRUARY, 2018

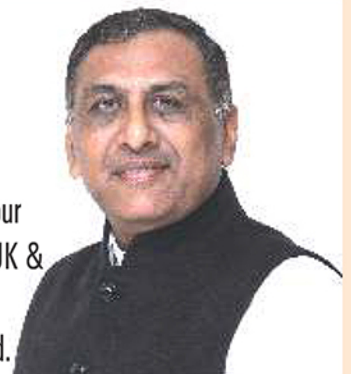
An awareness programme on PCOD & Safe motherhood will be held
on 13th Feb, 2018, Tueasday at 4:00 pm at R.M. Fozdar Hall, AMA.
Madam Sasha Ottey, the international crusader for problem of PCOS, the founder & executive director of PCOS challenge inc. - will grace this public awareness programme.
This programme is jointly organised with AOGS, AMA & SEWA (NGO). Divya Bhaskar is actively supporting this event.
For answering public questions on safe motherhood :
Dr. Kanthi Bansal, Dr. Hemani Bhatt, Dr. Jignesh Deliwala, Dr. Rajal Thaker,
Dr. Manish Banker, Dr. Alpesh Gandhi & Dr. M.C. Patel will remain present.
Chief Co-Ordinator : Dr. Snehal Kale

PG FORCE - 2018

FOGSI Force 2018 will be held on 17th & 18th March along with
AOGS at GCS Medical College, Amdupura, Naroda.
Details of the Programme will be publised in next bulletin.

Heartly Congratulations to

Dr. Mahesh Gupta



for getting compliments from Professor Rogson (a world authority on abnormal placentation) for your COMOC-MG technique to control atonic PPH & Its frequent use at Turnbridge Wells Hospital, Kent, UK & few other hospitals in different parts of England.
We appreciate the letter of compliment from Dr.Dib Datta from Turnbridge Wells Hospital, England.

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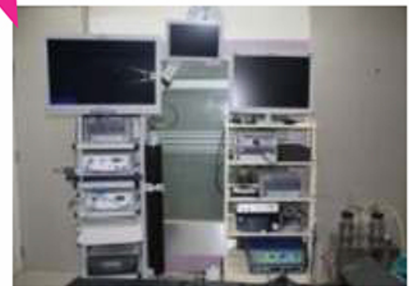

EVA Hospital offers one step solution to all gynaecology and onco-gynaecology problems treated by exclusive laparoscopy.

We proudly announce another milestone of Dr. Dipak Limbachiya in the journey towards excellence that Dr.Dipak Limbachiya received prestigious award at Annual British Society for Gynaecological Endoscopy conference held at Hull, United Kingdom on 18 & 19 May 2017.

for presenting 3 videos,

1. Laparoscoic reversal of sterilization
2. Complications of laparoscopy: A decade of experience
3. A laparoscopic retrieval of a foreign body(broken surgical knife) from retroperitoneal space: An interesting case.

**For video Watch
http://bsge.org.uk/video-library/**

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All India Fertility & IVF Ranking Survey - 2018

HAT TRICK!

2016, 2017 Now **2018**

AHMEDABAD

→ **Mumbai Institute**
Mumbai: 3rd
Western India: 6th

→ **Delhi Institute**
Delhi NCR: 7th
Northern India: 10th

→ **Kolkata Institute**
Emerging Institute
in 2018

(i3RCinsights Survey)

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Dr. Himanshu Bavishi M.D.

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