AOGS BULLETIN

AHMEDABAD OBSTETRICS
AND GYNAECOLOGICAL SOCIETY

NEWS LETTER | July 2019

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OUR MOTTO :

PRACTICE WITH PROTOCOL

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GYNAECOLOGICAL SOCIETY

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TEAM AOGS MESSAGE

Dr. Anil Mehta
President

Dr. Mukesh Savaliya
Hon. Secretary

તમે મન મૂકી વરસો, ઝાપટું આપણને નહીં ફાવે,
અમે હેલીના માણસ, માવઠું આપણને નહીં ફાવે.

કહો તો માછલીની આંખમાં ડૂબકી દઈ આવું,
પણ આ છીછરું ખાબોચિયું આપણને નહીં ફાવે.

તું નહીં આવે તો એ ના આવવું પણ ફાવશે અમને,
ઘરે આવી, તારું પાછું જવું, આપણને નહીં ફાવે.

- ખલીલ ધનતેજવી

Season's greetings

We all were eagerly waiting for rain and fortunately it has started.

First week of August is celebrated as Breastfeeding week, to create awareness amongst women.

"That's one small step for us, one giant leap for mankind"

We are organizing a wonderful HRPCON 2019 Conference. It is our humble request to all to register for the same, if not done yet.

"Family is the most important thing in the world : Diana, Princess of Wales"

So Let us all unite and live as AOGS Family.

Dr. Anil Mehta
President AOGS

Dr. Mukesh Savaliya
Hon. Secretary AOGS

AOGS PG SYMPOSIUM - DATE : 06.07.2019











CME : 10 - DATE : 07.07.2019











CME : 11 - DATE : 14.07.2019












CME : 12 - DATE : 21.07.2019












CME : 13 - DATE : 23.07.2019












FOGSI CONFERENCE ON HIGH RISK PREGNANCY

CONFUSION TO CONCLUSION

Venue :
Eka club,
Kankariya,
Ahmedabad

Dates :
30th, 31st August &
1st September, 2019

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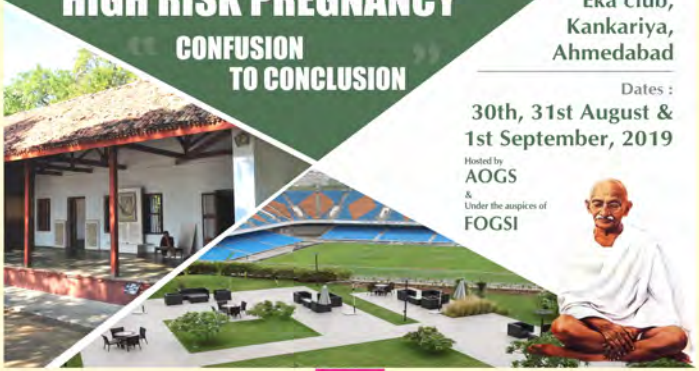

Post Menopausal Bleeding P/V - Management - Dr. Kalpana Kothari

Compiled by : Dr. Lata Trivedi

Post menopausalbleeding per vagina is a common symptom with which a patient can present to a gynaecologist. It is important to know that 90 % of these cases have a benign cause for this symptom but 10% will have cancer of reproductive tract. It is very important to identify these patients by doing proper investigations. It is very important to elicit proper personal and family history of cancer. While examining the patient a thorough general examination must be done which should include a breast examination, per speculum examination and a bimanual pelvic examination. Investigations begin by taking a pap smear which should include an endo cervical brush smear as in postmenopausal patients the transformation zone has receded inside the endocervical canal.

Result of pap smear may be suggestive of Pre invasive or invasive carcinoma of cervix.
If diagnosis is pre invasive lesion then a conservative treatment can be offered to the patient. LSIL is treated by evaporation and HSIL is treated by conisation – either by Laser or LLETZ and then ask the pathologist to look for margins which have to be free. It margins are positive than a reconisation has to be done. If it shows micro invasive carcinoma or invasive carcinoma than the management is Radical Hysterectomy with Bilateral Pelvic lymph node dissection after proper staging which is done by examination under anaesthesia and MRI pelvis with scanning of upper abdomen and pre-op blood workup.

If smear is normal, a sonography is done to rule out endometrial or ovarian tumors. If on USG endometrial abnormality is seen fractional D&C is done. If endometrial biopsy is positive than MRI pelvis is done and after proper staging extended hysterectomy with bilateral pelvic node dissection with / without para aortic node dissection is done depending on stage of endometrial carcinoma.

If on sonography we see an ovarian mass which is characterised as malignant then a CT Scan is done. Advanced ovarian tumor causing infiltration of uterus or an early / late stage granuloma cell tumor can cause post menopausal bleeding per vagina. If the disease is staged as IIIA/IIIC epithelial ovarian tumor and it seems possible to resect all visible disease than "Complete cytoreductive surgery" followed by "HIPEC" (Hyperthermic intraperitoneal chemo therapy) can be offered. If it does not seem feasible to remove all disease than neo adjuvant chemotherapy (NACT) is given followed by surgery and HIPEC. Same principles are applicable to granulose cell tumor, but usually these patient present early and so direct surgery is offered. In advanced disease NACT is followed by complete cyto reductive surgery but HIPEC has no proven role.

Vulvar cancer can also rarely be a cause of Post menopausal Bleeding and Radical vulvectomy with bilateral groin node dissection is done.

Role of Radiotherapy in Carcinoma of Cervix - Dr. Kinjal Jani

Compiled by : Dr. Lata Trivedi

Carcinoma of cervix is usually treated by Surgery, Radiotherapy and Chemotherapy. According to the type of the tumor & stage of the tumor, the treatment is decided in a multidisciplinary team. Radiotherapy is treatment of tumors with ionizing radiation. Radiotherapy for carcinoma of cervix is usually divided in to two techniques: Teletherapy (External Radiotherapy) and Brachytherapy (Internal Radiotherapy). Cobalt machines were used traditionally to deliver external radiotherapy. This conventional radiotherapy used to have more side effects. Then came Linear Accelerator machines, which are more precise than Cobalt machines. In last 50 years there has been tremendous development in the field of Radiotherapy to reduce complications and achieve higher tumor control. Nowadays we have highly conformal and accurate treatments like 3D Conformal Radiotherapy, Intensity Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Tomotherapy.

Carcinoma of Cervix is usually diagnosed after good local examination & biopsy report. Patients need to undergo blood investigations and radiological investigations like MRI of Pelvis, CT Scan / PET CT scan for proper staging of cancer. The FIGO staging for Ca Cervix was updated in 2018, with addition of stage IIIC for LN metastasis. If pelvic LNs are positive then it is Stage IIIC1 and if para aortic LNs are positive then it is stage IIIC2.

Early stage Cancer Cervix is usually treated by Surgery. For any stage of Cancer Cervix Radiotherapy can be used as a curative modality. Radiotherapy is usually given to cervix, uterus, external iliac LNs, internal iliac LNs, obturator LNs upto common iliac LNs with external radiotherapy. All patients are then given brachytherapy (intracavitary) to give higher doses to cervix and para cervical tissues. If patients parametrium also needs to be given higher doses we use Interstitial Brachytherapy. For stages IIB onwards concurrent Radiotherapy + Chemotherapy (Cisplatin/Carboplatin) is used. If patients have para aortic LNs positive then extended field radiotherapy is used to cover para aortic LNs. For post operative patients we may need to give adjuvant radiotherapy if patients have larger tumor, more stromal invasion, LVSI invasion, margin positive or LN metastasis.

Acute side effects of Radiotherapy are GI disturbances in form of nausea, vomiting and loose motions. Burning micturition, burning in defecation, skin rashes are also common acute complications. Late complications include cystitis, proctitis, fibrosis, stricture etc. With newer techniques like IMRT, IGRT & Tomotherapy the complications are much lesser than conventional radiotherapy.

Ian Donald Congress on Updates in Infertility and Ultrasound.

Register Now

21st 22nd September 2019

Venue : Hotel Crowne Plaza, Nr. Shapath 5, S. G. Highway, Ahmedaba

Prof. Asim Kurjak (Croatia)

Dr. Lara Spalldi Barisic (Croatia)

National Faculties

Dr. Jaideep Malhotra
Dr. Narendra Malhotra
Dr. Jatin Shah
Dr. Pankaj Talwar
Dr. Gautam Khastgir
Dr. Manish Banker
Dr. Rajan Vaidya
Dr. Neena Malhotra
Dr. Archana Baser
Dr. Chaitanya Nagori
Dr. Durga Rao
Dr. Sonal Panchal

Organizing Chairperson :
Dr. Chaitanya Nagori

Organizing Secretary :
Dr. Sonal Panchal

Program overview

21st September	9.00am- 1.30pm	: **3D-4D hands on workshop**
	3.00pm - 6.00pm	: **Academic Sessions** **Followed by oration by Prof. Asim Kurjak and Inauguration**
22nd September	9.00 am - 5.00 pm	: **Academic Sessions**

Registration

	Before 31st August	After 31st August
workshop	2500	3000 (only if available)
conference	3500	4000
Workshop + Conference	5000	6500
Student Delegates - Conference	2500	3000
Student Delegates - Workshop	2000	2500 (only if available)

Congress Secretariat

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

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

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