AOGS BULLETIN

क्षितिज

Knowledge is Power,
Unity is Strength

AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY
NEWS LETTER I JUNE 2018

AOGS

Aogs Ahmedabad
Our Heritage City Our Pride

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TEAM AOGS MESSAGE

Dr. Jayprakash Shah
President

Dr. Kamini Patel
Hon. Secretary

The Art of Massage and Yoga Therapy is dedicated to making yoga accessible, enjoyable and beneficial for all ages and levels of practice. We hope to improve the quality of life and promote an authentic approach to health and wellness.

Yoga is truly a gift that can last a lifetime.

In this month of June, we undertook two successful CME with a participation of more than 50 delegates in each CME. This month we completed one more GTR program making it in total of six successful GTR programs. International yoga Day was also celebrated with a boom with a good number of participation.
We hope you all can join our Israel trip in October to enjoy the sun in Tel-Aviv and the CME from their best speakers.

"The Older I get, the smarter my father seems to get"

This Father's Day, we thank all the fathers for their selfless supports and for being the back bone of the families.

GTR - Date : 28.05.2018 - V.S. Hospital




Gandhinagar - Date : 05.06.2018




Distribution of Reusable Pads at Mahipatram Rupram Ashram, Date : 13.06.2018




CME - Programmed Labour - Date : 16.06.2018












International Yoga Day - Date : 21.06.2018











CME - Oncology in Gynaec Clinic Date : 24.06.2018











Abstarcts for Onclogy in Gynec Clinic

Nuances in Radiotherapy- Mangement of Cervical Cancer - Dr. Arpana Shukla

Radiotherapy has a vital role in management of cancer cervix . With a paradigm shift in Radiotherapy Technology over last 2 decades with IMRT, IGRT, Adoptive Radiotherapy and 3D Image Based Brachytherapy Better Tumor Coverage and OAR Sparing is feasible which leads to improve locoregional control , improve survival with better Quality of life .

Extended field Radiotherapy and Reradiation are now feasible with proper patient selection and utilising appropriate technology.

Fertility Preservation- A step child in Oncology Dr. Vaishali Desai

As a result of advances in modern treatment, about 50% children and adults becomes long term survivor after cancer treatment. 60-65% of them face treatment related side effects like fertility. Fertility preservation counseling can help the patients retain their future fertility. The session covers different options both medically and holistically to treat/ preserve infertility in cancer patients.

Debate- Robotic Surgery vs Conventional Laparoscopy - Dr. Sujal Munshi

In spite of being a brilliant piece of technology and ergonomic superiority.. the vast difference in the cost of basic investment, cost per surgery and the cost of disposable with no added advantage in terms of safety, efficacy , time and unique complexities involved in terms of anesthesia and docking formalities doesn't justify the use of Da Vinci robot for all gynaec surgeries.

Apart from this there are obvious cosmetic disadvantages and complications unique to this technique which further justify my argument in favor of laparoscopy of current era.

Adnexal Mass - Dr. Neha Shah

Diagnostic Imaging Pathways- Adnexal Lesions.
The session covers structured evaluation of adnexal lesions to allow for improved communication of results and recommendations for follow up or surgical treatment.

Fertility Preservation- A step child in Oncology Dr. Manish Bankar

Fertility preservation is the effort to help cancer patients retain their fertility or ability to procreate. It is thus defined as a method of providing future reproductive opportunities before a medical treatment with known risk of loss of fertility. Oocytes and embryo preservation are now established techniques. Ovarian tissues preservation, though considered experimental at present, has wider clinical application and advantage of keeping fertility window open for a longer time. There is a need for collaboration between oncologists and reproductive specialists to improve awareness.

Algorithmic Approach to Adnexal Mass Dr. Meeta Mankad

Adnexal mass, commonest clinical finding, still poses challenge to clinicians. In spite of advances in radiological investigations and tumor markers, high risk adnexal mass are still missed and nappropriately managed. Though population screening in ovarian cancer is not recommended, there are learning lessons from certain studies, which can be extrapolated to day to day practice.

- Morphological Index is reliable method of following an adnexal mass.
- Normal CA 125 means BENIGN MASS is a MYTH.
- In first 2 decades, Germ cell tumor markers are mandatory.
- Laparoscopy is a safe method for low risk adnexal mass but in case of suspicion on scopy, it should be appropriately treated.
- or ovarian malignancy- laparotomy still remains the Gold Standard.

Programmed Labour - Dr. Manish Pandya

ACTIVE MANAGEMENT OF LABOUR

• Lowered C-section rates • No adverse perinatal effects • Ensures good obstetric outcome • Propagates the concept of safe motherhood (Irish Scheme) Components: -Artificial amnitomy -Oxytocin / P.G stimulation as required -Clinical monitoring – Cervimetric progress hourly -Clinical supervision of FHR -Lobour analgesia Programmed Labour • Three Pillars of Supports • Judicious Use of Oxytocics • Providing pain relief –Analgesia • Synergistic with Antispasmodics • Close Clinical Monitoring of Lobour on PARTOGRAM Use Of Drugs For Pain Relief • Immediate short term relief :PentazocineHCl – 6.0 mg + Diazepam – 2.0 mg • Long term Pain Relief :Tramadol : 50 – 100 mg IM • Supplementation in Advance Labour –SOS • KETAMINE : Continuous infusion Intermitted IV boluses ; Loading Dose – 0.5 mg /kg wt • Maintenance doses : 0.25 mg /kg wt every 30 min

CONCLUSION

- In this study you can see that duration and pain during labour is shorten.
- Rate of LSCS has gone down.
- Neonates are in good Apgar score and no entry into NICU.
- We can adjust our schedule as with this we can programmelabour as well of us.
- I used to inject the remains of Injection Fortwin and Injection Campose into Injection Dextrose 5% and this will give excellent relief of pain in early postpartum period.
- Patient experience is fantastic as number of new delivery is increased in practice.
- Patient attitude towards this protocol is appreciable by both patients as well as relatives.
- It may spread rumors like we make patients sleep and arrest the progress of labour as she in not taking pain while in sleep.

Programmed Labour Summary : Dr. Shirish Daftary and Dr. Munjal Pandya

India is a large country – the facilities for care of pregnant women vary in urban and rural communities.There is a Wide variation in quality and quantum of obstetric care and supervision.

Labour Pain is about the worst suffering that can afflict mankind. It is only humane to provide pain relief in labour. It is the RIGHT of a woman to expect pain relief from her attending obstetrician. The physician is bound by the Hippocratic oath to provide cure, to provide relief and alleviate human suffering.The method of pain relief will depend on available circumstances and training

PROGRAMMED LABOUR is A SCIENTIFIC AND RATIONAL APPROACH TO MANAGEMENT OF LABOUR. It is an Indegenously developed Protocol for Management of labour.

It was extensively evaluated at the Nowrosjee Wadia Maternity Hospital – Mumbai before publishing the data for recommending the same for general adoption. Pain relief during labour spells a humane approach to delivery. It allays fear and anxiety, and provides a more favourable environment for improved obstetric outcome.

- Labour analgesia ensures relief from pain, controls alterations of placental circulation thereby safeguarding the foetus against hypoxia and depression at birth.
- Pain relief prevents maternal hyperventilation and undue muscular efforts which exhaust the mother, ensures periods of restful sleep and willing cooperation .
- Pain relief favours cervical dilation resulting in labours of shorter duration, less traumatic and requiring lesser obstetric interventions.
- For the foetus, programmed labour confers the benefits of shorter and less traumatic labours and freedom from obstetric interventions necessitated by maternal distress. The obstetrician is benefited by having a better control over the events of labour, it ensures prevalence of optimum conditions at the time of delivery.

The PROGRAMMED LABOUR PROTOCOL rests on the following Three Pillars of Support

1. Judicious Use of Oxytocics **2. Providing Pain Relief - Analgesia**

3. Synergising with Antispasmodics **4. Close Clinical Monitoring of Labour on PARTOGRAM**

Extensive evaluation of this protocol by several clinicians in India, and their experiences published in scientific journals lead to the following conclusions.

1. This protocol is effective and provides satisfactory pain relief in labour
2. It is easy to implement and does not require any special training
3. It can be used in both rural and urban settings
4. It is entirely under the control of the practicing OBSTETRICIAN
5. The duration of labour is reduced, most patients experience substantial relief from pain
6. The need for OBSTETRIC INTERVENTIONS is markedly reduced
7. The Obstetric Outcome (Maternal and Perinatal) is satisfactory

The Art of Constructive Worrying

Chandy C. John, MD,
MS
Ryan White Center for Pediatric Infectious Diseases and Global Health,
Indiana University School of Medicine, Indianapolis.

Some nights I lie awake and think about patients from the past. Mistakes play back like a movie reel in my mind. Some details are now lost to me, as many of these mistakes hark back to when I was a resident. But the sick sensation of realizing an error comes back as vividly as if it were happening now. Why didn't I immediately transfer the patient with a suspected gastrointestinal bleed to the intensive care unit? Shouldn't I have made a diagnosis of sepsis earlier in the patient who had low blood pressure but no fever? Why did I question the need or a bronchoscopy in the patient who had a solid organ transplant a year earlier and ended up having pneumocystis pneumonia? The mistakes haunt me, as they should any conscientious physician. We carry deep within us the cardinal rule of medicine: first, do no harm. And yet all of us will make errors, and therefore do harm.

> We need to work toward a different culture, one in which we openly acknowledge our own mistakes ...

Aiming for perfection generates a toxic byproduct: we avoid admitting mistakes. If we confess to error or to lack of experience with a problem, fellow colleagues or trainees may see us as lesser, especially if we are the only ones confessing that we sometimes fail. So instead errors are treated as something that shouldn't be discussed, and trainees learn that the ideal is to know everything, and to not make mistakes, although no physician can accomplish either part of this false standard. When we make mistakes, we feel terrible about them yet often can't talk about them because we feel the shame of the error will only be magnified if we let others know about it.

We need to work toward a different culture, one in which we openly acknowledge our own mistakes and acknowledge that avoiding them completely is impossible. Doing so is critical to staying mentally healthy in the high-pressure world of medicine, particularly during the intense residency years. And the culture shift must start with the attending physicians. If we don't own up to our mistakes, how can we expect residents to take ownership of theirs?

When my patient had a bronchoscopy despite my saying it was not likely to be useful, and that bronchoscopy revealed pneumocystis infection, as suspected by the pulmonologists, I was embarrassed. I reviewed the case again. I realized that, by my third week of seeing the patient every day, I had stopped looking in detail at every vital sign, focusing only on the ongoing fever. I had missed the intermittent elevations of the respiratory rate—a clue to the sometimes slowly developing pneumonia caused by pneumocystis. I had personally reviewed the computed tomography (CT) scan, a test I had requested, but I had not seen the radiologist's reading that mentioned the diffuse changes could be due to pneumocystis. The data were there, picked up by the pulmonologists who saw the patient with fresh eyes, and fortunately proceeded with the bronchoscopy.

It wasn't pleasant to admit that I had neglected to thoroughly review the vital signs and subsequent CT reading. I felt I had to discuss with both teams what I'd missed and why, in the hopes that it would teach all of us, the residents, the students, andmewhat not to miss next time. I thanked the primary team and the pulmonologists for being on the ball when I was not, and I was grateful, as I often am, that patients are taken care of by a team. My status as a stellar clinician suffered a bit. Although the patient eventually recovered on appropriate treatment, recoverywould have been sooner and faster if I had been paying better attention to the signs and symptoms.

That mistake and others taught me to worry about missing key details of a patient's clinical picture. But since worry alone is destructive, I've had to learn what I call constructive worrying— thinking and worrying about the factors that matter most and making plans based on this worrying. I've trained myself to pay more attention to specific aspects of the history or physical examination (was neck stiffness assessed in the child with fever and altered mental status?); to check how individual laboratory assays were done (which of many histoplasma test results were positive in the patient "positive for histoplasma"?); and to ask again about details when the story is not clear to me (exactly how many days did the child have fever?). If I don't remember those details while rounding, my mind is jogged when I write the progress note or talk to a colleague or read an article, and I follow up. Constructive worrying uses the compassion and concern I have for my patient, and lessons I've learned from past mistakes and successes, to focus on what's most important.

I've previously viewed worrying as a sign of inadequacy on my part, perhaps because I know how harmful it can be when it's not constructive—when it overwhelms to the point of making a physician indecisive. I became aware of the value of constructive worrying only recently. Now that I'm a colleague to heroes from my medical school and residency days, we discuss how we stay sharp as clinicians. A legendary doctor in my field confided in me that she feels stressed when she starts a week of patient service. She constantly checks on clinical details in the Red Book, the bible of pediatric infectious disease, and a book she has contributed to generously. "It's at my bedside," she said. Another outstanding clinician, the guy we all turn to when we're stumped about a case, told me he likes to get patient sign-out early in the day, so he can read up about the illnesses before rounding. He seems to have facts effortlessly at his fingertips, but that is, of course, because he's constantly reading. It turns out the great ones may, in fact, be great because they check more thoroughly and worry more constructively than the rest of us. So in fact, it's not just OK to worry, it's good to worry, if you turn that worry into constructive habits: check the patient, check the laboratories, check the literature.

Dedication to constructiveworry has another benefit:over time the frequency andmagnitude of your errors tend tobecomesmaller. You read more and ask better questions. You learn to better distinguish normal from abnormal. You focus on the critical factors you should never miss. You make mistakes but catch them earlier. And you and your colleagues, also on constant alert, provide a safety net for each other.

The learning plan I've made from constructive worrying goes something like this: Learn carefully and well from those you work with. Try to avoid errors through constructive worrying. Make an error anyway (this is inevitable). Acknowledge the error. Apologize to your patient and their family for making it. Forgive yourself. Learn from the error. Teach others about it. Model vulnerability. And then repeat, starting at the first step.

Physicians aim at perfection of "do no harm," but we can't achieve perfection. The goal we can achieve is to do as little harm, and as much good, as is humanly possible.Worrying the right way can help bring us closer to that goal.

Perinatology Committee - FOGSI & Ahmedabad Obstetrics & Gynecology Society (AOGS)

Organizes

CME on 8th JULY 2018, SUNDAY

VENUE: HOTEL SILVER CLOUD, OPP GANDHI ASHRAM, AHMEDABAD.

Program Coordinator : Dr. Shashwat Jani.

Chief Coordinator, West Zone
Perinatology Committee – FOGSI.

Educational support from SPECTRA a SUN PHARMA division

SCIENTIFIC PROGRAM

TIME	TOPIC	SPEAKER
8:15 am - 8:45 am	BREAKFAST	
CHAIRPERSONS: Dr. Snehal Kale, Dr. Kamlesh Jagwani		
8:45am - 9:00am	Recent Article	P.G. Student
9:00am - 9:20am	Do Doppler Studies help in delivering Healthy Newborn?	Dr. Ami Shah
9:20am - 9:40am	Laparoscopy in Pregnancy - Indications & Limitations.	Dr. Sujal Munshi
9:40am - 10:00am	Evidence Based Practical Tips for Management of APLA.	Dr. Phagun Shah
CHAIRPERSONS: Dr. Akshay Shah, Dr. Divyesh Panchal		
10:00am - 10:20am	Umbilical Cord Abnormalities - Importance for Obstetric Outcome.	Dr. Niraj Jadav
10:20am - 10:40am	Evidence Based Guidelines for Management of Pre Term Birth	Dr. Rajal Thaker
10:40am - 11:00am	Induction of Labour in Special Situations.	Dr. Nitin Raithatha
CHAIRPERSONS: Dr. Dhaval Shah, Dr. Kashyap Sheth		
11:00am - 11:20am	Difficulties during LSCS.	Dr. Parul Kotdawala
11:20am - 11:40am	Management of Pre-Eclampsia - Recent Guidelines	Dr. Shashwat Jani
11:40am - 12:00pm	What not to do with Newborn Infant?	Dr. Ashish Mehta (Neonatologist)
12:00pm - 1:00pm	PANEL DISCUSSION – Adherent Placenta – Advances in Prediction & Management . PANELISTS Dr. Ajesh Desai Dr. Babubhai Patel Dr. Sushma Shah Dr. Harsh Desai Dr. Jignesh Deliwala Dr. Munjal Pandya Dr. Kirtan Vyas Dr. Parth J. Shah	MODERATORS Dr. Mahesh Gupta Dr. Jagdish Gohil
1:00pm - 1:40pm	DEBATE - Should Demand for C - Section be Entertained ? YES- Dr. Pawan Dhir (15 mins) NO- Dr. Darshana Thakkar (15 mins)	EXPERT COMMENTS Dr. Ajit Rawal Dr. Sanjay Munshi (10 minutes)
LUNCH		

Workshop 1 : FOGSI - Infertility Update 2018

Date: 15th July, 2018 - Sunday

Venue : Hotel Radisson Blu, Panchvati, Ahmedabad

President : Dr. Jaideep Malhotra, Vice President : Dr. Jayam Kannan **Co-Ordinators : Dr. Asha Baxi, Dr. Amit Patki**

Time	Topic	Speakers
10.00 am to 10.00 am	FOGSI Message, Welcome	
10.00 am to 10.30 am	Enhancing Success rate of IUI i) Role of Gonadotropins ii) Techniques used in IUI	Dr. Chaitanya Nagori
10.30 am to 10.50 am	Diminished Ovarian Reserve: A day-to-day problems I) Investigations ii) Adjuvents	Dr. Manish Banker
10.50 am to 11.30 am	**Panel Discussion** - "Ovulation Induction in PCOS" **Panelists :** Dr. Nisarg Dharaiya, Dr. Nisarg Patel and Dr. Hitesh Patel, Dr. Sheetal Punjabi	**Moderator:** Dr. Kanthi Bansal
11.30 am to 11.40 am	**TEA**	
11.40 am to 12.00 pm	Recurrent Implantation Failure and Miscarriages i) Investigations ii) Current Treatment Modalities	Dr. Sunil Shah
12.00 pm to 12.20 pm	**Debate :** IUI Vs IVF/ICSI in the Era of ART	Dr. Raman Patel and Dr. Falguni Bavishi
12.20 pm to 01.00 pm	**Panel Discussion** - "ART Pregnancies are they Different" **Panelists :** Dr. Hitendra Somani - Bhavnagar, Dr. Jayprakash Shah - Ahm. Dr. Purvi Shah - Ahm., Dr. Jignesh Deliwala - Ahm., Dr. Jagdish Gohil - Vadodara, Dr. Mukesh Savaliya - Ahm., Dr. Nitin Lal - Rajkot.	**Moderator** - Dr. Himanshu Bavishi

Sponsored by : INTAS

CME : 6 - Mixed Bag

Date: 29th July, 2018 - Sunday

Venue : Hyatt Regency, Ashram Road, Ahmedabad

Time	Topic	Speakers
09.00 am to 09.00 am	**Breakfast**	
09.00 am to 09.40 am	**Anemia in Pregnancy**	**Dr. Sapana Shah**
09.40 am to 10.30 am	**Parenteral Iron Therapy**	**Dr. Vineet Mishra**
10.30 am to 11.15 am	**Medical Management of Endometriosis**	**Dr. Sonal Kotdawala**
11.15 am to 12.00 pm	**Novel Technique to Control Atonic PPh - COMOC MG**	**Dr. Mahesh Gupta**
12.00 am to 01.00 pm	**Panel Discussion : How to tackle Anemia in Pregnancy?** **Panelists :** **Dr. Sushma Shah , Dr. Yamini Trivedi, Dr. Ameya Metha**	**Moderators :** **Dr. Artiben Patel & Dr. Sapna Shah**
01.00 to onwards	**LUNCH**	

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6 NIGHT / 7 DAYS

CME: Indo-Israel Knowledge Exchange at Tel- Aviv, Israel.





NOVEMBER 11TH TO 17TH 2018 I 50 PAX

FOR MORE INFORMATION CONTACT : DR. KAMINI PATEL MO.: 94260 48748

Hutheesing Jain Temple

ShethHathisinhKesarisinh, a wealthy trader of Ahmedabad started construction of the Hathisingh Jain temple but passed away at a young age of 49. It was left to his wife ShethaniHarkunvar and their son MaganbhaiHutheesing, to complete the temple in 1850 AD at the then astronomical figure of Rs 8 lakhs. The temple is dedicated to Dharmanath, the fifteenth Tirthankara. It was a spiritual act as well as a humanitarian gesture since India was in the grip of a famine at that time and, by employing hundreds of workers for two years, the family supported people.

The Temple

Surrounded by chaotic traffic and noise the temple is a haven. Enter the spacious temple premises from the beautifully carved ornamental gate with its toran and you enter a world of peace and quiet. You see the main temple and another smaller building, as well as a towering pillar on the lines of the Jain Manastambha and Kirti stambha, found in Chittor, Rajasthan. Built-in fine white marble, the temple is a typical representative of Jain style of architecture. The temple was built under the supervision of its architect, Premchand Salat. The main structure in white marble is two-storeyed and houses the idol of Mulnayak Lord Dharamnath, the 15th Tirthankar. There are eleven idols in the main temple on the ground floor, five in bay sanctuaries and six in the cellar and the main building has exquisitely carved pillars. In addition, there is an open courtyard in the middle surrounded by a building within the complex and, as you walk the gallery, you come across 52 small shrines, each housing an idol in exquisitely carved and polished marble of each of the Tirthankaras.

"It is better to win over self than to win over million enemies"

Responsible Tourism and Women Empowerment in India

by Gaurav Bhan Bhatnagar | May 22, 2018

How responsible tourism can help lead women empowerment in India

Woman learning to be a solar engineer at Barefoot College. Photo credit: Gaurav Bhan Bhatnagar.

A guest post by Gaurav Bhan Bhatnagar of The Folk Tales, an award-winning responsible tourism company operating in India.

From my solo travel experiences in India, I have always noticed that women play a major role in tourism. But often it goes unnoticed because of its very nature. For example, in the case of community-run, responsible tourism projects in villages, women tend to take up the roles of cooking, cleaning, and other household chores. These chores are of great importance in running a homestay, but do not get the required recognition. While women get the roles of decision making in household chores, they seldom get the same role outside. Which is why we need women empowerment in India.

According to a study by UNWTO, women make up majority of the tourism workforce in this world, irrespective of the geographical region.

It was a pleasant surprise when I visited Barefoot College in Tiloniya village, Rajasthan, which was founded by Bunker Roy in the year 1972. Women from more than 70 developing nations — from South Asia, Middle East, Latin America, and Africa — are trained as solar engineers over a six-month course. Every year, more than 50 women participate in this course, which is led by female teachers from the local villages. The goal is to use time tested village wisdom and knowledge to evolve village-based solutions in the areas of solar power, waste paper recycling, and rain water harvesting.

After completing the course, women have gone back to their villages in Afghanistan, for example, and electrified the houses for the first time. Barefoot College is creating success stories.

"I have only studied till class six. I don't know how to read and write. But we teach women how to design circuit boards for solar lanterns," a proud but humble female teacher told me as she kept one eye fixed on her students. I could clearly see how grounded and settled she was as a teacher and as a decision maker in leading the course for students.

Woman cooking in a village homestay, Rajasthan. Photo credit: Mariellen Ward

Taking a day tour to Barefoot College

Day tours to Barefoot College are available for people and students who would like to see the campus and learn more about what they do. You will get an orientation of the college and the projects that help empower and teach women and children. The introduction of these tours have opened up a plethora of opportunities for the exchange of ideas between the community and the visitors.

Although Barefoot College is not entirely dependent on tourism for funds, the additional funds through responsible tourism provides opportunities for projects like night schools for children and conservation of indigenous plants of Rajasthan.

Barefoot College keeps alive the primary focus: Women first.

I stayed for two days in the guest house on the campus of Barefoot College. It was a small, clean, and cozy place that runs entirely on solar power. Highly energetic Brijesh Mishra showed me the campus, crafts centre, solar engineer training centre, waste paper recycling unit, and puppet centre.

How they achieve women empowerment in India

Prashant, a volunteer at Barefoot College told me that Bunker Roy bought old UN reports and recycled the paper to make puppets and dolls that are now used to teach aspects like cleanliness, education, and human rights in villages of Rajasthan — where it is better to communicate through visual cues.

On the street in Bikaner with women and girls of Rajasthan. Photo credit: Mariellen Ward.

Many people who started working at Barefoot College as children have now grown old. But they are still content and very committed to their work. I call this a real example of retention of talent within the village.

During my visit to Barefoot College, my belief in the ability of responsible tourism to help in the empowerment of women in India was reinforced — though it cannot be executed in isolation. It is just one pillar of the many required for the sustainable development of humanity and for **women empowerment in India.**

In 2015, the United Nations, along with the participating nations, adopted 17 Goals for Sustainable Development. Goal number five is about Gender Equality through various actions, one of which is active involvement of women in decision making in the responsible tourism sector.

A shift to responsible tourism

Women of Rajasthan. Photo credit: Mariellen Ward.

There is a gradual but visible shift in the way people are travelling now. I clearly see that the new trends in travel are about reaching out to cultures, nature, traditions, and to the local people. This is not entirely achievable without active involvement of women in responsible tourism. Involving women corresponds to helping them in employment, promoting fair market for local goods produced in cottage industry, and in eliminating any discrimination.

India is a diverse country, which is mostly noted for its patriarchal society where men are in authority over most aspects of society. Rajasthan finds a special mention when we talk about a society with strong patriarchal roots in India. Barefoot College is not only a shining example of gender equality in Rajasthan, but also a guiding light for many such possible projects in other parts of India.

I believe that amidst all the negativity projected by media, examples like that of Barefoot College need to be brought forth through responsible tourism.

How to reach Barefoot College: Tiloniya is approximately 14 kilometres from Kishangarh and 50 kilometres from Ajmer in Rajasthan. Superfast trains going to Ajmer stop briefly at Kishangarh from where you can either take a private taxi or a government bus to Tiloniya.

ગુજરાતી ગીત-સંગીતનાં યુગપુરૂષ

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સ્થળ :

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LECTURE SESSION

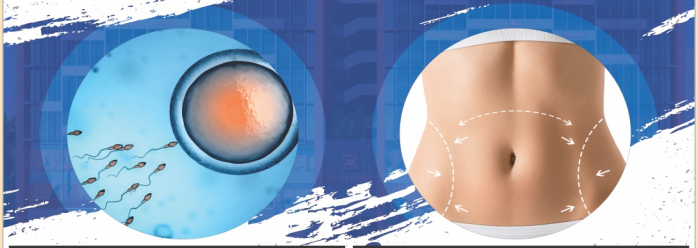
- Past,present and future of ART
- IUI(Indication,Induction protocol)
- Semen prep for IUI
- Role of counseling
- Ovulation Stimulation
- OPU/ET procedures
- Complication related to ART
- Endocrinology in ART/Ovarian Reserve Testing
- Patient selection and preparation for IVF
- Overview of IVF & Different ART procedures
- Role of hysteroscopy in ART
- Setting of ART Lab
- Different Stimulation Protocols
- USG/Follicular monitoring
- Male infertility overview
- Surgical procedure in Male infertility
- Poor Responders/PCO
- Luteal phase support
- Oocyte selection/Embryo grading 4/8/blastcysts

PRACTICAL SESSION

- Tour of the Centre(Embryology lab, Molecular Lab and Andrology Lab)
- Observation in Lab:- Semen preparation/Egg pickup: IUI/Embryo transfer
- Advanced Embryo procedure: ICSI/IMSI/LAH /Embryo Biopsy/Poloscope/Embryoscope
- Observation, Hands on Mock transfer Oocyte pick up
- Hands of semen prep/ Observing Embryo Biopsy /Vitrification of oocytes/embryos and semen/Embryo and oocyte thawing

MERRYLAND Women's Hospital

IVF & COSMETIC SURGERY CENTER



IVF (Test Tube Baby)

- IUI
- IVF
- ICSI
- Surrogacy
- Crypreservation
- Donor: Egg/Sperm/Embryo
- Frozen Embryo Transfer
- TESA/PESA/PGD/PGS
- Vitrification egg/sperm/embryo
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Cosmetic Surgery

- Breast Implantation & Reduction Surgery
- Breast Shape up After Pregnancy
- Facial Treatment
- Permanent Hair and Tatoo Removal
- Removal of Fat-Abdomen/ Buttock/Thigh
- Vaginoplasty
- Pelvic Floor Surgery

OUR CONSULTANTS

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All India Fertility & IVF Ranking Survey - 2018

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THE TIMES OF INDIA
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