AHMEDABAD OBSTETRICS AND GYNAECOLOGICAL SOCIETY

AOGS TIMES

VIHAAN

FEBRUARY 2024 I VOLUME 11

MOTTO : REDEFINING WOMEN HEALTH

THEME : CATCH THEM YOUNG

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TEAM AOGS MESSAGE

Dr. Mukesh Savaliya
President

Dr. Mukesh Patel
Hon. Secretary

Dear Members,

As we are approaching end of the tenure of the team AOGS 2023-24, we thank you for all the support across the whole year. Details of election for the year 2024-25 have been attached within this issue of bulletin, kindly note the dates and participate in the election whole heatedly to serve AOGS better.

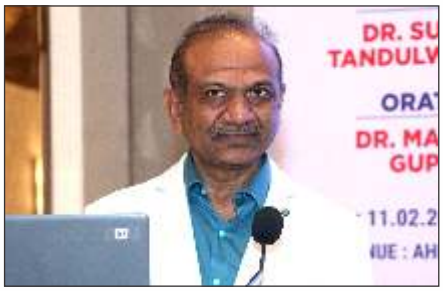
We have had 2 Orations last month and we got Great insight in the subjects covered. We wish to continue the academics as well as practical bonding amongst the members of AOGS and make it an organisation which is united and supportive for all of its members.

We look forward to keep serving you for the remaining month of the tenure to the best of our capacity.

Thank you!

GOLDEN & SILVER JUBILEE ORATION OF AOGS

DATE : 11.02.2024, SUNDAY



GOLDEN & SILVER JUBILEE ORATION OF AOGS

DATE : 11.02.2024, SUNDAY



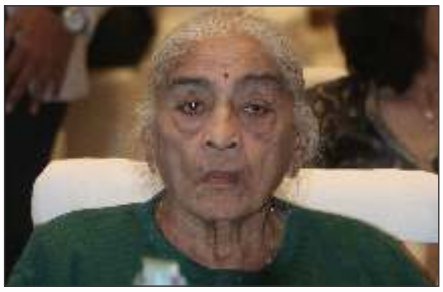












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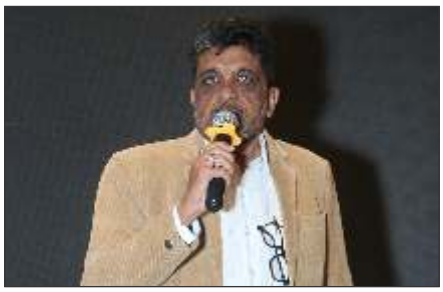
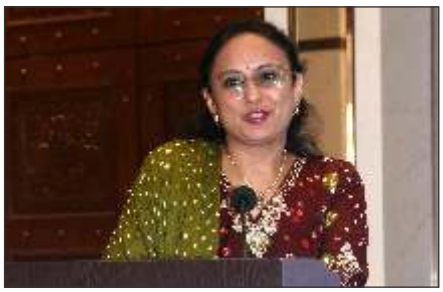
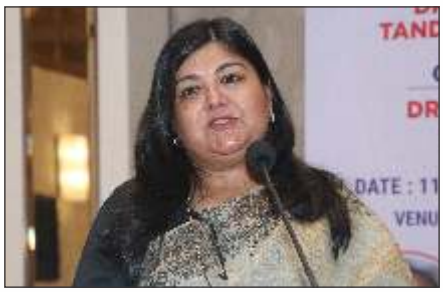




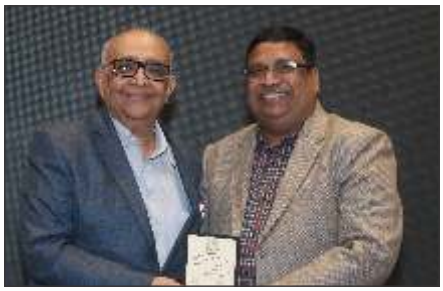
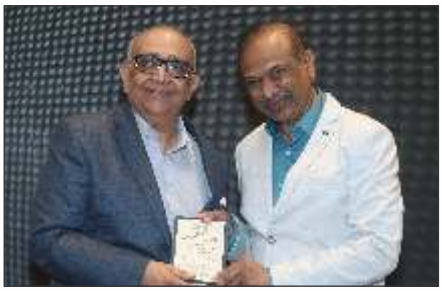


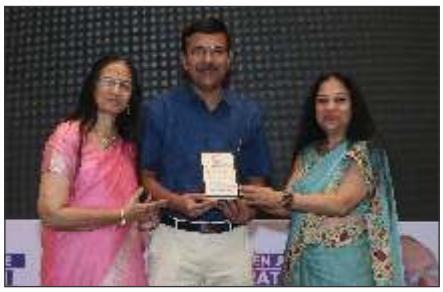


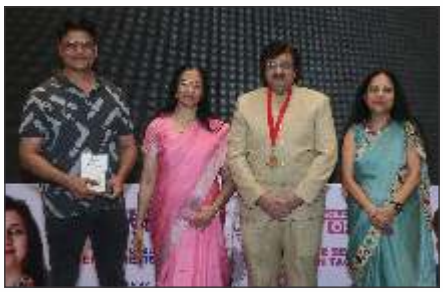


GOLDEN & SILVER JUBILEE ORATION OF AOGS

DATE : 11.02.2024, SUNDAY











Ahmedabad Obstetrics and Gynaecological Society (AOGS)

Electoral Notification for year 2024-2025

The nominations are invited on prescribed form for the following posts of Ahmedabad Obstetrics and Gynaecological Society for the year 2024- 25

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 of the elected members of managing committee of AOGS and he must be an "A category" life member of AOGS.
4. An eligible member can contest for the post of treasurer only after completing at least Two years as an elected member in the managing committee of AOGS.
5. President-Elect will be the president for the year 2025-2026.
6. A member who has served as president of AOGS cannot contest for the post of treasurer.
7. The tenure for each post is of one year.
8. No member shall remain on the same post 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 i.e Rs.one thousand five hundred only and for the post of office bearer is Rs.2500 i.e Rs.Two thousand five hundred only
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 : https://ahmedabadobgyn.org (3) From **23rd February, 2024.**
b. The duly filled nomination form with required nomination fees should reach AOGS office **before 5 pm. on date:27.02.2024**
c. Last date for withdrawal is **29.02.2024 by 5 pm**
d. Scrutiny of forms by managing committee on **29.02.2024 at 8.00pm**

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 ask for 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 date **06.03.2024 at 09.00 am to date 09.03.2024 at 06.00 pm**

17. Annual General Body Meeting at AMA Building, Ashram Road, Ahmedabad will be held on **Date 09.03.2024 at 8.00 pm.**
18. Result of election will be declared in Annual General body by President
19. In case of any kind of dispute, the decision of president would be final.

Dr. Mukesh Patel
Hon. Secretary

Ahmedabad Obstetrics & Gynaecological Society

Nomination form for Annual Electionfor year 2024-2025

The nominations are invited on prescribed form for the following posts of Ahmedabad Obstetrics and Gynaecological Society for the year 2024- 25

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 2024-25

Signature of Proposer: _____

I, Dr._____second name of

Dr._____for above said post for annual

election of AOGS for year 2024-25

Signature of seconder:_____

I, Dr._____give consent to contest for above

said post for annual election of AOGS for year 2024-25

Signature of Candidate:_____

.....

For office use

Received nomination with requisite fees from

Dr._____for annual election of AOGS for year 2024 -25

Hon. Secretary, AOGS

Clinical Pearls on HPV Vaccination

Dr. Mona Naman Shah, MD,

Fellowship in Gynaecologic Oncology (CMC Vellore).

- Ex. Assistant Professor- Department of Gynaecologic Oncology-GCRI, Ahmedabad
- Gynaecologist and GynecOncosurgeon, Laparoscopic and Robotic Surgeon, Zydus Cancer Hospital, Ahmedabad

Abstract: Females are the backbone of every civilisation. The optimal health of every member of society drives a nation better on the path of progress and growth.

India faces a massive challenge in the form of health issues of cancer in females, cervical cancer being the second most common cancer in females. In 2023, 123907 women are expected to have been diagnosed with cervical cancer, and 77348 are expected to have died from the disease. About 5.0% of women in the general population are estimated to harbour cervical HPV-16/18 infection at a given time, and 83.2% of invasive cervical cancers are attributed to HPVs 16 or 18.

This article is an attempt to simplify information regarding HPV vaccination.

A. INTRODUCTION

HPV is a group of more than 200 related viruses, of which more than 40 are spread through direct sexual contact.

Human papillomavirus (HPV) is a sexually transmitted pathogen that causes anogenital and oropharyngeal disease in males and females, causing genital warts and cervical, anal, oropharyngeal, penile, vulval, and vaginal pre-malignant and malignant lesions.

Persistent viral infection with high-risk HPV genotypes causes virtually all cancers of the cervix. The high-risk HPV genotypes

1) 16 and 18 cause approximately 70% of all cervical cancers worldwide
2) 31, 33, 45, 52, and 58 cause an additional 20 %
3) HPV types 16 and 18 also cause nearly 90 % of anal cancers and a significant proportion of oropharyngeal cancer, vulval, vaginal and penile cancer
4) HPV types 6 and 11 cause approximately 90 % of anogenital warts.

B. VACCINE TYPES

Table 1. Licensed vaccines that prevent infection with disease-causing HPV

Name	Active against HPV types
Gardasil®9 (MSD India)	6 ,11, 16 , 18, 31, 33, 45, 52, 58.
Gardasil® (quadrivalent) (MSD India)	6, 11, 16, 18
Cervarix® (GSK India)	16,18
Cervavac®(Serum Institute of India)	6,11,16,18

These are all **prophylactic vaccines designed to prevent** initial HPV infection and subsequent HPV-associated lesions.

Therapeutic vaccines designed to induce regression of existing HPV-associated lesions are in development but are **not clinically available**.

C. TARGET POPULATION FOR HPV VACCINATION AND IMMUNISATION SCHEDULE

The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) develops recommendations regarding all vaccinations in the United States, including HPV vaccination. The current ACIP, American Society of Clinical Oncology (ASCO) and World Health Organization (WHO) recommend that the primary target of HPV vaccination programs be:

Category	Recommendation – Immunisation schedule	Strength of recommendation
Females aged 9 to 14 years	• Two doses • 0 and at 6 -12 months.	Grade 1A
Catch up HPV vaccination: All females aged 15 to 26 years who were not adequately vaccinated earlier.	• Three doses. • 0, 2 and 6 months. • Along with routine screening with PAP / HPV DNA starting from age 25 years	Grade 1B
27 to 45 years	• (FDA) approved to be given up to 45 years. • Less efficacy and less cost-effective • It is not routinely recommended for all • If Given, then three doses at 0, 2 and 6 months. • Along with routine screening with PAP / HPV DNA starting from age 25years	Grade 2C

- Males: HPV vaccination provides a direct benefit to male recipients
  - HPV types 16 and 18 cause nearly 90% of anal cancers and a substantial proportion of oropharyngeal and penile cancers.
  - Also protects against anogenital warts (90% of which are caused by HPV types 6 and 11).
  - The overall burden of HPV-associated cancers and pre-cancerous lesions among males is **less** than the burden of cervical cancer in females.
  - Despite a smaller direct absolute benefit of HPV vaccination in males compared with females, the overall benefit of vaccinating males outweighs its potential risks because of additional population benefits from herd immunity and the documented safety of HPV vaccines.
- In **resource-limited settings**, expert groups recommend that public health efforts **focus primarily on vaccinating young females**, the group in which the absolute benefit and cost-effectiveness of HPV vaccination is the highest.

D. SPECIAL POPULATION GROUPS

Interrupted doses	• Continue with the remaining doses per age-based vaccination recommendations; the vaccination series need not be restarted.	Grade B
Pregnancy and Lactation	• Not recommended in pregnancy (if inadvertently given, no need for MTP) • It can be given during lactation	Grade B
Victims of sexual abuse	• Same age recommendation • Three doses • Initiated preferably at the same time of examination at the healthcare facility	Grade B
Women with a history of abnormal screening reports	• Same age recommendation • Women should be counselled regarding **reduced efficacy** in older age groups, the importance of regular follow-up., and **no therapeutic benefit**.	Grade B
Immunocompromised patients (HIV, HIV with CD4 counts <200 cells/microL, transplant recipients, etc.)	• Three-dose • At 0, 1 to 2, and 6 months • Regardless of age, if they have not already been vaccinated	

E. CHOICE OF VACCINE

If cost and availability are not an issue, recommend the Gardasil nona-violent vaccine. But in India, it is pretty costly, so Gardasil's quadrivalent is equally effective.

The same formulation should be used to complete the series, if possible.

F. LIMITED BENEFIT OF SINGLE DOSE, REVACCINATION, AND BOOSTER DOSE

- Randomised controlled trials have also been conducted to evaluate the immunogenicity and efficacy of a single HPV vaccine [53-55]. For example, in a multicentric trial of 2275 women aged 15 to 20 years, the regimen was found to be promising but still not ideal for the recommendation of 1 dose. Research is underway to conclude whether a single dose is effective or not.
- HPV vaccines have demonstrated durable protection from HPV-associated diseases, and there is no evidence that revaccination is necessary.
- As of now, a routine booster dose is NOT recommended.

G. HOW EFFECTIVE ARE HPV VACCINES?

HPV vaccination effectively prevents cervical disease, including cervical intraepithelial neoplasia (CIN2 or 3) and Carcinoma in situ (CIS).

The efficacy of quadrivalent HPV vaccine for preventing

- CIN2 or more severe disease due to was:
  - 97 -98% among HPV-naïve populations
  - 44-60% percent of the overall population
- Efficacy for preventing VIN2 or 3 and VaIN2 or 3 was similarly
  - 98-99% among HPV-naïve populations
  - 62% of the overall population
- Anogenital warts and efficacy for preventing vulvar and vaginal condylomatawas
  - 90-98% among HPV-naïve participants and
  - 70-78% of the overall population

H. DURATION OF PROTECTION

Protection against high-grade intraepithelial neoplasia or condyloma has been observed for at least 10 years following vaccination among both female and male participants in trials.

- Persistent antibody levels and protection against HPV infection have also been reported up to 10 years following vaccination.
- Of note, the precise antibody level needed for protection against infection is unknown.
- Further data will become available as vaccine study participants are followed over time.

I. VACCINE SAFETY

- Mild injection site reactions were the most commonly observed adverse events. (pain, erythema, and swelling)
- Systemic adverse effects (e.g., headache, fever, nausea, dizziness) and Serious adverse effects occurred in <0.1 per cent.

J. IMPORTANCE OF CANCER SCREENING CONTINUATION

Cancer screening continues to play an essential role in the detection and treatment of HPV-associated disease.

HPV immunisation is not effective in clearing HPV infection, genital warts, or cervical intraepithelial neoplasia that is already present, and the vaccine does not protect against 100 per cent of types known to cause cervical cancer.

Until further data are available and new screening guidelines issued, Routine cancer screening as per guidelines with PAP / and or HPV DNA testing has to be continued in all vaccinated females.

Union Finance Minister Nirmala Sitharaman announced the government's plans to focus on vaccination against cervical cancer for girls between 9 and 14 years of age as part of the Interim Budget 2024. It is undoubtedly a welcome step towards reducing incidence, morbidity and mortality from cervical cancer. As gynaecologists, let us spread awareness towards this goal and bring health to society.

Gastro-Intestinal Infections and Infestations affecting Pregnancy

Dr. Kirtan Vyas

M.S., FICOG

- Consultant Director, Sevak Maternity & Surgical Hospital, Ahmedabad
- Teaching experience as an Assistant Professor at P.D.U. Govt. Medical College, Rajkot for 4 years
- Recipient of many awards and appreciations from Gujarat University and from FOGSI
- Keenly interested in Indian Classical Music, Reading and Travelling

Case Discussion

Mrs. Meena Patel, aged 26 years, gravid 1 para 0, married for 3 years, hailing from a rural place in Gandhinagar. She had worked as a farmhand. She presented herself with 7 months amenorrhea, easy fatigability and swelling of the feet. Clinical Examination: General Examination showed her height to be 5ft.2", Weight 46 kg and Blood Pressure 100/60 mmHg. She had mild tachycardia of 100 bpm. She appeared pale, and there was presence moderate edema of the feet. Systemic examination revealed presence of a hemic murmur in the chest. Obstetric Examination and USG revealed 26 weeks Single Intrauterine Fetus, Cephalic presentation and normal Fetal Heart Rate. She was prescribed, a high protein diet, oral calcium and vitamin supplements. She was given the first dose of Tetanus Toxoid and advised to undergo routine tests.

In view if of her being a farm hand, she was advised to undergo a stool examination after a saline purge. The test results revealed a hemoglobin of 7.0g%, and presence of microcytic hypochromic anemia. Stool examination showed presence of ova of A. duodenale.

The patient was prescribed parenteral iron therapy, and oral albendazole to deworm the patient. She responded favorably to treatment and delivered normally at 38 weeks, a male baby weighing 2.6 Kg. Both the mother and baby were discharged in satisfactory condition.

Conclusion: Clinical examination revealed presence of moderately severe anemia with presence of circulatory overload. Obstetric examination was suggestive of SGA. History of working on the farm gave the clue of possible presence of helminthiasis. Aggressive treatment with parenteral Iron therapy, and anthelmintic helped to improve her health. The outcome of pregnancy was satisfactory.

Objectives:

1. To enumerate the commonly encountered gastrointestinal parasitic (protozoal and helminthic) infestations during pregnancy.
2. To list their effects on pregnancy.
3. Discuss clinical symptoms and management.

Introduction :

The gastrointestinal tract plays an important role in providing and maintaining the nutritional requirements of the mother and fetus during pregnancy. For reaching this goal, the pregnant mother must be counseled about the importance of consuming a balanced diet that will provide adequate calories and essential nutrients to ensure satisfactory progress of pregnancy.

In India, malnutrition is rampant. Food fads, and poor quality of nutrients are contributory factors. Poor sanitation and hygiene add to gastrointestinal upsets, poor absorption of nutrients that leads to poor maternal weight gain in pregnancy, low birth weight infants and a higher incidence of preterm births contributing to higher perinatal morbidity and mortality.

In India, gastrointestinal infections and infestations are common. Hence the obstetrician must be on the alert to detect and treat the same. Acute gastroenteritis often follows ingestion of ontaminated food causing vomiting, intestinal colic and loose stools. These illnesses call for urgent medical attention. However chronic infections contribute to prolonged ill-health leading to adverse effects on the mother and fetus.

Common parasitic infestations

Amoebiasis:

The causative organism is a protozoan, Entamoeba histolytica. About 2-5% of the world population is affected[1]. The incidence rises to 80% in some tropical countries[1]. Its prevalence is parallel to the level of sanitation and personal hygiene awareness in the community.

Epidemics have occurred in Central and South America, Southeast Asia and along the West coast of Africa. Maternal deaths following severe amoebic infection have been reported from Tanzania[2].

Entamoeba histolytica is transmitted through exposure to contaminated food, water and vectors like flies and cockroaches. The ingested cyst disintegrate in small intestine and release trophozoites, which invade the large gut wall and cause ulcers.

Patients may be asymptomatic or complain of abdominal discomfort, frequency of stools, malaise, anorexia, flatulence, weight loss. In case the liver is also affected, the patient

may suffer from fever and abscess formation. On examination there may be evidence of subcostal pain. Stool examination on gross examination often reveals presence of mucus and blood. Microscopic examination may reveal trophozoites in the acute stage, later in the chronic stage microscopy usually reveals presence of cysts. Clinically, the patient suffers from chronic malnutrition, which in turn leads to maternal anemia and poor weight gain and contributes to fetal growth restriction. Pregnancy is associated with fulminant course of amoebiasis and may prove fatal.

Treatment during an acute attack consists of prescribing oral tablet Metronidazole 400mg three times/day for 7 days, preferably on a full stomach. An alternative treatment is Paromomycin 25-30mg/day for 7 days, in three divided doses[1]

Patients suffering from recurrent amebiasis or chronic cyst passers should be advised Metronidazole 400 mg along with Diloxanide furoate three times/day for 7 days. Some patients who do not tolerate Metronidazole may tolerate Tinidazole 500 mg bid for 5 days, or Secnidazole 2g in a single dose.

Patient education in personal and food hygiene is important.

Giardiasis:

The causative organism is Giardia lamblia. This flagellate parasite is transmitted through fecal contaminated water containing cyst of giardia. Clinically the patient complains of diarrhea, passage of bulky foul smelling stools, flatulence, and nausea, loss of appetite, abdominal rumbling and discomfort. Stool examination reveals trophozoites and cysts.Pregnant women may complain of hyperemesis and repeated gastrointestinal upsets. Maternal malnutrition contributes to failure of maternal weight gain and fetal

growth restriction. Treatment consists of oral Metronidazole 200 mg three times / day for 7 days. Alternatively, she can be prescribed Tinidazole 500 mg bid for 5 days. Emphasis on personal hygiene, proper handling and treatment of drinking water is essential.

Helminthic (Worm) infections

Ankylostomiasis (hookworm):

Hookworm infestation is caused by infection of small intestine by Ankylostoma duodenale or Necator americanus. This infestation is common in rural India, particularly the farming community. The practice of open defecation, and walking bare foot predisposes to acquiring the disease.

The larvae penetrate the skin of feet and reach lungs through blood and lymphatic circulation. They are swallowed and cause mechanical laceration and enzymatic damage to the mucosa of the small intestine, leaving behind small bleeding lesions. Iron deficiency anemia follows chronic infection within 3–5 months after exposure. Clinically, these patients suffer from cough, breathlessness, severe anemia, hypoproteinemia and in severe disease, cardiac failure is known to occur. The fetus is at risk of low birth weight, prematurity and increased neonatal mortality.

Investigations reveal presence of microcytic hypochromic anemia, eosinophilia, and stool examination reveals presence of ova. Maternal anemia and hypoproteinemia predispose to IUGR. Radhika[3] reported that hookworm infestation is a burden during pregnancy. The gastrointestinal blood loss, malabsorption and appetite inhibition further aggravates the iron, zinc and protein-energy deficiencies and anemia of pregnancy. Hence the policy recommended by WHO of administering routinely anthelmintic to all pregnant women after the first trimester should be universally accepted.

Treatment consists of administering oral Pyrantel pamoate 1.0g stat

Alternately, one may prescribe tab. Mebendazole 100mg bid for 3 days / or Albendazole may be substituted. Mebendazole and Albendazole are category C drugs but can be safely administered in 2nd and 3rd trimester of pregnancy.

Ascariasis (roundworm):

Ascariasis in humans is caused by ingesting the eggs of Ascaris lumbricoides. These eggs hatch and the larvae migrate through the gut walls into the bloodstream and then to the lungs. From the lungs, they move up the trachea are swallowed, the worms mature to adulthood in the small intestines. Diarrhea is usually not a feature of round worm infestation. Ascaris can grow in length to over 25 cm.

The acute phase of the infection is characterized by fever, cough, and pulmonary congestion. Infections are asymptomatic initially but as the worm multiples cause abdominal pain, intestinal obstruction, and biliary and pancreatic duct obstruction. Pregnant women are more prone to biliary infection. Ascariasis may be diagnosed on ultrasound by visualizing moving linear echogenic foci in intestine. On blood picture eosinophilia and altered coagulation profile is seen (increased clotting time, prothrombin time and partial thromboplastin time). This make the women more prone to post-partum hemorrhage.

Treatment is with Pyrantel pamoate 11mg/kg as a single dose, in women with heavy infestation.

Enterobiasis (Pinworm/threadworm):

The causative organism is Enterobius or Oxyuris vermicularis. The main clinical presentation is perineal pruritus especially at night. Occasionally it may be implicated in pelvic inflammatory disease. Stool examination reveals presence of ova. The white thread like worm can be seen by naked eye on an adhesive tape pressed against perianal region overnight. A single 1 g dose of Pyrantel pamoate suffices. Alternatively, mebendazole or albendazole may be prescribed.

Strongyloidiasis (threadworm):

The causative organism is Strongyloidis stercoralis. It is widely prevalent, in areas of poor sanitation and hygiene. Immunocompromised persons are susceptible. Buresch AM[4] reported on a fatal case of strongylodosis in pregnancy.

This infestation leads to malabsorption, protein losing enteropathy, weight loss, iron deficiency anemia, poor maternal weight gain, fetal growth restriction, preterm delivery, susceptibility to infection. Respiratory symptoms of cough and breathlessness. Urticarial may be present. There is high maternal and perinatal morbidity.

Treatment is by Albendazole 400mg BD for 3 days.

Trichuriasis (whipworm):

The causative organism is Trichuria trichuris. It causes gastroenteritis, dysentery, malabsorption and adversely affects maternal and fetal health. Stool examination helps to settle the diagnosis. Hemogram often reveals presence of maternal anemia.

Treatment consists of oral administration of a single dose of Praziquantel 10mg/kg. Alternately – a single dose of Mebendazole 400mg may be prescribed.

Tapeworm Infestation:

Three types have been described. (a) Tenia saginata (beef tape worm). T.solium (pork tape worm), Echinococcus, Diphylobothrium latum (fish tape worm). T.solium can cause cysticercosis. Fish tape worm can cause echinococcal cyst formation in the liver, lungs or pelvis. A pelvic cyst causing obstructed labor has been reported. Tapeworm infestation can cause gastrointestinal disturbances, malabsorption, fish tape worm has been known to cause folate deficiency. Sweet[5] recommend preventive measures to avoid tapeworm infestation. Frequent hand washing, avoiding handling of raw meat, avoiding travelling to places where tapeworms are common. However, if necessary anthelmintic (Praziquantel 10mg/kg, Niclosamide or Albendazole) administered under medical supervision is recommended.

Schistosomiasis (liverfluke):

Infection with Schistoma mansoni produces intestinal disease, while infection with S. hematobium is urogenital and S japonicum occurs in Asia. The fresh water snail is the intermediate host.

Schistosomiasis is known to be more prevalent in Africa. Larvae penetrate the skin of swimmers. Infection results in mucus diarrhea, hepatosplenomegaly and colonic polyposis. Involvement of urinary bladder results in hematuria and bladder polyposis. Urine and stool examination help to settle the diagnosis. Infection is associated with salpingo-ophritis, infertility and ectopic pregnancy. During pregnancy schistosomiasis is associated with a chronic proteinuria, hematuria, chronic UTI, malnutrition, higher risk of abortion, IUGR, labor dystocia is also known to occur. Urogenital infection may facilitate HIV transmission. Treatment advised is single dose of Praziquantel 40-75mg/kg.

Non obstetric causes of acute abdomen that can occur in Pregnancy: These include abdominal pain caused by surgical causes like appendicitis, peptic ulcer, pancreatitis, cholelithiasis and cholecystitis, and intestinal obstruction. In all these conditions, a surgical opinion should guide treatment options.

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EVA™
Women's Hospital & Endoscopy Centre

DR. DIPAK LIMBACHIYA
M.D., D.G.O., Endoscopy Specialist
Specialist in Advanced LAP Gynaec Surgeries &
LAP Onco Gynaec Surgeries

PRESENTING THE FIRST EVER STUDY FROM INDIA ON CARCINOMA ENDOMETRIUM

SURGICOPATHOLOGICAL OUTCOMES AND SURVIVAL IN CARCINOMA BODY UTERUS: A RETROSPECTIVE ANALYSIS OF CASES MANAGED BY LAPAROSCOPIC STAGING SURGERY IN INDIAN WOMEN

Objectives: The context of this article is based on two main titles those being Gynecologic Oncology and Minimal invasive surgery. **The aim of this study was to report the laparoscopic management of a series of cases of endometrial carcinoma managed by laparoscopic surgical staging in Indian women.**

Materials and Methods: This study was conducted in a private hospital (referral minimally invasive gynecological center). This was a retrospective study (Canadian Task Force Classification II-3). Eighty-eight cases of clinically early-stage endometrial carcinoma staged by laparoscopic surgery and treated as per final surgicopathological staging. All patients underwent laparoscopic surgical staging of endometrial carcinoma, followed by adjuvant therapy when needed. Data were retrieved regarding surgical and pathological outcomes. Recurrence-free and overall survival durations were measured at follow-up. Survival analysis was calculated using Kaplan–Meier survival analysis.

Results: The median age of presentation was 56 years, whereas the median body mass index was 28.3 kg/m2. Endometroid variety was the most commonly diagnosed histopathology. There were no intraoperative complications reported. The median blood loss was 100 cc, and the median intraoperative time was 174 min. There were a total of 5 recurrences (5.6%). The outcome of this study was comparable to studies conducted in Caucasian population. **The predicted 5-year survival rate according to Kaplan–Meier survival analysis is 95.45%, which is comparable to Caucasian studies.**

Conclusion: Laparoscopic management of early-stage endometrial carcinoma is a standard practice worldwide. However, there is still a paucity of data from the Indian subcontinent regarding the outcomes of laparoscopic surgery in endometrial carcinoma. The Asian perspective has been highlighted by a number of studies from China and Japan. **To our knowledge, this study is the first from India to analyze the surgicopathological outcomes following laparoscopic surgery in endometrial carcinoma.** The outcome of this study was comparable to studies conducted in Caucasian population.

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