2024 - 25

AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

AOGS TIMES

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Motto : Knowledge is Power - Unity is Strength
Theme : Health & Happiness for Her

JULY 2024 I VOLUME 04



Health & Happiness for Her





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TEAM AOGS MESSAGE

Dr. Sunil Shah
President

Dr. Akshay C. Shah
Hon. Secretary

Dear AOGS colleagues,

ॐ શાંતિ. પરમાત્મા ડૉ. રાજલ બેન ના આત્મા ને શાંતિ અર્પે. The sad demise of our beloved Rajalben happened last month due to Ca Pancreas. Dr. Rajal Thaker was a fighter.

Festival season is starting in India. Enjoy all the festivals with due care of health.

This is a Month of lots of national and international activities. Election results have come and a new government took the oath under the leadership of Narendra Modi. Election in the USA is due. Israel-Iran war is imminent. Bangladesh is under crisis. France is dealing with internal riots and what not. All these are impacting financial markets.

We wish we Indians and our capital remains safe.

Paris Olympics is in full swing and Indian athletes and sports teams are doing hard work to get medals. We wish all the best to them.

In FOGSI we have elections and we AOGS support our senior member Dr. M. C. Patel for his presidential candidature. We wish them all the best.

SAMBHOG SE SAMADHI TAK :

Dr. Dilip Gadhavi
(MD) OBST & GYNAE - FICOG
President Ahmedabad Medical Association (AMA) 2021-22

Sexual Union to Spiritual Enlightenment **"Sambhog Se Samadhi Tak,"** a phrase popularized by Osho, translates to "From Sex to Super consciousness." This concept encapsulates Osho's revolutionary approach to spirituality, wherein he views sexual energy as a potent force for achieving higher states of consciousness

Osho's teachings diverge from traditional asceticism, which often suppresses or renounces sexual desire. Instead, he advocates for embracing and transforming sexual energy as a pathway to spiritual awakening. According to Osho, sexuality is not merely a physical act but a profound experience that can lead to deep self-realization and transcendence. The Journey from Sambhog to Samadhi Acceptance of Sexuality :Osho stresses the importance of accepting one's sexual nature without guilt or repression. He believes that acknowledging and embracing sexual desires is the first step towards understanding oneself deeply. Mindfulness in Union : Engaging in sexual activity with mindfulness and presence turns the act into a meditative practice. By being fully present, individuals can transcend the mere physicality of sex and connect at a deeper, spiritual level.

Transformation of Energy: The crux of Osho's teaching is the transformation of sexual energy into spiritual energy. This process involves channeling the intense energy generated during sexual union towards spiritual growth and higher consciousness.

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.Osho's teachings diverge from traditional asceticism, which often suppresses or renounces sexual desire. Instead, he advocates for embracing and transforming sexual energy as a pathway to spiritual awakening. According to Osho, sexuality is not merely a physical act but a profound experience that can lead to deep self-realization and transcendence. The Journey from Sambhog to Samadhi

1) Acceptance of Sexuality : Osho stresses the importance of accepting one's sexual nature without guilt or repression. He believes that acknowledging and embracing sexual desires is the first step towards understanding oneself deeply.

2) Mindfulness in Union : Engaging in sexual activity with mindfulness and presence turns the act into a meditative practice. By being fully present, individuals can transcend the mere physicality of sex and connect at a deeper, spiritual level.

3) Transformation of Energy : The crux of Osho's teaching is the transformation of sexual energy into spiritual energy. This process involves channeling the intense energy generated during sexual union towards spiritual growth and higher consciousness.

4) Transcendence : As individuals learn to transform and transcend their sexual energy, they move towards a state of samadhi. This state is characterized by a profound sense of unity with the cosmos, where the boundaries of the self dissolve, and one experiences oneness with the universe.

The Philosophical Underpinning Osho's philosophy is rooted in Tantra, which views every aspect of life, including sexuality, as a potential doorway to the divine. Tantra teaches that by fully experiencing and transcending dualities like pleasure and pain, individuals can reach a state of non-dual awareness. "Sambhog Se Samadhi Tak" is thus a journey from experiencing the duality of sexual pleasure to achieving the non-dual state of samadhi.

Practical Implications For practitioners, Osho's teachings offer a path that integrates physicality with spirituality. It challenges societal norms and taboos around sex, advocating for a healthy, open, and respectful approach to sexual relationships. By doing so, it aims to heal the disconnect between body and spirit, promoting holistic well-being and spiritual growth. In essence, **"Sambhog Se Samadhi Tak"** is about transforming the ordinary into the extraordinary. It is a journey that begins with the most basic human experience and culminates in the highest form of spiritual enlightenment, demonstrating that the path to the divine can be found in the embrace of human nature. ak" is thus a journey from experiencing the duality of sexual pleasure to achieving the non-dual state of samadhi. Practical Implications For practitioners, Osho's teachings offer a path that integrates physicality with spirituality. It challenges societal norms and taboos around sex, advocating for a healthy, open, and respectful approach to sexual relationships. By doing so, it aims to heal the disconnect between body and spirit, promoting holistic well-being and spiritual growth. In essence, *"

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the most basic human experience and culminates in the highest form of spiritual enlightenment, demonstrating that the path to the divine can be found in the embrace of human nature.

" Sambhog se Samadhi Tak " is a lecture series by Osho that explores the journey from physical and emotional attachment to spiritual enlightenment.

Here's a summary:

Osho discusses how humans seek connection and union **(Sambhog)** through relationships, desires, and possessions, but ultimately find sorrow and suffering. He guides listeners to transform their energy from attachment to awareness, meditation, and inner growth, leading to samadhi **(Enlightenment).**

Key points:

- Attachment and desire create bondage.
- Awareness and meditation liberate us.
- The body and mind are separate, and understanding this distinction is crucial.
- Inner transformation is the key to true freedom.
- Samadhi is the ultimate state of consciousness and union with the divine.

Osho's lectures are known for their insightful and thought-provoking content, encouraging listeners to question their beliefs and seek inner truth.

So. Read It & Enjoy The Sex For Enlightenment Of Soul

"संभोग कब?"

जब पुरूष संभोग करना चाहे तब नहीं!
पर स्त्री संभोग करना चाहे तब!
संभोग तभी करना उचित होगा
जब स्त्री आनंद कि उंचाई पर हो
और वो संभोग करना चाहती हो !
ज़्यादातर पुरुष संभोग करना तब पसंद
करते हे जब वो तनाव में हो!
ख़ुशीमें नहीं! ख़ुशीमें तो वो
अकेला रहना पसंद करता है या
अपने दोस्तों के साथ रहना पसंद करता हे!
और "तनावमें कभी प्रेम नहीं होता!"
स्त्री को पुरूष के भीतर प्रेमको
जन्म देनीवाली जननी भी कहा जाता है!
और स्त्री आनंद में अपने प्रेमी या पति
के साथ रहना पसंद करेगी!
क्योंकि स्त्री संभोग तभी करना पसंद
करेगी जब वो भीतरसे आनंद से भरी होंगी!
ओर "प्रेम से ही आप आनंदको जान सकते हो!"
और इसलिए कहते है की आप
प्रेम और संभोग आपकी आध्यात्मिक
ऊंचाई से भी जो ऊपर हो उसके साथ करो!
क्योंकि वो ही आपको "प्रेम से परमात्मा का
अनुभव करवा सकता है!"
~ ओशो

Dr. Dilip Gadhavi

Maternal Sepsis:

Dr. Alpesh Gandhi

Introduction: Sepsis is one of the four main causes of Maternal morbidity and mortality, across the globe. Puerperal sepsis account for 10-12 % of all maternal deaths. In the UK, sepsis accounts for as many as 25% of all maternal deaths. As per WHO (2018), If mother develops septic shock from sepsis, the risk of mortality increases to 55 % - 60%.

Maternal sepsis leading to septic shock is seen in nearly 0.002-0.01% of all vaginal and cesarean deliveries. There has been rise in incidence of sepsis and septic shock, due to various factors like: increasing maternal age at the time of delivery, increased incidence of CS, increasing incidence of pregnancy with obesity, HDP, placental abruption, placenta accrete, GDM etc.

Definition: The definition of sepsis continues to evolve. When there is life threatening organ dysfunction caused by a dysregulated host response to infection is considered sepsis. When sepsis is with persistent hypotension requiring vasopressors to maintain MAP > 65, knowns as septic shock.

Challenges of Sepsis in Obstetrics: Physiological changes in vital signs and inflammatory response are overlapping in pregnancy and sepsis. Signs and Symptoms are less distinctive, for example- High pulse rate and low BP are common to find in Pregnancy and Sepsis.

- Disease progression is much more rapid and faster development of complications like Septic shock, DIC, ARDS, ARF, MOF, Death etc.
- Possibility of abortion, Preterm Labor & neonatal sepsis, cerebral palsy and other fetal complications.
- Infection has been associated with 10–25% of cases of stillbirth in HICs and may be as high as 50% in LMICs.
- Our patients are young, look very well until they are almost serious.

Pathophysiology: Vascular collapse leads to reduction in functional intravascular blood volume, leading to reduction in blood pressure and tissue perfusion, which in turn leads to hypoxia and acidosis, leading to end-organ failure.There are various causes of sepsis and septic shock in pregnancy: Septic abortions, retained placenta, pyelonephritis, pneumonia, chorioamnionitis and surgical causes (mastisis, appendicitis, cholecystitis).

Clinical features for Maternal Sepsis:

Pregnant patient having following signs will require urgent attention:

Temperature > 38.3° C or <36° C

Pulse >110/min

Respiratory rate≥ 24 breaths/minute

Random Blood Sugar>140 mg/dl in a non-diabetic patient

Decreased Hb%

WBC >20,000 or <4000/cmm

Altered mental status

Oliguria or Anuria

When one or more of the following signs are present, they indicate organ dysfunction:

Systolic Blood Pressure <90 mmHg

PT INR >1.5

Platelet count < 1,00,000/cmm

S. Creatinine >1.5 mg/dl

S. Bilirubin > 2 mg/dl

S. Lactic acid level > 2 mmol/L

Alter mental status

Management: Maternal deaths from Sepsis are largely preventable. Delay is dangerous.Eternal vigilance and early detection with prompt initiation of standard management protocols will reduce its incidence. Rapid diagnosis and management are very critical in reviving the patient from sepsis. Pregnant woman with early suspicious of or diagnosed Maternal Sepsis needs to be admitted in Obstetric HDU.

Hour-One bundle: It should be initiated within the first hour of the recognition of sepsis.

1) Start high flow oxygen when there is impaired oxygen delivery.

2)I.V. Line is to be taken immediately with wide bore needle. Rapid Fluid resuscitation with I.V. fluids (30ml NS/kg) need to be started to restore depleted intravascular compartment. This recommendation is modified to 20 ml/kg by the RCOG due to an increased risk of pulmonary oedema in pregnancy caused by decreased colloid oncotic pressure.

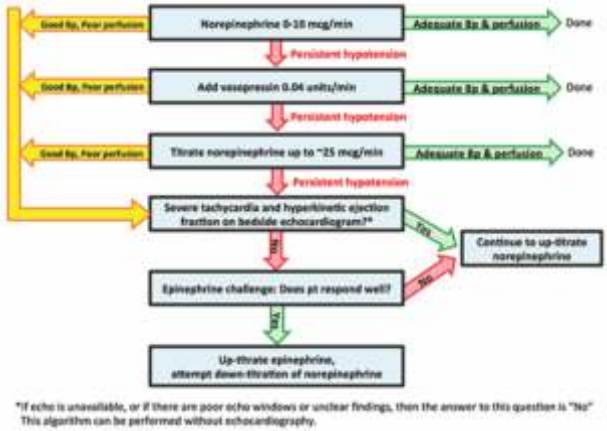
3)Blood investigations and culture are advised and samples should be sent for investigations.

4)Injectable broad-spectrum antibiotics are started without waiting for the result of blood culture, which can later on, be shifted to specific antibiotics depending upon culture sensitivity report.

5)Vigilant and regular monitoring of vital data, Oxygen saturation, urine output, mental status, Hb, CBC and S. Lactate needs to be done. Increase in pulse pressure on passive leg raising and collapsibility of IVC with inspiration in a spontaneously breathing patient are indicative of fluid responsiveness. Aim of fluid resuscitation is to bring S. lactate < 4 mmol/l and to achieve a mean arterial pressure >65 mm Hg.

If hypotension still persists after fluid therapy, shift the patient to ICU for inotropic support as per the follow.

Vasopressor titration algorithm for septic shock



*If echo is unavailable, or if there are poor echo windows or unclear findings, then the answer to this question is "No" This algorithm can be performed without echocardiography.

Source control: In maternal sepsis, Escherichia coli and group B streptococcus are the most common bacterial pathogens, but the most severe outcomes are associated with E. coli and group A streptococcus. In obstetrics, common infections are post-partum endometritis following CS or vaginal delivery, Lower UTI, Septic Abortion, chorioamnionitis, Necrotizing facitis, toxic shock syndrome, mastitis, wound infection and others.

Antibiotics :

A simple regimen such as ampicillin and once-daily gentamicin is recommended as first-line antibiotics for the treatment of chorioamnionitis. A combination of clindamycin and gentamicin is recommended as first-line antibiotics for the treatment of postpartum endometritis (WHO -2020). Cefuroxime or Cefotaxime and Metronidazole; with Clarithromycin or clindamycin and gentamicin as alternatives in those with penicillin allergy. In critically unwell patients, Piperacillin-Tazobactem or Meropenem and Gentamicin, may be preferred.

Sometimes antibiotics alone are inadequate and drainage of abscess or removal of infected material or surgery is required like Uterine evacuation, Hysterectomy, Abscess drainage, CS for Chorioamnionitis depending on the etiology.

WHO 2020: Routine Antibiotic administration is recommended for

- women with preterm prelabour rupture of membranes.
- women undergoing manual removal of the placenta
- women with a third- or fourth-degree perineal tear.
- women undergoing elective or emergency caesarean section.
- Vaginal cleansing with povidone-iodine immediately before CS is recommended.
- For caesarean section, prophylactic antibiotics should be given prior to skin incision, rather than intra-operatively after umbilical cord clamping
- Intrapartum antibiotic administration to women with group B Streptococcus (GBS) colonization is recommended for prevention of early neonatal GBS infection

Septic Abortion: Abortion usually considered septic when there is rise of temperature of at least 100.4°F (38°C) for 24 hours or more, offensive or purulent vaginal discharge and other evidences of pelvic infection such as lower abdominal pain & tenderness. It occurs when proper antiseptic and asepsis are not taken, when there is incomplete evacuation or inadvertent injury occurs to the genital organs and adjacent structures, particularly the bowels.In 80% of septic abortion, organisms are endogenous in origin, in 15 % cases iinfection produce localized endomyometritis and in 5 % cases it can cause generalized peritonitis and/or endotoxic shock. Active surgery may be required when suspected injury to uterus or bowel, presence of foreign body in abdomen, mass felt through fornix on P/V, unresponsive peritonitis s/o collection of pus or uterus is too big to safely evacuated per vaginum.

Steroids: Hydrocortisone should be reserved only for septic patients with refractory shock (those who remain hypotensive following initial fluid resuscitation and vasopressors). Patients receiving corticosteroids should be cautiously monitored for hyperglycemia and hypernatremia. Low dose steroids can be given for septic shock according to ICU policy. Administer recombinant human activated protein C according to ICU policy. Try to maintain glucose control < 180 mg/dl.

Prevention of DVT: It is essential in septic pregnant patients as both pregnancy and sepsis are associated with hypercoagulability. Methods of prophylaxis are the use of compression stockings, intermittent lower limb compression, and low molecular weight or unfractionated heparin.

IVIG: It is recommended for severe invasive streptococcal or staphylococcal infection if other therapies have failed because of its immunomodulatory effect. High dose IVIG has been used in pregnant women and is effective in exotoxin shock caused by streptococci and staphylococci

Delivery Decision: Generally, in a critically ill pregnant woman, birth of the baby may be considered if it would be beneficial to the mother or the baby or to both. Attempting delivery of unstable mother increases the maternal and foetal mortality rates unless the source of infection is intrauterine. If surgical intervention is mandatory, the anaesthetist has to make the decision on regional or general anaesthesia. Septic hypotensive patients may not tolerate the sympathetic block and vasodilatation associated with spinal anaesthesia. GA is highly likely to be required in a septic parturient.

Prevention:

- Routine perineal/pubic shaving prior to giving vaginal birth is not recommended.
- Take proper antiseptic and aseptic precautions during examination or operation.
- Train support staff for catheter care, I.V. line care, oral care, skin care, position care etc.
- Encourage abortion in legally practicing institutes only.
- Boost up family planning acceptance to prevent unwanted pregnancy.
- Take care of Pre-existing anaemia, DM and other co-morbidities during pre-conceptional period.

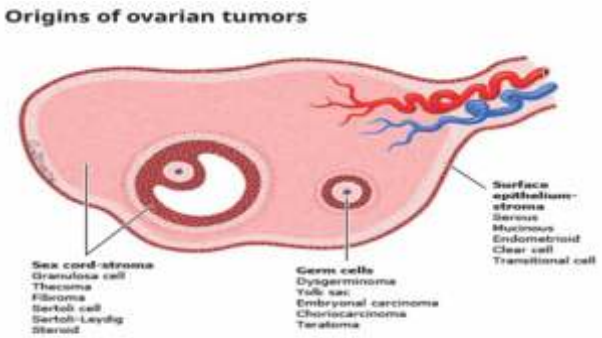
Evaluation of ovarian mass

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

Ovarian masses are a common gynecologic problem in females of all ages. In clinical practice, diagnostic dilemmas arise regarding whether the setumours are1) benign, 2) borderline malignant, or3) malignant.

1 Types of Ovarian Tumours

Primary ovarian tumours can be classified into threema in categories according to tumour origin:1) epithelial,2) germcell,or3) sexcord-stromal tumours.



Many epithelial ovarian carcinomas, such as high-grade serous carcinomas, originate in the fallopian tube epithelium.

2 Diagnostic Evaluation

2.1 Thorough medical history, taking into consideration

- Age
- Symptoms [bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, urinary symptoms (urgency or frequency)] and their duration. Women who have these symptoms almost daily for more than a few weeks should be evaluated carefully.
- Characteristics of the pain (if present)
- Menstrual history (including last menstrual period and presence/severity of dysmenorrhea)
- Sexual history
- Family history
- Presence/absence of infertility

Germ cell tumours affect the age group of 10 to 35 years predominantly. Stromal tumoursoccur in perimenopausal women in the age group of 40 to 50 years. Epithelial tumours can occur at any age but predominantly occur after 40 years of age.

2.2 Physical examination

Physical examination, including pelvic examination, assesses a mass's size, consistency, and mobility if palpable. Findings such as pain with palpation, abdominal distention, ascites, and a mass that is irregular, fixed, and associated with posterior cul-de-sac nodularity should be noted. Nodularity and fixation can be signs of endometriosis, infection, or malignancy. Signs of a hormonally active mass, such as virilisation, should also be noted.

Per-rectalexamination and breast examination also play an essential role.

Gynecologic: Ovarian	Gynecologic: Tubal	Gynecologic: Extraovarian and extratubal	Nongynecologic
Benign			
• Functional (physiologic) cyst • Corpus luteal cyst • Luteoma of pregnancy • Theca lutein cyst • Polycystic ovaries • Endometrioma • Cystadenoma • Benign ovarian germ cell tumor (eg, mature teratoma) • Benign sex cord-stromal tumor	• Ectopic pregnancy • Hydrosalpinx	• Paraovarian cyst • Paratubal cyst • Uterine leiomyoma (pedunculated or cervical) • Tubo-ovarian abscess	• Constipation • Appendiceal abscess • Diverticular abscess • Pelvic abscess • Bladder diverticulum • Ureteral diverticulum • Pelvic kidney • Peritoneal cyst • Nerve sheath tumor
Malignant or borderline			
• Epithelial carcinoma • Epithelial borderline neoplasm • Malignant ovarian germ cell tumor • Malignant sex cord-stromal tumor	• Epithelial carcinoma • Serous tubal intraepithelial neoplasia	• Metastatic endometrial carcinoma • Cystadenocarcinoma (rare)	• Appendiceal neoplasm • Bowel neoplasm • Metastasis (eg, breast, colon, lymphoma) • Retroperitoneal sarcoma

Figure 2. Differential diagnosis of an adnexal mass

2.3 Roleofimaging :

Diagnostic imagingis crucialindetecting, characterising and stagingadnexalmasses.

- USG
- MRI
- Contrast-enhancedCTscan
- PETCT

2.4 Assessing the risk of malignancy

2.4.1 USG

USG is the most commonly used first-line imaging technique. Due to its noninvasive nature, it is widely available and well-accepted by patients. USG characterises the mass. The goal is to determine whether the mass is "almost certainly benign" or whether it has some"reasonable chance of being malignant."

USG characteristics of malignant tumour

- solidcomponent
- papillaryprojection
- septations, if present, that are irregularly thick (>2to3mm)

The Doppler study can demonstrate both the presence and the localisation of new tumour blood vessels: a predominantly central blood flow is more often associated with malignancy, while a peripheral flow is more typical of a benign lesion.

the International Ovarian Tumor Analysis (IOTA) Rules and the Ovarian-Adnexal Reporting and System (O-RADS) are widely used.

The International Ovarian Tumor Analysis (IOTA) Simple Rules.

This is based on five ultrasound features indicative of a benign tumour (B-features) and five of a malignant tumour (M-features).

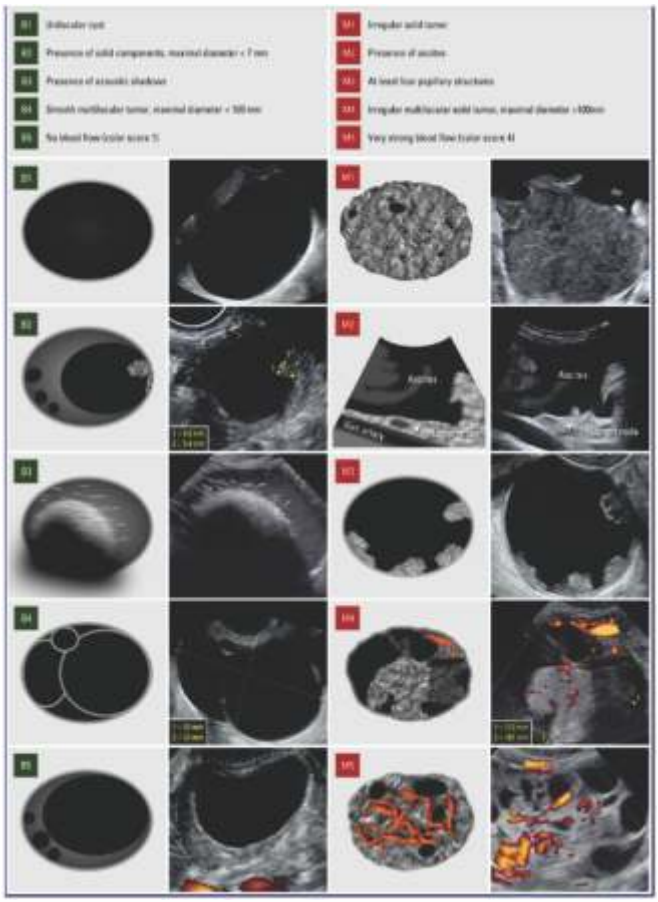


Figure 3. IOTA "Simple Rules": Benign and malignant features

Ovarian-Adnexal Reporting and Data System (O-RADS) of the American College of Radiology (ACR)

- Normal ovary (O-RADS 1)
- Almost certainly benign (O-RADS 2; <1% risk of malignancy [ROM])
- Low risk of malignancy (O-RADS 3; 1 to <10% ROM)
- Intermediate risk of malignancy (O-RADS 4; 10 to <50% ROM)
- High risk of malignancy (O-RADS 5; ≥50% ROM)

Observations that result in O-RADS 1 and 2 categorisations can be considered "almost certainly benign,", O-RADS 4 and 5 masses have a "reasonable chance of malignancy" and justify additional imaging or surgical intervention.

2.4.2 MRI

It is more sensitive and specific, with a higher positive predictive value than USG. MRI is best for indicated when the sonographer is unable to differentiate simple versus malignant.

- site of origin of a pelvic mass,
- to characterise ovarian mass as non-neoplastic or neoplastic (solid areas, necrosis, haemorrhage, abscess)
- to detect local invasion

Both T1- and T2-weighted sequences are needed. Fat-saturated T1-weighted images help detect haemorrhagic areas and fat tissue. IV gadolinium contrast improves the detection of enhancing septa and solid components within the mass of peritoneal and omental implants.

2.4.3 Contrast-enhanced CT

CECT has a limited value in the primary detection and characterisation of an ovarian mass.However, it can play an important role for

- evaluation of the spread of malignant lesions
- imaging technique of choice in staging, especially for omental and peritoneal implants, ascites and lymphadenopathy
- therapy response evaluation
- detection of recurrence after therapy

2.4.4 18F-FDG PET/CT

PET/CT is NOT indicated in the initial evaluation of ovarian mass as it may lead to false-positive and false-negative results.

- False positive can be seen in several benign lesions, e.g. physiological uptake in cyst fluid; teratomas and endometriomas may show FDG uptake.
- False negative in small lesion(<0.5cm), necrotic and low-grade tumour.

It can play a crucial role, especially when CT scans are negative, and there is a strong suspicion of malignancy, and serum marker(s) levels are increased. It can also be used to evaluate the recurrence of malignancy in selective cases.

2.5 Serum tumour markers

Tumour markers are the substances selectively produced by tumour cells and released into the circulation in detectable amounts. It may aid us for

- predicting the probability of mass being malignant
- disease extent
- response to treatment
- early diagnosis for recurrence of cancer after treatment on follow-up

• Type of ovarian cancer	Tumor marker
Epithelial (Serous , Mucinous, endometrioid , clear cell)	CA 125 CEA
Sex Cord stromal tumor (Granulosa , Sertoli Leydig)	Inhibin A , B AMH Estradiol Testosterone DHEA
Germ cell tumor (Dysgerminoma, yolk sac, Embryonal , choriocarcinoma)	BHCG AFP LDH
Metastatic GI / Other primary	CEA CA 19-9 CA125/ CEA ratio

2.5.1 Cancer antigen 125 (CA 125)

It is a commonly used marker which generally increases in epithelial ovarian tumours.

The upper limit for CA 125 is 35.0 U/mL in premenopausal and postmenopausal patients.

Limitations of CA 125 are:

- low sensitivity and a low overall specificity
- values will be lower in early-stage compared with late-stage disease
- not consistently produced by some histologic types of EOC, including mucinous, clear cell, endometrioid type

• can be high in **benign** conditions like fibroids, endometriosis, functional ovarian cysts, pregnancy, PID, TB, cirrhosis, abdominal /peritoneal infections, menstruation, smoking

• increase in other nonovarian malignancies, including metastases from the gastrointestinal tract, endometrial, or breast primary tumours

2.5.2 Human epididymis protein 4 (HE4)

HE4 is more sensitive and specific than CA 125.

HE4, when combined with CA-125, shows improved sensitivity and specificity, as in the ROMA index. Not recommended routinely in all ovarian lesions.

2.5.3 Carcinoembryonic antigen (CEA)

CEA is **Not** a primary marker of ovarian cancer; it has been studied in conjunction with CA-125 in the evaluation of tumour burden and prognosis.

• increase in certain malignancies, **primary GI- colorectal** and lung cancers

• increases in ovarian mucinous and sero-mucinous carcinomas

• increases in non-malignant gynecologic causes, inflammatory conditions, endometriosis.

2.5.4 Cancer Antigen 19-9 (CA19-9)

Pancreatic-biliary cancers commonly produce it. It may be increased in gynaecologic mucinous cancers and benign conditions like endometriomas and mature teratomas.

2.6 Algorithms based on combined tumour markers :

1)RMI (Risk of malignancy index)

2) ROMA (Risk of Malignancy Algorithm) are biomarker panels approved by the US Food and Drug Administration (FDA) to assess the likelihood of malignancy.

2.6.1 RMI -Risk of Malignancy Index

is a multimodal approach that combines pelvic ultrasound ("U"), menopausal status ("M"), and serum CA 125 into an index score)

I = U x M x CA 125

• "U" – The ultrasound result is scored 1 point for each of the following characteristics: multilocular cyst, solid areas, metastases, ascites, and bilateral masses. U = 0 for an ultrasound score of 0 points, U = 1 for an ultrasound score of 1 point, and U = 3 for an ultrasound score of 2 to 5 points.

• "M" – Menopausal status is scored as 1 = premenopausal and 3 = postmenopausal. "Postmenopausal" is defined as no menses for more than one year or a patient over 50 years of age who has had a hysterectomy.

• CA 125 – Serum CA 125 is measured in units/mL.

RMI is less sensitive but more specific than ROMA. The NICE guideline on ovarian cancer recommends that people with an RMI I score of 250 or more should be referred to a specialist gynaecologic oncologist.

2.6.2 ROMA- Risk of Malignancy Algorithm

ROMA is a non-proprietary algorithm which uses CA 125 and HE4 markers

• The score is interpreted as follows:

• Premenopausal patients – High risk of malignancy ≥13.1%

• Postmenopausal patients – High risk of malignancy ≥27.7%

Age	Sensitivity of ROMA index	Specificity of ROMA index
Pre menopausal	99%	74%
Post menopausal	92%	76%

A definitive diagnosis of ovarian neoplasm can only be made by histopathologic examination.

Preoperative biopsy :

Should **NOT** be performed in ovarian masses, particularly if the mass appears to be surgically resectable at the moment. As this invasive procedure raises the risk of spreading cancer cells and potentially leads to iatrogenic upstaging worsening the prognosis.

pre op biopsy is only done in cases where there is sure diagnosis of malignancy made with imaging and tumor markers ; and primary complete surgical cytoreduction is not possible due to extensive disease . As these patients receives neoadjuvant chemotherapy first .

Role of Frozen Section :

Intraoperative histological assessment of ovarian tumors helps to discriminate between benign, borderline and malignant ovarian tumors.

thus guides the operating surgeon in a direction toward the extent of the surgery.

it helps clinicians to select an appropriate surgical procedure for patients, avoiding both under and over-treatment; avoid extensive surgery, and make decisions about fertility-preserving surgeries in young patients, and avoid incomplete surgery in malignant tumors .

accuracy of intraoperative frozen section diagnosis for ovarian tumors ranges between 73% and 98%.

less sensitive to differentiate borderline versus malignancy, specially in large tumors mucinous variety; and less common histologies.

With proper pre operative work up - History, Examination, proper imaging , tumor markers , we can diagnose 70-90% times that the tumor is potentially borderline or malignant.

we can choose right surgical approach (open versus minimal invasive) ;avoid operative mishaps . And Can offer optimal oncological treatment and better survival outcome without major morbidity.

Pre-operative missed diagnosis of malignancy leads to

• incomplete surgeries

• improper surgical approach - Open/minimally invasive / fertility-sparing

• surgical spill - Upstaging of the stage in case of a malignant mass

• increased morbidity- Pt Requires repeat completion surgery

• overuse of chemotherapy

• increased Early recurrence (most times extensive widespread aggressive recurrence)

• decreased survival- overall life span(years of life) of patient

OBITUARY : DR. RAJAL THAKER

We are saddened to announce the passing of **Dr. Rajal Thaker**, a renowned gynecologist and beloved teacher at Shardaben Hospital. Dr. Thaker dedicated her life to medicine and education, leaving an indelible mark on her colleagues and countless students. Her commitment to excellence in patient care was matched by her passion for social work, as she tirelessly advocated for women's health and empowerment in underserved communities. She was President of AOGS 2020-21 and was a caring soul for birds and animals. Her compassion, wisdom, and generosity touched the lives of many. Dr. Thaker will be deeply missed by her family, friends, patients, and all who had the privilege of knowing her.









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2	Causing injury or hurt to Doctor or Medical staff	Voluntarily Causing hurt (by dangerous weapons)	115, 116, 117, 118	3 to 7 years imprisonment + Fine
3	Threat to Doctor or Medical Staff	Criminal intimidation	351(2)	2 years imprisonment + Fine
4	Attack on Govt Doctor / Govt Medical Staff	Voluntarily causing hurt or grievous hurt to deter public servant from his duty.	121(2), 224	3 to 10 years imprisonment + Fine
5	Damage to Hospital, Property and equipment	Mischief, and causing damage	324 (4), (5), (6)	2 to 5 years imprisonment + Fine (3 times of the cost)
6	Mob Attack / Forceful Entry into the Hospital	House-trespass / unlawful assembly / criminal trespass (with deadly weapon)	189, 190, 329, 330, 331, 332, 333	1 to 7 years imprisonment + Fine
7	Attack and harassment to lady doctor	Assault or use of criminal force to woman with intent to outrage her modesty	74	1 to 5 years imprisonment + Fine
8	Wrong or defamatory news posting against a doctor or hospital in newspaper or social media	Defamation	356(1), (2)	2 years imprisonment + Fine

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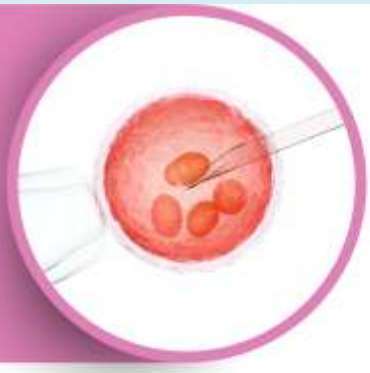

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