AHMEDABAD OBSTETRICS & GYNAECOLOGICAL SOCIETY

AOGS TIMES

2024 - 25

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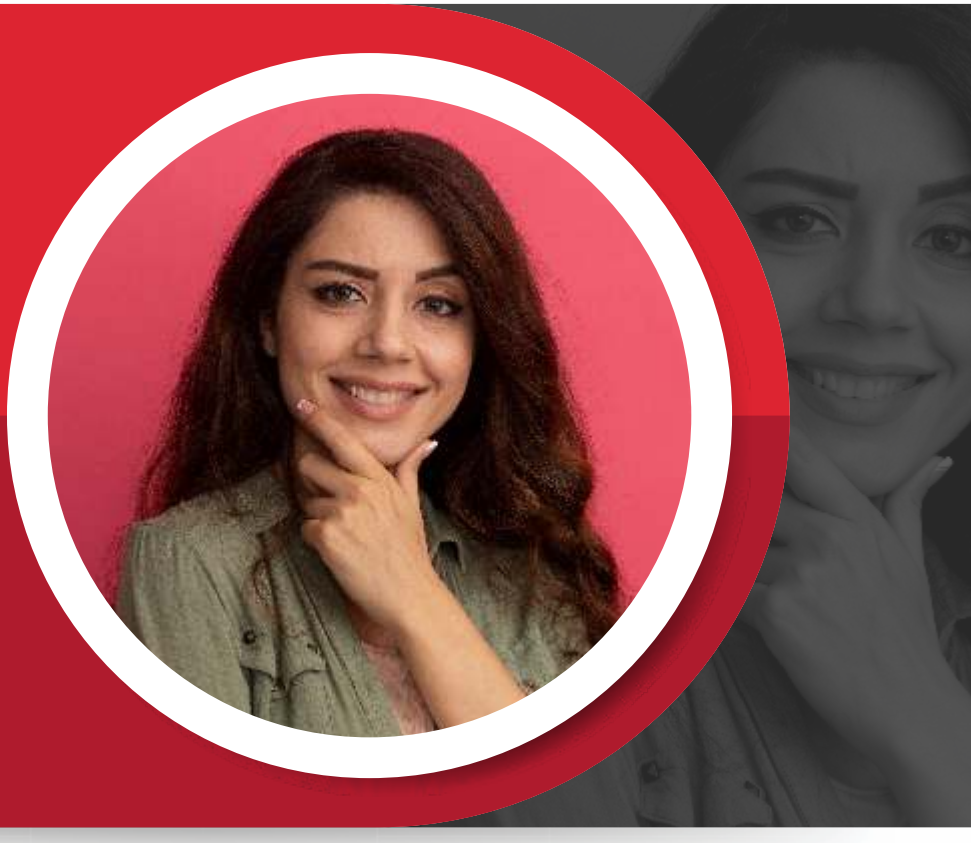
DECEMBER 2024 I VOLUME 09

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

President
Dr. Sunil Shah
+91 90999 77077
sunilshah0501@gmail.com

Hon. Secretary
Dr. Akshay C. Shah
+91 94264 85805
drshahakshay1974@gmail.com

Health & Happiness for Her



President - Elect
Dr. Nita Thakre
+91 98250 42238
drthakre@gmail.com

Vice President
Dr. Parth Shah
+91 94296 17556
parthpjs@yahoo.com

Hon. Treasurer
Dr. Munjal Pandya
+91 97129 11784
munjal171184@gmail.com

Hon. Jt. Secretary
Dr. Mehul Sukhadiya
+91 98254 40292
mehulsukhadiya@yahoo.com

Clinical Secretary
Dr. Arati Gupte
+91 96620 28127
arati2811@gmail.com

www.ahmedabadobgyn.org

2nd Floor, Dream Icon @ PARIMAL, Nr. Krupa Petrol Pump, Nr. Kalgi Cross Road, Surendra Mangaldas Rd, Ellisbridge, Ahmedabad, Gujarat 380006 Phone : 079 - 26586426 M : +91 78610 11818 I E-mail : office@ahmedabadobgyn.org

TEAM AOGS MESSAGE

Dr. Sunil Shah
President

Dr. Akshay C. Shah
Hon. Secretary

Dear AOGS members,

Wishing you all a wonderful summer and happy Holi in advance.

We are about to finish our term as new elections are coming soon. We will have new team soon under able leadership of Dr. Nita Thakre. I wish her good luck for successful tenure. Our election dates are informed here in the bulletin. Please confirm it with the office. I request all to participate in the election. For last 5 years we are using electronic medium for voting., so everyone can utilise their voting rights from home or hospital at anytime during stipulated voting dates.

In all bulletin we tried to cover different topics which are useful to the members of association. Wishing you a happy reading. It's a request to all if you want to share and write which is good academically and socially you can reach to us we will try to include in the bulletin.

Thank you very much and regards,

SURGICAL MANAGEMENT OF STRESS URINARY INCONTINENCE

Dr. Nita A. Thakre

INTRODUCTION

Stress urinary incontinence (SUI) is a prevalent condition, particularly among women, characterized by the involuntary leakage of urine during activities that increase intra-abdominal pressure such as coughing, sneezing, or exercising. Female stress urinary incontinence (SUI) is a condition that can cause significant distress to patients and occurs in approximately 20% of women, making it a major cause of reduced quality of life. Therefore, timely diagnosis and appropriate treatment for SUI is critical.

Nonoperative/conservative management options stand as the first-line of management strategy for SUI. Surgical options are reserved for cases with failed medical/conservative treatments. Conservative treatments like pelvic floor exercises and lifestyle modifications can be effective for some, others may require surgical intervention to achieve satisfactory symptom relief. Surgical management of SUI aims to restore the support of the urethra and bladder neck, thereby preventing urine leakage. These procedures range from minimally invasive sling operations to more complex reconstructive surgeries, each with its own benefits, risks, and success rates. Understanding the surgical management of SUI is essential for healthcare providers to offer informed recommendations and for patients to make educated decisions about their treatment options.

Some patients discontinue conservative therapy or become dissatisfied with its outcomes. For these individuals, surgery becomes the primary treatment for stress urinary incontinence (SUI). The aim of surgical intervention is to enhance urethral resistance to prevent urine leakage during increases in intra-abdominal pressure while maintaining voluntary, low-pressure, and complete bladder emptying.

Numerous surgical options exist for treating stress urinary incontinence (SUI). To determine the most appropriate surgical therapy, several factors must be considered. Such as:

The severity of SUI

Table 1 Goals of surgical options for stress urinary incontinence

Surgical option	*Goal*
Anterior repair	Reposition the urethra or "plicate" the sphincter
Retropubic approach: MMK, Burch colposuspension	Reposition and/or stabilize the urethra or create a "backboard" of support for urethral compression during increased intra-abdominal pressure
Vaginal approach: Pereyra, Stamey, Gittes, Raz	Same as retropubic approach with the avoidance of a large abdominal incision and associated morbidity
Sling: Autologous, cadaveric, synthetic, vaginal wall, etc.	Same as retropubic approach with/ without direct urethral coaptation or compression
TVT and other polypropylene midurethral slings	Provide dynamic midurethral support
Artificial urinary sphincter	Provide intermittent, dynamic urethral coaptation and compression
Bulk injectables	Improve urethral coaptation
Radiofrequency	Reposition or stabilize the urethra

- Associated conditions such as vaginal prolapse
- Any concurrent abdominal or pelvic pathology requiring surgical correction.

Generally, surgical correction of female SUI focuses on one of two primary goals:

1. Repositioning or stabilizing the urethra and bladder neck in a well-supported retropubic position.
2. Enhancing urethral resistance through augmentation of the intrinsic sphincter.

For patients with SUI primarily caused by hypermobility of the bladder neck and proximal urethra (anatomic incontinence), surgical interventions that restore or stabilize the bladder neck to its normal anatomical position can achieve success rates of 80%–90%. Conversely, for patients with significant intrinsic sphincter deficiency (ISD), especially those with or without anatomical hypermobility, simply restoring normal anatomy may not be sufficient (**Table 1**).

ANTERIOR REPAIR (KELLY PLICATION)

Historical background: The Kelly plication procedure, introduced in 1914 by Dr Howard A. Kelly and colleagues at Johns Hopkins Hospital, remains in use among surgeons despite its limitations in long-term efficacy and durability.

Procedure details: The Kelly plication involves making a midline incision in the anterior vaginal wall and plicating the endopelvic fascia at the level of the bladder neck. This plication acts as a buttress to support the urethra. It is often performed in conjunction with an anterior colporrhaphy, particularly in patients presenting with a mild to moderate cystocele. The technique is relatively straightforward and avoids the need for a retropubic dissection. It is associated with a low complication rate.

Clinical outcomes: Despite its ease of performance and low rate of complications, the long-term success of the Kelly plication is poor compared to other surgical options for SUI. As a result, recent guidelines from the International Consultation on Incontinence (ICI) do not recommend Kelly plication for the definitive treatment of SUI.

TRANSABDOMINAL (RETROPUBIC) SUSPENSION

Description and historical background: The transabdominal approach to vesicourethropexy has been a mainstay in surgical practice for many years. This method offers several advantages, including its durability and the ability to address concurrent abdominal pathologies through the same or slightly extended incision.

Advantages

- *Durability*: Transabdominal suspension procedures are known for their long-lasting effects.
- *Opportunity for concurrent pathology repair*: Surgeons can address other abdominal issues simultaneously during the procedure.

Disadvantages

- *Large incision*: The transabdominal approach typically requires a significant incision.
- *Prolonged hospital stay and recovery period*: Patients undergoing this procedure may experience longer hospitalization and recovery times.

- *Limitations in addressing vaginal pathology*: Unlike some other approaches, the transabdominal method may not allow for the simultaneous repair of coexisting vaginal pathologies.

Common types of procedures: The three most prevalent forms of open retropubic suspension procedures are:

1. Marshall-Marchetti-Krantz (MMK) procedure
2. Burch colposuspension
3. The paravaginal (Richardson) repair

These surgeries boast excellent long-term success rates, often exceeding 80% at four years postoperation.

MMK Urethropexy

Description and historical background: The MMK procedure, first described in 1949, involves entering the space of Retzius to mobilize the anterior bladder and urethra. The periurethral fascia is anterolateral to the urethra is then sutured to the posterior periosteum of the symphysis pubis using 2 or 3 sutures, extending from the midurethra to the bladder neck.

Procedure Details

- *Entry into the space of Retzius*: The surgical approach involves accessing the space of Retzius.
- *Mobilization of bladder and urethra*: The anterior bladder and urethra are carefully mobilized.
- *Suturing of periurethral fascia*: The periurethral fascia is sutured to the posterior periosteum of the symphysis pubis to provide support to the urethra.
- *Additional fixation (optional)*: In some cases, the anterior bladder wall may also be fixed to the posterior rectus sheath.
- *Limitations*: The MMK procedure is not effective for correcting a moderate cystocele.

Risks and Complications

- *Osteitis pubis*: The MMK procedure carries a risk of osteitis pubis, estimated at 2.5%.
- *Urethral obstruction and voiding dysfunction*: There is a risk of urethral obstruction and subsequent voiding dysfunction associated with the MMK procedure, although it is less common than with other surgical procedures for stress urinary incontinence (SUI).

Bursch Colposuspension[1]

Description and procedure: Burch colposuspension involves mobilizing the bladder neck and proximal urethra in the retropubic space. Suspended sutures are then placed laterally into the tissue on either ipsilateral Cooper's ligament (ileopectineal ligament). This technique supports the vesicourethral junction within the retropubic space.

Clinical Considerations

- *Correction of cystocele*: Burch colposuspension can effectively correct a mild to moderate cystocele.
- *Guideline recommendations*: The European Association of Urology (EAU) guidelines recommend Burch colposuspension if midurethral slings cannot be considered as a treatment option.

Complications

- *Risk of enterocele formation*: However, there is a potential risk of postsurgical de novo enterocele formation.
- *Voiding difficulty*: Complications associated with Burch colposuspension include voiding difficulty, occurring in approximately 10.3% of cases.
- *De novo detrusor overactivity*: Another potential complication is de novo detrusor overactivity, affecting approximately 17% of patients.
- *Genitourinary prolapse*: Genitourinary prolapse, including enterocele, cystocele, or rectocele, may occur in about 13.6% of cases.

Laparoscopic Procedures

Description and benefits: Laparoscopic bladder neck suspension offers several potential advantages, including:

- *Reduced blood loss*: Compared to traditional open surgery, laparoscopic procedures typically result in less intraoperative blood loss.
- *Decreased pain*: Patients may experience less perioperative pain with laparoscopic techniques.
- *Shorter catheterization and hospitalization*: The duration of catheterization and hospital stay may be shorter with laparoscopic bladder neck suspension.
- *Approaches*: Both retroperitoneal and intraperitoneal approaches have been described for laparoscopic bladder neck suspension. Each approach has its own set of advantages and considerations.
- *Importance of surgeon experience*: Success with laparoscopic procedures may be closely linked to the individual surgeon's experience and proficiency in performing these types of surgeries. Surgeons who are skilled and experienced in laparoscopic techniques may achieve better outcomes for their patients.

TRANSVAGINAL NEEDLE SUSPENSION PROCEDURES

Advantages

- *Avoidance of large abdominal incision*: The transvaginal approach eliminates the need for a large abdominal incision, reducing surgical trauma.
- *Shorter operative times*: Procedures performed transvaginally typically have shorter operative times compared to abdominal approaches.
- *Reduced postoperative discomfort*: Patients may experience less postoperative discomfort with transvaginal procedures.
- *Shorter hospital stay*: Transvaginal surgeries often result in shorter hospital stays, facilitating faster recovery.
- *Ability to address vaginal pathology*: The transvaginal approach allows for simultaneous repair of coexisting vaginal pathology, such as prolapse, through the same or slightly extended incision.

Disadvantages

- *Poor intraoperative visualization*: Limited visualization during the procedure can pose challenges for accurate needle placement.
- *Risk of bladder and urethral injury*: Blind passage of needles through the retropubic space carries a risk of injury to the bladder and urethra.
- *Risk of significant bleeding*: Poor access from vaginal incisions may increase the risk of significant bleeding in the retropubic space.
- *Infection or erosion of foreign body*: There is a risk of infection or erosion associated with the use of foreign bodies during the procedure.

SLING PROCEDURES

Historical overview: Sling procedures,[2] originally described almost 100 years ago, have gained popularity over the past several decades. Unlike transabdominal or transvaginal approaches to urethropexy, sling surgery aims to provide support for the vesicourethral junction while also facilitating urethral coaptation or compression.

Midurethral slings: Midurethral[3] slings have emerged as the standard surgical treatment for stress urinary incontinence (SUI) due to their minimal invasiveness and high efficacy. Traditionally, autologous rectus fascia and fascia lata were commonly used as sling materials. However, synthetic slings made primarily of polypropylene mesh, such as tension-free vaginal tape (TVT-R), are now prevalent. These synthetic slings are placed at the midurethra level and function by reducing urethral mobility or creating a dynamic kink in the urethra during intraabdominal pressure increases.

Procedure details: Introduced in the mid-1990s, TVT is a minimally invasive surgical therapy for women with SUI. The procedure involves making two small incisions in the lower abdominal wall and a 1- to 2-cm incision in the vaginal wall overlying the midurethra. A long, thin strip of polypropylene mesh tape is then passed through the retropubic space and positioned underneath the urethra.

Outcomes: TVT has demonstrated superior objective cure rates and low failure rates. Complication rates are minimal when performed by experienced surgeons, with urinary retention and de novo urgency or urge incontinence occurring

in very few patients. However, there is a slightly higher risk of complications, including intraoperative bladder perforation, urinary retention, and de novo urgency or urge incontinence occurring in very few patients.

On the other hand, TOT was described later when Delorme performed an "outside-in" approach and subsequently an "inside-out" procedure. TOT was developed in an effort to provide a sling that could avoid passage through the retropubic space and potentially decrease complication rates.

NEW SURGICAL METHODS FOR SUI TREATMENT

Introduction of single-incision mini-slings: In response to complications associated with conventional midurethral slings, new surgical methods have been introduced for the treatment of stress urinary incontinence (SUI) in women. Single-incision mini-slings[4] offer a solution to overcome the drawbacks of traditional midurethral slings.[5] These innovative methods involve using a short tape through a single vaginal incision, eliminating the need for passage through the retropubic or obturator spaces. By utilizing this approach, single-incision mini-slings can significantly reduce the risk of various complications, including nerve or vessel injury and groin-related issues.

Efficacy of slings: Long-term studies evaluating slings made of both autologous and synthetic materials have shown promising results. Cure rates exceeding 80% and rates of improvement greater than 90% have been reported, indicating the effectiveness of sling procedures in managing SUI.

Regulatory actions and safety concerns: In 2008, the US Food and Drug Administration (FDA) issued a Public Health Notification and Safety Communication following the reporting of over 1,000 transvaginal mesh-related complications in the Manufacturer and User Device Experience database. While the FDA strongly cautioned against the use of transvaginal mesh for pelvic organ prolapse (POP) repair in 2011, no definitive claims were made regarding synthetic midurethral slings for SUI treatment. Despite the reclassification of meshes used for POP repair as class III devices by the FDA, similar actions were not taken for midurethral slings. In 2014, the UK Medicines and Healthcare Products Regulatory Agency (MHRA) stated that, from a regulatory perspective, the benefits of using these devices outweighed the associated risks.

Bulking Agents

Introduction: Bulking agents, administered periurethrally, have been utilized for decades in the treatment of stress urinary incontinence (SUI) in women. Various substances have been employed, including bovine glutaraldehyde cross-linked collagen, polytetrafluoroethylene, silicone, carbon-coated zirconium beads, and autologous tissues such as fat and cartilage. Despite extensive use, the ideal periurethral injectable agent has yet to be identified.

Administration and mechanism: Most periurethral agents are injected retrogradely under direct cystoscopic guidance. The exact mechanism by which these injectable agents exert their beneficial effects on continence remains unclear. While suggestions of an obstructive or improved "seal" effect have been proposed, a definitive mechanism has not been established. Initially believed to be most effective in patients with intrinsic sphincter dysfunction (ISD), subsequent reports indicate clinical efficacy in individuals with urethral hypermobility as well.

Comparison to surgical intervention: Periurethral injectable therapy is considered inferior to anti-incontinence surgery, particularly in long-term follow-up. While bulking agents may offer symptomatic relief, they are not recommended for patients requiring definitive treatment for SUI according to the European Association of Urology (EAU) guidelines.[6]

Artificial Urinary Sphincter Placement

Introduction: In France, the placement of an artificial urinary sphincter (AUS) is a prevalent option for the treatment of stress urinary incontinence (SUI) in women. This approach is particularly beneficial for cases of recurrent SUI and intrinsic sphincter dysfunction (ISD), where other treatments may have failed.

Procedure: The AUS consists of a silicone cuff placed around the urethra, a pressure-regulating balloon, and a control pump usually positioned in the labia or lower abdomen. The cuff compresses the urethra to prevent urine leakage, and when urination is desired, the patient manually deflates the cuff using the control pump.

Indications

- *Primary use*: AUS placement is typically considered for women with recurrent SUI or significant ISD who have not responded well to other surgical interventions.
- *Recurrent SUI*: Particularly effective for patients who have experienced surgical failure or have undergone multiple prior SUI surgeries.

Outcomes: According to various studies, AUS placement can offer excellent functional outcomes in women with recurrent SUI and ISD. Patients often report significant improvements in continence and quality of life following the procedure.

Exploration: While AUS placement shows promise, further research, and long-term data are needed to fully establish its efficacy and safety profile in women with recurrent SUI and ISD. Continued advancements in device technology and surgical techniques may enhance outcomes and reduce complications.

Conclusion

In conclusion, the surgical management of stress urinary incontinence (SUI) offers effective solutions for those who do not respond to conservative treatments. These interventions have proven success rates and can significantly improve the quality of life for patients. However, the choice of procedure must be carefully considered based on patient-specific factors, including the severity of incontinence, overall health, and personal preferences. Ongoing advancements in surgical techniques and materials continue to enhance outcomes and reduce risks.

Artificial urinary sphincter placement is a viable option for women with challenging cases of SUI, particularly those involving recurrent incontinence and intrinsic sphincter dysfunction. While it presents a promising solution, further exploration, and data are necessary to optimize patient selection and procedural outcomes.

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CME - 26.01.2025, SUNDAY
















DEMYSTIFYING CONFUSION OF ANEUPLOIDYSCREENING TEST

Dr. Jayprakash Shah
Director Rajni women's hospital
Fetal medicine expert

Dr. Parth Shah
Consultant at Rajni women's hospital
Endoscopy surgeon and fetal medicine expert

Declaration –

This Discussion is not to promote any Lab / Test / False Recommendation. As lot of confusion and query is raised by fellow colleagues. This is an effort to give healthy and simplified version and explanation is given.

Lets us First Understand some terms

Screening VS Diagnostic Test–

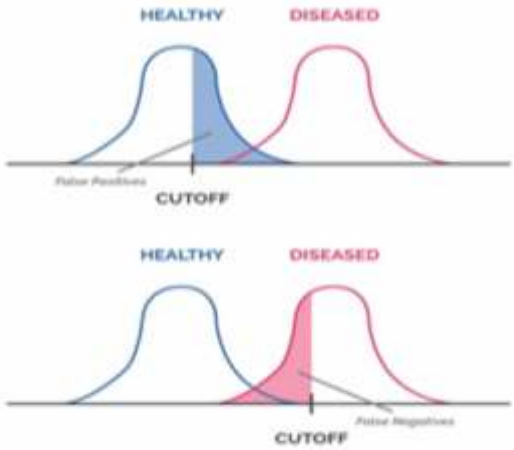
Screening test is "for all" whereas diagnostic test is for Indicated and high risk category cases for definitive confirmation. Example –Thalassemia screening test is recomended for all (pregnant / School going/premarital test, for school and college students it is done free of charge by govt and muni corporation authority)but CVS/ Amnio for Thalassemia mutation is for thalassemia minor couple only as prenatal diagnostic test

Screening test–

Medical Test / Procedure that checks for Disease / Condition and result will be given as Screen Positive / Screen Negative , which does not mean disease positive or negative .

Sensitivity and Specificity of test-

Test with high sensitivity is focused on finding actually more True positive disease case detection. Test with high specificity is focused on to rule of who do not have disease i.e. ruling out true negative for disease. for Example in figure 1.1 – if we keep cut off low - more number of healthy will be included as screen Positive(false Positive) and will be subjected to more definitive test to be offered. and if we keep cut off high more number of diseased person will be missed (False Negative).



Pretest Counselling and Post test Counselling-

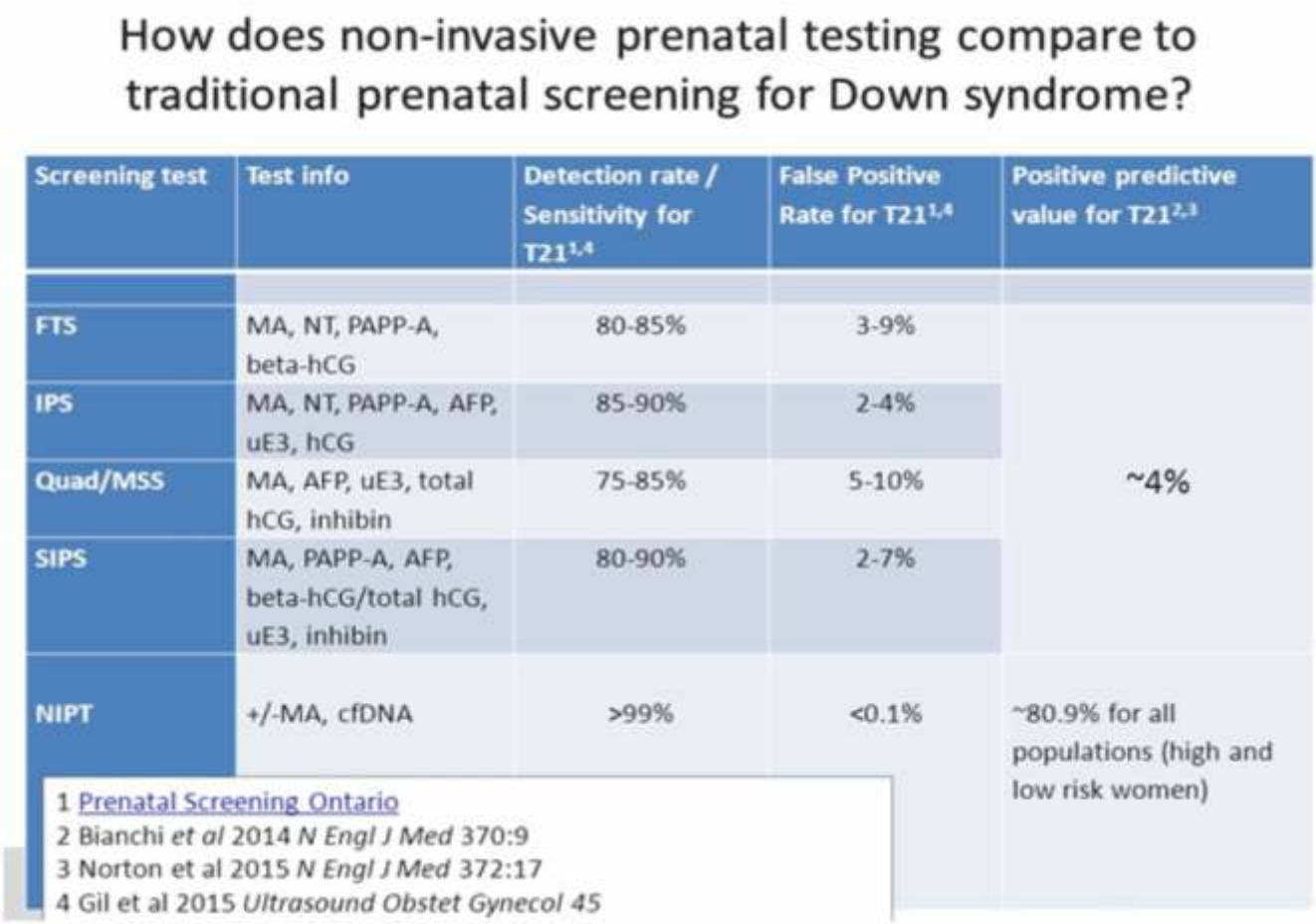
Before offering / suggesting / advise any screening or diagnostic test, couple and family need to be counselled about particular disease, its impact , why to test , benefit of test and disadvantage of No test result , Cost and what can be outcome of test with further possible management . Also Post test result need to be counselled for result and further steps .At any time, couple is free to decide not to opt for test can mention this counselling in OPD paper.

Option of Aneuploidy screening Test available–

- Good 11-14 weeks scan with FMF protocol (usg can't be replaced- Point of good practice)
- Double marker (11 - 14 weeks)

- Quadruple / Tripple marker (16 weeks onwards - till 20 weeks)
- NIPT (Best Screening if cost ignored)

Comparison in figure 1.2



How does non-invasive prenatal testing compare to traditional prenatal screening for Down syndrome?

Screening test	Test info	Detection rate / Sensitivity for T21[1,4]	False Positive Rate for T21[1,4]	Positive predictive value for T21[2,3]
FTS	MA, NT, PAPP-A, beta-hCG	80-85%	3-9%	~4%
IPS	MA, NT, PAPP-A, AFP, uE3, hCG	85-90%	2-4%	
Quad/MSS	MA, AFP, uE3, total hCG, inhibin	75-85%	5-10%	
SIPS	MA, PAPP-A, AFP, beta-hCG/total hCG, uE3, inhibin	80-90%	2-7%	
NIPT	+/-MA, cfDNA	>99%	<0.1%	~80.9% for all populations (high and low risk women)

1 Prenatal Screening Ontario
2 Bianchi *et al* 2014 *N Engl J Med* 370:9
3 Norton et al 2015 *N Engl J Med* 372:17
4 Gil et al 2015 *Ultrasound Obstet Gynecol 45*

As discussion is for Blood test to do or not , First Trimester ultrasound is not be discussed here . Good Scan is first step with Preterm delivery and Preeclampsia screening and good anatomical survey for malformation. it can be combined and followed by other biomarker or NIPT (Some recommend NIPT even without basic 11-14 weeks scan, not having good support and recomendation by guidelines) , .

Advantages of Each test

1) **Double marker – can be integrated with NT , NB parameter and combined test have sensitivity of 90-93% with FPV of 2.5 % . Early test (11-13 weeks) . Extra risk assessment for Preeclampsia , FGR and placenta (PAPP-A MOM Value as Cut off) , Low Cost , Time Tested**
2) **Quadruple marker – For Late comers , cost effective but having low sensitivity and specificity**
3) **NIPT – Best for Tri 21. good for T13, 18 21 also give fair risk for sex chromosomal abnormalities and other Aneuploidy , cost has dropped gradually**

Disadvantages

1) **Double marker – Good NT scan with FMF protocol is must. Alone DM sensitivity can be as low as 60% , High false positive , lab to lab variation and sample alteration with temperature and transportation of sample.**

2) **NIPT – High cost, false impression that genetic disease are ruled out. Low sensitivity for rare mutation testing , No call result in low fetal fraction, Obese patient/ early gestaion 9-10 weeks.**

Recommendation

1) FOGSI-ICOG Good Clinical Practice Recommendations – Aneuploidy screening to be discussed and Offered. But no compulsion to patient by counsellor .

2) NHS recommendations are:

- Pregnant women should be informed of common fetal aneuploidy that can be detected, risks for chromosomal abnormality according to the maternal age, detection rate and false positive rate for common fetal aneuploidy with each screening test, limitations, as well as the benefits and risks of invasive diagnostic testing,
- It is ideal to give counselling about prenatal aneuploidy screening and diagnostic testing at the first prenatal visit, and counselling is recommended to be given early in pregnancy,
- All pregnant women should be informed about maternal serum screening regardless of their age,
- cfDNA screening can be used for the screening of trisomy 21, 18, 13 and sex-chromosome aneuploidy. It is not recommended for the screening of microdeletion,
- The optimal timing of cfDNA screening is 10 weeks of gestation and beyond, and
- cfDNA screening is not recommended for women with multiple gestations.(Limited Data)

3) The American Society of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) released Practice Bulletin 226, "Screening for Fetal Chromosomal Abnormalities," in October 2020, advocating that all pregnancies be screened with NIPT. This guideline endorses NIPT as the most sensitive and specific prenatal screening option versus traditional screening methods. My say for Americans – Land of opportunity and Law Suit –American society opposed NT implication .

Indian Scenario

As FOGSI recommended – Aneuploidy pretest counselling to be done and test to be offered **(No compulsion).** Incurrent scenario when patient is forcedfor test without information ,many confusion has arise between patient and doctors . 1)After High risk report patient's misinterpretation pregnancy termination happens 2)when high promises given at time of NIPT test and later Confirmatory genetic testing require patient loose faith in fraternity and allegation game starts .3)in scenario of NIPT reports inconclusive or Low DNA fraction - patient Refuses for repeat sample .4) Any strong marker in sonography – there is no role of NIPT , definitive test is must .

To Conclude,

- Proper cafeteria approach non forced counselling of test will help in more detection of aneuploidy.
- Proper 11-14 weeks scan (FTS)can't be replaced .
- NIPT has an upper edge and may be offered with proper counselling
- FTS + DM still work as good screening test with cost advantages in Indian scenario.

Ahmedabad Obstetrics and Gynaecological Society (AOGS)

Electoral Notification for year 2025-2026

The nominations are invited on prescribed form for the following posts of Ahmedabad Obstetrics and Gynaecological Society for the year 2025- 26

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. To contest candidate should be member of Ahmedabad Obstetrics and Gynaecological Society, Social Security Scheme. (AOGS SSS)*
3. 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).
4. 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.
5. 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.
6. President-Elect will be the president for the year 2026-2027.(no election for the post of president)
7. A member who has served as president of AOGS cannot contest for the post of treasurer.
8. The tenure for each post is of one year.
9. No member shall remain on the same post for more than three (3) consecutive terms.
10. The proposer, seconder and the candidates should be in good standing position without any outstanding fees/dues towards society(AOGS)
11. A member can contest for the one post only.
12. In case of valid nominations for more than one post, all nominations shall be considered invalid.
13. 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
14. Please use prescribed form only.Nomination on and in any other form will beconsidered invalid.
15. Nomination form will be rejected if nomination form is incomplete or form found with incorrect information.
16. **Important dates for election:**

a. The nomination forms will be available from (1) AOGS office (during office hours2pm to 6:30 pm). (2) AOGS Website (3) AOGS Whatsapp / Email link from **3rd March, 2025.**
b. The duly filled nomination form with required nomination fees should reach AOGS office **before 5 pm. on date:06.03.2025**
c. Last date for withdrawal is **08.03.2025 by 5 pm**
d. Scrutiny of forms by managing committee (MCM) on **08.03.2025 at 8.00pm**

17. 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 **15.03.2025at 09.00 am to date17.03.2025at 06.00 pm**

18. Annual General Body Meeting at 2nd Floor, Dream Icon @ PARIMAL, Nr. Krupa Petrol Pump, Nr. Kalgi Cross Road, Surendra Mangaldas Rd, Ellisbridge, Ahmedabad will be held on **Date 17.03.2025 at 8.00 pm.**
19. Result of election will be declared in Annual General body by President on **17.03.2025**
20. In case of any kind of dispute, the decision of the president will be final.

Dr. Akshay Shah
Hon. Secretary

Ahmedabad Obstetrics & Gynaecological Society

Nomination form for Annual Electionfor year 2025-2026

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 2025-26

Signature of Proposer:_____

I,Dr._____second name of

Dr._____for above said post for annual

election of AOGS for year 2025-26

Signature of seconder:_____

I,Dr._____give consent to contest for above

said post for annual election of AOGS for year 2025-26 and my Ahmedabad Obstetrics and Gynecological Society Social Security Scheme no is _____

Signature of Candidate:_____

.....

For office use

Received nomination with requisite fees from Dr._____for annual election of AOGS for year 2025 -26

Dr.Akshay Shah
Hon. Secretary, AOGS

SNEH hospital
ASSURING BETTER HEALTH
AN ISO 9001 : 2008 CERTIFIED HOSPITAL

Advanced IVF Lab Setup At Bopal Center


ICSI Unit


Laminar Flow & Microscope


Co_2 Incubator


Dry Incubator


Incubators Tri Gas

SNEH IVF EXPERT TEAM

DR NISARG DHARAIYA
(Chairman & Director, IVF Specialist)

MANINAGAR (HO):
Dr Ushma Patel I Dr Shetal Deshmukh
Dr Krunal Modi I Dr Kushal Shah I Dr. Ami Patel

PRAHLADNAGAR:
Dr Khushali Shah I Dr. Sadhana Fufal

GOTA: Dr Kajal Jajal

BOPAL: Dr Kanthi Bansal I Dr Rushi Patel

VADODARA: Dr Dipa Patel I Dr Tejal Shah

EXPERIENCED TEAM WITH MORE THAN 1,00,000 INFERTILITY TREATMENT CASES....

OUR SERVICES:
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MANINAGAR (HO)
Sneh Hospital, Hateshwaar Circle to Seven day school road. Maninagar.

PRAHLADNADAR
3rd floor Sanjanand Palace, Above Gopi Dining Hall, Prahladnagar.

GOTA
2nd Floor, Shree Vishnudhora Gardens, Jaguar Showroom Road, Jugotpur, Gota.

BOPAL
1st Floor, Turquoise-3, Nr. Urban Health Center, Gala Gymkhana Road, Bopal, Ahmedabad-58.

BRANCHES:
GUJARAT: VADODARA | RAJKOT | JAMNAGAR | JUNAGADH | BHUJ | MORBI | ANJAR
RAJASTHAN: BARMER | BALOTARA | SANCHORE | BASWARA