GUWAHATI OBSTETRIC AND GYNAECOLOGICAL SOCIETY

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COVER DESIGN "PROMISES TO BE KEPT, POSSIBILITES NOT BEREFT, GENERATION TO BE USHERED , BLOSSOM YET TO BLOOM"

PRAGYAA PRAAPTI BORA

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Keshab Mahanta

सत्यमेव जयते

MINISTER
Health & Family Welfare Dept.
Medical Education & Research Dept.
Science,Technology & Climate Change Dept.
Information Technology Department

MESSAGE

Importance of Obstetrics and Gynaecology is deemed very crucial in today's medical scenario. We all know that the healthy future of society depends on the health of the children of today and their mothers, who are the guardians of that future. A child cannot stay healthy and happy in the absence of a healthy and happy mother. A child's health and well-being depend upon the mother's health up to a great extent. Therefore, prenatal & postpartum maternal health is critical to the physical & mental well-being of a mother. At the same time, maternal and child Mortality and morbidity are considered key indicators as they reflect the state of female healthcare. As such, the Government of Assam has given full priority in intensifying the efforts towards improving maternal and newborn health in the state. Under the National Health Mission, concentrated efforts and strategically focused interventions have already been initiated in order to upgrade the status of maternal health in Assam in the last few years. Here, I would like to extend my gratitude to our Obstetricians and Gynaecologists who have always been playing a great role in ensuring the health of both expecting mother and the child in the society.

It gives me immense pleasure to know that the annual general body meeting of Guwahati Obstetric and Gynaecological Society, an affiliated member society of the Federation of Obstetric and Gynaecological Society of India (FOGSI), is going to be held on September 25, 2022 at Guwahati.

I wish the annual general body meeting and release of the Bulletin all success.

(Keshab Mahanta)

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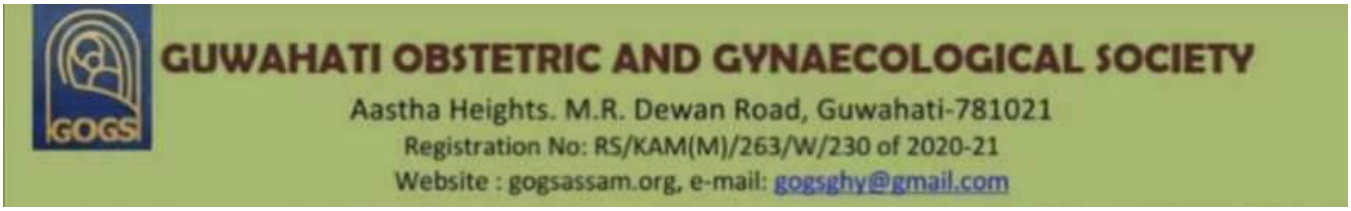

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Guest article

Scientific paper

Mixed Bag

FROM THE DESK OF THE PRESIDENT

Dear Members,

Greetings from Guwahati Obstetrics and Gynaecological Society.

Today GOGS has a member strength of about 200 gynaecologists. It has been our effort to impart the recent advances in the field of medicine among our members. This bulletin is the mouth piece of our members where they can express their academic excellence and literary skills. Our editor, Dr. Amrit Krishna Bora with the members of editorial board has done a fabulous job. It is a great pleasure for us to deliver this bulletin to our members.

Vision and Mission

Besides organising academic activities we have some social and moral responsibilities too. I, as the president of GOGS with my team has decided to propagate the message 'Preserve the Uterus'. We have decided to spread the conservative mode of treatment wherever possible and it's advantages in improving the quality of life. But such a task is not possible without the help of our members. I request our members to join hands in fulfilling our goal.

Thank You

Dr. Niakshi Phukan Kumar
President GOGS

From the desk of the Secretary

Guwahati Obstetrics and Gynaecological Society (GOGS)

FOREWORD

It gives me great pleasure to write this foreword for the 1st publication of our GOGS magazine, after the successful completion of one year. Under the dynamic leadership of our president, Dr. Nilakshi Phukan Kumar, and the executive members, we conducted many CMEs, webinars, workshops, and Public Awareness Programme, thereby giving a platform to the members of our society.

It is our dream to have many guideline-based CMEs and workshops with maximum participation, and the representation of the GOGS members at National and International levels, in the future.

My best wishes to the editor, Dr. Amrit Krishna Bora, for bringing out this important publication.

Lastly, I would like to express my gratitude to all the members for allowing me to serve as the Secretary of GOGS.

"The capacity to learn is a gift; the ability to learn is a skill; the willingness to learn is a choice."

- Brian Herbert.

Goswami

Dr. Dipti Goswami
Secretary, GOGS

EDITORIAL

"Gone is the era when any scientific breakthrough took more than a decade to reap the benefits by the targeted public as sharing of knowledge was snail paced. Now, everyday thousands of new ideas, research findings have been added in the digital repository which can be accessed at any time and from anywhere. This 'Open Acess' type of scientific publication has an inherent risk of faulty qualitative standardization which calls for much regulation specifically in the field of Health and Medical Science."

We offer our sincere gratitude to the dynamic leadership of Guwahati Obstetrics and Gynaecological Socitey for bestowing the immense trust to carry forward the noble task of publishing this bulletin. Sincere regards to all the respected members of the editorial board for their valuable guidance and special thanks to our authors for their contribution.

Dr. Amrit Krishna Bora

Dr. Isha Goel

MATERNAL MORTALITY IN THE NORTH EASTERN REGION

Prof. Dilip Kumar Dutta , MD, FRCOG, Ph.D., CHAIRMAN ICOG FOGSI 2015
Ex Vice-President, FOGSI

Mr. SB lost his wife due to eclampsia at the age of 19 years leaving behind one child. Mr. SA 30 years, lost his wife who had h/o home delivery and died spontaneously without any professional help. Mr. SR, 27 years, lost his wife at the age of 18 years due to sepsis caused by illegal abortion. Mrs. AR, 20 years, delivered a baby at the road- side on way to hospital died due to a retained placenta.

All these preventable unwanted catastrophes and mourning of their families has been echoing in my heart for the last 30 years. "Why Mothers' Die" ? Whether it is due to delay to seeking treatment, delay to reach the hospital, delay on the part of the doctor to start treatment or lack of transportation due to bad road condition.

During my tenure of (5yrs) as chairman of IMA standing committee, initiative of safe motherhood {2021 and chairman of safe mother hood committee of FOGSI [2000 - 2005] and as a vice-president, FOGS [1998], I have visited most of the parts of rural area of India. While visiting the rural area, I was so much depressed to see the pathetic situation of some of the pregnant women because of lack of commitment by some of the obstetricians, nursing staff, and health providers or due to lack of the eco-socio political commitment.

Women are doing their long journey of 280 days during pregnancy period without antenatal checkup, investigation and treatment. Every minute, a women dies as a result of pregnancy or child birth somewhere in the world may be due to – a) Teenage pregnancy, physically not fit to deliver the baby leading to obstructed labor, sepsis, eclampsia and anaemia etc. b) Due to want of blood or drug, c) Elderly women from low socio economic resources going for illegal abortion.

Such a tragic picture still exists in many states of India excluding Nagaland, Sikkim, Kerala, Mizoram [death rate is as per report by SRS, RGI 2016 -18.] low etc. Maternal death review are not done in many state till date. No CME on MMR in many places. Government (state and central) in good faith started National Rural Health Mission (NRHM) by spending a lot of fund but no positive result to prevent MMR so far. [Dr. Dilip Kumar Dutta, Insight Maternal Mortality – An Indian Face Book, FOGSI Publication, published by Jaypee, page 37 to 171, 2012]. Idea to publish this issue is to high light the different causes of maternal death in different states and strategies to prevent such death and valuable suggestions given by experts from Assam, Manipur, Meghalaya.

A) Silchar Medical College & Hospital (Assam) Reported by

Prof. Ashish Kumar Bhattacharya, Head of the Department, O&G SMCH

As Silchar medical college and hospital is the only tertiary centre serving the whole Barak Valley, North Cachar hill district, part of Tripura, southern part of Meghalaya, part of Manipur and entire Mizoram. So all the critically ill patients are referred here. Unfortunately, most of the cases arrive very late due to several reasons including distance and road condition. Reduction of maternal mortality not only depends on the service provided by the O&G Department but also depends on other departments like – Pathology, Radiology, Pediatrics, Neurology, Hematology, Medicine and last but not the least Department of Anaestheia. [Insight Maternal Mortality-An Indian Facebook, 2012 page 38 -42 , publish by Jaypee brothers]

Facility of ICU with multidisciplinary approach need to be present in the Department of O&G exclusively. Maternal mortality also reflects several socioeconomic and other aspects which need to be addressed by appropriate experts in order to reduce its incidence. Improvement of only medical care facility may not be able to achieve the targeted goal.

Measurement taken so far:

a) Number of doctors on emergency duty have been increased with the existing staff to the maximum.

b) Patients and attendance are motivated for voluntary blood donation, contraception and for sterilization operation in appropriate cases.
c) Patients are motivated for regular antenatal check – up.
d) Two ICU beds commissioned near labor room for care of critical cases.

Scope for improvement:

a) Creating awareness for regular antenatal checkup remain to be addressed at the periphery.
b) While institutional delivery is promoted, more doctors at peripherial level (Medical Officers), nurses and paramedics are needed to tackle the increased burden of the department to offer optimum patient care.
c) Construction of a full-fledged ICU with staff within the O&G Department.

Measured Suggested:

a) Good antenatal care at the periphery.
b) Timely detection and referral of high risk patients.
c) Raising the nutritional status (correct anaemia in particular) of childbearing mother.
d) Quick transportation of critical cases with medication prior to transfer (eclampsia,hemorrhage)
e) Low risk /routine cases to be tackled at PHC/FRU or Civil hospital to reduce the workload of tertiary care center.

Suggestions to improve overall scenario:

a) Creation of awareness among population regarding maternal health problems.
b) Improvement of PHC system.
c) More functioning FRUs.
d) Better treatment facility with improvement of road facility.
Safe motherhood is a vital, cost-effective economic and socio investment Even one women dying is too many women dying.

B) Dibrugarh Medical College & Hospital (Assam) Reported by :-

Dr. Pranay Phukan, Associate Professor, Dr. Swati Jain Asst. Prof

Improving women's health requires a strong and sustained government commitment, a favorable policy environment, and well-targeted resources. The Government's strategy should include balancing the role of the public and private sectors to maximize resources and to extend care to women whom government programs do not reach.[Insight Maternal Mortality-An Indian Facebook, 2012 page 43 - 48, Jaypee brothers]

The unacceptably high maternal mortality rate in India can be reduced by making concerted efforts along the following lines:

a) Allocation of sufficient funds to all the health institutions including primary health centers.
b) Construction of better roads and transport facilities especially in the rural areas.
c) Periodic training programs for local dais and female health workers.
d) Early registration of antenatal cases.
e) Health education of couples to make them understand the importance of antenatal check-ups, hospital deliveries and small family norms.
f) Wide spread availability of iron-folic acid tablets and fortified food to remote areas.
g) Prevention and early treatment of infection, antepartum and postpartum hemorrhage.
h) Treatment of concomitant illnesses like diabetes, tuberculosis and malaria.
i) Emphasizing the importance of observing proper aseptic measures while conducting deliveries.
j) Providing facilities for hospital deliveries for high risk cases like severe anemia, diabetes and heart disease.
k) Accountability in case of the unfortunate event of any maternal death. Taking appropriate remedial measures for preventing lapses noted in the management of these cases will be of immense value in reducing the maternal mortality.

Maternal mortality is a global problem facing all those involved in women's care. Strong health system are needed to analyze the cause for these deaths. Women living in rural areas or those belonging

to low socioeconomic class have the highest risk of dying and carry most of the burden. We need to target specific interventions for specific populations and engage health care providers as well as policy makers if we are to meet the challenge set to reducing maternal mortality.

"Safe motherhood is a vital, cost-effective, economic and social investment……. Even one women dying is too many women dying".

C) Guwahati Medical College : A Tertiary Care Hospital (Assam) Reported by:-

Dr. Saswati Sanyal Choudhury, Prof Guwahati Medical college, Guwahati

Maternal deaths due to hypertensive disorders are found to be highest in Guwahati Medical College and consist of 26% of all deaths. Next cause is sepsis and it consists of 25% and it is a cent percent preventable cause. Maternal death due to hemorrhage is less and consists of 19% as transfusion facility has improved due to the presence of the state of art transfusion center. Anemic heart failure as a direct cause of death was found to be 12.85%. It is also a cent percent preventable cause by the existing facilities and simple measures of iron supplementation and deworming and malaria prevention, considering the area to be endemic for malaria.[Insight Maternal Mortality-An Indian Facebook, 2012 Page 49-52, Jaypee Brothers]

Rupture uterus and obstructed labor is consist of 7.84% which is preventable. Partographic management of labor in all cases with institutional delivery can prevent these deaths. So it has been seen that almost 72% deaths are preventable if regular antenatal check-up to pick up all hypertensive cases as early as possible and iron supplementation with cent percent institutional delivery for sepsis prevention and provision for safe abortion service. To reduce the highest incidence of hypertension regular antenatal check-ups with blood pressure measurements are very important and achievable simply by training ANMs to check blood pressure and referring her in case of hypertension. Assuring iron tablets intake by pregnant mother is another area where ASHAs and ANMs can play a vital role.

Government of Assam has already taken measures to save lives of these poor mothers and one project to give free IV iron sucrose injection in mothers with severe anaemia has already been started recently in September 2011. Some social changes of more female literacy, improvement of road conditions with better connectivity, full ANC and cent percent institutional delivery can definitely bring down MMR to MDG 5 goal very soon.

D) Maternal Mortality in Meghalaya

Prof. A Santa Singh, Director, Associate Prof. S Panda, NEIGRIHMS

The causes of maternal mortality are multiple, interrelated, complex and almost always preventable. Delayed referral, poor transport facilities, under utilization of health facilities, and poor socio economic status are all responsible for the high rate of maternal deaths.

The reasons' for death of a woman in pregnancy and childbirth are many layered. Behind the medical causes are logistic causes, failure in the healthcare system, etc. And behind these are the social, cultural and political factors which together determine the status of women, their health, fertility, and health seeking behaviour.

In India, the use of maternal health care services is directly or indirectly associated with women's socio economic status.A17 In terms of delivery assistance, antenatal check-up and place of delivery, there appear to be a big gap according to the standards of living. Women from poorer section of the population are less likely to avail maternal health care services than rich women. Poor families do not find themselves in a position to be able to bear the cost of delivery care service." Health care is a public right, and it is the responsibility of the Government to provide this care to all people equally. There should be a proper health policy by the Government to decrease maternal mortality and it should be declared as a priority public health issue. Health budget should be increased and available resources should be mobilized to its fullest extent. Some useful steps include developing educational programms on health maintenance and prenatal care within the community, disseminating information through the news media and the internet, educating all women of reproductive age on the benefits of family planning, and promoting research in areas of woman health, cultural competency, and maternal mortality.

We can take the example of Sri Lanka where in 1948; its maternal mortality ratio at 630 was comparable to that of India, The MMR in Sri Lanka has shown a marked decline and as per estimates for the year 2000 is pegged at 57.0 Other indicators of maternal health are equally impressive, 96% of deliveries are attended by trained personnel and 92% of all live births take place in government hospitals. These gains have been achieved through improving both geographic and economic access to institutional health services, availability of emergency obstetric care and no health strategies like female education and woman empowerment." The first referral hospital should be situated in areas where the MMR is high so as to avoid delay in transporting patients in obstetric emergencies. Poor road infrastructure and lack of telecommunication in the rural areas are major areas of concern. It is a very good idea to establish either maternity homes or maternity villages, close to the district hospital so that high risk cases from the remote areas can come and stay for 10-15 days prior to the onset of labour. Essential and emergency obstetric care should beavailable in primary health centre (PHC) level throughout the day. There should be a network of organized blood bank services. Basic amenities like ambulance services, blood pressure apparatus, weighing machine, haemoglobin meter, test tubes and acetic acid for routine urine examination for protein must be avail- able at PHC level. Good co-ordination between maternal and child health field staff and doctors can help a great extent in reducing maternal deaths. Since complications are not predictable, all women need care from skilled health professionals, especially at birth, when rapid treatment can make the difference between life and death. For instance, severe bleeding after birth can kill even a healthy woman within two hours if she is unattended. Data shows that less than two thirds (62%) of women in developing countries receive assistance from a skilled health worker when giving birth.[Insight Maternal Mortality-An Indian Facebook, 2012 page 53 -60, 168-170, jaypee brothers]

Training of the nursing staff is not up to the mark in our country. In our teaching program of nursing staff, they only have six months of rotational midwifery posting where they do not have sufficient exposure. In contrast, in Sri Lanka there is specific two year course for midwifery where their MMR is less than 100. Medical officer should be trained to tackle obstetric emergency so that they can help at PHC level. Institutional delivery should always be encouraged and the schemes like “Janani SurakshyaYojana” should always be welcome. Nongovernmental Organizations (NGOS) should also be responsible for public awareness about women health, family planning and safe motherhood. We should acknowledge the role of trained birth attendants and accredited social health activists (ASHAS) and support their training and integration with health care system. We should coordinate with women's organizations to promote women's health, social and economic development.

Analysing maternal mortality in Meghalaya and various steps taken by the government. Most of the mothers died because of indirect causes in 2009, mainly anaemia and malaria. These two indirect causes of maternal death are preventable. Anaemia can be due to poverty and illiteracy and poor knowledge about health. In order to prevent deaths due to malaria weekly chloroquine prophylaxis can be incorporated in iron and folic acid prophylaxis during ante- natal period. Lack of proper infrastructure and adequate man power are obstacles in public health. There are various steps taken by Meghalaya government to reduce maternal mortality and to improve general obstetric care, Steps have been taken to ensure access to skilled birth attendants and increase safe delivery to 45% by 2010. Encouragement for institutional delivery and by trained birth attendants and ASHA at village level is also done. Training co-coordinators are already appointed to train birth attendants, staff nurse and auxiliary nurse midwives (ANMs). Steps are taken to ensure supply of essential drugs and other commodities needed for skilled birth attendants in subcenters, PHCs as well as at CHCs. Steps are taken to strengthen subcenters with second ANM and provision of emergency obstetric care (EmOC) as a fall back mechanism. Initiation has been taken for redeployment of medical officers, nurses and additional ANMS and other preclinical staff like laboratory technicians and pharmacists, etc. Strategy has been planned out to ensure round the clock services in the PHCs and emergency obstetric care in the first referral units (FRUs). Many CHCs are commissioned as FRUs for comprehensive emergency obstetric care. Government is hiring skilled specialist doctors in specialty like Gynaecology, Paediatrics, and Anaesthesia. Steps are already taken to

improve the infrastructure starting from PHC, CHC and civil hospitals with blood storage facility in CHCs. Reproductive and child health (RCH) consultants are appointed for Commissioning of FRUs along with the Director (Maternal and Child Health and Family Welfare), on behalf of government of Meghalaya. Government is coordinating with various NGOs to promote health education, sanitation and to prevent malaria. Government is also running 108 ambulance services for safe referral of emergency patients. North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS) is a tertiary health care centre situated in Shillong and established by the Ministry of Health and Family Welfare, Government of India. It is almost fully functional at present and will soon be able to reduce maternal mortality in Meghalaya to some extent.

Maternal mortality is not only a health related medical issue but also a socioeconomic issue. It remains a major challenge to health systems worldwide. Reliable information about the rates and trends in maternal mortality is essential for resource mobilization, and for planning and assessment of progress towards millennium development goal (MDG), the target of reduction in the maternal mortality ratio (MMR). Therefore, all the health workers, media person, NGOS and the government should work together in a well-coordinated way to make the millennium development goal a success.

E) Maternal Mortality And its Causes in RIMS : A Tertiary Center In Manipur

Reported by :-
Khumanthem Pratima Devi, Ng Nabakishore Singh, Chanam Manglem Singh, RIMS IMPHAL MANIPUR.

Globally maternal deaths are a manifestation of an enormous health inequality of our time.

Individual and family level: Every girl child should be given special care from childhood and proper education to be given. Every woman should plan for pregnancy after reaching a certain age and in good physical as well as in mental health. Every pregnancy must be given good diet, nutrition, and proper rest and health facilities. Male involvement is mandatory. [Insight Maternal Mortality-An Indian Facebook, 2012 page 61-67 Jaypee brothers]

Health service level: Easy access should be there for basic antenatal, intranatal and postnatal care to all women. There must be 100% delivery by trained birth attendant. Strong, quick and functioning referral system is a must. Emergency obstetric care is to be provided at the door step of a pregnant woman or preferably at the first referral unit (FRU). Safe abortion services are to be provided to prevent unwanted pregnancies.

Community level: Regular health education program involving all people must be arranged. There should be proper communication, roads and transport facilities. We must change social and cultural bad norms.

Policy maker and Government: Maternal mortality reduction should be the top priority among all problems and every country should reform laws in relation to women's health.

What is tragic is that most of these deaths are preventable ? Maternal deaths are still high in comparison with developed countries. Sustained reductions in maternal mortality will only be possible if modern high-quality obstetric care is made available to all women through a system of professional midwifery and referral hospital care in the context of political commitment arid accountability of health providers.

A recent systemic review of the causes of death stressed the need for increased emphasis on prevention and treatment of obstetric haemorrhage and noted that most postpartum deaths should be avoidable by appropriate management. “Much needs to be done for maternal health care in rural areas, as most of the deaths reported are referral from peripheral centres. Concentrated efforts are required to obtain the missing data by improvising better and accurate data collection. Health education of masses along with good quality health care and transport facilities can prevent many deaths.”

Mothers are dying not because of disease or lack of services but due to non recognition by the society that they are worth living - Md. Fatahallah

◆◆

MATERNAL AND PERINATAL HEALTH RESEARCH COLLABORATION, INDIA (MaatHRI)

Dr. Manisha Nair, Associate Prof., NPEU, Nuffield Department of Population Health, University of Oxford

Maternal and perin**at**al **H**ealth **R**esearch collaboration, **I**ndia (MaatHRI) is a UK-India collaboration for translating evidence from new scientific discoveries to improve clinical care for mothers and children. It includes 16 hospitals across six states in India. MaatHRI has created a large and diverse platform for academics and scientists to conduct large-scale epidemiological research to improve maternal and perinatal health in a setting with a high burden of mortality and morbidity. Studies that are critical to informing policies and planning to address new and emerging complications in pregnancy can be quickly and efficiently rolled out through MaatHRI. Details are available on https://www.npeu.ox.ac.uk/maathri MaatHRI is a hospital-based research and training platform.

Figure-1: MaatHRI study states

We have created a unique database of clinical, biochemical and imaging data. We currently have data from more than 8000 pregnant women and infants and this is expected to be around 11,000 by the end of 2023.

The MaatHRI team includes 29 clinical collaborators, mainly obstetricians, but also cardiologists and public health specialists. We have 16 research nurses posted in the collaborating hospitals and a project manager based at the MaatHRI coordinating office at SrimantaSankaradeva University of Health Sciences, Guwahati, Assam. Methodology paper https://f1000research.com/articles/9-683

Research

A salient feature of the MaatHRI research platform is standardisation. We have standardised all study tools, equipment and blood biochemical measurements. There are three research Workstreams:

Workstream-1 is a repeated monthly survey of severe maternal complications. This was instrumental in measuring the impact of COVID-19 on mothers. During waves 1 and 2 of the pandemic, childbirth in hospitals decreased by 21% and there were 33% excess maternal deaths compared with the same period in the previous year. There was a 23% increase in case-fatality from severe pregnancy complications, but most importantly, the hospital admissions related to septic abortion increased by 56% during the pandemic compared with the pre-pandemic period. This demonstrated a clear negative impact of the COVID-19 pandemic on the progress towards achieving the Sustainable Development Goal (SDG) of reducing maternal deaths in India, a country which already has the second highest number of maternal deaths in the world. Policy recommendations developed based on the findings are presented in Figure-2.

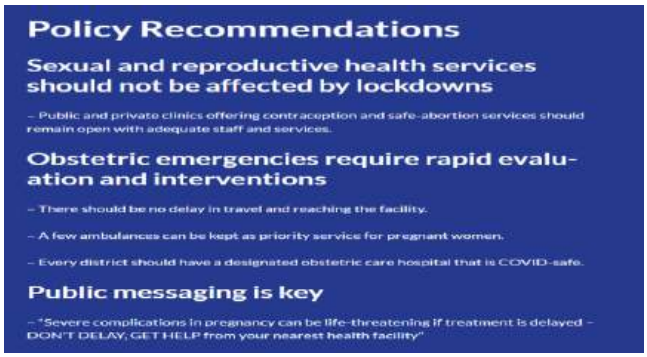
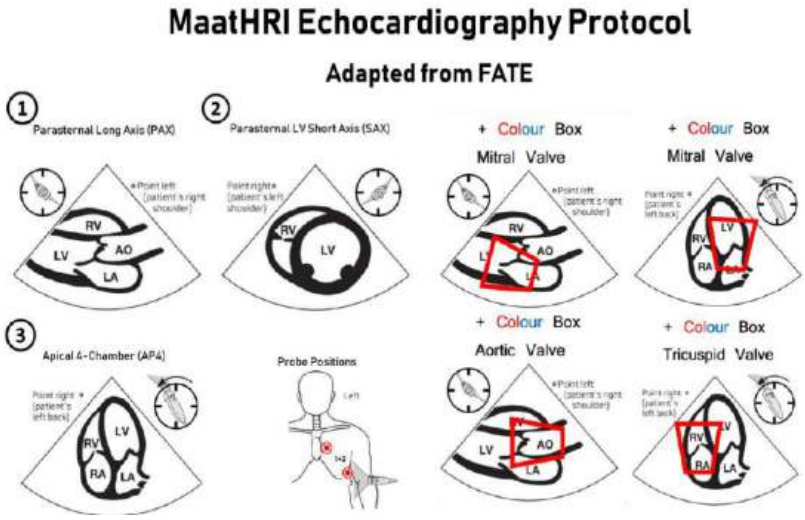
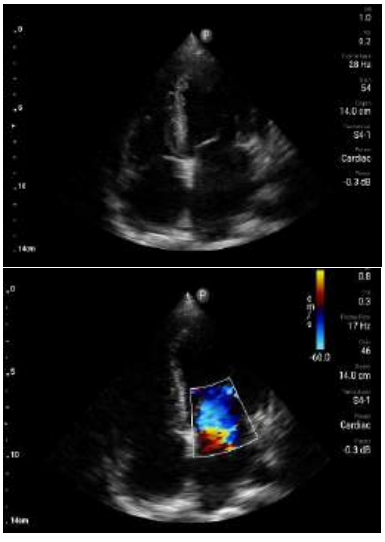


Figure-2: Recommendations to prevent disruptions to accessing reproductive health services in future pandemics to prevent risk of excess maternal morbidity and mortality due to the indirect effects of lockdowns and other social restrictions, or fear among pregnant women and their families in accessing healthcare services, timely. Article in Lancet-eClinicalMedicinehttps://doi.org/10.1016/j.eclinm.2021.101063

Workstream-2 is the first study, globally, that is investigating the rate, risk factors, clinical characteristics and outcomes of acute heart failure syndrome (AHFS) in pregnancy. It is a case-control study that is recruiting cases of suspected heart failure in pregnant and postpartum women since February 2019. The cases are confirmed using a novel echocardiography method that we developed and tested (see details below). The incidence of AHFS in pregnancy and postpartum in the study hospitals is 0.3%, but case-fatality is high leading to the death of almost half of the women admitted with AHFS. The study will complete recruitment in December 2023. Until the end of August 2022, we were able to recruit 352 suspected cases of heart failure and 840 control participants. We developed and validated a Focused cardiac ultrasound method and trained obstetricians to conduct echocardiography of pregnant women using hand-held machines, which are interpreted remotely by experts. This will enable obstetricians to screen women suspected of cardiac problems for early referral to cardiology for further investigation and treatment. Use of technology will overcome the shortage of cardiologists to provide regular screening services. Instead, obstetricians can do the initial screening and share the echocardiographs with experts in real time, using in-built cloud-based service, for diagnosis. Article available in JASE doi.org/10.1016/j.echo.2022.07.014





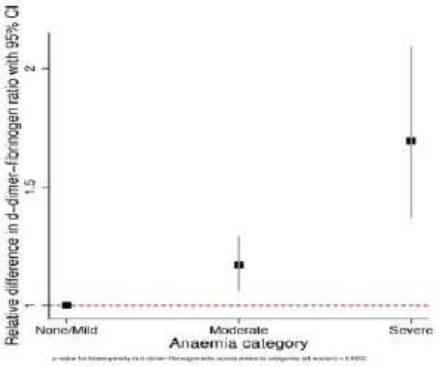
Workstream-3 is investigating the safety of induction and augmentation of labour in pregnant women with anaemia through a prospective cohort study of more than 10,000 pregnant women. This study is testing the hypothesis of an increased risk of postpartum haemorrhage (PPH) in pregnant women with anaemia who undergo induction and/or augmentation of labour. This is the first study globally that will generate this much needed evidence to inform local and global guidelines and clinical practice. Since October 2018, we have recruited and followed-up more than 8000 pregnant women. This work to date has already generated new evidence about derangement of coagulation parameters in pregnant women who have moderate-severe anaemia resulting in a potential risk of haemorrhage during childbirth.

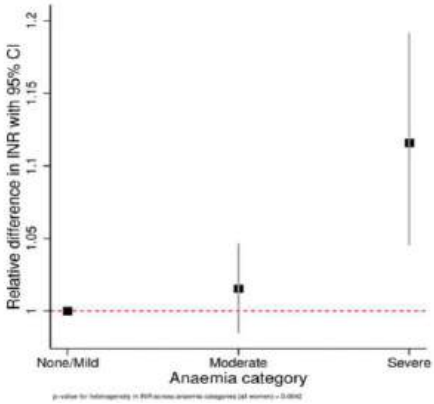
Comparing the blood coagulation profile of pregnant women with and without anaemia

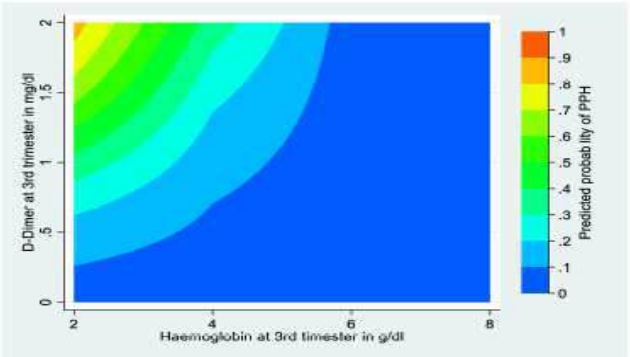
This was the first study to investigate the role of coagulation in relation to the increased risk of PPH in women with moderate-severe anaemia. Previous studies in India have repeatedly shown that pregnant women with anaemia (particularly severe anaemia) are at a higher risk of PPH. It is the first of its kind to study to identify a new potential role of an impaired coagulation profile in pregnant women with anaemia that could lead to PPH. The prospective cohort study found that coagulation parameters in pregnant women with moderate-severe anaemia are deranged which could lead to an increased risk of PPH, which can be a life-threatening complication. The role of coagulation parameters has not been studied before, so this is highly valuable scientific evidence that has the potential to prevent PPH and save the lives of thousands of mothers globally, where anaemia in pregnancy is a public health problem. Please read the article published in BMJ Open https://bmjopen.bmj.com/content/11/10/e050815

Key findings

- Pregnant women with moderate-severe anaemia (Hb<10gm/dl) during the third trimester of pregnancy had a higher D-dimer, lower fibrinogen and therefore a higher D-dimer/fibrinogen ratio compared to those with mild or no anaemia (Hb ≥10gm/dl).
- Pregnant women with moderate-severe anaemia also had a higher INR compared to those with mild or no anaemia
- Having a lower haemoglobin (Hb) and higher INR during the third trimester of pregnancy was independently associated with higher risk of PPH at childbirth.
- There was a pattern of increasing predicted probability of PPH with a decrease in Hb and increase in D-dimer







Preventing anaemia during pregnancy has been a priority worldwide. This study further demonstrates the need to do this to prevent adverse effect of anaemia on the coagulation cascade during pregnancy. However, further studies are needed to understand the mechanisms.

TRAINING

Training is an integral part of MaatHRI. Till date, we facilitated the training of more than 100 clinicians from the collaborating hospitals in research methods and international collaborative research. More than 30 obstetricians are trained to acquire images of the heart using hand-held trans thoracic echocardiography machines and a standard protocol. MaatHRI has also built the capacity of research

nurses training them to conduct data collection, blood sample collection and processing. This improves their skills and employability. In addition, MaatHRI is facilitating the training of four PhD students, two post-doctoral fellows, four MSc students and two interns at Oxford. MaatHRI Ph.D. projects are regularly advertised for candidates to apply from India and across the world.

MAATHRI COMMUNITY ENGAGEMENT AND INVOLVEMENT GROUP (CEI)

CEI in research is key to the success of research projects as community members can guide projects through their lived experiences and make the outputs more relevant to the needs of the population. By working together we can develop a shared agenda. An active partnership will enable us to learn from each other and agree on the research priorities together through a shared decision making process. The CEI group provides independent advice for planning new research, implementing and monitoring projects and research outputs, developing policy and community briefs from the research outputs, and evaluate the impact of CEI on MaatHRI's work.

FUNDING

The MaatHRI platform is funded by a Medical Research Council, UK fellowship for Associate Professor Manisha Nair, who is the Chief Investigator of MaatHRI. The individual projects have further funding from the Nuffield Department of Population Health, University of Oxford and Ultromics, UK. Wellcome-DBT India Alliance co-funded a training workshop.

MaatHRI team photograph May 2022

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SHARED DECISION IN CLINICAL PRACTICE

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". . . can't explain. There is some respect for him and I can't tell him directly. There is also some fear. So I can't ask. So doubts remain. Then I ask the person who has accompanied me to ask the questions."

"…we "can't force them [doctors] to do what we want; they are higher authorities with a position and status. We are small people."

"….The doctor has told me what must be done and that is enough."

"…Getting cured is more important than getting information…."

These are some of the reactions from patients after visiting a doctor. Many of the people either get confused or not assured by the physicians they visit. But the time has come for us to introspect regarding the doctor-patients relationship. The doctor-patient relationship is changing as we are living in a more consumerist society, with better-informed patients (e.g., from their use of the Internet), a greater public involvement in healthcare institutions. Shared decision making (SDM) is one of the important issues in dealing with the patients.

Faith in the doctor is based on a general perception of the good intentions and capabilities of doctors, while trust is largely based on previous good experiences. Some patients make a reference to the doctor as "like God," and therefore whatever the doctor does is right. Some consider the doctors as a Higher Authority. Most of the people in our society do not feel free to ask questions, express their wishes, or dissent with their doctor and would do so only if their doctor specifically ask them. They feel inhibited by the important position of doctors.

Let's start with a clinical scenario. Mrs A, 42 years old lady, p2, came to my clinic with AUB with a predetermined attitude of getting a hysterectomy done. She heard a lot about abnormal bleeding and cancer and wanted to take the uterus out. After proper clinical evaluation necessary laboratory investigations cancer was ruled out. The diagnosis was AUB for ovulation disorders which can be treated medically without resorting to surgery. The lady with her husband were counselled regarding the different options of treatment with their merits and demerits. Th lady wanted to go for the Mirena applications which was quite effective without the morbidities and cost associated with surgery. The decision was taken after discussion with the lady and her husband. Initially the patient was hesitant to ask me the merits and demerits of the Mirena, but when I asked her opinion regarding the use of Mirena she readily agreed

Shared decision making (SDM) involves discussion and collaboration between a consumer and their health care provider. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment. In order to reach the most appropriate health care decisions for that person. SDM is widely accepted as a core feature of good health care. It is not about convincing the patient to follow the doctor's recommendation. Nor is it about giving the patient whatever test or treatment he or she requests, or about leaving your patient to decide on his or her own. SDM is a process whereby clinicians collaboratively help patients to reach evidence-informed and value-congruent medical decisions. This process is especially relevant in screening for conditions in which there is a close trade-off between harms and benefits.

'It is between physician and patient' is an idea founded in ethics and the law and in some evidence of superior health outcomes. SDM is the practical reconciliation of respect for persons (autonomy) and the monopoly and power of physicians. SDM includes the notion of a medical encounter as a 'meeting of experts' – the physician as an expert in medicine and the patient as expert in his or her own life, values and circumstances .The doctor prescribes but the patient takes the pills (or doesn't). Trends in healthcare policy emphasize involvement of community and service users in many aspects of their care. Indeed, the popular enthusiasm of governments for self-care initiatives cannot be imagined without such involvement. However, authentic involvement surely requires participation in decision-making.

There are 2 core elements to SDM: risk communication and values clarification. The former happens when we attempt to communicate the benefits and harms of interventions based on evidence. Values clarification involves clarifying what matters most to the patient and his or her family. Shared decision making becomes embedded within a process in which a health care provider and a patient relate to and influence each other as they collaborate in making a choice about health care. The choice must be congruent with what matters to the patient's values and preferences are to be incorporated into the decision. Better-informed patients make different, often more conservative, less costly choices about treatment, because it is thought, that information provides a realistic appreciation of likely benefits and risks of treatment and enables decisions about the potential outcomes in a more considered way.

Recent guidelines from health professional bodies in Canada, the United States, the United Kingdom and Australia (Australian Council for Safety and Quality in Health Care 2005) now prescribe SDM as part of training programs and good practice. For example, in the United Kingdom, the General Medical Council states:

Whatever the context in which medical decisions are made, we must work in partnership with our patients to ensure good care. In so doing, we must:

(a) listen to patients and respect their views about their health

(b) discuss with patients what their diagnosis, prognosis, treatment and care involve

(c) share with patients the information they want or need in order to make decisions

(d) maximise patients' opportunities, and their ability, to make decisions for themselves

(e) respect patients' decisions.

When possible, shared decision-making should begin in advance of any discussion or appointment to maximize the person's ability to participate and to reassure them that shared decision-making will be supported by the healthcare professional they see.

- Offer the person access to resources that encourage them to think about what matters to them, what they hope will happen as a result of the discussion, and what questions they would like to ask.
- Ask the person if they would like to invite a friend or relative to join the discussion, in order to help them understand the resources provided and support them to take an active part in decision-making.
- For people who do not have anyone they would like to ask to support them, and who might find it difficult to share in decision-making, offer additional support—for example, from a nurse, social worker, translator, or volunteer. During an appointment
- Create a collaborative atmosphere: agree an agenda for the conversation; make sure patients or service users understand that they can participate as much as they want; encourage people to think about what matters to them; allow enough time to answer questions; and offer a further opportunity for discussion.

- Discuss the risks, benefits, and consequences of the possible tests, treatments, or interventions openly: clarify what the person hopes to gain from the intervention and discuss their ideas and concerns. Explain the potential benefits and harms of each option, including doing nothing.
- Make a record of the discussion (for example, in the clinical notes or care plan) that includes any decisions made along with details of what the person said was important to them in making those decisions. Share this with the person, for example, in a post-clinic letter (letters should be written directly to patients and copied to the relevant healthcare professionals). Following an appointment
- Offer people resources to help them understand what was discussed and agreed. This could be a printout summarizing their diagnosis, the options and decisions or plans made, and links to high quality online resources options.
- Ensure that information provided after discussions includes details of who to contact with any further questions.
- Offer additional support to people who are likely to need extra help to engage in shared decision-making. This could include encouraging them to record the discussion, explaining in writing the decisions that have been made, or arranging follow-up by a clinical member of staff or a suitable alternative.
- Before using a particular decision aid, healthcare professionals should be familiar with it, including how it will help people to understand which option is best for them.

Shared decision making is both a philosophy and a process. It requires a partnership between patients and professionals, working together to select tests, treatments and support packages based on patient preferences, clinician experience and research evidence. This often necessitates a shift in the perceived roles of patients and professionals, the provision of evidence-based information about options, outcomes and uncertainties, and support and feedback to ensure that patients and professionals are actively engaged. Surveys and observations have found that shared decision making is often talked or written about but is less common in day-to-day clinical practice.

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MORAL, ETHICAL AND LEGAL PROBLEMS IN THE TREATMENT OF INFERTILITY

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Infertility is an age old problem , which requires a delicate approach, analysis and treatment. Causes of infertility, presently encountered in about 15—20% of couples, are numerous: tubal, ovarian, anatomical, immuno-logical, endometriosis, cervical, psychological, idiopathic and male factors. Reproductive medicine is one of the fastest growing branch of medicine in the world today. Ever since the first IVF baby was borne in 1978 in Oldham in England, there was tremendous development in the field of Assisted Reproductive Technology. "Assisted Reproduction" is associated with certain treatments which give hope to numerous patients, clinical personnel and researcher, but also open numerous ethical, legal, religious and moral questions .

In vitro fertilization (IVF), ICSI, Surrogacy, donation of gametes, embryos, cryopreservation of gametes, embryos, ovarian and testicular tissues, embryo transfer, genetic reproductive techniques, cloning and other sophisticated methods used in infertility treatment require cooperation of medical, ethical and legal professions, with the aim of combing research work and individualized clinical approach. Ethical aspects of human reproduction and assisted fertilization are based on full respect of the life of an individual even before conception, from pre-embryonic stage, to a newborn infant. Due to the rapid advancements it is imperative that there should be legalization of all ART procedures, unencumbered exchange of information and consensus about their application, and adherence to the basic ethical principles of autonomy, benefit, justice and common welfare.

Indian government in 2021 passed an act in parliament called "ART and surrogacy act 2021" which provides legislation for the control of the procedures of assisted reproduction in our country

Law and ethics are in an inevitable interaction with each other, as two systems of normative ordering, which sometimes overlap and are sometimes in conflict. On one hand, the law may seem a more powerful instrument than ethics, because its provisions are more authoritatively and comprehensively presented by political legislation and courts while its use may be more impractical, difficult tand institutionally challengeable. On the other hand, the law is seen to lack an ethical dimension. The law sets a framework for practical utilization of ethical choices, but the ethics sets limitations that are voluntarily obeyed, as expressed through respect for the law, which in its turn asserts the merits of the society it governs.

Before undergoing the various procedures of the assisted reproductive techniques, patients should be fully acquainted with the following: How the treatment will be carried out, how long it will take, how effective it will be and what possible complications MAY ARISE. They have to sign their consent for the performance of the treatment. Gamete and embryo donation procedures are absolutely secret, except in rare and legally foreseen cases. The ART act made it mandatory for all ART centres to Register with Government and keep a record of the all the procedures in their centre.

DONATION OF GENETIC MATERIAL

Genetic material donation has become an integral part of infertility treatment. Donations of spermatozoa, oocytes, embryos are successful in the medical and technical sense and ethically approved. Medical problems and ethical dilemmas that require understanding and evaluation are: selection of donors, evaluation of recipients, quality control of genetic material, relationship between biological and social parents, and protection of the rights of offsprings . Sperm donation has to be anonymous, and the donors cannot be known donors, friends or relatives. Oocyte donation is also ethically permissible in specific cases: in patients with premature ovarian failure , in patients with inferior-quality oocytes and in patients after several unsuccessful IVF treatments. The act however prevents oocyte-sharing (donors share their oocytes with an anonymous recipient and in return, recipients share the costs of treatment of the donor) and the recruitment of a donor by the patients themselves.

Embryo donation were earlier used in women without oocytes and men with azoospermia, in which cases only embryos obtained from spermatozoa and oocytes of unknown donors were used. The new act however prevents such use of Embryo donation. Embryo donation was earlier achieved in two ways: (I) using a combination of oocytes and sperm donation — such donors should already have been properly counseled; and (II) using spare cryopreserved embryos from patients who have already been successful and have consented to the donation of their remaining embryos. The reason of banning Embryo donation might be to avoid future complications regarding the status of the offspring borne out of such embryos.

CRYOPRESERVATION OF GENETIC MATERIAL

Sperm and embryo cryopreservation is permitted and they can be preserved up to 10 years. Sperm cryopreservation has long been routine and helpful in preserving the fertility potential of many young men treated for iatrogenic sterility or threatened by cancer. Oocyte cryopreservation is also allowed. Ovarian tissue cryopreservation is permitted, with significant prospects for clinical use in reproductive medicine and oncology. Ovarian cryopreservation, which lately has been in the focus of experimental research, opens new moral and ethical dilemma, requiring critical consideration for tissue preservation , and also require working out specific instructions by the new act on the criteria for future clinical use and benefits of such procedures.

POSTHUMOUS REPRODUCTION

Recent events posing ethical dilemmas relate to posthumous reproduction, pre-implantation genetic diagnosis (PGD) and cloning. The new act is however silent on this.

The advent of successful techniques of spermatozoon and embryo cryopreservation makes the birth of a child whose genetic father is dead technically possible, following the usual period deemed legally necessary to recognize the paternity of the posthumous child. Most of the centers for infertility treatment arount the world like UK and USA support the idea of posthumous reproduction, and the treatment is permitted provided explicit prior written consent has been given after the gamete(s) provider(s) had received counselling. General attitude is that each case should be individually analyzed and approved by a multidisciplinary committee consisting of a gynecologist, a psychiatrist, a sociologist, a clergyman and other appropriate specialists before allowing posthumus reproduction.

PREIMPLANTATION GENETIC DIAGNOSIS

Preimplantation genetic diagnosis (PGD) and PGS is a result of development and convergence of assisted reproduction techniques and genetic methods, allowing the couples at risk for an early diagnosis of hereditary diseases,and selecting the best healthy embryos before embryo transfer in IVF treatment.. PGD and PGS, however, triggers the fear of potential genetic manipulation, sex selection and of getting closer to criminal eugenics, and therefore the standpoint of the new act is that PGD/PGS is justified only in medically indicated cases. Within the framework of infertility treatment pre-implantation genetic diagnosis is part of a range of potential diagnosis options, which help couples make important decision about screening their future child from serious diseases .

CLONING

Human reproductive cloning is unjustified and unnatural for it offends human dignity and violates the individual rights to genetic uniqueness. This is banned all over the world now. One can consider reproductive cloning of embryos by means of nucleus transplantation or embryo splitting, and the ethical aspects in the context of genetic reproductive techniques are to be evaluated separately. Many countries and institutions have analyzed possibilities of therapeutic cloning when other alternatives are exhausted, as well as the cloning within the framework of genetic engineering with the aim of producing appropriate human proteins. Therapeutic cloning technology serves to culture stem cells that are genetically identical to those of the patient, with an aim of replacing diseased cells, for example in nerves damaged by neurodegenerative disorders, in the heart muscle affected by infarction, in diabetes or in liver damaged by poisoning. Stem cells may be derived from the embryo (more precisely, from blastocysts), the fetus or the adult. There are several types of embryonic stem (ES) cells: those issued from blastocysts either as supernumerary or created *de novo* and those created by nuclear transfer from somatic cells (SCNT). The final report of the European Group on Ethics (EGE), made public in November 2000, forbids reproductive cloning. It deems ethically unacceptable to create embryos from donated gametes, because supernumerary embryos are an alternative available source. In the case of embryos obtained by SCNT, extreme concern is voiced, despite the awareness that the creation of such embryos may be the most effective way for obtaining pluripotent stem cells genetically identical to the patient's and thus obtaining perfectly compatible tissues with the aim of avoiding rejection after transplantation . Nevertheless, the concerned scientists agree that research should continue with all sources of stem cells, as we cannot yet know which source if any is going to fulfill the therapeutic expectations. Cloning is due to receive extensive legislation, but is has to be carefully and selectively performed in order to make room for further improvements in this field of research for the benefit of the entire mankind.

CONCLUSION

Sex selection, multiple pregnancies and embryocide, surrogate parentage and treatment of older women open numerous ethical and legal dilemmas and call for multidisciplinary and an expert approach to analyze each individual case as well as to define clear ethical and legal regulations open to correction in respect to further investigative work. Ethical postulates provide unequivocal directions in the creation of new life and resolve all possible ethical dilemmas, protecting the rights of doctors and participant in relevant procedures alike and reasserting the crucial principle — respect of human dignity. Defined legal principles are to be reconciled with the ‘natural laws’ for the sake of protection of the freedom of thought and the right of individual choice and for the realization of the goal aimed at the preservation of life and justification of the purpose of existence.

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RESPECTFUL MATERNITY CARE

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Respectful maternity care refers to care organized for and provided to all women in a manner that maintains their dignity ,privacy and confidentiality ,ensures freedom from harm and mistreatment and enables informed choice and continuous support during labour and childbirth . Respectful care during childbirth has been described as "a universal human right that encompasses the principles of ethics and respect for women's feelings, dignity, choices and preferences." The call for respectful maternity care in our country came as the Government of India was designing a bold program for maternity care –the Labour Room and Quality improvement initiative (LaQshya).To enhance the satisfaction of beneficiary and positive birthing experience respectful maternity care (RMC) was introduced as part of LaQshya initiative by ministry of health and family welfare(GOI) on 11th December,2017.

Respectful maternity care is an approach centered on an individual based on principles of ethics and respect for human rights and promotes practices that recognize the need of the women and the newborn during delivery and the post partum period. Skilled assistance during pregnancy and childbirth is one of the key interventions in reducing maternal morbidity and mortality. Some studies have shown that many women across the globe experience disrespectful and abusive treatment during labour and childbirth in institutions, which forms an important barrier to improving skilled care utilization and improving maternal health outcomes. RMC is a universal human right that is due to every childbearing woman in every health system. The reported forms of Dis-Respect and Abuse (DRA) have been classified into seven categories : non-consented care, non-confidential care, non-dignified care, discrimination based on patient's attributes, abandonment of care and detention in facilities.

So, respectful maternity care means freedom from disrespect and abuse.

FIGO recommends principle of Beneficence -Maternity care must be supportive, individualised and value-based . Health care practitioners must ensure that their practices are driven by health needs and expectations, as well as by health outcomes and cost-effectiveness. Health care practitioners are expected to follow evidence-based practice.

Principle of Non –Maleficence-Health care practitioners are expected to avoid harmful practices and should avoid disrespect and abuse.

Principles of justice- provide respect, dignity and informed choice – maternity care incorporates a rights-based approach, preventing exclusion and maltreatment of individuals . Provide free or affordable care with cost transparency . Promote wellness and the prevention of illness as the foundations of improving maternal and newborn health. Implement educational and public health measures that enhance wellness and prevent illness and complications for the mother and baby ,provide education about and foster access to good nutrition, clean water and a clean and safe environment Make water, sanitation and hygiene (WASH) measures part of maternity services. Provide education in and access to methods of disease prevention.

Principles of autonomy-Health care practitioners should listen to what women and their families says and should communicate health knowledge and information in a culturally safe and sensitive manner, and in a language that the woman and her family understand. Health care practitioners should fully inform and communicate with the woman and her family in decision making about care for herself and her baby, ensuring her the right to informed consent and refusal.

Physical abuse-There is right to freedom from harm and ill treatment -hitting, slapping, pushing or even roughly touching a woman is physical abuse.

Non consented care- All Woman irrespective of their level of educational attainment, language and cultural background, a careful explanation of proposed procedure should be explained in a language that they can understand. The freedom to consent or to refuse care is the right of each patient.

Non dignified care-All delivering mother dignity and respect during labour. All healthcare worker must maintain dignity of the mother in their words, actions and all non-verbal communication.

Discrimination-All Woman are equally worthy of respectful care regardless of ethnic background, religion, culture, socio-economic status or educational status.

Abandonment of care- All Woman are equally worthy of respectful care regardless of ethnic background, religion, culture, socio-economic status or educational status.

Detention in facility-A woman or her baby should never be kept forcefully in the Health facility.

There are few studies on perception of women regarding respectful maternity care during facility based childbirth in our country , the results are not very encouraging. We have to give more attention to the different aspects of respectful maternity care and which in turn increase and improve the facility based care in the coming days and thereby improve the maternal and newborn health parameters.

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SLE IN PREGNANCY - AN OBSTETRICIAN'S PERSPECTIVE

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Pregnancy serves as a mirror to the revelation of a gamete of maladies in the parturient. One such ominous event is an unremitting systemic lupus erythematosus (SLE) which, coupled with medical disorders, brings about an apocalypse in the management. SLE is a complex heterogeneous autoimmune disease that mainly affects women (about 90% cases in women), and its prevalence has been estimated to be 1 in 500 in the women of reproductive age group. It has varied manifestations altering the course of pregnancy. During pregnancy, in a third of women, lupus tends to improve. It remains unchanged in a third, and in the remaining one-third, it worsens. It has been observed that at least half of patients have renal involvement. The management issues in pregnant women suffering from SLE necessitate a multidisciplinary approach.

Consistent with the recommendations laid out by **the European Alliance of Associations for Rheumatology (EULAR; European League Against Rheumatism) and the American College of Rheumatology (ACR)**, patients are advised to conceive when the lupus activity has been quiescent for at least six months before conception. Apart from this, it has been extensively studied that the pregnancy outcome is best when women fulfill the following:

(i) There is no lupus nephritis manifest by proteinuria or renal dysfunction
(ii) Antiphospholipid syndrome or lupus anticoagulant is absent
(iii) Superimposed pre-eclampsia does not develop

We want to enunciate two cases of SLE during pregnancy that highlight the disease's wavering potential concerning maternal and fetal outcomes.

A 31-year-old booked G2P1L1 was diagnosed with SLE in 2014 when she developed renal impairment two years following her first pregnancy. As the renal biopsy had revealed Class II Lupus, she was started on immunosuppressant therapy with cyclophosphamide, mycophenolatemofetil, and azathioprine. She was on regular follow-up with the multidisciplinary team. She had undergone extensive periconceptional counseling before conceiving for the second time until the remission phase was achieved. Eight years later, she had conceived spontaneously. She was then switched over to Prednisolone, Tacrolimus, and Hydroxychloroquine. At this time, she had progressed to Class III lupus nephritis. She had regular antenatal visits until 36 weeks of pregnancy. There was no evidence of lupus flare (no worsening of proteinuria or no decline in the complement levels or increase in the anti dsDNA levels). Her blood pressure was well controlled with antihypertensives without progression to pre-eclampsia. She had undergone labor induction in view of preterm premature rupture of membranes and delivered a healthy baby girl weight 2.3 kg. The intrapartum period was uneventful. Postpartum, she received medical care for 72 hours, and upon discharge, she was advised to continue her medications for maintenance therapy.

Biochemical parameters at the time of delivery

S Albumin	3.1 gm/dl
S urea	35.5mg/dl
S creatinine	1.66 mg/d l
Sodium	132 mmol/L

Potassium	3.3 mmol/L
Cholesterol	217 mg/dl
Triglycerides	273 mg/dl

This case brings to light that lupus nephritis in remission is a successful predictor of optimized maternal and fetal outcomes and that the following factors (well controlled in this case) are associated with an increased risk of SLE flare during pregnancy:

(i) Active disease during the six months before conception
(ii) Discontinuation of hydroxychloroquine
(iii) Primigravida

The following case will illustrate how the presence of another medical condition has affected the feto-maternal well-being.

A primigravida, aged 26, first presented to dermatology OPD at 23 weeks of gestation (unaware of pregnancy) with desquamating lesions of palms and soles and oral mucocutaneous ulcers. She underwent evaluation for autoimmune disease.

ANA	POSITIVE	SSA Ab	POSITIVE
DS DNA Ab	NEGATIVE	SSB Ab	NEGATIVE
U1RNP Ab	STRONGLY POSITIVE +++	APLA	NEGATIVE

There was no derangement in the hematological parameters. The liver function was preserved. The complement levels were normal. Although the serum creatinine was within the normal range, there was worsening proteinuria throughout pregnancy (24-hour urine protein > 1 g/dl), suggestive of active lupus nephritis. She was also diagnosed with hypothyroidism, and thyroxine supplementation was commenced accordingly. End organ workup also showed a co-incidental severe pulmonary hypertension and severe tricuspid regurgitation with preserved left ventricular function. She was started on hydroxychloroquine and prednisolone. Although asymptomatic for the cardiac lesion, the risks and the benefits of continuation of pregnancy were discussed with the patient. As the risk of cardiac decompensation following a mid-trimester termination of pregnancy almost equals that during the third trimester, she was advised to continue the pregnancy with periodic assessments and under high vigilance. At 28 weeks of gestation, she was admitted to the obstetric ward for in-patient monitoring with ICU and ventilator back-up. She underwent periodic fetal surveillance for fetal growth restriction. At 34 weeks of gestation, during a serial ECG monitoring, changes (a prominent 'p' wave in the leads II, III, and aVF) suggestive of a dilated right atrium were noticed. Due to an anticipated right heart failure, the cardiology team advised an urgent pregnancy termination. She underwent an emergency Caesarean section and delivered a preterm male baby weighing 1.3 kg uneventfully. Postoperatively, she was shifted to the intensive care unit. However, within the next 24 hours, she developed pulmonary edema, unresponsive to pharmacological therapy. Her vitals deteriorated, and she could not be revived despite all resuscitative attempts.

Learning points:

- Women with SLE should be optimized to achieve remission at least six months before conception
- Primigravida and those with a history of lupus nephritis or active nephritis are at the highest risk of a flare.
- Increased severity of maternal disease generally correlates with higher maternal and fetal risks during pregnancy. Thus, cardiac involvement, pulmonary hypertension, advanced renal insufficiency, severe interstitial lung disease, and recent stroke can be a harbinger of adverse maternal and fetal outcomes.
- The severity of organ involvement best guides the treatment of active SLE during pregnancy and should not be withheld during pregnancy. A delay in the initiation of therapy portends an increased risk of maternal and fetal mortality.

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CHANGING PATTERN OF CAESAREAN DELIVERY

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From time immemorial, Caesarean section is one of the most commonly practised operative delivery done all over the world. The word 'Caesarean' is believed to have originated from the surgical birth of Julius Caesar, but it is perhaps very unlikely. Many controversial legend and tale has travelled sands of time without any promising evidence. One of this, is Roman Law under Caesar decreed that all women who were so feted must be cut open; hence Latin word Caesarean. Initally it was done as a desperate attempt to salvage the unborn form a dying Mother. The evolution of the procedure specially the technique is quite interesting and can be termed as one of the finest example of quest and brevity of human consciousness to elevate the sufferings of fellow-being. Many disputes still persist regarding early period of it's evolution amongst the scientific community. After German Gynaecologist Max Sanger in 1882 suggested closing of Uterine wound, leading to a spectacular drop in the Maternal Mortality. Prior to that most of the women died due to bleeding and sepsis. Improvement of surgical technique, specially development of suture material needed many centuries to attain the present state of safety to the patients and convenience to the surgeon. Like-wise improvement of Anaesthetics and it's technique, Broad spectrum Antibiotic and development of the idea of Asepsis and newer Instruments make it one of the safest and most commonly practised surgery all over the world.

Caesarean section is done both as an elective and emergency procedure, where the former is a planned surgery performed due to previously anticipated medical complications. Emergency procedure has increase Maternal and Perinatal mortality and Morbidity including Obstetrics catastrophes, Increase blood transfusion rate, increase possibility of ICU admission and detrimental future reproductive outcome. The ratio of Caesarean section delivery with Normal delivery has huge differences all over the world. The variation reflected as developed- developing country, Urban-Rural locality, Private-Public settings even has Institution wise or Surgeon wise differences. Usual Clinical practice has certain type of indication both Maternal and Foetal where there is evidence based justification for the section. But medical science is evolving every day and the type of indications varies depending upon the settings or Service provider. For example, the criteria for the diagnosis of Foetal distress that is intra-uterine compromise situation of unborn, a real emergency procedure to save the baby is not uniform all over the world. Where's most sophisticated Biochemical marker has been utilised in advanced setup, for which mere clinical examination and judgement can be termed as a gold standard for resource crunch setup. Ultimately it rests upon the decision of the Clinician which should be supported by the standard protocol followed by other Institution of same type of settings within the same regional/ geographical Boundary.

Last few decades we have seen tremendous advancement of Science and technology. Though the basic premises of any subject seems to be constant, but finer nuances of Medical science has been relooked through the advancement of molecular science, Biotechnology and nanoscience, advancement of Medical Instrumentation, bio informatics and wide spread use of Information technology by both service seeker and provider. Likewise changing social norms and behavioural pattern like late age of Marriage, small family, huge participation of women in work force both professional and white coloured job, more dependence upon digital information , media and not the least paradigm shift of Medical service from samaritan one to Service sector business mode associated with consumerism and legal

consequences. All these social factors have some direct and indirect impact upon the reproductive Health including Delivery process. Last two decades of the last century shows exponential rise of C-section in western countries to avoid litigation as long term prospective studies shows that normally delivered babies without any complication develops subtle intelligence and Cognitive deficit in later life. But very recent studies show that long term neurocognitive outcome of C-section babies does not have any significant difference with former group. The manifold increase of C-section rate provokes widespread criticism and debate not only in Medical community but social circles including Health planner, Health economist and Right and Consumer bodies and different National and international Health Regulatory agencies.

According to WHO guideline, the rate of C-section should be 10-15% of total deliveries of a particular community. In India, NFHS study shows jump of this rate from 8% in 2008-9 to 14% in 2018-19. Decadal growth seems to be 311% for public Health Institute and 413% for private sector. The rise of the incidence in India both in public and private sector has been termed by many non-medical Right based organization as “Epidemic” and blaming due to “Un regulatory market” or as a supplier induced demand driven. This indicate the economic gain of the private hospital as one of the major factor but the parallel increase of C-section rate in the public hospital where economic gain factor is negligible refute the allegation. Recently, Central Health Authority has started third party audit of C-section both in public and private sector hospital where the indication of the surgery has to be justified. For the public Health Institution, it will create Devil and Sea situation for the service provider. Timely C-section will save the Mother and Child but at the same time, service provider’s justification of the rationale for the section on later date which will be based upon the documentation which is not up to the mark due to increase work load and lack of a system for documentation.

Reducing the number of primary C-section and vaginal Delivery of previous C-section seems to be the gold standard for the service provider of maternal health. In our national setup, service provider and authority of many private and public health institute reluctantly adopted the safe surgical delivery procedure as there is strong resentment and public vandalism of the Hospital along with media trial and defamation of the Clinician in case of unavoidable adverse Maternal and/or Neonatal outcome. With this we have seen gradual replacement of operative or high risk vaginal delivery cases both public and private setups towards C-section. Patient’s choice become another contributing factor as the mother or her family choose the C-section without any valid indication, only to avoid uncertainty of normal procedure requiring at times, a prolonged expectant period either at Home or in Hospital and chances of last minute emergency situation. It is worth mentioning that the Vaginal delivery will be termed normal only in retrospect where the process starts without any intervention and having less assistance culminating to delivery of a Healthy Baby without any jeopardy in Mothers Health.

India with an exponential growth of population faces heavy burden upon Maternal Health services in both public and private set up. Last decade showed tremendous improvement of health Infrastructure due to heavy funding from Government and private agencies. Now the time has come for the health policy makers for serious thinking about the soft issues of the subject. Perhaps then, formulating a futuristic vision to reduce the C-section rate for the overall development of the society will and achievable goal.

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LAPAROSCOPIC SALPINGO-OOPHORECTOMY ON A CASE OF 14 WEEKS PREGNANCY WITH RIGHT OVARIAN CYST - A CASE REPORT

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Introduction:

Ovarian masses are not uncommon in pregnancy. Incidence of ovarian mass in pregnancy is reported to be about 1 in 1000 .[1] Almost all unilocular cyst with a diameter <5 cm and persistent in second and third trimester are not associated with complications and are regressive during pregnancy; in these cases, abstention seems warranted.[2] Ovarian cysts with diameter ≥6 cm which persist or enlarge beyond 16 weeks' gestation, are at risk of complications and need tissue diagnosis and, therefore, surgical evaluation [3] Torsion is the most common and serious complication of large benign ovarian cysts in pregnancy. The other complications which might occur are rupture of cyst, infection, malignancy, impaction of cyst in pelvis, obstructed labour and malpresentation of fetus [4]. Most surgical options for adnexal masses in pregnancy are managed ideally in the second trimester after organogenesis is complete decreasing the risk of fetal loss, eliminating the 15% to 20% background risk of spontaneous miscarriage and allowing for spontaneous regression of the mass.

In the last two decades, operative laparoscopic procedures are performed increasingly in both gynecology and general surgery. The major advantages of this newer minimally invasive approach are: decreased postoperative morbidity, less pain and decreased need for analgesics, early normal bowel function, shorter hospital stay, and early return to normal activity. With the advancement of laparoscopic surgery, its use during pregnancy is becoming more widely accepted . [5]

Case Report:

A 28 year old G3P1+1 woman at 6 weeks 6 days reported to ANOPD GMCH on 4.8.2022 for her 1st ANC with no major complains. Ultrasonography was done in ANOPD which revealed a single intrauterine pregnancy with CRL 0.93, 6wks 6days G-sac. Cervical length was 4.1cm. A Right ovarian unilocular cyst 15x8 cm2 .

She was then planned for laparoscopic ovarian cystectomy/oophorectomy in 2nd trimester (around 14 weeks of pregnancy) after proper counselling regarding the risk of abortion.

Her first Pregnancy was uneventful which was 8 years back. She had delivered a 3kg baby girl vaginally at a district hospital. She had a spontaneous abortion at 3 months of gestation 1 year back following which Dilatation and Evacuation was done at a local hospital.

On examination, she was 158cm in height with a weight of 60 kg. Her vitals were stable. Cardiovascular and respiratory systems were clinically normal. She had a 24 weeks size lump abdomen.

Investigations showed Hb: 11.6gm%, Blood Group A+ve. Other haematological and biochemical parameters were within normal limits. CA125- 48.3.

With the diagnosis of G3P1+1 at 13wks 1 day gestation with large right ovarian cyst, she was planned for Laparoscopic Cystectomy/ oophorectomy.

She underwent Laparoscopic Right sided Salpingo-oophorectomy under GA at the Department of Obstetrics& Gynecology, Gauhati Medical College on 13/9/2022. Intraoperatively, a right sided ovarian cyst 15x8cm2 which clinically looked benign with clear fluid inside was seen cushioning the 14 weeks size uterus. The content of the cyst was aspirated and right sided salpingo- oophorectomy was done. There was no free peritoneal fluid or adhesion. Specimen of the cyst wall which was extracted was sent for histopathological examination. Report is being awaited.

Patient's postoperative period was uneventful. She was given uterine relaxants and injectable antibiotics for 48 hours. Ultrasonography was done postoperatively and viability of the fetus was ensured. She was discharged on the 3rd post operative day and was asked to review with her histopathological examination report in ANOPD for follow up.

Fig: Large Right Ovarian Cyst cushioning the 14weeks size uterus

Fig: Uterus after Right sided salpingo ophorectomy

Discussion: Laparoscopic cystectomy in pregnancy was first reported in 1991 by Nezhat et al[6] and then a second case in 1994 by Howard and Vill.[7] The major advantages of laparoscopy are magnification and panoramic view of the pelvis resulting in reduced intra-operative uterine manipulation which may lead to decreased postoperative uterine irritability, miscarriage rate and preterm labour which is seen in 50% of third trimester cases with an open approach. There are several reports on the safety of the laparoscopic procedure for gynaecologic and non-gynaecologic surgery such as cholecystectomy and appendicectomy during the second trimester of pregnancy with no increase in miscarriage rate. The reduced postoperative pain, rapid recovery as well as the other described typical advantages after laparoscopic surgery are of potential benefit to pregnant women and may encourage more widespread use of this procedure in pregnant women [8]. In addition, the cosmetic results are much better and the discomfort of stretching and distension of the laparotomy scar due to the rapidly growing uterus is avoided.

Conclusion: Laparoscopic management of adnexal masses in pregnancy by an experienced team, is a safe and effective procedure that allows, compared to the traditional surgery, a shorter hospital stay, a reduced rate of postoperative complications and a decreased maternal and fetal morbidity.

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OUR EXPERIENCE WITH UTERINE ARTERY EMBOLIZATION FOR SECONDARY POSTPARTUM HAEMORRHAGE

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Postpartum haemorrhage (PPH) affects approximately 14 million women yearly, accounts for 25% of delivery-related deaths in the world and is the main cause of emergency peripartum hysterectomy [1]. Secondary PPH is defined as bleeding that occurs after 24 hours to 12 weeks from delivery [2]. Secondary PPH occurs in just under 1% of women, is associated with primary PPH and retained placenta, and may result in significant maternal morbidity. [3] If medical management fails, minimally invasive intervention of uterine artery embolization (UAE) can be explored, which has shown up to 95% success rate. The first step in common management of PPH is the use of uterine stimulants (uterotonics) such as oxytocin, ergot derivatives, prostaglandins, and misoprostol, and bimanual compression of the uterus. Recommended operative procedures for the management of PPH include surgical repair of lower genital tract lacerations, uterine hypogastric artery ligation, and hysterectomy. [4] More recently, the relative benefits of uterine UAE versus hysterectomy have been debated. UAE is generally accepted to be a safe and reliable procedure; however, the success rates and complications for this procedure have been published, and these presented only a small number of cases. [5]. We report here two cases of secondary PPH which were managed by UAE and a hysterectomy could be avoided.

The first patient presented at two weeks after she had undergone a caesarean section. She was a primigravida at 33 weeks 4 days IVF pregnancy with chorioamnionitis and had undergone an emergency caesarean section. During her immediate postpartum period she didn't have any complications. However, two weeks after the delivery she presented with secondary PPH. The patient was anaemic and hypertensive. An ultrasound revealed a post-partum uterus with a 6X5 cm intrauterine clot. Her WBC count was 14,400/Cumm and CRP was 27.92 mg/L. A high vaginal swab revealed growth of KlebsiellaSpp and Enterococcus Spp. Initially she was managed with uterotonics and injectable broad spectrum antibiotics. However, on the second day of hospitalisation she had another episode of PPH and a decision was made to perform UAE. Following which PPH was controlled.

The second patient was a second gravida who had a spontaneous vaginal delivery and had primary PPH. Primary PPH was controlled with uterotonics and antibiotics. However, she presented two weeks later with secondary PPH. An ultrasound revealed clots in the uterine cavity. Initially she was managed with uterotonics and broad spectrum injectable antibiotics. However, bleeding continued and on the second day of presenting with secondary PPH a decision was taken to perform UAE. Following the procedure the patient improved.

In both these cases hysterectomy could be avoided and the patients didn't have further episodes of PPH. A team of obstetricians and interventional radiologists is crucial to increase the success rate of UAE [6]. UAE is preferable for patients who are stabilised hemodynamically. Obstetricians and interventional radiologists should decide whether to perform UAE or hysterectomy based on the hemodynamic stability of the patient [7]. A skilled interventional radiologist is necessary to increase the success rate of UAE [8]. Complications of UAE include injury to the uterus, infection of the uterus or the puncture site, haematoma at the puncture site, injury to the artery being used, infertility, and

amenorrhea. Postembolization syndrome may last from two to seven days and include pelvic pain and cramping, nausea and vomiting, low-grade fever, fatigue and discomfort. It is treated with NSAIDs and antiemetics. [9]. If a primary care facility does not have the necessary equipment for treating PPH, patient transfer should be considered as soon as possible. UAE is a safe and effective procedure for preserving patient fertility following PPH and a team approach involving both obstetricians and interventional radiologists is critically important to increasing the success rate of UAE.

Figure 1: Embolic agent (polyvinyl alcohol) being injected into the uterine artery

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"DECIPHERING DYSMENORRHEA IN A CASE OF OVARIAN TUMOUR" – *A case report of an Accessory and Cavitated Uterine Mass* (ACUM).

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Background Accessory and Cavitated Uterine Mass (ACUM) is a benign lesion and newly recognized Mullerian anomaly. It is an accessory cavity lined by functional endometrium within an otherwise normal uterine cavity, in contrast to the other Mullerian anomalies in which the uterus is malformed. The cavitated mass is confined to the myometrium, is encapsulated, and bears uterus-like histological organization unlike diffuse adenomyosis, myoma, and adenomyoma respectively. ACUMs are included in Group 4 of the updated embryological-clinical classification for female genito-urinary malformations in the recently published Human Reproduction Update. The usual presentation is refractory dysmenorrhea in young females not responding to usual drugs. TVUS and MRI is utilised to reach the diagnosis.

Methods We are reporting a case of a 22-year old girl referred to our tertiary care oncology centre with an ovarian tumor. Her chief complaints were severe and refractory dysmenorrhea since menarche. The co-existing ACUM with an ovarian mass on MRI caught our attention as a probable cause of dysmenorrhea. Accordingly, she was planned for exploratory laparotomy and frozen section. The patient underwent fertility- sparing staging of borderline tumour along with excision of the ACUM.

Results The histopathology report confirmed it to be a case of stage 1a serous borderline ovarian tumour. The patient has been planned for observation and is currently free of dysmenorrhea.

Conclusions The diagnosis of ACUM is essential to provide a relief to both patients and physician by resorting to appropriate treatment in timely fashion. Early surgical treatment can provide the symptom relief to these young women.

Keywords

Accessory and Cavitated Uterine Mass, Dysmenorrhea, Uterine anomaly, juvenile cystic adenomyosis.

Case Report

A 22-year-old unmarried female presented with severe dysmenorrhea since menarche. It started one day before the menses, was maximum on days 2-3, and persisted throughout the menses. Her menstrual cycles were regular with a 28-30 day cycle with the normal flow for 4-5 days. There was no history suggestive of pelvic inflammatory disease. She could not get rid of the pain with non-steroidal anti-inflammatory drugs (NSAIDs) and other over-the-counter drugs. During her evaluation for dysmenorrhea, she was diagnosed with an ovarian mass. USG reports revealed a large 10*10* 8 cm left adnexal mass suggestive of an endometriotic cyst. MRI pelvis confirmed a left-sided 11*11*8 cm left adnexal lesion with internal echoes and also revealed a 10*8 mm cavitating lesion along the left lateral wall of the uterine wall suggestive of ACUM (Figure 1). CE-CT of the upper abdomen was essentially normal. Her serum CA-125 level was 86 IU/mL and other markers for germ cell tumors were normal. With the above reports, she was referred to our center. The further evaluation did not add to other causes of dysmenorrhea. She was taken up for exploratory laparotomy with a frozen section and proceed. A 12*10 cm left ovarian cystic mass with a smooth surface and intact capsule was noted twisted by one and a half turns along its pedicle. The lesion reported as ACUM was found to be attached to the left upper uterine wall just below the attachment of the left round ligament (Figure 2). Bilateral fallopian tubes and right ovary were normal with no endometriotic deposits. The frozen section of the left adnexal mass was suggestive of borderline serous ovarian tumor. Fertility-sparing surgical staging of the tumor

was done. Thereafter, an oblique incision was made over the anterior wall of the suspected ACUM and 1-2 ml of chocolate-colored fluid was drained. The mass was enucleated with meticulous dissection. The uterine cavity was not entered into and the myometrial defect was closed. There was no communication of the lesion with the main uterine cavity. The postoperative course was uneventful and the patient was discharged on the third day of surgery. Histopathology confirmed it to be a stage Ia serous borderline ovarian tumor without a micro-papillary pattern. The section through enucleated cystic mass revealed cavitated lesion lined by functional endometrium with glands and stroma surrounded by irregularly arranged smooth muscle cells. The patient has planned been planned for observation and is currently free of dysmenorrhea.

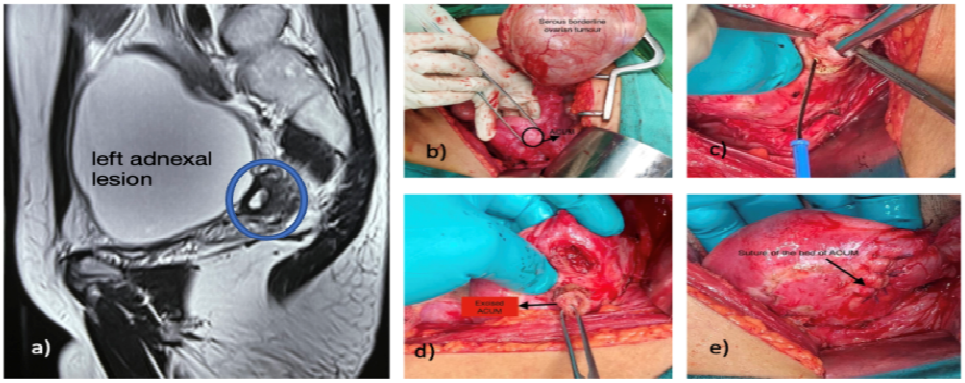

Figure 1. a) T2- weighted MRI image of pelvis showing an adnexal mass and ACUM (within the blue circle), b) intra-operative picture showing left ovarian tumour and ACUM, c) enucleation of ACUM without breaching the endometrium, d) excised ACUM out of its bed, e) sutured bed of the ACUM.

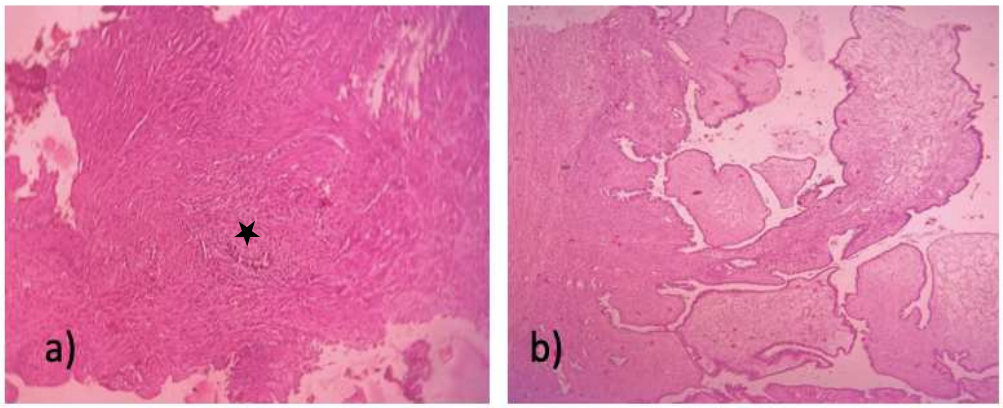

Figure 2. Histopathological picture of Hematoxylin and Eosin stain showing a) endometrial gland (marked as asterisk) amidst smooth muscle of the myometrium, b) Serous borderline ovarian tumour with hierarchically branching papillae lined by stratified, heterogenous epithelium with up to moderate atypia.

Discussion

Severe dysmenorrhea in the post-menarchal period is usually taken as primary dysmenorrhea unless proven otherwise (1). After further ruling out congenital female genital tract anomaly in cases of primary dysmenorrhea, non-responsiveness to usual antispasmodics or hormonal treatment makes gynecologists venture into other causes of primary pathology. Uterus-like mass (ULM) is the term given to the structures resembling the uterus both grossly and histologically (2). ACUM falls under the category of non-communicating ULM arising in the normal uterus. The first description of such features dates back to the early 20th century, however, the term ACUM was given by Acien in 2010. Acién et al. illustrated a detailed analysis of cases of ACUM reported as different entities like juvenile and isolated cystic adenomyomas owing to non-recognition of this anomaly in the European Society of Human Reproduction and Embryology classification (3).

The usual age of presentation of ACUM is reported to be <30 years, with severe and progressive primary dysmenorrhea or chronic pelvic pain. It is attributed to distention of the lesion cavity by repeated bleeding. The other features can be dyspareunia, hypogastric pain or it may be asymptomatic. The three theories of the development of ACUM have been proposed: (i) congenital anomaly theory, (ii) heterotopias theory, and (iii) metaplasia theory (2). The first theory advocated by most considers duplication of ductal Mullerian tissue in the critical area as the origin of ACUM. Such a critical area can be at the level of attachment of the round ligament, possibly related to gubernaculum dysfunction.

The criteria for diagnosing ACUM are: (1) an isolated accessory cavitated mass usually located under round ligament; (2) normal uterus, fallopian tubes, and ovaries; (3) a surgical case with excised mass and pathological examination; (4) an accessory cavity lined by endometrial epithelium with glands and stroma; (5) chocolate brown colored fluid contents; (6) no adenomyosis in the uterus (if resected), although there could be tiny foci of adenomyosis in the myometrium of the accessory cavity due to increased intracystic pressure(2). The above criteria are, however, not exclusive. Most of the previously diagnosed JCA is now considered to be ACUM. A new diagnostic criteria for JCA has been proposed: (i) the age of onset of severe dysmenorrhea is within 5 years after menarche or ≤18 years of age; (ii) no history of suspected endometrial or uterine injuries; and (iii) the presence of a cystic lesion 0.5 mm indicated by imaging studies or observed during surgery. However, these criteria are not considered essential to categorize a JCA as an ACUM(3). Histologically, the cavity lined by stroma and glands which are positive for CD10, ER, and PR.

The role of Imaging in establishing the diagnosis of ACUM has been tabulated in table no.1 (3). As Müllerian anomalies are sometimes associated with urinary tract malformations, their proper evaluation is warranted (1).

Table 1. Salient features of ACUM on different imaging modalities.

Imaging modality	Imaging features
Ultrasound	Solid isoechoic to predominantly cystic masses resembling endometrioma arising within the uterus
Hystero-salpingogram	Rules out any Mullerian anomaly, e.g. non-communicated cavitated rudimentary uterine horn.
Magnetic Resonance Imaging	Cavitated mass with hemorrhagic contents; with the normal uterus. Thin sections (3 mm) help in ruling out Mullerian anomaly by demonstrating both cornua clearly. Cystic degeneration in adenomyoma and fibroid will not show T2-hyperintense endometrial lining and hemorrhagic contents.

The differential diagnosis and their differentiating features are tabulated in Table No. 2.

Table 2. Differentiating features of lesions simulating ACUM (4).

Entity	Age of presentation	Presenting features	Gross features	HPE
ACUM	Adolescents	Dysmenorrhea	Main uterine cavity and myometrium is otherwise normal	Resembles uterus
Cystic adenomyosis	Middle-aged	Dysmenorrhea	Diffusely spread adenomyotic foci, Small cysts, usually less than 5 mm.	Lack typical endometrial lining and uterus-like smooth muscle
Mullerian anomalies	Reproductive age group	Dysmenorrhea, infertility, Abnormal uterine bleeding (AUB)	Presence of vaginal or uterine septa, unilateral/ bilateral cornuaetc	Fibrous or muscular partition in the cavity
Leiomyoma	Middle- aged	AUB, pressure symptoms, infertility	Round-to-oval firm mass arising within myometrium	Whorled appearance of smooth- muscle cells

The severity of pain is such that patients usually require surgical treatment. As fertility preservation is one of the most concerning factor in such age group, excision of the tumor without hysterectomy is often the treatment of choice(1). The tumour enucleation can be performed laparoscopically or by open technique; depending on the available expertise.

Conclusion

The diagnosis of ACUM is essential to provide a relief to both patients and physician by resorting to appropriate treatment in timely fashion. As it has been established that ACUM is not so rare as previously thought, the physicians should be well aware of this entity. TVUS and MRI is utilised to reach the diagnosis. Early surgical treatment can provide the symptom relief to these young women.

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DANCING IN PREGNANCY

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Dancing is a safe and fun way to exercise during pregnancy. It helps to maintain flexibility and improve muscle strength in addition to being a great stress buster. ACOG advises 150 minutes of moderate intensity aerobic exercise and dancing being an aerobic exercise is a great way to achieve that. Also it improves the mood and helps to relax. Of course , it goes without saying that dancing is not advisable in high risk pregnancies like anemia or heart disease.

Jazz dance, samba, ballroom dancing (minus the lifts) , salsa and Indian classical forms such as Bharat Natyam are different types of dance forms that can be tried. Gentle belly dancing, which uses slow, controlled movements, is a great way to exercise in pregnancy. Belly dancing uses abdominal muscles and helps to keep the back supple. It also helps to focus on good posture and work in the pelvic floor muscles. The important thing to keep in mind is to keep both feet on the floor at all times. Hip-hop, urban, street dance, tap dance or dances which are involved with jumping, standing on one leg, twisting or turning suddenly should be avoided.

The timing of the dance sessions can be reduced in the third trimester and if it is too strenuous or making the patient breathless. It is important to take breaks in between, drink adequate water and take a light snack either before or after the session. It is also essential to do some warm up exercises before starting the dance session. Dance can be done at home or with a trainer but it is advisable to be with a professional trainer if she is just starting to learn.

Aranyani Bhargav is a Bharatnatyam dancer, director of Vyuti Dance Company and was recently in limelight for bringing a piece to Bangalore audience where in her sixth month of pregnancy, she performed as a regular dancer. In one of her interviews she says “But dancing through pregnancy is something that should be just normal. Pregnancy is not an illness, it is not a disease, it is not a crippling condition. Yet, when women become pregnant, so many restrictions imposed on them, many of which don’t have any medical basis for it. One of them is dancing. Of course, please understand that I am talking about low-risk pregnancies with no complications. Not all pregnancies are the same, and it would be foolish for anyone to blindly disregard medical advice in favour of what I’m saying here. I am not a doctor. But having said that, for a lot of people, and it was certainly true for me – there was absolutely no medical reason for why I should not dance through my pregnancy. My pregnancy has been low-risk and I am a healthy and active woman. So it became clear that there were other factors that contributed to the reasons for why women were being discouraged from dancing – societal pressures, fear and superstition, the guilt instilled in the mothers-to-be by society about possibly harming the baby, the shame attributed to the public display of the pregnant form – whatever the reason, it wasn’t medical.”

Dancing is therefore not only a healthy but a very enjoyable exercise that can be a part of an antenatal workout regimen.

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ART AND HYPERTENSIVE DISORDERS OF PREGNANCY

Dr. Deepak Goenka , Dr. Preeti Moond
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INTRODUCTION

Since the field of assisted reproductive technologies (ART) has expanded, more than ten million children have been born as the result of IVF. The estimated annual increase is half a million children. Hypertensive disorders of pregnancy (HDP) occur in about 10% of all women around the world. In Asia and Africa, nearly 1/10th of all maternal deaths are associated with HDP. Artificial reproductive technique is also considered as a risk factor among all other risk factors for (HDP) of (RR–1.8, 95%CI).Various factors can be involved in relation to hypertensive disorders of pregnancy and ART.

1. Larger proportion of multiple births
2. Immunological intolerance in donor gametes and embryos
3. Higher body weight
4. Advanced maternal age
5. Absent corpus luteum in programmed and oocyte donation cycles (modifiable)
6. Altered hormonal profile due to – ovarian stimulation, cycle substitution and technology itself.
7. Various ART procedures

- FRESH CYCLES
- FET CYCLES
- EMBRYO BIOPSY FOR PGS
- DONOR GAMETES

FRESH CYCLES AND HDP: Low levels of estrogen in early pregnancy allow for migration of extravillous trophoblasts into uterine spiral arteries with artery remodeling. If estrogen is elevated prematurely, extravillous trophoblast invasion of spiral arteries is suppressed. Supraphysiological hormonal levels in early pregnancy lead to impaired trophoblastic invasion. Superovulation alters the expression of genes critical to endometrial modeling during early implantation.

FROZEN EMBRYO TRANSFER (FET) AND HDP : Improved cryopreservation techniques and growing practice of single embryo transfer (SET) and improved pregnancy rates has lead to an increase in the incidence of frozen embryo transfer. A potential factor in developing hypertension during FET is the type of endometrial preparation. A specific analysis comparing HRT versus natural cycles in FET found that HRT cycles lead to an increased risk of HDP compared to natural cycles, adjusted odds ratio 1.78. It is the number of corpus luteum that differs in natural (one CL), fresh cycles (supraphysiological number of CL), absent CL in artificially programmed cycles and donor oocyte cycles. Corpus luteum is important for the production of vasoactive substances like relaxin and VEGF which are important for the initial placentation.

GAMETE DONATION AND HYPERTENSION: Oocyte donation is becoming a common standard practice for patients with reproductive disorders, diminished ovarian reserve, or advanced maternal age due to its relatively high success rate and comparable live delivery rates in comparison to autologous IVF pregnancies. Pregnancies achieved from oocyte, sperm or embryo donation are unique, since they have resulted from donor gametes that are immunologically foreign to the mother. Fetal HLA-C is different from maternal HLA-C because it also expresses paternal HLA-C cells. When donated oocytes

are used the trophoblastic HLA-C is less recognizable for the immunological system of the mother because it is completely allogenic. This can lead to an altered functioning of the uterine natural killer cells. This is supported by the increased risk of HDP in primiparous women and after the change of paternity in multiparous women.

EMBRYO BIOPSY AND HDP: The use of preimplantation genetic testing (PGT) is increasing rapidly. Current indications for PGT include aneuploidy assessment for recurrent pregnancy loss, advanced maternal age, sex selection, human leukocyte antigen-matched siblings and testing for genetic disorders such as unbalanced translocations and single gene mutations. Because trophectoderm biopsy removes cells that are destined to form the placenta, there is potential for increased risk of adverse pregnancy outcomes that are associated with abnormal placentation. Abnormal initial placentation has been strongly suggested to be involved in later development of pre-eclampsia and restricted fetal growth.

CONCLUSION: As ART and FET rate has increased, our safety concerns, about the procedures has also increased. Patient BMI should be optimised before doing embryo transfer. The chances of multiple pregnancies should be reduced by performing more of single embryo transfer (SET). Whenever possible, FET should be performed in a natural, modified natural or ovulation induction cycle (rather than an artificial cycle). Knowing the possible relationship between infertility treatment and HDP specific care plans and interventions should be developed to decrease the incidence and subsequently the risk of maternal morbity and mortality.

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UTERINE LIPOMA A RARE ENTITY – CASE REPORT

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Came across two such cases during my long thirty three year career. The first case was 58 years post menopausal lady, para -3, presented with spotting and lower abdominal discomfort. Ultrasonography showed features of interstitial leiomyoma (58 x 56 mm). D & C and histopathological examination revealed no abnormality. Total Abdominal Hysterectomy with Bilateral Salpingo ophorectomy was carried out.

The second case was aged 49 years, Para-2 presented with menorrhagia and suprapubic lump. Ultrasonography showed presence of interstitial fibroid (70 x 66 mm) in the fundus of uterus with bulge in the endometrium. D & C and histopathological examination showed evidence of endometritis. Total abdominal hysterectomy with bilateral salpingo ophorectomy was done.

It was only after dissection and eneucleation, the nature of the tumor was thought to be lipomatous tumor of uterine corpus. Both the specimens looked yellow with smooth surface. Micoscopically, both the lesions were almost comprised of mature adipocytes occasionally defined by fibrous tracts containing capillary vessels. Peripherally the lesions was surrounded by fibrous capsule.

Discussion :

Lipoma of the uterine corpus is a rare benign tumor, the incidence being 0.03 to 0.25 %. The genesis of lipoma in the uterine wall continues to be an enigma as fatty tissues lack in the uterine wall under normal conditions. Many theories have been proposed in this regard-

a) Migration of adipose cells through uterine arteries.
b) Mesencymal cellular remains of a pluripotential nature with the cabacity to differ toward adipocytes.
c) Adipose metaplasia from the smooth muscle fibre component of the uterine corpus.

The other close variant of lipomatous tumor in uterine corpus is lipoleiomyoma looked like uterine lipoma morphologically. On histopathological examination lipoleiomyoma reveals a characteristic pattern of mature adipocytes interaspersed in uterine smooth muscles. Imaging modalities, histopathology and immunohistochemistry (indicating positive or negativity of markers like Vimentin, Actin, CD 10, CD 99, CD 34 and HMB 45)

Both uterine lipoma and lipoleiomyoma mostly developed in perimenoposal and post menoposal women, the clinical presentation being similar to those found in leiomyomas. Most are post operative chance finding following hysterectomy for leiomyoma though certain radiological investigations may suggest their existence prior to surgery. Treatment modalities are similar to those applicable in cases of leiomyoma. Prognosis is excellent in cases of lipomatous benign tumors of uterine corpus unless there are associated malignant lesions in the cavity, ovary or within.

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DISSECTION

Dr. NilimaThakuria Haque,
Sr. Consultant

The four of them were sleeping close together.
In the guest-house where they lodged
the bees of sleep hovered and left
finding no flower on their eyelids.

They have a common destination.
In ethnic-design bags
Are stuffed all the paraphernalia for the trip.
Now and then, they yawn or hiccup
Or flip the pages of a dictionary.

The first is an ancient peepal tree with matted roots,
The leaves hanging from it
are but pieces cut out of his heart.
His body carries deep battle-scars
Deep-rooted is his grief.
The nights of baul-geet
Keep sawing at the flesh of the void
Fill it up, fill it up, dear heart!

The second is the bookworm.
Endnotes! footnotes! quotations
And cobwebs of theory.
Half-perceiving, simple folks see themselves as fools
They might even turn deaf
listening to the pseudo-intellectual gibberish.
The pedantic self knows that in this bookish circle
A big zero is swallowing him up.
Knowing too well his incapacity
To dig a hole and extract a drop of water
He floats nonetheless in a foamy sea
and wields his sword,
Shoots arrows, occasionally a gun.

The other is himself a cannon, a gunshot.
He is a revolutionary, explodes now and then.
Rallies, slogans, strikes, etc.
Against all the injustice and exploitation of the world
A voice of protest. Within parentheses,
An interesting character who loves his comfort.

The novice is all excited and restless
This is his first taste of the hospitality
Of such a guest-house.
He ventures out of the window
And comes back elated
He wants to scream and tell others
about the fountain in his mind
Sleep stares, astonished,
at his open-eyed dreams.

Oh! they are but four poems in the poetry section
Four balloons, or firecrackers,
in the festive issue of a magazine
Maybe bottles of liquor or a bunch of flowers

And here I am,
Awake in the middle of the night
Dissecting all four
Blood on my fingers.

(Translated by Anindita Kar)

পাগলাদিয়া

ডাঃ ৰাতুল দত্ত, ডাউন টাউন হস্পিতাল

পাগ্লাদিয়া
পাগলাদিয়া
মোৰ মন পাগল কৰি নিয়া
তুমি পাগ্লাদিয়া।

চাৰি দশকৰ পাচত
তোমাক আজি
নচকুৰে চালো
একাবেকা তোমাৰ
ঢৌ খেলোৱা দেহা
কিযে এক নষ্টালজিয়া
পাগলাদিয়া
পাগল কৰিলা মোৰ হিয়া।।

মনত ভাহে ছবি
আধা মচখোৱা
শৈশৱৰ কোনোবা
হেমন্ত বা শীতৰ পুৱা
দেউতাৰ হাত ধৰি
তোমাৰ বুকুৰেদি
পাৰ হৈ যাও
সৰিয়হৰ হালধীয়াবোৰ পাৰ হৈ হৈ
পাওঁ মোৰ ওপজা গাঁও
সেয়া যেন সোঁৱৰণী যুগমীয়া
আজি পাগল কৰিলা মোৰ হিয়া।।

তোমাৰ ৰূপালী বলুকাত
মোৰ পোত খোৱা দুভৰি
ঝাওগছৰ ফাঁকে ফাঁকে
লুকাই থকা
শুভ্ৰ শহাবোৰ বিচাৰি
বুকু ভৰা অলেখ
স্মৃতি সুঁৱৰি
মনত দোলা দি যোৱা
মোৰ হিয়াৰ কোণৰ পাগলাদিয়া
আজি পাগল কৰিলা মোৰ হিয়া।।

শৰতত তোমাৰ শীৰ্ণ দেহা
শাওণত দুকূল বাগৰি
নৈপৰীয়াৰ চকুলো নিগৰোৱা
তথাপিও যেন তুমি
নলবৰীয়াৰ স্বাভিমান
শকতি আৰু সুন্দৰৰ প্ৰতীক
তুমি বৈ থাকা
যুগে যুগে আমাক
প্ৰেৰণা দিয়া
হে মোৰ পাগ্লাদিয়া
যেন সদায়ে পাগল কৰি ৰাখা
মোৰ হিয়া।।

অথঃ ঘৈণী সংবাদ

"ৰসৰচনা"

ডাঃ চন্দন চৌধুৰী, জ্যেষ্ঠ চিকিৎসক

ভাৰতীয় হিন্দু দণ্ডবিধি অনুযায়ী এজন মানুহে দুবাৰ বিয়া কৰোৱাটো অপৰাধ। কাৰণ ভাৰতীয় দণ্ডবিধি অনুযায়ী কোনো এজন মানুহে এটা ভুলৰ বাবে দুবাৰ শাস্তি দিব নেৱাৰি।

হুহু হুহু হু যি পত্নী পতিৰ দুৰ্বলতাৰ সুযোগ লৈ মূৰৰ ওপৰত উঠে আৰু গুৰু-গোসাঁই নমনা হৈ যিহকে পায় তাকে কৰে তেনেবোৰ পত্নীক 'ওভতগোৰে নচা পত্নী' বোলে। এনেবোৰ পত্নী ওচৰ-চুবুৰীয়া, বন্ধুবৰ্গ বা আত্মীয় স্বজনৰ ওচৰত সতী-সাবিত্রী হৈ দেখুৱাই কিন্তু মাজে সময়ে যেতিয়া তাণ্ডৱ নৃত্য ধৰে তেতিয়া বেচেৰা পতিৰ 'জিনা হাৰাম' হৈ যায়।

বিয়াৰ আগতে এনেবোৰ পত্নী সাইলাখ ৰূপৱতী আৰু গুণৱতী। খোজে-কাতলে, চালে-চলনে তথা চাৱনীৰে চকুত লগা বিধৰ । মজলীয়া উচ্চতা, লাহী ককাল, হৰিণী চকু, দীঘল কেশেৰে সুশোভিতা তেওঁলোক। দেখিলে এনেকুৱা লাগে যেন হাই-কাজিয়া, দ্বেষ-বিদ্বেষ, মাৰি-মৰক তেওঁলোকৰ বাবে অভিধান বিৰুদ্ধ কথা।

এনেবোৰ পত্নীৰ আচল স্বৰূপটো ওলালে দুর্গা গোসাঁনীৰ লগত তুলনা কৰিব পাৰি। কিন্তু আনসময়ত যেতিয়া কিবা বস্তু বা কাম আদায়ৰ সময়ত নানান চলাহী কথাৰে আকর্ষণৰ কেন্দ্রবিন্দু হৈ পৰে। তেনে সময়ত তেওঁৰ শান্ত, সমাহিত ৰূপে আটাইতকৈ খঙাল আৰু উগ্রপ্রকৃতিৰ পুৰুষকো ভোল নিয়াব পাৰে।

হেজাৰ আহুকালৰ মাজতো পত্নীৰ উপকাৰিতা অনস্বীকার্য্য। তেওঁ গোটেই ঘৰখনৰ চালিকাশক্তিস্বৰূপা গৃহ তথা বর্হিপৰিত্রহ্মা দপ্তৰৰ তেওঁ গুৰি ধৰোঁতা। গতিকে গার্হস্থ্য জীৱনৰ সন্তুলন বজাই ৰাখিবলৈ তেওঁক সন্তুষ্ট কৰি ৰখাৰ কলাটো সকলো পতিয়ে আয়ত্ব কৰাটো নিতান্তই আৱশ্য।

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পত্নী ঃ তোমাৰ বন্ধু ধীৰাজে লীনাক বিয়া কৰাব ওলাইছে, তুমি মানা নকৰা কিয়?
পতি ঃ কিয় ?
পত্নী ঃ লীনা ইমান বেয়া ছোৱালী।
পতি ঃ কিয় কৰিম? সি মই বিয়া কৰোঁতে মোক মানা কৰিছিল জানো ?

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দাস ঃ বুজিছে বৰুৱা, আমাৰ গোটেই জীৱন ভয়ৰ মাজেৰে পাৰ হয়। শৈশৱত মা-দেউতালৈ ভয়, চাকৰিত বচলৈ ভয়, বৃদ্ধ বয়সত মৃত্যুলৈ ভয়।
বৰুৱা ঃ পত্নীলৈ একা ?
দাস ঃ তেওঁৰ নাম লবলৈও ভয়।

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ৰাতিপুৱাৰপৰা পতি-পত্নীৰ মাজত দুর্বাদল কাজিয়া। কোনেও হাৰ মানিব নোখোজে। দুপৰীয়া কাৰো ভাত-পানী নাই। অৱশেষত সন্ধিয়া ডার্ক লিউচ পদ্ধতিৰে পত্নীক জয়ী ঘোষণা কৰাতহে কাজিয়াৰ ওৰ পৰে।

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