EOGS BULLETIN

JAN 2019.

WE FOR स्त्री

Safer • Stronger • Smarter

Dr Nandita Palshetkar,
FOGSI President

WE FOR स्त्री
Safer • Stronger • Smarter

ERODE OBSTETRIC AND GYNAECOLOGICAL SOCIETY

Affiliated to FOGSI

Office Bearers 2019 - 20

Dr. E.S. Usha
President EOGS

Dr. Sri Revathy Sadasivam
Secretary EOGS

Dr. Dharani
Treasurer EOGS

Monthly Bulletin of Erode Obstetric and Gynecological Society
Editors: **Dr. E.S. Usha & Dr. N. Poongothai**

Dr. E.S.Usha
Lotus Hospital,
90, Thayumanavar Sundaram Street,
Kollampalayam, Erode 638002
9952362196
esusha@gmail.com

Dr. Sri Revathi Sadasivam
Maaruthi Medical Centre and Hospitals,
564, Perundurai road,
Erode 638011
98651 96660
sada.reva.9.6.88@gmail.com

EOGS

Presents

An Academic feast on

Role of Blood and Blood Products in Obstetrics

Speaker

Dr. B. Abhishekh

MD (Transfusion Medicine)
DNB (Immunohematology)
MNAMS, PGDCR

Transfusion Medicine - Associate Professor
JIPMER

Case Presentation by :

Dr. E.S. Usha MD., DGO.,
Fellow in fetal medicine

Date	:	**Jan 20th 2019, Sunday**
Time	:	**2.30 pm - 4.00pm**
Venue	:	**Atrium Hotel, Erode**

Lunch : 1.30 pm - 2.30 pm

Sponsored by ***Jagsonpal***

Message from the President

Dear members,

Happy New Year and Happy Pongal…

Thank you for choosing us as the office bearers of this Prestigious Society for the next two years. I feel blessed to be installed by our Founder president Madam Rajalakshmi.

First of all we would like to place on records our appreciation to the outgoing team.

They have done a really wonderful work by bringing in eminent faculty and covering topics of clinical relevance. Appreciations also for conducting the Chit smoothly, for the Bulletins and for organising wonderful trips.

We are planning our regular meetings and the monthly bulletin. We are open for your feedback and suggestions. Kindly let us know your expectations and more importantly participate in all activities – present cases in our regular meetings, contribute articles to the Bulletin.

Let us all unite a little more stronger so that we are all ready to offer world class services to our patients and at the same time equip ourselves physically and mentally to face the challenges of our profession and family.

I thank all of you once again.

Dr. E.S. Usha MD., DGO.,
Fellow in fetal medicine
President EOGS

Letter from Secretary's Desk

Dear EOGS doctors,

I am extremely honoured and it gives me an immense sense of pleasure to pen this message as Secretary of our Erode OG Society. EOGS had always been a vibrant society with numerous outstanding academic activities.

To add more flavor, our immediate past President and Secretary had set sky high standard for this society. I ensure to put in my best possible efforts to make EOGS find its unique place in the map of FOGSI. We office bearers as a lot are very keen in knowing everybody's individual concern, to keep the society's spirit high. We promise to give you not just an Academic bonanza, but also unique fun filled gatherings.

We'll make sure that we do absolute justice for those hours that you spend with us, and you'll get back home with lot of scientific updates to improvise and streamline the regular clinical protocols and to have focused conclaves of International Standard. Lets promote more peer review sessions and open forum discussions to further strengthen our different arenas which makes us grow more Strong, Smart and Safe, because ultimately our safety also matters.

With heartfelt gratitude, I earnestly long for unprecedented attendance and support for all our endeavors in future. Let's all march together, towards the upliftment of women's health.

Dr. Sri Revathy Sadasivam MD (OG)., DNB (OG)., MICOG., MRCOG (UK)., Masters in Reproductive Medicine (UK)
Secretary EOGS

Mission for 2019

We for "ஸ்திரீ" Making Women Safer.. Stronger .. Smarter..

10 priorities for betterment of women in India

1. To provide optimal antenatal care for the best maternal and fetal outcomes.
2. To reduce maternal mortality by detecting and treating High risk pregnancies.
3. To help make childbirth safe, successful and satisfying experience.
4. To encourage and promote breast feeding in India.
5. To promote contraception.
6. To make abortion safe and accessible.
7. To condemn and strongly oppose female feticide.
8. To propagate awareness and screening for genital cancers in women.
9. To diagnose and aggressively treat reproductive tract infections.
10. To educate adolescent girls on health, hygiene and nutrition.

Dr. Nandita Palshetkar
FOGSI President

Excerpts from the speech during installation in AICOG 2019

POLYHYDRAMNIOS

Polyhydramnios, or hydramnios, is an abnormal increase in amniotic fluid volume and is typically diagnosed in the second or third trimester.

INCIDENCE

The incidence of polyhydramnios in a general obstetric population generally ranges from 1 to 2 percent.

AMNIOTIC FLUID VOLUME REGULATION

The volume of amniotic fluid reflects the balance between fluid production and movement of fluid out of the amniotic sac; the regulation of this process is incompletely under stood. In late gestation, the primary sources of amniotic fluid production are fetal urination and secretion of lung fluid; oral and nasal secretions make minimal contributions. The main routes of amniotic fluid removal are fetal swallowing and absorption via the intra membranous pathway.

CAUSES OF POLYHYDRAMNIOS

Physiologically, the fluid increase in many of these cases can be attributed to one of the two mechanisms: (1) impaired fetal swallowing, or (2) overproduction of fetal urine due to a high-output cardiac state, renal abnormality, or osmotic fetal diuresis.

IMPAIRED SWALLOWING

GI obstruction - Duodenal atresia ,TE Fistula, Thoracic mass, Diaphragmatic hernia.

Craniofacial - Cleft lip/palate, Micrognathia, Neck masses.

Neuro-muscular-Myotonic dystrophy, Arthrogryposis, Intra -cranial anomaly

EXCESS URINE PRODUCTION

Renal/urinary - UPJ obstruction, Mesoblastic nephroma, Bartter syndrome

Cardiac - Cardiac structural anomaly, Tachyarrhythmia, Sacrococcygeal teratoma, Large Chorioangioma

Osmotic diuresis/other- Diabetes, Hydrops, Idiopathic

When no etiology for the excess amniotic fluid is identified, polyhydramnios is termed "idiopathic." Idiopathic polyhydramnios is a diagnosis of exclusion, and a predisposing condition may become evident with advancing gestation or after delivery. Therefore, polyhydramnios with no identified cause in the prenatal period may also be referred to as unexplained. Idiopathic polyhydramnios accounts for approximately 60–70% of cases of polyhydramnios.

CLINICAL SIGNIFICANCE

Many idiopathic cases resolve spontaneously, especially if mild. However, polyhydramnios has been associated with an increased risk of several adverse outcomes in addition to the poor outcomes related to the associated morphologic abnormalities:

- Maternal respiratory compromise
- Preterm labor, premature rupture of membranes (PROM), preterm delivery

- ✤ Fetal malposition
- ✤ Macrosomia (potentially leading to shoulder dystocia)
- ✤ Umbilical cord prolapse
- ✤ Abruption upon rupture of membranes
- ✤ Longer second stage of labor
- ✤ Postpartum uterine atony

These complications increase the risk of cesarean delivery and neonatal intensive care admission.

ASSESSMENT OF AMNIOTIC FLUID VOLUME

After 20 weeks of gestation, amniotic fluid volume is assessed by using either the Deepest vertical pool (DVP) or Amniotic fluid index (AFI). In multiple gestations, the Deepest vertical pool is used. These semiquantitative measures are preferred over subjective assessment because of their reproducibility, and in the setting of amniotic fluid abnormalities, a numerical estimate permits serial assessment over time.

To measure the DVP, the ultrasound transducer is held perpendicular to the floor while scanning in the sagittal plane (parallel to the long axis of the patient's body), and the largest vertical pocket of amniotic fluid is measured. To calculate the AFI, the uterus is divided into 4 equally sized quadrants and the depth of the single deepest fluid pocket in each quadrant is measured; the sum of these measurements is the AFI.

To be included in either the DVP or AFI, each measured amniotic fluid pocket must be at least 1 cm wide. The measured pocket(s) should not contain fetal parts or loops of umbilical cord. Color Doppler is useful to avoid overmeasurement of a pocket that contains loops of umbilical cord.

DIAGNOSIS

Polyhydramnios may be suspected when there is a discrepancy between fundal height and gestational age (a size-date discrepancy), but it is more commonly an incidental finding detected during an ultrasound examination performed for another indication.

When the single DVP is used, polyhydramnios is defined as a measurement of > 8.0 cm. With AFI, the threshold is generally considered to be 24 cm or 25 cm.

The degree of polyhydramnios is frequently categorized as mild, moderate, or severe, based on an AFI of 24.0–29.9 cm, 30.0–34.9 cm, and > 35 cm, or a DVP of 8–11 cm, 12–15 cm, or > 16 cm, respectively.

EVALUATION AFTER DIAGNOSIS

The following parameters should be assessed by ultrasound

- Fetal growth- idiopathic polyhydramnios may be associated with macrosomia. Fetal growth restriction associated with polyhydramnios presents a high risk for an underlying fetal abnormality, including trisomy 13 or 18.

- ✤ Fetal cardiac anatomy
- ✤ Placenta for presence of large chorioangiomas
- ✤ Fetal movement to assess neurologic function
- ✤ Positioning of fetal hands and feet to rule out arthrogryposis syndromes
- ✤ Presence and size of fetal stomach to rule out Tracheoesophageal fistula or esophageal atresia. These abnormalities may be difficult to diagnose by ultrasound, but should be suspected in cases in which the fetal stomach is visualized but small.
- ✤ Anatomy of the fetal face and palate
- ✤ Positioning and appearance of the fetal neck to rule out an obstructing mass
- ✤ Fetal kidneys to assess for ureteropelvic junction obstruction
- ✤ Lower spine and pelvis for evidence of sacrococcygeal teratoma

In a structurally normal fetus with mild polyhydramnios, consideration should be given to causes such as diabetes, alloimmunization, and potential congenital infection. Congenital infection usually presents with additional sonographic findings, such as NIHF, hepato-megaly, splenomegaly, or placentomegaly.

In cases of polyhydramnios associated with NIHF or additional sonographic features, evaluation for fetal anemia and congenital infection is recommended.

Disorders associated with apparently isolated polyhydramnios include genetic syndromes for which there may not be sonographic findings or a screening or diagnostic test available.

The underlying risk that a structural or genetic abnormality will be discovered postnatally in a pregnancy associated with apparently idiopathic polyhydramnios ranges from 9%in the neonatal period to as high as 28% when infants were followed up to 1 year of age depending on the severity of polyhydramnios.

MANAGEMENT

Management of polyhydramnios depends on the gestational age, severity, presence of symptoms, and cause.

AMNIOREDUCTION

Amnioreduction should be considered only for the indication of severe maternal discomfort, dyspnea, or both in the setting of severe polyhydramnios.

A course of corticosteroids is given prior to amnioreduction because of the increased risk of preterm birth.

INDOMETHACIN

Indomethacin reduces fetal urinary output and hence reduces polyhydramnios. Indomethacin can be used in selected cases below 32 weeks.

The primary fetal concern with use of indomethacin is constriction of the ductus arteriosus. If the duration of therapy exceeds 48 hours and the pregnancy is over 24

weeks of gestation, serial fetal echocardiographic evaluation with Doppler velocimetry should be done at intervals of two days to one week. Sonographic signs of ductal narrowing include tricuspid regurgitation and right ventricular dysfunction. The risk of ductal constriction increases with advancing gestational age and is almost 50 percent at 32 weeks of gestation. Constriction generally resolves within 24 hours after discontinuing the drug.

Other possible fetal adverse effects include neonatal necrotizing enterocolitis and intraventricular hemorrhage, but these associations are more controversial.

INTRAPARTUM MANAGEMENT

Fetal position should be checked.

Spontaneous rupture of membranes can cause sudden severe uterine decompression with risk of cord prolapse or abruption. Controlled amniotomy may be performed.

There is an increased rate of structural abnormalities or genetic syndromes in the neonate following a gestation complicated by apparently idiopathic polyhydramnios. Pediatric support should be available at delivery for women with mild, idiopathic polyhydramnios.

REFERENCES

1. **Uptodate**
2. **SMFM consult series**

by

Dr. E.S. Usha MD., DGO.,

President EOGS

GENITAL HSV INFECTION

Genital herpes virus infections are a major global public health problem.

Both HSV – 1 and HSV - 2 can cause genital herpes.

Types of infection - Primary , non primary and recurrent.

Primary infection refers to infection in a patient without preexisting antibodies to either HSV - 1 or HSV - 2. Non primary infection refers to acquisition of genital HSV in a patient with preexisting antibodies to the alternate serotype. Recurrent infection refers to reactivation of genital HSV of same serotype.

CLINICAL MANIFESTATIONS :

Painful, shallow, multiple genital ulcers, dysuria, fever, tender local inguinal lymphadenopathy and headache.

The average incubation period is 4 days (2 -12 days) and the lesions resolve within a mean of 19 days. After resolution of primary genital HSV, asymptomatic intermittent viral shedding can occur. Hence infection can be transmitted unknowingly.

EXTRAGENITAL COMPLICATIONS :

Aseptic meningitis.

Urinary retention (due to sacral radiculitis)

Proctitis.

Increased risk for HIV – 1 infection

DIAGNOSIS OF HSV:

PCR

Viral culture

Type specific serologic tests.

PCR and culture are preferred for active lesions and serologic testing is the preferred method in patients without active disease.

DIFFERENTIAL DIAGNOSIS:

1. Syphilis (chancre)
2. Chancroid
3. Drug eruptions
4. Bechets syndrome

PREVENTION:

1. Consistent condom use.
2. Chronic suppressive therapy to reduce recurrences and viral transmission.
3. No vaccine currently exists.

TREATMENT:

Acyclovir 400 mg tid

Famciclovir 250 mg tid

Valacyclovir 1000 mg bd

The usual duration of treatment is 7 -10 days.

TREATMENT OPTIONS FOR RECURRENT DISEASE

1. Chronic supressive therapy - appropriate for those with very frequent recurrences or HSV sero positive patients with uninfected partners.

Options :

Acyclovir 400 mg twice daily

Famciclovir 250 mg twice daily

Valacyclovir 500 mg once daily

2. Episodic therapy - involves self administered anti viral therapy for individual outbreaks. Patients are counseled to start medications at the very first sign of prodromal symptoms (eg., tingling, parasthesias, pruritis). Self initiated therapy leads to faster resolution of symptoms and lesions.

3. No intervention - for those with minimal symptoms.

GENITAL HSV AND PREGNANCY

Use of Acyclovir is safe for the fetus at all stages of pregnancy. Transmission of HSV to neonates usually occurs during labour and delivery due to direct contact with virus shed from infected sites (vulva, vagina, cervix, perianal area). Viral shedding can occur even when maternal symptoms and lesions are absent.

For women with history of genital HSV during pregnancy, suppressive therapy (Acycloir 400 mg TID) is recommended from 36 weeks till delivery. This reduces the risk of clinical recurrences and the need for Caesarean delivery.

Caesarean delivery can decrease but not eliminate the risk of neonatal HSV infection. But for women with first episode genital infection during later weeks of pregnancy (within six weeks of delivery), elective Caesarean section is preferable.

by

Dr. P. Jayanthi MBBS., DNB.(O&G),
Lotus Hospital, Erode.

Congratulations to the outgoing Office Bearers

President :

Dr. Y. Thamizhselvi

Secretary :

Dr. Suganthy Kumar

Joint secretaries :

Dr. Hajra Atheeb

Dr. Rani Senthilkumar

Magazine in charge :

Dr. Hajra Atheeb

Dr. N. Poongothai

Dr. Prabha Rajasekar

Well done

Office Bearers 2019 - 2020

President :
Dr. E S. Usha MD DGO
Fellow in Fetal medicine

Secretary
Dr. Sri Revathy Sadasivam MD., DNB., MICOG., MRCOG(UK)
Masters in Reproductive Medicine (UK)

Treasurer :
Dr. N. Darani MS(OG).,CCiGDM.,

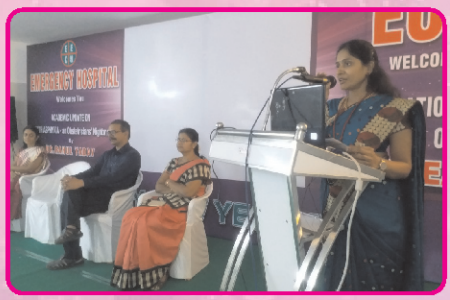
Vice President :
Dr. K. Anuradha M.S(OG)
Dr. Suganthy Kumar MD (OG)

Joint secretary :
Dr. Vani Madhavan MS (OG)
Dr. Purnimaa M.D.(OG)., F.MAS., F.ART

Executive committee :
Dr. R. Sulochana karuppannan MBBS.,DGO..,
Dr. Nancy Thanu MBBS.,DGO
Dr. S. Janaki MBBS.,DGO
Dr. N. Poongothai MBBS.,DGO
Dr. K . Mangaiyarkarasi M.B.B.S,DGO
Dr. Y. Thamizhselvi DGO., DNB (OG)
Dr. G. Gomathy MBBS DGO

EOGS Office Bearers 2019 – 20 Installation Ceremony

Our founder President **Dr. C. Rajalakshmi** Installing the Incoming President **Dr.E.S. Usha** and team of office bearers



Fall in Love with Yourself . . .

Spend time to care of yourself . . .

Your body, mind and yourself . . .

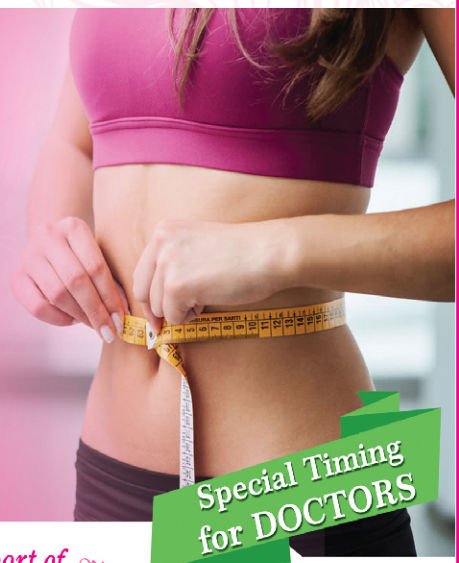
@

Women's

Medical Fitness & Ayurvedic Massage Centre

We Offer

- Fitness & Body Shaping
- Weight Reduction & Weight Gain
- Control of Diabetes, Hypertension, Hyperlipidemia, Hypothyroidism and PCOD without Medicine
- Ayurvedic Relaxation Massages
- Pain Relief treatment
- Personality Development



Special Timing for DOCTORS

With the support of

Doctors, Dietician, Physiotherapist, Life Coach, Ayurvedic Therapists

Adhithya Hospital

Nadarmedu, Erode. 94892 09082 | 94889 56833