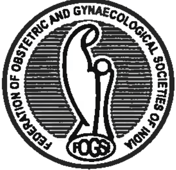
January 2014

ICOG EVIDENCE

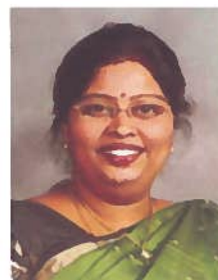


Newsletter of The Indian College of Obstetrician & Gynaecologists

www.icogonline.org

Evidence Changing Practice & Practice Changing Evidence

Editor's Message



Dr. S. Shantha Kumari
Editor – ICOG News Letter
Vice President FOGSI 2013
Professor of
OBGYN, Malla Reddy
Medical College for Women,
HYDERABAD

Dear Colleagues,

The art of clinical diagnosis in emergency obstetrics should be pursued by all the obstetricians, so that there can always be early diagnosis and management, decreasing the life threatening situations in the mothers. I wanted to make a small attempt to spread the thoughtful and well crafted knowledge for quick and easy understanding of relevant and essential facts in Gynaecology and Obstetrics for busy Obstetricians like us. So, I have included few articles of academic importance and recent advances not forgetting the social condition of Indian women to create awareness and to remind the role of obstetricians in woman's life. Like a drop of water in an ocean, my attempt will be successful only if all esteemed, talented obstetricians, academicians who have the quest for knowledge will contribute to my work. We all together can make a big difference in reducing the maternal and infant, mortality and morbidity. ICOG Newsletter reflects the enthusiasm, hardwork, team spirit and organization to improve the knowledge of all the members. So, we invite healthy criticism and contribution to our work. Hope my dream comes true!!!

With Regards
ICOG Newsletter- Chief Editor, Dr. S. Shantha Kumari

Editorial Board-
Drs.Laxmi Shrikhande, Parag Biniwale, Geetha Balsarkar, Roza Olyai, B.Aruna Suman, D.Kiranmai.

Administrators:
Dr. C. N. Purandare, Dr. Sanjay Gupte, Dr. Narendra Malhotra, Dr.P.C.Mahapatra

President's Message

DR HEMA DIVAKAR
President - FOGSI 2013

Greetings to everyone at FOGSI !
We at FOGSI want to do more and more to see the change in women's healthcare in India. We are determined to harness our strength of human resources of 28,000 members and strive to make a change.
Our Vision beyond the MDG 5 is a mission
beyond 2015 ... We want to see- (1) Anaemia free India (2) Build contraceptive choices and fight population explosion (3) Reduce the burden of non communicable diseases, Cancer cervix, Diabetes,Thyroid deficiency (4) Build the capacity of Front line Health Workers to offer emergency obstetric care (5) Bring in health equity and accessibility for women's healthcare. (6) Train the generation next young ObGyns in technology based healthcare and make India the destination for women's health care. We are sure that we will be able to fulfill this dream if we partner with the Government of INDIA . This gives us an opportunity to offer technical training and lend expertise to implement some innovative programs in the country. To promise to do more to our collaborators and the government, we need YOUR commitment to implement the innovative strategies. We seek your continued co-operation and support for a bigger and broader cause .

With Warm Regards,
Dr Hema Divakar,
President (FOGSI)

Chairman's Message

DR. HIRALAL KONAR
Chairman, ICOG Professor
Calcutta National Medical College & Hospital MD (PGI), DNB, MNAMS, FACS (US), FICOG, FRCOG (London) Email: h.kon@vsnl.net/ h.kondr@gmail.com

Dear Colleagues,
We are all delighted to see the January 2014 issue of the Newsletter of the Indian College. This issue is really rich and focused to reflect the all round activities of the College.
ICOG midterm activities reflect the dynamicity of Indian College to show a marvelous progress in the field of clinics and academics. **ICOG Fellowship promotion announcement** and ***"The Journal of Obstetrics and Gynaecology of India, Vol. 63, No. 3"*** is a step to encourage our senior members of FOGSI and also the specialist from International field to join this academic body. It is worth to note that the Indian College is gaining popularity both in the national and the international field. This year we have got the enriching experience of having good number of new fellows and members of the colleges. **ICOG special activities** this year of note is the **academic exchange with the International Bodies.** Few of them are: SAFOG-FOGSI-ICOG at Agra, February-March-2013, NESOG-SAFOG-FIGO –ICOG at Kathmandu, Nepal, April 2013, OGSB-SAFOG-ICOG at Dhaka, Bangladesh, September 2013. ICOG is being popularized nationally and internationally.
ICOG Good Clinical Practice Guidelines (GCPR) had already been introduced. **MICOG-MRCPI examination** is going to be introduced in India soon. Last meeting at Hyderabad September 2013, Irish College Representative Prof. Robert Harrison, Mr. Michnor O' Cornwell and the Indian College Representatives have made a clear picture of it. I do specially thank the editor, Dr. Santha Kumari, Vice- President FOGSI and the editorial board members Dr.B.Aruna Suman, Dr. D. Kiranmai for their hard work to make this issue of ICOG newsletter as an educational resource.

With Warm Regards,
Hiralal Konar

Dean's Message

Dr. C. N. Purandare
President Elect FIGO Dean of ICOG

It gives me pleasure to write this message for ICOG newsletter as the Founder Dean of ICOG.

Academics have always been the priority of ICOG from its inception. A lot of hard work was put in by all of us in FOGSI to fulfill the dream of putting MICOG on par with MRCOG.
The first step was the successful MICOG-MRCOG Refresher Course held in January 2013. The MICOG-MRCOG – Part I exam was held in March 2013. 4 out of 9 have passed.
ICOG has completed the negotiations with RCPI – Royal College of Physicians of Ireland. MOU has been worked & would be signed same.

The first exam of MICOG – MRCPI will be held in early 2014, which is recognized by MCI. It gives me great pride to see ICOG growing by leaps & bounds. A new beginning to a great future for Obstetricians & Gynaecologists of India.

With Regards
Dr. C. N. Purandare
President Elect FIGO
Dean of ICOG

Secretary's Message

Jaideep Malhotra
Secretary - ICOG

Dear ICOGians,

Greetings from the Indian college of Obstetrics and Gynecology.
It has given me immense satisfaction working for our college and I am very happy to say that our college is growing by leaps and bounds.
As you all must have noticed that ICOG has steadily inched towards organising number of academic activities and our accreditation program is going great . ICOG website is fully updated waiting for your interaction and contributions.
Our collaboration with The Royal college of Obstetrics and Gynaecology and also with the Royal college of Physicians of Ireland for the MICOG-MRCOG combined exam and also MICOG-MRCPI is a new chapter in the history of college, with some very successful refreshers courses and training programs in place.
What is very encouraging is that ICOG is getting constant requests from our societies and neighbouring countries for the ICOG sessions and CMEs and in this session, two big feathers in our cap have been ICOG session at International conferences at Nepal and Bangladesh.
Our Fellowship programmes are very popular with ever increasing number of students applying for it and the demand of CMEs is on the rise, but this is not all what ICOG wants to achieve, the college has its eyes set on streamlining the academics and also bringing about a sea change in the practice of our members and also bringing in uniformity in our teaching practices.
ICOG is planning a great academic feast at the AICOG Patna and all the Yuva conferences and my aim as the secretary of the college is to put the college on top of academics in our fraternity and involve as many as possible.
Your inputs regarding the expectations from the college will be very welcome, please do not hesitate to write to ICOG secretary at jaideepmalhotraagra@gmail.com.
Looking forward to hearing from you all soon.
My heartiest congratulations to Dr. Shantha Kumari , Dr.Kiranmai and Dr. Aruna Suma for putting this newsletter together.

Happy reading and life is short, do enjoy also.
Prof Jaideep Malhotra
Secretary ICOG
jaideepmalhotraagra@gmail.com

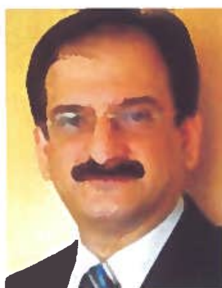
Vice Chairman's Message

Dilip Kumar Dutta,
Vice-chairman - ICOG

I am very glad to know that ICOG Newsletter January issue,2014 will be released very soon.
I hope scientific content in this issue will be innovative work done by beloved ICOG members. My best wishes for this issue.

With Regards
Dr Dilip kumar Dutta
Vice chairman ICOG FOGSI

Message



Dr. Nozer Sheriar
Secretary General, FOGSI

Dr. Hrishikesh D. Pai
Deputy Secretary General, , FOGSI

Dear Fogsians,

FOGSI is a dynamic body of more than 28,000 members all over the country. ICOG the academic wing of FOGSI is becoming stronger day by day.

We need to focus on Research and FOGSI – ICOG protocols for evidence based practice in field of OBGYN. We wish more number of members from FOGSI to be a part of ICOG, to make FOGSI a strength to reckon with. In the future issues we invite you to come out with original articles and studies which can be used to better maternal health in India and reach MDG GOALS.

With Regards

Dr. Nozer Sheriar
Secretary General

Dr. Hrishikesh D Pai
Deputy Secretary General

Team – ICOG – 2013

DR. HEMA DIVAKAR
President

DR. HIRALAL KONAR
Chairman

DR. DILIP DUTTA KUMAR
Vice Chairman

DR. JAIDEEP MALHOTRA
Secretary

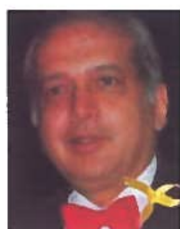
DR. C.N. PURANDARE
Dean ICOG

Incoming and Outgoing Team of FOGSI-ICOG

A Grand Welcome to all the Incoming team members !

Dr Suchitra Pandit
President

Dr Atul Munshi
Chairman



Dr C.N Purandare
Dean

Dr Mala Arora
Vice Chairman

Dr Jaideep Malhotra
Secretary ICOG

Dr Nozer Sheriar
Hon Secretary FOGSI

A Big Thank you to all the Outgoing team members !

Dr Hema Divakar
President

Dr Hiralal Konar
Chairman

Dr Dilip Dutta
Vice Chairman

Governing council member

Dr. Arora Mala,Faridabad
Dr. Acharya Prashant,Ahmedabad
Dr. Biniwale Parag
Dr. Balsarkar Geetha,Mumbai
Dr. Dutta Dilip Kumar , Kalyani
Dr. Das Gokul,Guwahati
Dr.Ganguli Indrani,New Delhi
Dr. Jha Urvashi,New Delhi
Dr.Kriplani Alka,New Delhi
Dr.Konar Hiralal,Kolkata
Dr.Kotdawala Parul J.,Ahmedabad
Dr. Modi Rajesh,Akola
Dr.Munshi Atul P,Ahmedabad
Dr. Olyai Roza,Gwalior
Dr. Pattanaik Hara P.Cuttack
Dr. Patel Pravin,Ahmedabad
Dr. Patki Ameet,Mumbai
Dr. Shah Pragnesh, Ahmedabad
Dr. Shrikhande Laxmi,Nagpur
Dr. S. Shantha Kumari, Hyderabad
Dr.Trivedi Prakash H.,Mumbai
Dr,Thanawala Uday J.,Navi Mumbai
Dr. Tandulwadkar Sunita,Pune
Dr. Wagh Girija ,Pune

About Indian College of Obstetricians & Gynaecologists (ICOG)

The Indian College of Obstetricians and Gynaecologists was established on December 21, 1984 as the Academic Wing of FOGSI at Durgapur on the occasion of the 28th All India Obstetric and Gynaecological Conference.

The College was established to promote education, training, research and spread of knowledge in the field of Obstetrics, Gynaecology, Reproductive health, Family Welfare and related areas. The College is actively involved in National Family Welfare Program and actively associates and co-operates with Central and State Government Health authorities and corporate bodies in implementing all national programmes of Family Planning including training of paramedical and health personnel.

ICOG Activities-

1. Membership- from 1997 to 2013 (204)
2. Fellowship-
   - Founder Fellows - 1984 to 1986 (167)
   - Academic Fellows – 2004 to 2010 (47)
   - Honorary Fellows 2001-2012 (15)
   - Millennium Fellows – 2000 to 2003 (69)
   - International Fellows 2004 - 2012 (4)
   - Fellows - 1987 to 2013 (723)
3. Membership is now combined with RCOG as MICOG-MRCOG Part 1 exam and in March 2013, one batch has finished and second batch will be in September 2013.
4. FOGSI-ICOG Dr. C. L. Jhaveri Symposium at all AICOG Conferences.
5. Certification courses in Reproductive Medicine, Ultrasound, Endoscopy and Perinatology.
6. ICOG involved in EmoC programme.
7. ICOG Convocation held at all AICOG Conferences.

ICOG organizes –

CME programmes through all FOGSI societies- One day or two days.
Dr. Usha Saraiya, Guest lecture – One per year.
Dr. C. S. Dawn, CME – Three per year.
Dr. C. S. Dawn, Guest lecture – One per year.
Dr. C. G. Saraiya, CME – One per year.

Be a Fellow of Indian College of Obstetricians and Gynaecologists of The Federation of Obstetric and Gynaecological Societies of India

What is ICOG?
Indian College of Obstetricians and Gynaecologists (ICOG) is the academic wing of Federation of Obstetric and Gynaecological Societies of India (FOGSI), one of world largest professional organisations of Medical Practitioners. ICOG was established on December 21, 1984 at Durgapur on the occasion of 28 All India Congress of Obstetrics and Gynaecology (AICOG).

Why was the ICOG created?
ICOG was created to promote education, training, research and spread of knowledge in the field of Obstetrics and Gynaecology, Family Welfare and other related areas for students and specialists involved with or interested in women's health care and to address the academic requirements of FOGSI members.

What are the academic activities of ICOG and the benefits for fellows of the ICOG (FICOG)?
Being an academic wing the main activities of the ICOG are listed below:
(Further details on the website: http://www.icogonline.org).

a) Good Clinical Practice Recommendations (GCPR) based on Indian perspective.
b) ICOG Certificate courses in the sub-specialties of ultrasonography, reproductive endocrinology, perinatology and endoscopic surgery.
c) ICOG Newsletters with review articles on various topics for the postgraduate students and specialists.
d) FOGSI-ICOG Post Graduate Revision courses conducted all over the country.
e) ICOG continued Medical Education (evidence based) for the postgraduate students and specialists.
f) MICOG-MRCOG – Revision course and examination to be conducted in partnership with Royal College of Obstetricians and Gynaecologists (RCOG) in India.
g) MICOG-MRCPI course and examination to be initiated in partnership with Royal College of Physicians of Ireland (RCPI) in the near future.
h) Visiting Professorship from ICOG to any Teaching Institute in India.
i) ICOG-International Academic activities with: SAFOG, AOFOG, FIGO, as well as with Societies of neighbouring countries- Nepal, Bangladesh.
j) Member or Fellow of ICOG can apply for ICOG Emcure Travel Award so that he/she can take short term training of about 2-4 weeks anywhere in India.
k) Fellow can start ICOG certificate courses centres in Reproductive Medicine, Endoscopy, USG and Perinatology after recognition by ICOG.
l) Fellow can get chance as a invited speaker at ICOG CME's and special lectures organized by member societies of FOGSI.

If I am a Member or Fellow of any International Bodies (like FRCOG, FACOG FRCPI), do I need to be a Fellow of the Indian College?
Yes, it is always desirable for clinicians working in India or desirous of maintaining ties with their home country to also belong to the ICOG. ICOG keeps you abreast with all round progress in the science and art of Obstetrics and Gynaecology. Importantly ICOG stresses on this sub continental perspective for any management issue. As an illustration hypertension and hemorrhage are the lead causes of maternal deaths in India as opposed to thromboembolism in the West and cancer cervix is a major concern in this subcontinent than that of any other Gynaecological cancer.
How does one apply for the fellowship and when will the Fellowship (FICOG) be awarded next?
The Fellowship is awarded on the basis of set criteria which are listed on the ICOG website along with the application form for the same. The new fellows will be honored at the prestigious ICOG Convocation which will be held in Patna during AICOG 2014. ***Looking forward to seeing you at the Convocation***
Thanking you,

With kind regards,

Dr. Hema Divakar	Dr. Hiralal Konar	Dr. Dilip Kumar Dutta	Dr.Jaideep Malhotra
PresidentFOGSI- ICOG	Chairperson - ICOG	Vice Chairperson - ICOG	Secretaryof ICOG

N.B.: For any further queries please contact ICOG Office: icogoffice@gmail.com

New ICOG Membership 2013

Fellows of ICOG

M0172- Dr. G. Ashwini Sidhmalswamy Bangalore
M0173- Dr. Chhikara Archana Bharti, Haryana
M0174- Dr. Dhiman Niharika, Shimla
M0175-Dr. Gaur Yashodhara, Gwalior
M0176-Dr. Ghongdemath Jyoti S,Bengalur
M0177-Dr. Gupta Megha, New Delhi
M0178-Dr. Jain Ritu V, Chhattisgarh
M0179-Dr. Ingale Kundan Vasant,Pune
M0180-Dr. Malhotra Vani,Rohtak
M0181-Dr. Pawar Sona Ramesh,Nashik
M0182-Dr. Preetha P. R.,Kerala
M0183-Dr. Priyadarshini Pallavi,Ghaziabad
M0184-Dr. Sahu Indu Lata Lucknow,UP
M0185-Dr. Sarada Mamilla,Hyderabad
M0186-Dr. Shah Tasneem Nishah,Bangalore
M0187-Dr. Sharma Alok,New Delhi
M0188-Dr. Singh Pratibha,Bihar.
M0189-Dr. Siwatch Sujata,Chandigarh.
M0190- Dr. Sreedharan Rinoy,Kerala
M0191-Dr. Tiwari Sweta,Bhubaneswar
M0192- Dr. Tripathi Archana,Bhopal
M0183-Dr. Priyadarshini Pallavi,Ghaziabad
M0173- Dr. Chhikara Archana Bharti,Haryana
M0187-Dr. Sharma Alok,New Delhi
M0175-Dr. Gaur Yashodhara ,Gwalior
M0189-Dr. Siwatch Sujata,Chandigarh
M0177-Dr. Gupta Megha,New Delhi
M0191-Dr. Tiwari Sweta,Bhubaneswar
M0179-Dr. Ingale Kundan Vasant,Pune
M0181-Dr. Pawar Sona Ramesh,Nashik
F0938- Dr. Adhikari Sudhir,Kolkata
F0939-Dr. Arora Arun,J & K
F0940-Dr. Banerjee Dibyendu,Kolkata
F0941-Dr. Bahadur Anupama,Kanpur
F0942-Dr. Balamurugan Kalpana,Tamil Nadu
F0943-Dr. Behera Ritanjali,Odisha
F0944-Dr. Bhat Vidya,Bangalore
F0945-Dr. Bharti Maheshwari,Meerut
F0946-Dr. Biswas Pranab Kumar,Kolkata.
F0947-Dr. Budhwani Chhaya Keshav Sagar, MP
F0948-Dr. Chakrabarti Suranjan,West Bengal
F0949-Dr. Chakraborty Sakti Rupa, Kolkata
F0950-Dr. Chakraborty Barunoday,West Bengal
F0951-Dr. Chandran Jyoti Ramesh, Kerala
F0952-Dr. Chaudhary Vidya, Jhansi-UP
F0953-Dr. Chavan Niranjan N.,Mumbai
F0954-Dr. Chellamma V. K.,Kerala
F0955-Dr. Deka Prasanta Kumar, Assam
F0956-Dr. Dey Ramprasad,Kolkata
F0957-Dr. Gohil Jagdish T.,Vadodara
F0958-Dr. Gupta Sabhyata,Haryana
F0959-Dr. Geetha S.,Tamil Nadu
F0960-Dr. Gupta Meeta,Jammu-J & K
F0961-Dr. Gupta Amrit, Lucknow
F0962-Dr. Gadre Sandhya Bhopal,MP
F0963-Dr. Gandhi Alpesh Gujarat.
F0964-Dr. Goenka Deepak Guwahati-Assam.
F0965-Dr. Jain Sunanda Ashok Indore
F0966-Dr. Janaki Chitra Kanyakumari, TN
F0967-Dr. Kittur Sahaja,Hubli-
F0968-Dr. Kumar Rekha Rajendra, Karnataka
F0969-Dr. Kanakaraya Jamuna,Karnataka
F0970-Dr. Kumar Surender ,Jammu- J & K
F0971-Dr. Kalra Ruchi Bhopal,MP
F0972-Dr. Kumar Aswath, Kerala
F0973-Dr. Kulshrestha Sonal Saxena,MP
F0974-Dr. Kotdawala Sonal, Gujarat
F0975-Dr. Kumar Aruna,Bhopal
F0976-Dr. Kamra Sangeeta, Chhattisgarh
F0977-Dr. Louis Fessy T. ,Kerala
F0978-Dr. Lodgi Fahmida Banu ,Hyderabad
F0979-Dr. Maitra Arghya, Howrah
F0980-Dr. Mishra Nalini Raipur
F0981-Dr. Mathew Agnes, Kerala
F0982-Dr. Madhuri Alwani ,Indore
F0983-Dr. Mehta Anil ,Jammu- J & K
F0984-Dr. Mariyappa Narayana Swamy, Karnataka
F0985-Dr. Meka Krishna Kumari, Hyderabad
F0986-Dr. Metgud Vanita, Belgaum
F0987-Dr. Mukherjee Basab, Kolkata
F0988-Dr. N. K. Mahalakshmi ,Madurai
F0989-Dr. N. Sumathi ,Madurai,TN.
F0990-Dr. Nirmala C., Trivandrum-Kerala.
F0991-Dr. Pal Seetha Ramamurthy, West Bengal
F0992-Dr. Panigrahy Sandhya Rani, Orissa
F0993-Dr. Pandey Alka, Patna
F0994-Dr. P. Angayarkanni, Madurai
F0995-Dr. Pathak Varuna ,MP
F0996-Dr. Parihar Bharti Choudhary ,Bhopal
F0997-Dr. Pawar Sunita ,Mumbai
F0998-Dr. Phukan Pranay ,Assam
F0999-Dr. Raghunandan Chitra ,Delhi
F1000-Dr. Revwathy Kailairajan, Madurai-TN
F1001-Dr. Rao Asha R., Coimbatore
F1002-Dr. S. Samundi Sankari T. Nagar,Chennai
F1003-Dr. Singh Abha, Chhattisgarh
F1004-Dr. Singh Abha, New Delhi
F1005-Dr. Sankhwar Pushp Lata,Lucknow
F1006-Dr. Saha Shyama Prasad ,West Bengal
F1007-Dr. Selvaraj Yazhini, Madura
F1008-Dr. Saxena Pinkee ,New Delhi
F1009-Dr. Soman Urmila ,Cochin
F1010-Dr. Shobhane Hema Jai, Jhansi
F1011-Dr. S. Lalitha, Madurai
F1012-Dr. Singh Swasti ,Azamgarh-UP
F1013-Dr. Sultan Shabana, Bhopal-MP
F1014-Dr. T. Umadevi Madurai,Tamil Nadu
F1015-Dr. Taher Uzma Zeenath ,Bangalore
F1016-Dr. Tirumala Reddy Vindhya ,Hyderabad
F1017-Dr. Tripathi Gajendra, Azamgarh

FOGSI-ICOG-MRCOG Combined Exam

Royal College of
Obstetricians and Gynaecologists

Bringing to life the best in women's health care

September 25, 2013

Dear All,

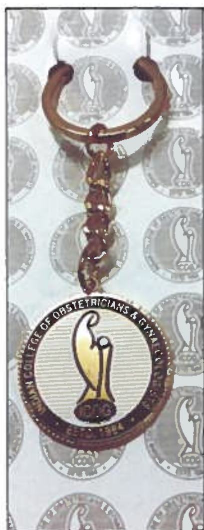
It gives ICOG great pleasure to inform you that combined **FOGSI-MICOG-MRCOG part 1 exam** is being held in India and in helping our students to prepare for the same, the first and second Refresher Courses were held at FOGSI office, Mumbai on January 21-23, 2013 and July 25-27, 2013 under the able guidance of Dr. Andrew Sizer and approved Faculty from RCOG. **3rd MICOG Part I examination** will now be conducted in **MARCH 2014**. **3rd Refresher Course** for March **2014 exam** will be held in **January 27-29th, 2014 at FOGSI Office, Mumbai between 9.00 am to 6.00 pm.** This course will have faculty from the RCOG and will focus on the various aspects which students from UK lack or miss during preparation for the MRCOG PART 1.

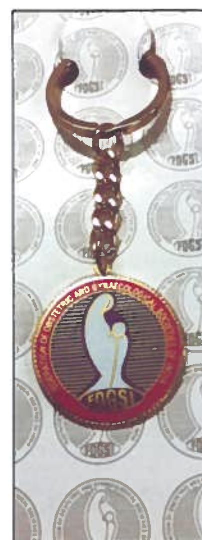
For any further queries write to:
ICOGOffice@gmail.com

Watch Out for Future Programmes of ICOG With European Perinatal Network

Travelling seminars in major metros from 7-15th Oct 2014, with the faculty from FOGSI-ICOG and European perinatal network
Coordinater: Dr Jaideep Malhotra, Prof Gian Carlo de Renzo, Prof Moshe Hod, Luis Cabero and faculty from FOGSI-ICOG

FOGSI-ICOG Branding Merchandise





ICOG Special Activities

ICOG CMEs, Workshops are being held in many societies across the country. It is good to see that ICOG is having a special session in almost all the conferences including the YUVA FOGSI. FOGSI-ICOG–PG revision course is a combined programme at present. Trainee Residents, Post Graduates are immensely benefited with this educational programme. ICOG Academic feast planned at the AICOG Patna and all the Yuva Conferences.

ICOG special activities this year of note is the **academic exchange with the International Bodies.**

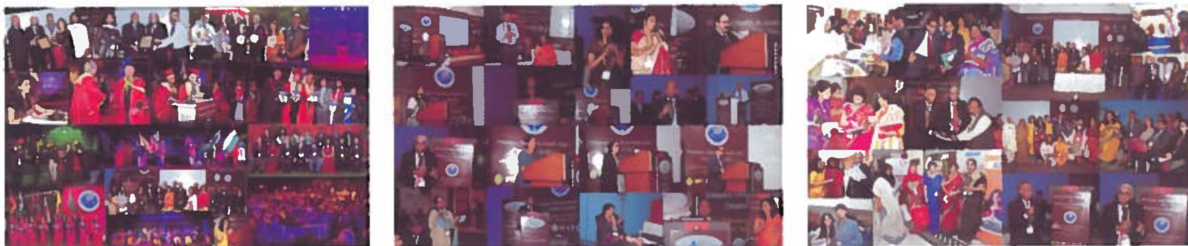
- SAFOG-FOGSI-ICOG at Agra, February-March-2013
- NESOG-SAFOG-FIGO –ICOG at Kathmandu, Nepal, April 2013
- OGSB-SAFOG-ICOG at Dhaka, Bangladesh, September 2013

ICOG is being popularized nationally and internationally.

International Meet of ICOG

11th International Conference of NESOG

SAFOG 2013



International CME on PCOS Dhaka

ICOG Convocation

Refreshers Course with MICOG and MRCOG

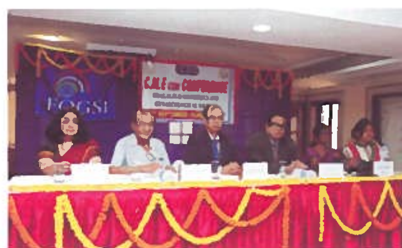
MOU with MRCPI

Live Colposcopy Workshop

ICOG Meet at Kolkata

Kalyani Conference on Save the Girl Child

ICOG CME cum Conference, Bhagalpur Obstetrics and Gynaecological Society



37th Annual Conference Association of Obstetrics & Gynaecology, Odisha

Is Radical Hysterectomy an Outdated Exercise?

HIRALAL KONAR, MBBS (Cal), MD (PGI), DNB, MNAMS FACS (US), FICOG, FRCOG (London)
Chairman: Indian College of Obstetricians & Gynaecologists (ICOG) **Professor, Department of Obstetrics & Gynaecology**
Calcutta National Medical College & Hospital
Kolkata-700 014

***Address for correspondence*:** **Prof. Hiralal Konar**
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Mobile: (0) 9433033225
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IS RADICAL HYSTERECTOMY AN OUTDATED EXERCISE?

Radical Abdominal Hysterectomy (RAH) for cancer of the uterus was first advocated by W.A. Freund in 1878. Clark in 1895, was first to perform the operation on a living woman in Johns Hopkins Hospital. Subsequently RAH with pelvic lymphadenectomy was done with modifications by Joe V Meigs (1944) and Wertheim (1905), Okabayasi (1921) and Mitra of Calcutta in 1957. Dissatisfaction with radiotherapy because of radiation hazards and tissue resistance, RAH had been adopted by many surgeons subsequently. Progressive improvement in surgical techniques, anesthesia, antibiotics, blood transfusion and technology resulted significant reduction in morbidity and mortality of RAH.

Primary mortality from the operation had been reduced from initial 30% (20th century) to almost nil in the current years. Selection of cases for radical hysterectomy is an important factor besides the other areas of improvement. RAH should be performed by a skilled surgeon with sufficient knowledge and experience so that the morbidity is acceptably within the limit of 3-5%. Wide tissue dissection is needed. Tissues removed are extensive too. The procedure includes: removal of the uterus, upper 1/3rd of the vagina, entire uterosacral cardinal and uterovesical ligaments, all the parametrium from either side, along with pelvic lymphadenectomy (hypogastric, external iliac, common iliac, obturator and ureteral). Commonly it is known as type III radical hysterectomy. Preservation of ovaries is possible specially for young woman as ovarian metastasis is rare.
This surgical procedure is not only extensive but also complex. The main reason is, dissection is in close proximity to many vital organ like bowel, bladder, ureter and great vessels of the pelvis.

In India 5,56, 400 people died from cancer in 2010[1]. This represents 8% of all estimated global cancer deaths and about 6% of all deaths in India. Three most common fatal cancers in the age group 30-69 years in female were: Cervix [33400 (17.1%)],stomach [27,500 (14.1%)] and breast [19,900 (10.2%)][1]. Cancer cervix is a leading cause of death in women in both rural and urban areas. Estimated risk of dying from cervical cancer for a 30 year old Indian women before the age of 70 yrs is about 0.7% compared to a women aged 15-49 yrs who run the risk of dying during pregnancy is about 0.6%.

Over 99.7% of patients with CIN and invasive cancer are found to be positive with HPV infection. This infection could be prevented entirely. The progression of the disease from the phases of cervical dysplasia, intraepithelial neoplasia (CIN) to micro invasion to invasion take about 10-15 years or more. Genital tract infection with HPV- DNA could be prevented even at the adolescent age by type specific HPV Vaccines. Early detection of any cervical epithelial abnormalities could be detected by Cervical Cytology screening (Liquid based cytology), HPV DNA testing (hybrid capture), visualizing the cervix following application of acetic acid (VIA) or Lugol's (5%) iodine (Schiller's test), Colposcopy and targeted biopsy. CIN can be treated completely as it is a pre-malignant condition. Therefore in an ideal world the place of radical hysterectomy does not arise.
Cervical carcinoma in situ can be prevented by screening and also be treated and cured completely. Definitive treatment of CIN CIS, includes the ablation procedures: cryotherapy, electrodiathermy, or laser; alternatively by excession procedures like conization, large loop excision of transformation zone (LLETZ), or even hysterectomy depending upon the individual case. Therefore cancer cervix is a completely preventable disease

Biopsy can confirm the diagnosis of pre-invasive and early invasive stage of the disease when the diagnosis of CIN and CIS is missed. Even at this stage cancer cervix could be prevented and cured. Conservative management or the fertility sparing surgery, radical trachelectomy could be done in cases with Stage (FIGO) IA2 or IBI (with tumour diameter <2 cm). Radical trachelectomy could be done vaginally abdominally or even laparoscopically or robotically. It is accompanied by pelvic lymphadenectomy. Pregnancy rate following radical trachelectomy is reported to be 52.8%. It Therefore place of radical hysterectomy in the overall management of cancer cervix is very selective.

Radical Abdominal Hysterectomy (RAH) is mainly indicated in cases with Stage (FIGO) IA2 – 11A Cancer cervix, FIGO Stage IIB Cancer endometrium, in invasive cancer of the upper vagina and in few other situations.

However it is true that radical hysterectomy has got an alternative too. Radiotherapy can be used for all Stages of Cervical Cancer with cure rate of about 70%. 5 year survival rate of radical hysterectomy when compared to radiation therapy for cases with Stage IB/11A (FIGO), remains the same (85%)[2]. Different modes of radiation therapy are: external teletherapy, brachytherapy interstitial implants and intensity modulated radiation therapy (IMRT). Computer based assessment has got several advantages like normal tissues could be spared by measuring the target tissue volume. Accurate radiation therapy is possible and radiation side effects could be minimized to a large extent. However radical hysterectomy has got an edge over the radiation therapy for an individual patient in terms of quality of life, particularly when she is young. Radiation therapy ends with vaginal stenosis due to fibrosis, radiation menopause and chronic fibrosis of bowel and bladder.Techniques of radical hysterectomy have undergone significant changes in the current years. Good knowledge of pelvic anatomy and expertise in tissue dissection (though extensive), have reduced the morbidity and mortality of RAH significantly. In a selected case, 5 year survival following RAH is 83% compared to radiation (75%). Presently, many new methods of radical hysterectomy (RH) are in practice. Laparoscopic Radical Hysterectomy (LRH), Laparoscopic Assisted Radical vaginal Hysterectomy (LARVH) and Robotic Assisted Laparoscopic Radical Hysterectomy (RALRH) are the few.

LRH had been found to be safe, feasible and with same efficacy when compared to that of traditional RAH[3]. Quality of life, 5 yr survival rate and tumour recurrence rates are comparable in both the above two methods[4, 5]. Laparoscopic Robotic Radical Hysterectomy has certain advantages even. Improved dexterity, better visualization with magnification caused significantly reduced morbidity compared to RAH and LRH[6]. However long term results with randomized controlled trials are awaited[7].

Conclusion: In an ideal world cancer cervix is an entirely preventable disease. Therefore place of radical hysterectomy does not arise. Unfortunately in a resource limited setting cancer cervix is a killer disease. Cancer Cervix can be treated by method other than surgery e.g. radiation therapy. But in a selected individual radical hysterectomy has its place. Improved methods and techniques of radical hysterectomy (RAH, LRH, LAVRH and RALRH) have significantly reduced the morbidity and mortality. Results, in terms of long term survival and recurrence are comparable.

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Toppers of ICOG Certification Course Examination Of January 7, 2014 Batch

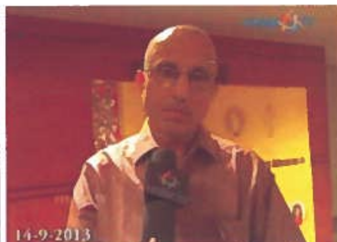
Candidates	Certificate course	Centre Incharge	Rank
Dr. Priyadarshini Neha, Dhanbad	Reproductive Medicine	Dr. Jaideep Malhotra, Agra	FIRST
Dr. Vidyashree, Bangalore	Gynaecological Endoscopy	Dr. Vidya A Bhat, Bangalore	FIRST
Dr. Parul Arora, Agra	USG	Dr. Narendra Malhotra, Agra	FIRST
Dr. Varsha Mahajan, Indore	Perinatology	Dr. Ratna Thakur, Indore	FIRST

ICOG Convocation

Congratulations to :

Honorary Fellowship

Prof. John J Sciarra



Dr. Himanshu Bhushan

Chief Guest

Prof. Carlo de Renzo

Congratulations to Dr. Hema Divakar and Dr. Narendra Malhotra who are going to be conferred the Hon. FRCOG Degree in March at Hyderabad

Ectopic Gestation - Past, Present and Future

Dr. Aruna Suman, Assistant Professor, Osmania Medical College, Hyderabad

Recent reports and studies concluded that ectopic pregnancy has become a medical rather than a surgical disease. The effective non surgical treatment can be done by early diagnosis. The diagnostic algorthims using serum progesterone, serum beta, human chorionic gonadotropic measurements, ultrasound and office curettage now will help in definitive diagnosis so now the definitive diagnosis possible without laparoscopy. The gold standard for treating the ectopic is laparoscopic salpingostomy but this is not without complications and morbidity.

The greatest advances in the management of ectopic pregnancy has been the development of medical management, but again there is a revolution in medical management,what is it ? The medical therapy previously required a long term hospitalization and multiple doses of methotrexate which has significant side effects, now single dose outpatient protocol is the newer advancement in medical therapy. This is slowly attracting rather than surgical options for reduced morbidity from surgery and general anesthesia, potentially less tubal damage, less cost and the decreased need for long hospital stay.

Expectant management is considered in asymptomatic patients and there should not be any evidence of rupture and haemodynamic stability should be there. Proper counseling regarding the potential risk of tubal rupture and accepting the need for emergency surgical intervention should be explained.

A signed written consent should be taken before starting the therapy, the course of treatment and information pamphlet should be given to the patient regarding the list of adverse effects, a follow up schedule and phone numbers of physicians or hospital in case of emergency should be given. The patient must be compliant and should be able to come for follow up

The evidence of resolution is by decreasing titers of beta human chorionic gonadotropin (β HCG) level, approximately with conservative management one fourth of the women will have declining beta HCG and 70% of this group experience successful outcomes with close observation. The gestational sac is 4cms or less in its greatest dimension, the initial beta HCG titers below 1000mIU/ml, the successful outcome is in 88% of cases. But one thing should be always in mind, rupture can occur despite of low and decreasing serum level of Beta HCG, so close follow up is necessary.

Indications for medical therapy with methotrexate indicates the patient should be haemodynamically stable, no signs or symptoms of active bleeding, an empty uterus with abnormal doubling rate of Beta HCG level, no chorionic villi in menstrual aspiration, USG showing gestational sac outside the uterus. Absence of fetal cardiac activity [or presence of fetal cardiac activity on USG is relative contraindication]. Beta HCG should be less than 5000 mIU/ml, higher levels are relative contraindication. Evidence of tubal rupture is a absolute contraindication. If hepatic and renal function test is compromised methotrexate can not given.

Most of the patients receiving methotrexate experience at least one episode of increased abdominal pain which occurs 2-3 days after injection this is due to separation of pregnancy from the implanted site. This should be differentiated from tubal rupture.

The accepted protocols of injected methotrexate include multiple dose regimen and single dose regimen. The multiple regimen include 1mg/kg IM on days 0,2,4 and 6 followed by leucovorin as 0.1mg/kg on 1,3,5, and7 days. This regimen is lost its popularity because of increased adverse effects, need for patients motivation and compliance.

The popular regimen today is single dose injection. Inj. Methotrexate 50mg/m^2 IM in a single dose or divided doses injected into the buttock. Efficacy is same in both but with single dose adverse effects are minimal and no need of leucovorin. Stovall et al achieved a 96% success rate with a single injection of methotrexate. After the injection the beta HCG level done on day 1, day 4 and on day 7, if the level has dropped to 15% or more since day 4 weekly Beta HCG level is done till they reach the negative level for the lab. If there is plateau or increase a second course of Inj. Methotrexate may be administered. If there is no drop by 14th day surgical therapy is indicated.

Based on the studies done by lipscomb et al, success exceeded 90% in single dose methotrexate regimen in the group of patients where Beta HCG was less than 5000 mIU/ml, 80% when the Beta HCG levels are less than 10,000 mIU/ml, 70% if it is greater than 15,000 mIU/ml. Failure of medical treatment is defined if Beta HCG increase ,plateau, or fail to decrease adequately by less than 15% from day 4 to 7, post injection, at this juncture surgical management can be considered. Re-evaluation of the patient is done and the repeat single dose of methotrexate can be given with close follow up.

What does the Research say? – Oral methotrexate is under investigation even though the results are promising, efficacy remains to be established. Direct local injection i.e., salpingocentesis of methotrexate into the ectopic pregnancy under laparoscopic or Ultrasonographic guidance has been reported, but the studies yielded inconsistent results and the advantage of this technique over IM injection remains to be established. The other protocols that are used are potassium chloride, hyper osmolar glucose, mifepristone (RU 486) and prostaglandins are given orally. These therapies remain experimental and there is no advantage over standard methotrexate protocol.
The surgical management is more conservative to unrupture ectopic gestation using minimally invasive surgery. This includes linear salpingostomy and milking of pregnancy out of the distal ampula. The more radical approach include resecting the segment of the fallopian tube that contains gestational sac with our without reanastomosis. Vasopressin can be injected to decrease the blood loss. Laparotomy is usually reserved for patients who are haemodynamically unstable or patients with cornual ectopic pregnancies and when the surgeons are inexperienced in laparoscopy and in the patients in whom a laparoscopic approach is difficulty in the presence of dense adhesions, massive haemoperitoneum.

Linear salpingostomy along the antimesentric border to remove the products of conception is the procedure of choice for unruptured ectopic pregnancies in the ampullary portion of the tube. There is no benefit of primary closure of salpingotomy over healing by secondary intention. If the patient has completed the child bearing and no longer desires fertility, in a patient with recurrence of ectopic pregnancy in the same tube, or a patient with severely damaged tube – total salpingectomy is the procedure of choice.

The post surgical management after excision of ectopic gestation weekly monitoring of qualitative beta HCG level is necessary until the level become zero to ensure that the treatment is complete. This should be done after salpingostomy which causes a 5-15% rate of persistant trophoblastic tissue. The average time of Beta HCG to clear the system is 2-3 weeks but upto 6 weeks is necessary. Robotic surgery is a recent development and is successful in ectopic pregnancy but it is more expensive, needs more skill, a good set up.

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New Hopes, New Horizon

I had a special interest in infertility and ART since my post-graduation days. With no facilities in my medical college for exclusive approach towards this subspeciality , the eagerness to learn continued . The search for appropriate training program followed thereafter. The official website of FOGSI – ICOG and the well co-ordinated staff at FOGSI head-office, Mumbai helped a great deal in this regard. It was a dream come true when I was informed that a 6 months training fellowship in Reproductive Medicine had been approved for me at Malhotra Test Tube Baby Centre ,Agra by ICOG.

I started my training at MNMH-MTTBC,Rainbow Hospital , Agra on 1st July, 2013. "Welcome ", she said, as I was greeted on the first day of training by my dynamic guide Dr.(Prof) JaideepMalhotra.This was most reassuring and I was immediately introduced to other workers which made my integration early and quick.MTTBC and Rainbow Hospital is a state of Art health care facility situated in the heart of Agra,India.By virtue of its time-tested popularity and expertise, this hospital attracts avast number of patients not only from the adjoining districts and states but also from the neighbouring countries.Thousands of patients are referred here with wide spectrum of diseases.This exposes the candidate to a great deal of pathologies.

During my training program I was exposed to all aspects of Infertility management and Assisted Reproductive Techniques ranging from the basics like case selection , history taking, examination , performing Ultrasounds,Ovulation Induction,IUIs to laboratory procedures like semen examination,semen preparation techniques, dish preparation,Oocyte retrieval, surgical sperm retrieval techniques,IVF , ICSI ,LAH and Embryo Transfer.

The other avenue to learn was from the operative work being performed regularly by Dr.NarendraMalhotra and his enthusiastic team.The opportunity to perform and assist in innumerable laprascopic and hysteroscopic surgeries made the training program well-integrated and structured.Dr.Jaideep made me incharge of two projects and guided me through each step of my clinical research.I had the opportunity of presenting my research work at the National North Zone Yuva Conference, Amritsar.Weekly lectures and case presentations amongst the specialized staff stimulated knowledgeable and sound discussion that changed my way of thinking and broadened my skills in decision-making.

My departure came with mixed feelings.Leaving was difficult as I had made lot of friends and a home away from home but the eagerness to come back and improve services at my institute based on everything I had learned was a great incentive.Agra is a beautiful place with warm and welcoming people and the Rainbow Hospital group is family for me of which I was a part for 6 months and continue to be so . I am most grateful to ICOG-FOGSI for opening this frontier not only for me but for all the budding gynaecologists across the country.I am indebted to my mentor, Dr.(Prof) JaideepMalhotra for providing me the platform to learn clinical work , technical aspects and its collaboration with social upliftment to bring smiles in many lives.

Dr.NehaPriyadarshini

The FOGSI-ICOG certificate courses in the specialties of Reproductive medicine and Infertility, Ultrasound & Perinatology & Endoscopy are recognized in various centers across the country.

These courses are useful for students who have just completed their post graduate training Obstetrics and Gynaecology and also for practicing gynaecologists, who wish to gain an insight into these fields and who wish to practice the same in the future.

The courses extend for duration of 6 months; each specialty has its own syllabus which the students have to follow.

The students are also required to maintain a log book during this period.

At the end of the course an exam is conducted by ICOG in one of the centers.

The fields of Reproductive medicine and Infertility, Ultrasound & Perinatology & Endoscopy are vast and it is not possible to gain all the experience and skills in a span of 6 months, however these courses provide a good platform for us to start with and sound knowledge about the basic aspects. It also helps us to make a decision and mould our ideas about our future practice.

As there are few fellowship seats in India and it is difficult to get fellowships abroad, the certificate courses are enabling many students of OBG an opportunity to work in the specialties of their choice. I have had an extremely fruitful experience with this course and it has opened a whole lot of new avenues for me to think and practice. Thanks FOGSI –ICOG for these wonderful courses and thanks to my guide and mentor Dr Madhuri Patil for giving great insight into the field of infertility.

In the future FOGSI-ICOG can provide opportunities for students who want to pursue fellowships in recognized centres abroad through distance learning programmes.

ignite

Icog Glaxo joiNt Initiative Towards educational Excellence

Dear Colleagues,

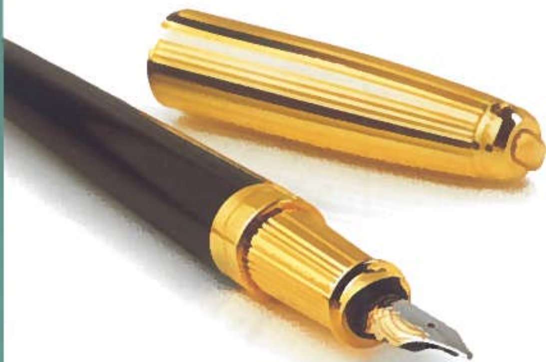
At the very outset a very happy and a fulfilling New Year to all of you.

I am happy to announce this year ICOG is launching a new initiative a masterclass christened 'IGNITE' (Icog Glaxo joiNt Initiative Towards educational Excellence) an educational initiative supported by GlaxoSmithKline (GSK).

As a part of this initiative we will be conducting a certificate course in approximately 80 locations pan India.

I sincerely urge every one of you to take part in this educational endeavour & make this initiative a thumping success.

With Regards,
Jaideep Malhotra
Secretary ICOG



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50% RDA^ of Immuno Nutrients[3] like Vitamin A and E, Selenium, Copper

[5]Codex guidelines

Immuno-nutrients is a creative rendition of nutrient function

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Iron, Iodine, Folic Acid, Zinc, Magnesium, Vitamins A, B6, B12 & D

^In 75g (3 serves) as per US RDA 2001; Macronutrients, Iron, Folate, Calcium and Vitamin C as per ICMR RDA 2010 *Chemical Score

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50% RDA^ of Immuno Nutrients[3] like Vitamin A and E, Selenium, Copper

Codex guidelines
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Iron, Iodine, Folic Acid, Zinc, Magnesium, Vitamins A, B6, B12 & D
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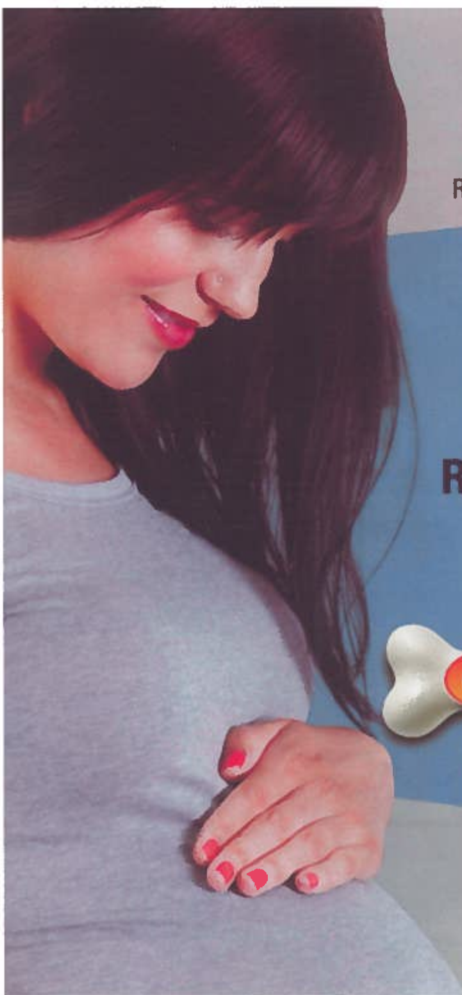

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