ISOPARB NEWSLETTER

NEWSLETTER

Healthy Mother Happy Baby

April 2018 - March 2019

Director - Dept. of OBGYN ,Surya group of Hospitals ,Mumbai
President ISOPARB (2018-20)
President Organisation Gestosis (2015-18)
Chair AICC RCOG (2017-20)
President FOGSI & ICOG (2014-15)
President Mumbai Soicety of OBGYN (2013-14)

I bring you greetings from ISOPARB.

It gives me immense pleasure to invite all of you to the 35th Annual ISOPARB Conference from 29th -31st March , 2019 to be held at Hyderabad and hosted by the Hyderabad chapter of ISOPARB.

Hearty Congratulations to the dynamic organizing chairperson ,Dr. Rooma Sinha and Dr. Madhumati and Dr. YK Swapna the vibrant Secretaries and their hardworking team for putting in huge efforts and thoughts together for organizing this conference.

The conference theme ' Controversies and Consensus in Obstetrics and Gynecology' is very unique and in keeping with the theme the team have organized have six workshops on Infertility , Hysteroscopy for all , Tips for a safe TLH, Caesarean section , Prematurity- Optimising outcomes and Ultrasonography in Gynecology . We have invited a galaxy of excellent speakers for scientific deliberations comprising of orations ,keynotes and symposium . I am sure all of you will relish this fusion of Evidence based Medicine and clinical experience which will help to have the best possible approach and management of a patients today.

Looking forward to meeting all of you soon in the city of Hyderabad .

Prof. Dr. Suchitra N. Pandit

Dr. Shanti H. K. Singh
Vice President, ISOPARB

My warm regards to all the fellow members.

As the name Indian Society of Perinatology and Reproductive Biology indicates, we have to care mother as well as the neonates. So we are regularly doing the CMEs and the workshops to take care of the mothers as well as the baby. Keeping an aim to reduce maternal mortality which according to Niti Ayog was 178 in 2010- 12 and 130 in 2014 2016. As you can see that it has come down 130 in in a hundred thousand but our aim should be reducing it as much as we can because in countries like America maternal mortality is 7.3 per hundred thousand and in UK it is 9 per hundred thousand. All of us in India are alert and in the conference at Hyderabad also we will have discussion on the various problems faced by the mothers and then neonates and how to solve them by learned speakers from various parts of India. My all good wishes to the members, organizers and speakers for the success of the conference.

Secretary General, ISOPARB

Meena Samant

Dear ISOPARBIANS
Greetings

It gives us immense pleasure in bringing out this e-newsletter of ISOPARB for the period 2018-19. Hope it covers all aspects of our activities within the period.

Today ISOPARB is a strong 2324 members association and we are striving hard to make our membership reach the 4000 mark by 2020. We have formed 23 city chapters by now and I am sure many more city chapters will come up within a year or two.

I congratulate Chief editor of our journal Dr Hiralal Konar and his team for improved quality of our journal and Copernicus accreditation for the same.

Let's make pregnancy and delivery a very safe journey for all. Let's work towards bringing out stillbirth registry and making perinatology and reproductive biology a concern for all.

Jai HIND
Long live ISOPARB.

Editor's Note

Amita Sinha

Dear ISOPARBIANS
Greetings from Patna

At the outset I would like to congratulate the winners of Yuva Quiz from all the four zones of India for their brilliant performances.

ISOPARB has always been known as an academic association of India. To achieve the goal of the association many chapters have been working hard.

Various Conferences, CMEs, Awareness programmes, Workshops, PG teaching classes and Health camps have been organised by dedicated ISOPARBIANS. Pictures of their activities have been included here.

We are fortunate to receive many articles from our Vice Presidents and Zonal Coordinators. Hope you will enjoy reading these articles.

Looking forward to meeting you all at Hyderabad for the 35th annual conference.

Wish you happy reading.

Isoparb : the journey

Founded in 1978 with a handful of dedicated visionaries.

Stands today at 2324 members.

Last one year 147 new member enrolled.

Concept of city chapters came up in 2010 with the growing number of members.

23 city chapters formed, we welcome the latest addition Vijaywada Chapter.

Journals

All quarterly issues of Indian Journal of Perinatology and Reproductive Biology were published. 2019 first edition under print.

Congratulations to Chief editor Dr Hiralal Konar and his team for successful term.

Online through our website

Copernicus accreditation

Improved quality

We remember one of our founders

Tarun Banerjee
(1921 2012)

Prof Tarun Banerjee left us for ever on
18th September, 2012
at Kolkata at the age of 91 years.

Prof Banerjee was the first Editor-in-chief (1978-1983) of Indian Journal of Perinatology and Reproductive Biology. He was one of the founders of the Indian Society of Perinatology and Reproductive Biology (ISOPARB) in 1978 along with Dr Kamala Achari from Patna as President and Dr Mrs Malti Rohatgi as Secretary General and Dr Banerjee himself as the chief Editor of the Journal of the society.

He graduated from Medical College, Calcutta in 1947. He became a member of The Royal College of Obstetricians & Gynaecologists, London in 1951 followed by Fellowship of the Royal College of Surgeons, London. On his return to India he joined the National Medical College in Kolkata and started also private practice. He was one of the best known gynaecologists in the city for nearly two decades from mid-sixties. He was very popular dynamic teacher in the National Medical College all through and retired as the Principal of the institution.

He took a great deal of interest in the Bengal Obstetric & Gynaecological Society and was the President for two successive years 1975 and 1976. He represented Bengal in the FOGSI in various capacities and became President of FOGSI in 1979-80. He also co-founded the Indian Society of Psychosomatic Medicine. He became the President of Federation of Asia and Oceania Perinatal Societies (FAOPS) in 1979. Prof Banerjee was the Organising Chairperson of World Congress of FAOPS held at Kolkata in 1983 organised under the banner of Indian Society of Perinatology and Reproductive Biology.

One of his significant achievements was to establish links with the RCOG in India. He was the driving force behind setting up of the All India Co-ordination Committee (AICC) and the Zonal Committees in India. He was the first Chairperson of the AICC.

All this clinical and academic work did not prevent him from being very active in the social circles in the city. He was also the President of the Calcutta Club and the Bengal Club.

He is survived by his wife, daughter and son. We deeply mourn the demise of this great man.

Placenta accreta spectrum- A Nightmare of Obstetrician

Dr Arup Kumar Majhi MD,DNB,FICOG
Professor, Obstetrics and Gynaecology, R G Kar Medical College, Kolkata
Vice President ,ISOPARB
Emeritus Editor, IJOPARB

Introduction

Placenta accreta spectrum is associated with significant morbidity and mortality due to life threatening haemorrhage and it is one of the leading causes of peripartum hysterectomy. Its remarkable rising frequency has made it one of the most dreadful problems in obstetrics.

Morbidly adherent placenta, now refers to as placenta accreta spectrum(PAS) which includes a range of pathologic adherence of the placenta, namely placenta accreta, increta and percreta. It is also called as placenta accreta syndrome.

Incidence-

Hundred years back the incidence was 1 in 20000 births, in 1980s it was 1 in 2500 and in 2015 1 in 731 and more recently it ranges from 1 in 300 to 500.

Risk factors, aetiology and pathophysiology

The important risk factors for placenta accreta spectrum are associated placenta praevia, prior caesarean delivery, history of accreta in a previous pregnancy , prior uterine surgeries or endometrial curettage and Asherman syndrome. The risk rises as the number of prior caesarean sections increases. The combination of placenta praevia and h/o prior caesarean delivery has higher chance of accreta. The additional risk factors are advanced maternal age and multiparity.

Antecedent 'constitutional endometrial defect' of endometrium explains the hyperinvasiveness of placenta

Abnormal placental adherence to the myometrium occurs due to the partial or total absence of the deciduas basalis and imperfect development of the fibrinoid or Nitabuch layer. Previous uterine surgical trauma also explains increase trophoblastic invasion. Failure of normal decidualization over the uterine scar due to defect of the endometrialmyometrial interface leads to abnormal infiltration of deep placental anchoring villi of the placenta into myometrium. Casarean scar pregnancy (CSP) and placenta accreta syndrome (PAS) share the same histopathology for which CSP and placenta accreta syndrome are considered in a spectrum of the same disorder. .

Types

It is said to be placenta accreta when placental villi is attached with myometrium, in placenta increta the villi invade the myometrium and in percreta villi penetrate through the myometrium to reach the serous coat of uterus. Morbid adhesion of placenta may be focal or total.

Diagnosis- clinical and imaging

Antenatal diagnosis of placenta accreta spectrum is highly desirable for planning of management to reduce the morbidity and mortality. Prior caesarean delivery and the presence of an anterior low-lying placenta or placenta should be thought of higher risk of placenta accreta spectrum.

Woman with placenta praevia or low lying placenta may present with antepartum haemorrhage. She may be asymptomatic.

Ultrasound -

The primary modality for antenatal diagnosis is ultrasonography and is highly accurate if done by skilled sonologist. USG features of placenta accreta may be visible as early as the first trimester but majority is diagnosed in the second and third trimesters. TVS is not contraindicated.

Presence of placenta praevia is the common association seen in >80% cases. Other features of placenta accreta spectrum are a) multiple placental vascular lacunae , b) loss of the normal hypoechoic zone between the placenta and myometrium, c) decreased(<1mm) retroplacental myometrial thickness, d) abnormalities of the uterine serosabladder interface (placental bulging), and e) extension of placenta into myometrium, serosa, or bladder. Turbulent lacunar blood flow is the most common finding of placenta accreta spectrum on color flow Doppler

In an woman with a history of prior caesarean section having an anterior low-lying placenta or placenta praevia during the routine fetal anomaly scan placenta accreta spectrum is screened.

There is no clear cut guideline in number and optimal timing of ultrasound in PAS. In asymptomatic woman it is reasonable to do at 1820, 2830, and 3234 weeks of gestation. This will allow for the assessment of placental location and invasion to optimize timing of delivery, and possible bladder invasion and possibility of preterm labour by measuring cervical length. .

First trimester USG finding of gestational sac found in the lower uterine segment with multiple irregular vascular spaces within the placental bed in first trimester is strongly associated with PAS .

Cesarean scar pregnancy diagnosed in the first trimester develops subsequent placenta accreta spectrum if pregnancy is untreated.

Role of MRI-

The detection of placenta accreta spectrum by MRI and ultrasound is similar if done by skilled persons . MRI may be to complement to USG for diagnosis of difficult cases, posterior placenta previa, and to assess depth of invasion, lateral extension of myometrial invasion.

Management

Place-A case of placenta accreta spectrum is managed in a tertiary care centre(level III or IV) with availability of adult ICU, neonatal ICU and immediate access to blood products by a multidisciplinary team with considerable experience managing PAS. The team should consist of experienced obstetric surgeon , urological surgeon, senior anaesthetist and interventional radiologist.

Time of management- Planned delivery should be the aim. Delivery is best scheduled for peak availability of all resource and team members though unscheduled delivery should also be needed and should be prepared for that.

Time of delivery (period of gestation)- In placenta accreta spectrum, planned delivery at 35+0 to 36+6 weeks of gestation is undertaken to balance best between fetal maturity and the risk of unscheduled delivery provided there is no risk factor for preterm delivery. In presence of continuous bleeding, preeclampsia, maternal comorbidities, labor, PROM or fetal compromise earlier delivery may be needed. Corticosteroid is recommended in women with antenatally diagnosed accreta and anticipated delivery before 37 0/7 weeks of gestation.

Preoperative considerations

Important preoperative considerations are maximization of Hb level, bed rest, to decide place of delivery ,time of delivery and counselling and discussions with the patient and family. Many prefer ureteric catheterisation.

In consent for caesarean section woman should be explained the risks associated with caesarean section in general, the specific risks of placenta accreta spectrum like massive bleeding, increased risk of lower urinary tract injury, the need for blood transfusion and the possibility of hysterectomy.

The need of interventional radiology if available may also be discussed.

Intraoperative

Types of surgery-

Cesarean hysterectomy -With obvious placenta percreta or increta the most accepted approach to placenta accreta spectrum is cesarean hysterectomy with the placenta left in situ after delivery of the fetus.

Attempt of removal of placenta is associated with significant risk of profuse hemorrhage and are strongly discouraged. Many prefer to close the caesarean wound and then proceed for hysterectomy.

Vertical skin incisions is preferred by many for better access. Inspection of the uterus after opening the abdomen is done to discern the level of placental invasion and to mark the upper level of placental location, above which uterine incision is given.

Internal artery ligation or other uterine devascularization may decrease blood loss, but its efficacy has not been full proven. The use of interventional radiology to embolize the internal iliac artery in cases of persistent or uncontrolled hemorrhage may be useful. Pelvic pressure packing,and aortic compression or clamping are other measures to control severe and intractable pelvic hemorrhage.

The use of a 1:1:1 to 1:2:4 strategy of packed red blood cells: fresh frozen plasma: platelets is reasonable to combat blood loss. Tranexamic acid is used as adjunctive therapy.

Conservative or expectant approaches - Consideration of conservative or expectant approaches to preserve uterus for fertility preservation should be rare and considered individually after proper counselling regarding risks and with informed consent.

Conservative management is defined as removal of placenta or uteroplacental tissue without removal of the uterus. In partial adhesion of placenta placental delivery may be amenable with haemostatic suture placement.It is possible when depth is less and entire placental attachment is accessible like anterior, fundal and

Expectant management is defined as leaving the placenta either partially or totally in situ and seldom indicated. When the placenta is left in situ, regular follow up, ultrasound examination and access to emergency care for complications, such as bleeding or infection should be available and need for secondary hysterectomy is informed . In some cases placenta resorbed spontaneously between 1 to 12 months (mean 6 months). In others the patient may develop complications and secondary hysterectomy may be needed in 20-60% cases. Serial USG or MRI is recommended for follow up in cases of expectant management and serial seum β- hcg is not informative. Methotrexate is prescribed in these cases in a contend that it will hasten placental involution and resorption but is not recommended now as it is of unproven benefit and has significant adverse effects.

Unexpected and unplanned discovery of PAS peroperatively

Where both mother and baby are stable and it is immediately apparent that placenta percreta is present on opening the abdomen, the caesarean section is delayed until the appropriate staff and resource persons and adequate blood products are available. This may need closure of abdominal incision and urgent transfer to a higher level facility. When placenta accreta spectrum is inadvertently discovered with the uterus already open after delivery of baby uterine closure is done rapidly and hysterectomy is proceeded. Other measures like packing the abdomen, tranexamic acid infusion, and blood transfusion are given.

Anaesthesia

The surgical procedure can be performed safely with regional anaesthesia but it may need to convert to general anaesthesia if required.

Conclusion

Placenta accreta spectrum is strongly associated with significant morbidity and mortality and its dramatic rise of incidence is of great concern. Antenatal diagnosis specially by USG is very important for optimizing management. Planned cesarean hysterectomy is preferable in obvious diagnosed cases and should be done by the most experienced surgeons and in well equipped centre. Conservative or expectant management is considered only for carefully selected cases after detailed counseling.

Sources:

1) Placenta Accreta Spectrum: ACOG and SMFM, Vol. 132, no. 6, December 2018 Obstetrics & gynecology
2) Placenta Praevia and Placenta Accreta: Diagnosis and Management. RCOG, Green-top Guideline No. 27a. September 2018 BJOG
3) Morbidly Adherent Placenta: Williams Obstetrics ed. F G Cunningham et al; Mc Graw Hill. 25 th edition 2018

Face Book Page of ISOPARB National was launched under the able guidance of Secretary General ISOPARB Dr. Meena Samant. It was Inaugurated by Dr. Manju Gita Mishra along with Dr. Meena Samant Secretary General ISOPARB, Dr. Pragya Mishra Choudhary Treasurer ISOPARB National, Dr. Shanti H. K. Singh, Dr. Rita Sinha and Dr. Amita Sinha.

34th Annual Conference of ISOPARB in association with AFG MUMBAI – 10th & 11th MARCH 2018

CMEs

17th April 2018

Quarterly CME of ISOPARB Burla/Sambalpur held at Sambalpur on
Fibroid Uterus.

25th April 2018

A CME was held on **Prenatal Diagnosis** by Lucknow Chapter

6th May 2018 : A CME organised by Assam (Guawahati) chapter ISOPARB.

6th May 2018: Patna Chapter of ISOPARB organised a CME. Dr. Rita Sinha was installed as President ISOPARB Patna Chapter. Dr. Shanti H .K. Singh the dynamic President exchanged medals. FaceBook Account of ISOPARB National was installed successfully. Almost 42 likes were received.

7th September 2018: CTG workshop for PG students in Ramakrishna Seva Sadan,Kolkata by Dr Narayan Jana, Dr Sukumar Barik, Dr Hiralal Konar on

Lucknow - 8th September 2018: A CME was held on **Obstetric Dilemmas** and a Panel Discussion on Non-TORCH Viral Infections in Pregnancy

Mid Term CME ISOPARB - Assam Chapter Guwahati theme "Emphasizing Touch in a World of Tech"

Two orations Late Rajkumari Jha Oration and Brahmaputra Oration were delivered by Dr. P. C. Mahapatra and Dr. Dipika Deka respectively.

A walking rally with theme "NO MEANS NO" was organized for generating awareness for the right and freedom of women and girls.

15th September
Inauguration Ceremony of Annual Conference of ISOPARB Chapter Bhubaneshwar.
Theme - **Fetal Medicine.**

15th Dec 2018
Quarterly CME of ISOPARB Burla/Sambalpur held at Sambalpur.
Theme **- Foetal Medicine**

Milind Shah got appointed as Deputy Secretary General for Asia Oeania Federation Of Perinatal Societies

The Annual membership to FOAPS was renewed.

Dr. Suchitra Pandit recipient of the common wealth's House of Lord's Award for exemplary work in women's health.

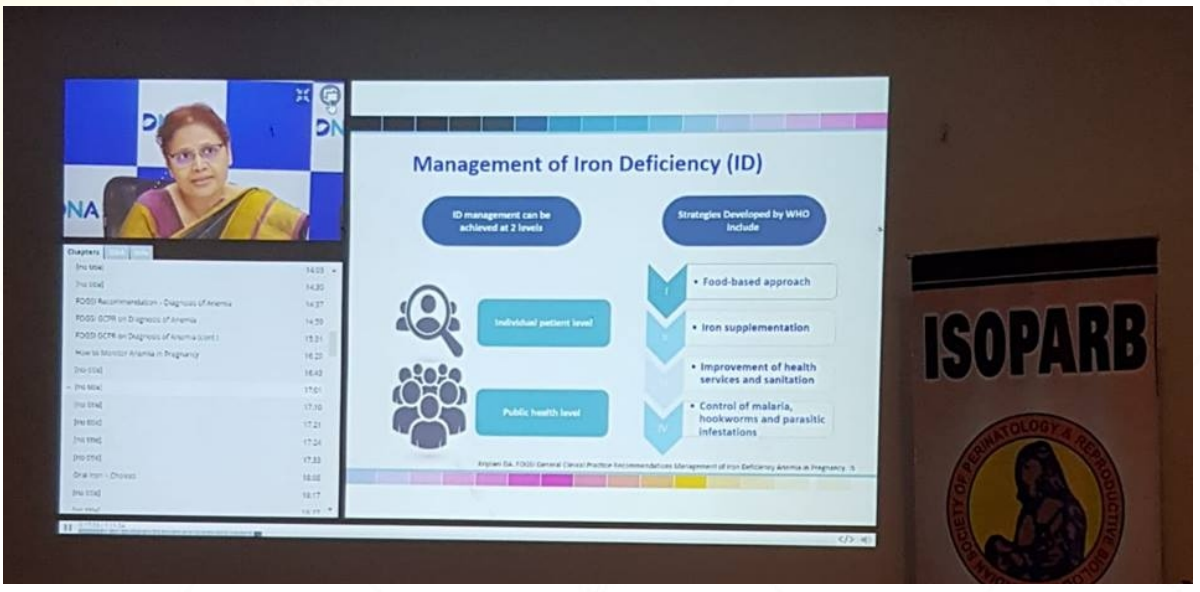
Award to be bestowed in London in the house of Lord 's by the mayor of London

6th January 2019 : Bihar Chapter of ISOPARB - A CME on **4th trimester of pregnancy**

15th March 2019
Quarterly CME by ISOPARB Bhubaneshwar Chapter.
Dr Panicker was felicitated by Prof. Susanta Mohapatra, immediate past president of ISOPARB Bhubaneswar and Dr Gangadhar Sahoo , Dean IMS and Vice-president ISOPARB.

10th March 2019 - CME by ISOPARB Patna Chapter
Junior members enjoyed hands on suturing skills.

16th of March 2019 – ISOPARB Patna Chapter organised a **Webinar** on Iron Deficiency Anaemia (FOGSI Recommendations) Clinical and Dietary aspects. Dr.Sadhana Gupta from Gorakhpur and Dr.Archana Sinha from Luchnow were speakers.



PERINATAL HELATH & BEYOND (CONCEPT OF FIRST 1000 DAYS)

Dr. Gangadhar Sahoo, Professor O & G & Dean
Dr. Lipilekha Pattanaik, Professor Community Medicine
IMS & SUM Hospital, Bhubaneswar

"The 1,000 days between a woman's pregnancy and her child's 2nd birthday (-9 to +24 months) offer a unique window of opportunity to shape healthier and more prosperous future for her baby. The right nutrition during this 1,000 day window period can have a profound impact on a child's ability to grow, learn, and rise out of poverty - providing the foundation for long-term economic growth and stability. Mother's nutrition is of utmost importance to deliver a healthy child with optimal growth.

Globally, malnutrition contributes to almost half of all deaths of young children. Close to 200 million children suffer from chronic nutritional deprivation that leaves them permanently stuntedunable to fulfil their genetic potential to grow and thriveand keeps families, communities, and countries locked in a cycle of hunger and poverty.

The impact of malnutrition during the critical 1,000 days between a woman's pregnancy and a child's 2nd birthday last a lifetime.Though human brain continues to develop and change throughout life, the most rapid period of brain growth and its period of highest plasticity is in the last trimester of pregnancy and the first two years of life. Thus, this time period harbors the greatest opportunity to provide optimal nutrition to ensure normal development and also the time of greatest brain vulnerability to any nutrient deficit. Malnutrition early in life can cause irreversible damage to a child's brain development, immune system, and physical growth. This can result in a diminished capacity to learn, poorer performance in school, greater susceptibility to infection and disease, and a lifetime of lost earning potential. The damage done by malnutrition translates into a huge economic burden for countries, with billions of dollars lost in productivity and avoidable health care costs.

Stunting that occurs by the age of 2 years is irreversible and severe. During pregnancy, under-nutrition can have a devastating impact on the growth and development of a child. Babies who are malnourished in the womb have a higher risk of dying in infancy and are more likely to face lifelong cognitive and physical deficits and chronic health problems. For children under the age of two, under-nutrition can be life-threatening. It can weaken a child's immune system and make him or her more susceptible to dying from common illnesses such as pneumonia, diarrhea and malaria.

Nutrition is the most cost-effective investment to drive global health and prosperity

Research has shown that $1 invested in nutrition generates as much as $138 in economic benefit.

Why maternal nutrition is crucial?

- Mother's diet in first three months of pregnancy influence birth weight and length both positively and negatively.
- Weight gain from 1st to 2nd trimester determines infant length at birth.
- Maternal micronutrient deficiencies (Iron, Vitamin A, Zinc, Iodine and Folate deficiency) negatively influence birth outcomes.
- Maternal stunting has negative impact on the fetal growth and development and subsequently growth faltering in her children.

Maternal nutrition and child health outcomes

The nutritional status of a child depends upon the mother's nutritional status prior to pregnancy. A chronically undernourished mother is likely to give birth to alow weight baby, who may be stunted as a child and in turn give birth to an undernourished baby. A well-nourished woman over the age of 18 has a much greater chance of surviving pregnancy and her child of growing up health. More than half of women in Odisha, 15-49 years are anemic (NHFS-4). This has serious consequences for women themselves and for the health, nutrition and development of their children.

Measures to improve nutrition in 1000 days

Solutions to improve nutrition in the 1,000 day window are readily available, affordable and cost-effective. These include.

- Ensure receipt of appropriate and necessary macro and micro nutrients by women, mothers and young children during pregnancy and after birth until 2 years of the child's age.
- Promoting good nutritional practices, including breastfeeding and appropriate, complementary foods for infants, and immunization as enlisted in the 10 Essential Nutrition interventions.
- Treating malnourished children with therapeutic foods.
- Feeding of children appropriately & adequately during illness

Reference:

1.http://www.thousanddays.org/resource/about-1000-days-2/
2.http://www.thousanddays.org/resource/1000-days-partnership-progress-report/

Newer Technologies in Gynecological Surgeries- ARE THEY HERE TO STAY?

Dr. Rooma Sinha, MD, DNB
Honorary Professor, AHERF
Honorary Associate Professor, Macquarie University, Australia
Laparoscopic & Robotic Surgeon

When Harry Reich first performed laparoscopic hysterectomy in January 1988 it generated both curiosity and skepticism. Surgeons with vision of this future technology embraced it but few disregarded it as well. As Steve Jobs has once said that the dots connect in the future and it has connected as far as the laparoscopic gynecological surgery is concerned.

It is accepted beyond doubt that laparoscopic gynecological surgeries have distinct advantages for the patient for its minimal access and comfort. It also allows surgeon to perform better surgery due to magnified vision and deep reach in the pelvis that a laparoscope can achieve. Today the surgeons who do not do laparoscopic surgery face a distinct disadvantage in their practice as they cannot offer the best treatment options to their patients. Many informed patients demand minimal access surgery.

Today, there are few reasons for the expert laparoscopic or vaginal surgeon to perform an abdominal hysterectomy. Abdominal hysterectomy should be done less frequently all over the world because laparoscopic surgery can be used effectively to accomplish a less invasive hysterectomy in most cases. The question is why laparoscopic gynecology surgery has not become a standard operative modality as laparoscopic cholecystectomy has? Conventional laparoscopic surgery has a steep learning curve for surgeons as it has two-dimensional imaging and involves mastering counter-intuitive hand movements. Laparoscopic gynecological surgeries like hysterectomy or myomectomy are more complex surgeries requiring long learning curve for the surgeons. For the conventional surgeon to convert open surgeries to minimally invasive surgery a robot can bridge that gap between laparotomy and advanced operative laparoscopy.

The view of the pelvis through a three-dimensional vision system in high definition is unimaginable with a routine laparoscopic set. The camera is stabilized by the robotic platform and controlled by the surgeon. The robotic arms and the EndoWrist instruments have wrist like intuitive motions that mimic movements performed in open surgery. In fact, the EndoWrist instruments are designed with seven degrees of freedom, one more than the human hand. A third instrument is also in the surgeon's control so a more precise surgery is possible with less dependence from assistants and giving control of the surgical field to the surgeon. It provides 3D stereoscopic vision and easier suture capability without tremor.

Why should a skilled laparoscopic surgeon embrace this new technology? As in any field of science a newer technology always offers certain advantage to older ones. If communication was the only need why did we move from landline to mobile technology? Even if we think we can achieve the best surgical outcomes with laparoscopy, in our heart we know the limitations of laparoscopy and at present Robotic assistance does seem to give us the advantage to overcome these limitations. However, the final outcome of surgery depends more on the surgeon rather than on the instrument she or he uses. According to a review published today in The Obstetrician & Gynaecologist, Robot assisted surgery can overcome many of the difficulties posed by laparoscopic surgery in gynaecological procedures. But one must remember Robotic platform is just a tool in the hands of a able surgeon.

In 2000, the US Food and Drug Administration approved the use of a robotic system for laparoscopy, and specifically for hysterectomy in 2005. In gynecology, robotics can be used for hysterectomy, myomectomy, endometriosis, endometrial and cervical malignancies. Robot has the potential to bring a wave of change in the pattern of surgery with more and more open surgeries being performed as laparoscopies. Five years ago, "robotic surgery" was not a term commonly used by surgeons or patients when discussing gynecologic treatment options. Today, we are thinking about it and gynecological surgeons are looking at robotics to see if it's an option for their practice.

The challenge we face today in taking robotic surgery forward is the lack of consensus about surgeon training. The FDA requires one- to two-day training to certify that a surgeon can use the system, but certification doesn't mean he or she is ready to operate on patients. There should be a standardized process for privileging or credentialing on the system. Each hospital should create a privileging or credentialing system to determine the requirements prior to performing robotic surgeries. The other challenge is in terms of cost and the bulkiness of the robotic system. But were these not the concerns when laparoscopy was introduced in gynecological surgical practice about 2 decades ago. Widespread use of laparoscopy has taken care of both these problems as the field of laparoscopy developed. With increasing number of surgeries being done by using these systems the cost will ultimately come down. Newer innovations will reduce the bulkiness of the robotic system and take care of the current limitations.

OTHER ACTIVITIES

(Health Camps, Awareness Programmes, PG Teaching, Workshops)

22nd April 2018

PATNA chapter ISOPARB with POGS and Rotary organized **Health Camp** at village Parsa.

Cancer Awareness Programmes under Global cancer concerns and ISOPARB at Sitamarhi, Bihar

LUCKNOW CHAPTER ISOPARB organized a **Rural Health Camp** in village Chilbilla,Mahuli in Distt. Pratapgarh on **1st April, 2018** where more than 100 women were examined and given free treatment.

Lucknow Chapter ISOPARB organized an **Awareness programme** for women on **Safe Motherhood day – 11th April, 2018**

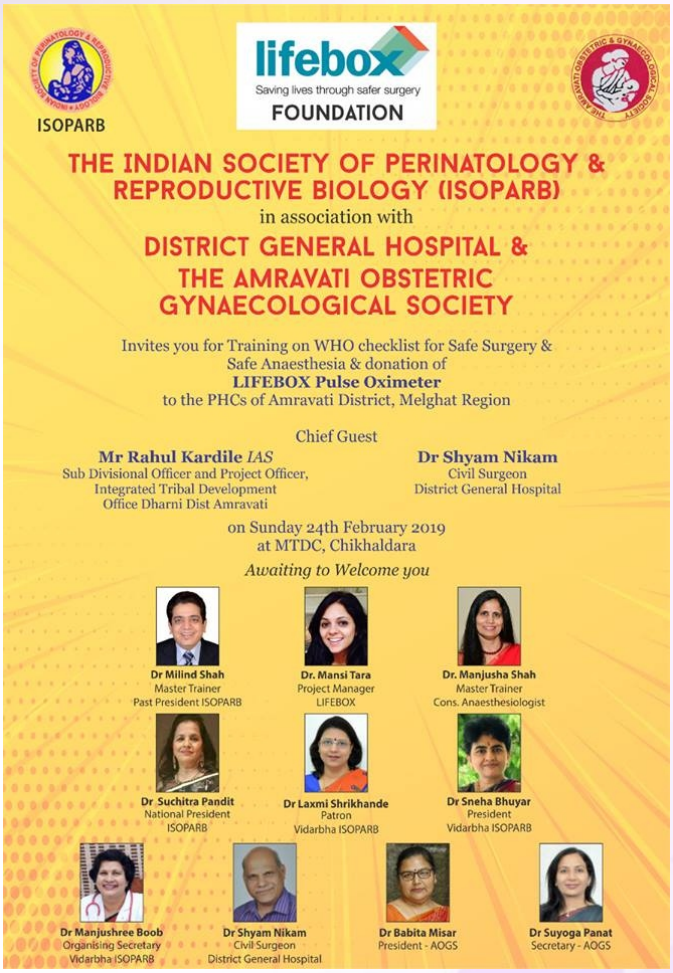
30th June and 1st July 2018

The Institute of Obstetrics and Gynecology, Sir Ganga Ram Hospital and ISOPARB Delhi Chapter organised "GURUKUL CLASSES" at Sir Ganga Ram Hospital Delhi

Cervical Cancer Screening Camp at Duegaon at Morigaon along with Hb estimation and BP measurement.

Pulse oximetry workshop at Burla under the leadership of Dr Milind Shah at Sambalpur.
Inauguration of 6th Annual meet of ISOPARB Burla /Sambalpur chapter.
We donated 14 oximeters to needy centers with training in "Safe Surgery and Safe Anaesthesia"

Safe Surgery and Safe Anaesthesia' workshop at Chikhaldara Melghat which is a tribal belt in Maharashtra with poor medical facilities and infrastructure . Through this project we will impart training to medical officers of Amravati district and donating pulse oximeters for rural health centres.This is a fifth project under the aegis of ISOPARB



Life Box (UK) ties up with ISOPARB to donate pulse oximeter in remote area

LIFE Box, a UK-based International NGO formed by Indian doctors has tied up with Indian Society of Perinatology and Reproductive Biology (ISOPARB), for taking important initiatives in making surgeries safer in India. They are donating 50 pulse oximeters to 50 centres and clinics of remote area, in a programme being organised at Hotel Centre Point, Ramdaspeth, Nagpur, on May 27. This was informed by Dr Chaitanya Shembekar,Vice-President of ISOPARB, in a press conference addressed at Tilak Patrakar Bhavan on Saturday. ISOPARB is a national organisation which was established in 1978 with the aim to give services to rural women and to uplift status of parturient women and babies. Dr Shembekar said that the machines are specially designed by Life Box to thrive in challenging environment. Dilivered along side training and education in safer anesthesia practice, this partnership is life saving investment in the future of healthcare providers across the State.

Dr Anuradha Shrikhande, Dean, IGMC, will be chief guest for the event. Dr Yadaorao Raut, senior physician from Umerkhed will be guest of honour.

A workshop is also organised from 8 am to train paramedical technicians in operating the unit. There will be a follow up and monitoring over use of the oximeter in recipient every hospital, said Dr Shembekar. He further added that this is first phase of the mission. In the second phase, ISOPARB will reach out to places like Gadchiroli, Amravati district.

Lucknow - 16th February 2019: A training of trainers was held on maternal infant and young child nutrition in collaboration with " Alive and Thrive". 30 master trainers were certified.

23rd December Patna : Walkathon

ISOPARB Bihar Chapter in Collaboration with POGS had participated in Walkathon for PCOS Awareness at Patna. Started with Mumbai warm-up followed by 3 km walk. Wonderful and thrilling experience...!

OBITUARY

With profound sorrow this is to inform that our dear Dr Nirmala Saxena, Past President and Past Secretary General ISOPARB left for her heavenly abode on 25th August. We pray for the departed soul.

OM Shanti.

Interventions to improve neonatal health

Dr Anjoo Agarwal
Prof Ob/Gyn, King George Medical University
Lucknow
President, Lucknow Chapter ISOPARB
North Zone Chairperson ISOPARB

It has been seen that most of the under five deaths are contributed to by neonatal deaths. WHO has identified certain simple but key interventions which can help markedly reduce this mortality & improve neonatal and child health.

Delayed cord clamping- The first and foremost recommendation is delayed cord clamping in all deliveries (unless contraindicated eg an asphyxiated newborn requiring immediate resuscitation) about 1-3 minutes after delivery. This provides an iron-rich placental blood flow to the infant, enough to create a reserve for the infant's first six to eight months of life.

Skin to skin contact- This is another very important intervention for neonatal health as hypothermia is a major hazard for neonates. So it is recommended that all neonates immediately after delivery be placed on the mothers abdomen and covered with a warm clean towel even before cord clamping and cutting. This improves temperature maintenance, bonding, early initiation of breastfeeding and permits delayed cord clamping. It also helps stabilize the infant's heart rate and respiration, improves oxygen saturation and helps conserve energy. Another advantage of the intervention is that it allows the baby to absorb beneficial bacteria from the mother's skin surface which helps boost the baby's immunity and protects it from infectious diseases. Care should be taken to ensure this skin to skin contact after both vaginal and caesarean deliveries. The role of a birth companion in ensuring this must be appreciated and emphasized.

Early initiation of breastfeeding- Breast milk has been described as a “personalized medicine” which provides the appropriate nutrients to the newborn along with other ingredients important for the baby's health and development at a time when gene expression is being programmed for a lifetime. In view of this initiation of breastfeeding within 1 hour of birth gains special significance and it is the responsibility of all medical and paramedical staff to ensure that it is practiced universally . Here again the birth companion is an important support person to help achieve this. Recent meta-analyses show that infants who started breastfeeding between two and 23 hours after birth had a 33 percent greater risk of neonatal mortality compared to infants who started breastfeeding within one hour of birth.

The mortality risk was doubled for babies initiating breastfeeding beyond 24 hours of birth. This benefit applies for babies of all weights and gestational age.

Exclusive breastfeeding- Importance of exclusive breastfeeding for 6 months cannot be overemphasized. All women need to be educated regarding the advantages and need of exclusive breastfeeding which means that the baby must not be given even water or prelacteals. The practice is required even for working women and is easily possible with proper counseling. Ensuring rooming in of babies with their mothers goes a long way in helping achieve these objectives. Even the retropositive women need to be counseled for exclusive breastfeeding in view of its increased safety with the recommendation of lifelong antiretroviral therapy in all reproductive age women.

Postpartum contraception The provision of postpartum contraception is the sine qua non for neonatal health. Too early and too many pregnancies are a major culprit in causing maternal and neonatal malnutrition. The drive for ensuring 100% institutional delivery must be coupled with provision of 100% postpartum contraception counseling. The opportunity must be fully utilized. The basket of choices for the postpartum contraception is wide and effective and repeated counseling ensures that the unmet need is minimized. Prior to discharge women can be offered postpartum intrauterine contraceptive device, minipills and centchromon as spacing methods and male and female sterilization as terminal methods. At 6 weeks postnatal visit the options are expanded to include injectable long acting progesterone preparations besides all the options available immediately after delivery. Barrier methods and natural methods including lactational amenorrhoea method are safe at all times but it is good to counsel for one of the other methods in addition because of the higher failure rate of these methods with typical use. The initiative of the Government in making these methods available free of cost in public facilities should be fully utilized and no woman should be left open for unwanted pregnancies..

The above interventions need to be implemented universally. They are the basis for a healthy future of the country by ensuring good nutrition and decreasing the epidemic of non communicable diseases like diabetes which is threatening our country at present.

QUIZ

ISOPARB YUVA QUIZ

Subject : "Medical disorders in Pregnancy"

31st January 2019

ISOPARB Zonal Yuva Quiz was conducted at –

East Zone at Patna,
North Zone at Delhi,
West Zone at Solapur and
South Zone at Hyderabad.

EAST ZONE

The ISOPARB East Zone Yuva Quiz was organised at Hotel Patliputra Exotica.
Dr Santwana Kumar and Dr Vineeta from *Narayan Medical College Sasaram* were the winners,
All the participants were given participation certificate and winners were given memento and certificate. Programme was coordinated by Dr Amita Sinha, secretary ISOPARB Patna Chapter and Dr Supriya Jaiswal, Communicator ISOPARB.

West Zone

Team of **Dr. Anchal Agrawal** from Nashik and **Dr. Shruti P** from Sholapur were the winners

NORTH ZONE

ISOPARB Yuva Quiz – North Zone was conducted by Institute of Obst. & Gynae, Sir Ganga Ram Hospital.
Winner of the quiz was team D of **Dr. Aparna Setia** and **Dr. Tarang Preet Kaur.**

South Zone

South zone quiz conducted at Modern Government Maternity Hospital.

Winners were **Dr. Pranitha Reshmi & Dr. Madhavi**

Tuberculosis in Pregnancy an Update

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Tuberculosis remains a global public health threat. Tuberculosis in pregnant women both at pulmonary and extrapulmonary sites is a high-risk obstetric condition because of its adverse effects on the mother, fetus and neonate. Compared to the healthy pregnancy, pulmonary tuberculosis in pregnancy is associated with approximately 2-fold increase in small for gestational age, prematurity, low birth-weight neonates, fetal distress in labour and low Apgar scores at birth (Figure 1). Similarly, tuberculosis at extrapulmonary sites abdominal, vertebral, renal, endometrial, and meningeal involvement (except tuberculous lymphadenitis) is also associated with adverse maternal-perinatal outcomes. More importantly, birth asphyxia and perinatal mortality is approximately 4-fold higher among women with tuberculosis. Pregnant women with active TB are associated with significantly increased risks of overall maternal morbidity [odds ratio (OR) 2.8], maternal anaemia (OR 3.9) and caesarean section (OR 2.1). These obstetrical impacts are more pronounced in cases with late diagnosis, incomplete or irregular drug treatment, and in those with advanced tuberculous lesions.

Although, pregnancy does not change the course of tuberculosis, diagnosis of tuberculosis during pregnancy is often delayed because of overlapping signs and symptoms of tuberculosis and pregnancy; reluctance of clinicians to perform chest X-ray in pregnant women, and relatively difficult access of the affected sites for biopsy, especially in extrapulmonary diseases. If tuberculosis is suspected, chest X-ray can be performed in pregnant women with proper shielding.

As untreated or incompletely treated tuberculosis poses a grave risk to pregnant women and their infants, all women with tuberculosis irrespective of sites involved must receive full course of antituberculosis drugs. Management of active tuberculosis during pregnancy is similar to that in nonpregnant women. During pregnancy, all first-line antituberculosis drugs (isoniazid, rifampicin, pyrazinamide and ethambutol) are considered safe, and have no proven teratogenic effects. As streptomycin-induced fetal ototoxicity (vestibular or cochlear defects) can affect 1 in 6 fetuses, it is contraindicated throughout pregnancy. Pyridoxine should always be given with isoniazid therapy during pregnancy to prevent potential neurotoxicity in the fetus.

Short-course chemotherapy for six months (2HRZE, 4HRE given daily) is effective in pregnancy. Current DOTS (directly observed treatment short-course; daily administration of drugs) strategy of the Revised National Tuberculosis Control Programme (RNTCP) is used for pregnant women with tuberculosis. Drug-resistant tuberculosis requires second-line antituberculosis drugs, which may not be safe during pregnancy because of teratogenic effects (especially aminoglycosides and quinolones). In this situation, detailed counselling is necessary regarding potential maternal-fetal hazards and option for medical termination of pregnancy. The current RNTCP guideline (2017) regarding management of drug-resistant tuberculosis in pregnant women provides a helpful algorithm for the clinicians.

Antenatal and intrapartum care may be modified according to severity of tuberculosis, and associated obstetric complications. It is important to evaluate fetal growth during third trimester because higher risk of fetal growth restriction. Congenital tuberculosis is very rare, when the mother has received antituberculosis drugs. Nevertheless, all neonates should be screened for tuberculosis and placenta should be examined for bacteriological and histopathological evidence of tuberculosis.

The women with tuberculosis should breast-feed normally while taking antituberculosis drugs. A barrier mask for the mother may be advised. Need and scope for isoniazid prophylaxis for the baby should be assessed by an experienced neonatologist. BCG vaccination should be considered in accordance with to the current national guidelines. Choice of contraception depends on breast feeding and current use antituberculosis drugs. These women should be counselled that rifampicin may interfere with effectiveness of combined oral contraceptives resulting in unplanned pregnancies.

In 2016, the World Health Organization (WHO) recommended that “In settings where the tuberculosis prevalence in the general population is 100/100000 population or higher, systematic screening for active TB should be considered for pregnant women as part of antenatal care.“ The WHO panel also suggested that the options for initial screening include screening for symptoms compatible with tuberculosis, or screening with radiography.

Considering the current burden and impact of maternal tuberculosis in India, and to achieve the ambitious goal to eliminate tuberculosis by 2025, a national guideline on the "management tuberculosis in pregnant women" is being framed jointly by the Central Tuberculosis Division and Maternal Health Division of the Government of India. This is a very prudent step for maternal health in India.

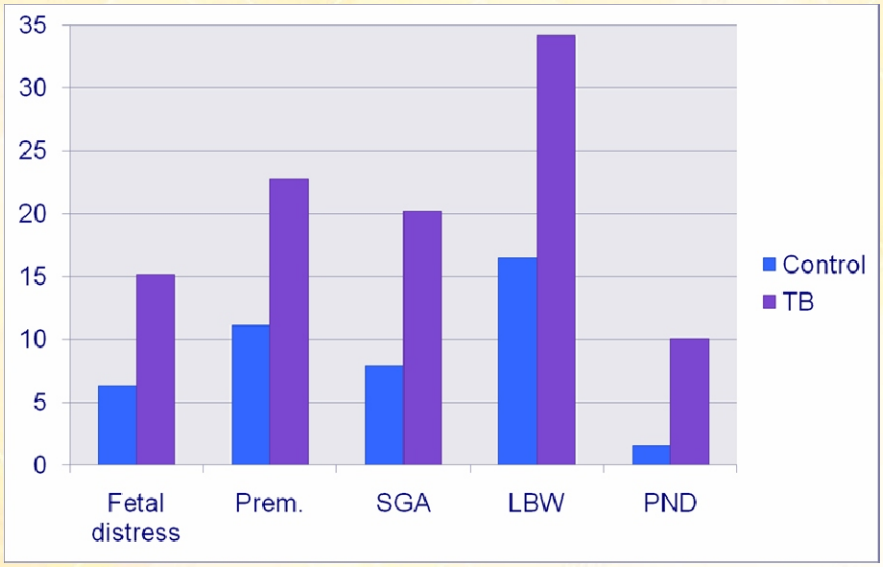

Figure 1: Data expressed in percentage (%). (Prem. prematurity; SGA small for gestational age; LBW low birth-weight; LBW low birth-weight; PND perinatal death). Reference: (Jana N et al. Perinatal outcome in pregnancies complicated by pulmonary tuberculosis. Int J Gynecol Obstet 1994;44:119-124).

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