Happy Gynecon 2019

Report of Contributions

https://events.rogs.in/e/HappyGC19

Contribution ID: **4** Type: **Paper**

Multiple Endocrinopathies in Pregnancy:She sailed through! A case report

The presence of multiple endocrinopathies in pregnancy is a rare occurance. It throws a significant challenge- beginning from conception, through the antenatum, during parturition and beyond. An intervening infection or an unexpected complication of the existing endocrinopathies further adds threats to the delicate situation.
Prompt recognition, early initiation of therapy, close monitoring and follow-up with multidisciplinary care are indispensable in order to achieve a successful outcome.
We present the case of a patient with pituitary adenoma, adrenal insufficiency, and hypothyroidism , of how she sailed through the diagnosis and management and walked home with a healthy baby.

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Presenter: Dr BHARGAVA CHANDRAMOHAN, Pavan (AIIMS)

Contribution ID: **5** Type: **Paper**

Systemic Lupus Erythematosus and pregnancy

Systemic lupus erythematous (SLE) is an autoimmune disease with a strong reproductive age female predilection. Hence pregnancy remains a commonly encountered yet high risk situation, morbidity includes higher risk of disease flares, pre-eclampsia and other pregnancy-related complications. Lupus nephritis is a common complication of SLE and can lead to scarring and permanent damage to the kidneys and possibly end-stage renal disease (ESRD).
A 29-year-old primigravida with 30+4 week's period of gestation, a referred case from a peripheral hospital, a known case of SLE(systemic lupus nephritis) with grade II lupus nephritis with chronic hypertension.
Patient was on follow up in AIIMS OPD from 18+5 weeks as a reffered case, already on prednisolone, azathioprine, HCQ and ecospirin. Patient started on lobetalol and nifidipine at 23 weeks of gestation and was managed in consultation with medicine , nephrology and rheumatology department on OPD basis.
Patient was admitted at 27+6weeks i/v/o superimposed preeclampsia patient managed conservatively in consultation with nephrology and cardiology department and discharged with escalated doses of lobetalol and nifidepine.
Patient presented to OPD at 30+4 weeks with Color Doppler study of the fetus, showing IUGR with Doppler changes. Repeat Doppler study at 30+5 weeks showed absent flow in the umbilical artery with brain sparing effect. Emergency LSCS was done and a preterm alive female baby of weight 850gm was delivered, baby cried spontaneously at birth and was shifted to NICU i/v/o prematurity and IUGR.The patient is admitted in PNC ward and is being managed in consultation with nephrology department, baby still in NICU and is doing well.

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Contribution ID: **6** Type: **Poster**

Rare case of rectovaginal fistula due to chronic constipaton

Abstract of “a rare case of rectovaginal fistula , caused due to chronic constipation” for Poster presentation

Primary author: Dr KANOI , sunita (CGMC 3439/2011)

Contribution ID: **7** Type: **Paper**

ROLE OF DIAGNOSTIC HYSTEROSCOPY IN EVALUATION OF ABNORMAL UTERINE BLEEDING IN WOMEN OF REPRODUCTIVE AGE GROUP AND ITS HISTOPATHOLOGICAL CORRELATION

ROLE OF DIAGNOSTIC HYSTEROSCOPY IN
EVALUATION OF ABNORMAL UTERINE BLEEDING
IN WOMEN OF REPRODUCTIVE AGE GROUP AND
ITS HISTOPATHOLOGICAL CORRELATION

Tripti Nagaria,Ruchi Kishore,Prateeti S. Thakur

ABSTRACT

BACKGROUND & OBJECTIVES: Abnormal uterine bleeding is the most common complaint in gynaecology and an important source of morbidity. This study evaluates the role of diagnostic hysteroscopy in the evaluation of Abnormal Uterine Bleeding in women of reproductive age group and its histopathological correlation.
METHODS: 65 patients with AUB who got admitted at DR. BRAMH Raipur in the Department of Obstetrics and Gynaecology were subjected to hysteroscopy and endometrial sampling. Histopathological analysis of the endometrial sample obtained. The hysteroscopic findings were correlated with the histopathology report.
RESULTS: AUB was more common in 35-49 yrs. The most common presenting complaint was Menorrhagia. Hysteroscopy was done successfully in all the patients. Abnormalities seen were endometrial hyperplasia (simple and complex), submucous , and atrophic endometrium, proliferative phase and secretory phase. Hysteroscopy was found to be 100% sensitive and specific in diagnosis of endometrial lesions. The positive predictive value was 100% for hysteroscopy in diagnosis of endometrial lesions.
CONCLUSION: This study confirms the conclusion of many others that hysteroscopy is an accurate and a feasible investigation in evaluating patients with Abnormal Uterine Bleeding.

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Contribution ID: **8** Type: **Poster**

Chronic ectopic casarean Scar pregnancy

CHRONIC ECTOPIC CESAREAN SCAR PREGNANCY
A CASE REPORT
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One of unforeseen consequences of our increasing reliance on cesarean delivery is gestation in cesarean scar. Cesarean scar pregnancy (CSP) is a rare entity and can cause serious complications. First case of CSP was reported by Larsen and Solomon in 1978 2 as a postabortal haemorrhage -uterine scar sacculus. Since then, cases have been reported leading to a better understanding.
Liberal use of imaging studies helps early detection and avoid complications like scar rupture and excessive hemorrhage, which may require a hysterectomy. Patients who are vitally stable have more treatment options including conservative management.
In this paper, we describe a case of cesarean scar pregnancy which presented as a case of suspected cervical pregnancy/ cervical abortion that was treated successfully by timely, systematic approach and anticipatory preparation for torrential hemorrhage.
CONCLUSION - Present day clinician should be aware of such a condition and have a high index of suspicion. As there are no evidence based recommendations available, clinicians will have to depend on available case reports and counsel women accordingly on various treatment options available to make informed choice.

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Contribution ID: **9** Type: **Paper**

Study of Awareness for screening of Cervical Cancer in Women Attending Gynecology Outdoor Patient in Pt. JNM College, Raipur

Cervical cancer is the fourth most common cancer in world & leading cause of mortality among women in India due to late detection & low screening rates. A comprehensive questionnaire prepared & cross-sectional survey was conducted for 1008 women. Out of 1008 participants only 336(33.3%) participants were aware about screening and < 28% participants were aware about pap smear, time of investigation, method of pap smear, health centre etc. Regarding risk factors less than 28% women were aware of increased risk of Cervical Cancer due to multiple partners, early initiation of sexual activity. Of the women interviewed less than 26% of participants are aware of symptoms of cervical cancer like postcoital bleeding, foul smelling etc. Younger women, low socioeconomic status, Education level and early marriage all had a significant relationship with the awareness of Pap smear test. Out of 1008 participants 730(72.4%) gave consent for pap smear and 278(27.6%) participants refused despite of counselling. We concluded that fear, pain and embarrassment, deterred females from undergoing screening and becoming aware when they were pregnant or receiving fertility treatment. Thus, a national awareness programme on Cervical Cancer screening should be developed for early detection and treatment of cervical cancer.

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Co-authors: Dr TIWARY, DR PRATIBHA; Dr KUJUR, DR AVINASHI

Contribution ID: **10** Type: **Articles for Souvenir**

Criminal Liabilities In Medical Profession

Criminal Liabilities In Medical Profession

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Ignorance of the law is never an excuse especially when it comes to the medical profession, the doctors are under tremendous pressure to perform at the best of their ability and follow the lawsuit in general as their performance reflects if the patient would be cured /saved. They have certain civil and criminal responsibilities. But, the double-edged sword of treatment burden, death of patient, and medical errors are always hanging above head of doctors. The doctors have to outperform and exceed their expectations but the truth is - death can never be controlled by anyone.
If found guilty, doctors are criminally liable under these circumstances:
A] Evidence and Record:
Section number Actual Act Explanation
174 Non-attendance in obedience of an order from a doctor A doctor is legally bound to appear in court or in front of the magistrate if he/she is in relation with that case.
175 Failure to produce document to legally bounded person A doctor is bound to produce all documents (e.g. medical reports or treatment record) in case of the medico-legal case.
176 Omission to provide notice or information to public servant by legally bounded person A doctor is bound to inform police about the medico legal, murder case, or a rape case which is admitted in their dispensary or hospital.
187 Not assisting public servant when bound by law to provide required assistance A doctor if he/she fails to treat a patient or public servant allotted to him.
192 Fabricating false evidence A doctor or a medical professional in any circumstance produces false evidence, makes a false entry , false statement.
197 Issuing or signing a false certificate A doctor in any way is not allowed to issue or sign a certificate which is intentionally constructed for a false manner.
470 Forged document or electronic record A document which is made partly or completely by forgery is legally not allowed in the court of law
471 Using a forged document as a genuine document Doctors at any cost are not allowed to utilize forged documents like an original document for whatever reason

B] Laws on Public Health, Safety and Drugs:
Section number Actual Act Explanation
269-271 Negligence resulting in the spread of infectious diseases & disobiedience of quarantine rule. The medical professionals are liable to follow strict standards which are set for treating patients under the guidelines and protocols especially for dangerous diseases like AIDS, Hepatitis etc.
274 Drug Adulteration The medical professionals aren't allowed to adulterate any medical preparation which arbitrarily affects the efficiency and safety of the drug rendering it useless.
276 Sale of drugs as a different drug or preparation The medical practitioners aren't allowed to retail drugs with their own formulation. All drugs which are liable to sale should be duly approved by the regulatory authorities.
278 Making the work atmosphere unreliable to work The medical practitioner caught violating the norms of the general practice that intoxicates the work environment on a large scale are liable.
284 Negligence while handling a poisonous substance If the medical practitioner, due to any unforeseen reason is involved in providing a poisonous or toxic substance to the patient which can endanger the life.
287 Negligence in handling medical devices The medical practitioner needs to be very careful while handling medical devices, if any sort of negligence occurs in any circumstance it could lead to se-

rious complications under this section.
C] Laws in relation to endangering life:
Section number Actual Act Explanation
319-22 Causing grievous hurt For example loss of limbs, loss of vision, loss of hearing or disfigurement.
336 Endangering the life or personal safety of others Act performed with negligent intentions which proceeds to endanger their life or personal safety.
337 Hurting life or personal safety of others A procedure performed which harms human life or personal safety.
338
Hurting grievously or personal safety of others An act which is responsible for grievously hurting someone which proceeds to endanger their life or personal safety
D] Laws in relation to indoor patients:
Section number Actual Act Explanation
340 Wrongful confinement A medical practitioner is not allowed to wrongfully restrain a person from his/her rights in a manner as to limit the medical proceedings further. It is totally unlawful to confine a person, withhold discharge for any given reason or withhold handing of the dead body due to payment disputes.
E] Laws governing death due to negligence:
Section number Actual Act Explanation
304-A

`Causing death due to negligence The medical practitioner who is found guilty of causing death d`

The Supreme Court of India is of view that situation should be very carefully analysed while imposing criminal offences on doctors .

Section 304 and 304-A
There is lot of discrepancy while applying these sections in cases of professional negligence by doctors. Most of the times the police authorities register the cases of professional negligence deaths under Sec. 304 of IPC. According to this Section the offence is non-bailable. This causes lot of hardship, bad reputation and mental agony to the doctors. In fact the police should register the cases of deaths due to medical negligence under Sec. 304-A of IPC, in which the offence is bailable and the doctor can be released on bail. The judgment has been passed by Bombay High Court in Criminal Revision application no. 282 of 1996 (Dr. Mrs. Mrudula S. Deshpandevs State of Maharashtra) dated 28th November 1998(3). The basic difference is that in Sec. 304 there is intentional act of negligence while in 304-A the act is never done with the intention to cause death.
When to Inform Police - Police must be informed in (i) cases of suspected homicide, (ii) cases of suicidal deaths, (iii) unknown, unconscious patient, (iv) death on operation table, (v) suspected unnatural death, (vi) sudden, unexpected, violent and unexplained death, (vii) instant death after treatment or reaction of medicine, and a (viii) married lady dying within seven years of marriage due to any reason.
It is advisable to inform police in following circumstances (i) undiagnosed death within 24 hrs. of admission or specially if there is any suspicion, (ii) any cases of poisoning, (iii) accidental deaths, and (iv) in cases of hospital deaths if (a) accidents not related to medical management like fall from staircase etc., though there is no legal obligation on doctor, it is advisable to inform the police, (b) unexpected or rare complications may occur sometimes, e.g. a child may vomit, aspirate the content and may die. This is very unpredictable and it is not obligatory on part of the doctor to inform such deaths. But it is better if we inform the police because sometimes patient's relatives may allege negligence in such cases.
"Brought dead cases": In such cases, if the cause of death is apparent and there are no reasonable grounds to suspect some medico-legal complications then it is not necessary to inform the police. If the cause of death can't be ascertained in any case then it is desirable to send the body for postmortem examination preferably with the help of the police.

Information to police shall preferably be in writing and the written acknowledgement should be obtained. If the information is telephonic one must note down name, buckle number and designa-

tion of the police.

Can a Doctor be Arrested?
Doctors have no immunity against arrest (as any other citizen of India) for the various criminal acts as per the provisions of IPC or CPC of India.
Illegal organ trading, unlawful sex determination etc. are non-bailable offenses.
But the question is whether a doctor be arrested for:
(a) alleged medical negligence during day to day care of a patient,
(b) unexplained hospital deaths like SIDS etc.,
(c) postoperative complication or failure of operation;
(d) not attending or refusing a patient (who was not already under his care) who becomes serious or dies and
(f) not attending a case of roadside accident.
The Supreme Court directives (criminal writ petition no. 270 of 1988) in a roadside accident include:
• The medical aid should be instantaneous. It is duty of registered medical practitioner to attend the injured and render medical aid, treatment without waiting for procedural formalities unless injured person or guardian (in case of minor) desires otherwise.
• The effort to save person and preserve life should be top priority, not only of doctor but also of police officer or any other citizen who happens to notice such an accident.
• The professional obligation of protecting life extends to every doctor, whether at Government hospital or otherwise.
• The obligation being total, absolute and paramount, no statutory or procedural formalities can interfere in discharging this duty.
• Whenever better or specific assistance is required, it is duty of treating doctor to see that patient reaches the proper expert as early as possible.
• Non-compliance of these directives may invite prosecution under provisions of Motor Vehicle Act or IPC(7).

If FIR is lodged by patient or relatives then the police may arrest the doctor. Hence better approach in cases where we feel that patients or relatives may create nuisance will be as follows:
1. The doctor should lodge a FIR that a particular incidence has happened in my hospital.
2. A crisis management committee may be formed at each Taluka or District level. The committee shall include doctors, social workers, legal personalities, politicians, press reporters etc. The committee members may meet the police officers and request them for complete investigation of the incidence and to avoid prosecution till the guilt is proved. The committee can also request the press reporters not to give unnecessary publicity to such cases.

The Government of Kerala (G.R. no. 3231/SS-B4/92/Home dated 20.09.1993) has issued the following instructions if there are any cases of criminal negligence against a private practitioner, doctor or private hospital. According to G.R. the investigating Deputy Superintendent of Police shall refer the case to a panel of Superintendent of Police, commissioner of Police, District Medical Officer or Principal of Medical College. Still if the views differ, the opinion of an apex body consisting of Director of Health Services and expert in that particular speciality may be taken. The affected doctor is also free to approach the apex body with appeals.

Do's and Don'ts -
• Inform police whenever necessary.
• Extend all possible co-operations to police.
• Furnish copies of medical records to police, court or relatives whenever demanded. Consent of patient may be taken while providing information to police.
• Follow legal procedures or provisions.
• Have valid informed consent for treatment.
• Preserve documents, records especially in medico-legal, controversial or complicated cases.
• Insist for post-mortem examination if cause of death can't be ascertained.
• Involve medical associations, medico-legal cells, and voluntary organizations whenever legal problem arises.
• Consult your lawyer before giving any reply.
• Don't become panicky.

• Don’t manipulate or tamper with documents.
• Don’t do unlawful or unethical acts.
• Don’t issue false or bogus certificates. Certificate was issued on request is no defense.
• Don’t neglect treatment while completing legal formalities especially in serious or emergency situation.

Finally, it needs to be remembered that establishing a strong doctor-patient relationship could assist in many ways.

More time you spend with your patient in your consulting room, it might reduce your time in courtroom.

Reference-Textbook on Medicolegal Issues. https://www.ima-india.org/ima/left-side-bar.php?scid=207

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Contribution ID: **11** Type: **Articles for Souvenir**

Enhanced recovery after surgery (ERAS)

Enhanced recovery after surgery (ERAS)

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Enhanced recovery after surgery (ERAS), a multidisciplinary care pathway composed of evidence-based interventions, has challenged the traditional perioperative care paradigm with a goal of enhancing recovery and improving perioperative outcomes 1.
Enhanced recovery" or "fast track" surgical principles were first described in 1990s.by European anesthesiologists and surgeons most notably Dutch professor, Henrik Kehlet.1,8 They introduced the concept (1) limit the degree of the surgical injury itself and (2) find ways to help the body cope by decreasing its stress response to injury. The response to surgical stress is mediated by neurohormonal pathways and complement pathways leading to increased catabolism, immunosuppression, relative hypoxia, insulin resistance, and generalized organ dysfunction that can delay the body's ability to recover.
The first pathway was developed in Europe for colorectal surgery and has since been adapted for other surgical specialties, including gynecology.3,4 The most studied population in gynecology are oncology patients undergoing laparotomies with hospitalizations longer than 2 days.5,After ERAS implementation these patients experienced decreased length of admission, hastened return of bowel function, and decreased narcotic use, resulting in better postoperative pain control, and high patient satisfaction.1,6,7
Central to ERAS are the core components of patient education, preoperative optimization, avoidance of preoperative fasting, carbohydrate loading, intraoperative euvolemia, standardized opioid-sparing anesthesia, prevention of postoperative pain and nausea, and early mobilization.1-2 "Fast-track" protocol, aims to minimize the physiologic stress of surgery and optimize the rehabilitation of patients.This is a multidisciplinary team effort and requires active patient participation in the process.
ERP has been rigorously studied in many surgical specialties. Data showing benefit of ERP principles and protocols is most robust in colorectal surgery, but it has also been implemented with similar positive outcomes in a variety of other surgical specialties including vascular surgery, thoracic surgery, cardiac surgery, urology, hepatobiliary surgery, orthopedics, as well as in gynecologic oncology. However, there is limited data in obstetrics and benign gynecology.
ERAS components 1- ERP protocol for gynecology and gynecologic oncology patients.
Preoperative optimization
 Assessment preoperative office visit or phone call
 Screen for chronic conditions and assess optimization for surgery
 Screen for tobacco and alcohol abuse- cessation 4-6 weeks prior to surgery
 Assess for weight loss and malnutrition
 Assess postoperative nausea and vomiting risk using simplified Apfel criteria
Perioperative expectations, reinforcing the patient's role in their own recovery
 Provide ERAS brochure and nutrition patient information
 Exercise 30 minutes of walking daily until surgery
 Diet Protein and carbohydrate-rich foods 1 week prior to surgery
 Regular diet until midnight the night before surgery
 Clear liquids until 3 hours prior to surgery (water, black coffee, clear tea, carbonated beverages, fruit juice without pulp, Gatorade)
 Patients with diabetes should avoid sugar-containing liquids
 Verification Preoperative phone call the day prior to surgery
 Nothing by mouth instructions reviewed
 Medications reviewed

 Shower with soap the night before surgery
Day of surgery- Preoperative –
 Multimodal pain management:
Celecoxib 400 mg PO (200 mg if age >65 y); omit if GFR <60
Acetaminophen 1000 mg PO (omit if hepatic dysfunction)
Morphine sulfate ER 30 mg PO (15 mg if age >65 y)
 Postoperative nausea and vomiting prevention:
Perphenazine 8 mg PO
Anesthesia can add scopolamine patch if age <65 y
 Antibiotic prophylaxis - Cefotetan 2 g IV within 60 minutes of incision
 No routine fluid administration
 No IV opioid premedication
Intraoperative Induction:
 Propofol (1-2 mg/kg or titrate to amnesia and anesthesia)
 Ketamine 20 mg
 Lidocaine 100-200 mg bolus
 Muscle relaxant (no opioids)
 For spinal block-Bupivacaine + hydromorphone (40-100mcgm)
 Dexamethasone 4-5 mg IV (avoid if diabetes)
Maintenance:
 Ketamine 10 mg q 1 hour (avoid in final hour)
 Lidocaine boluses q 1 hour (1 mg/kg)
 Avoid opioids intraoperatively unless patient c/o pain at emergence
 Avoid routine use of NGT
 Fluid management: Goal is euvolemia: 2 mL/kg per hour, Boluses for MAP <60 mm Hg or 20% of baseline
Emergence:
 Propofol titration
 Ondansetron 4 mg IV
 No IV ketorolac (unless celecoxib not given preoperatively)
 No IV acetaminophen (unless not given preoperatively)
 Postoperative Transition from IV to PO opioids for rescue pain management
 Avoid patient controlled anesthesia
 Ketorolac and acetaminophen scheduled
 Start ice chips/sips of clear liquids as tolerated
 IV fluids at 40 mL/h until tolerating oral fluids
 Discharge checklist Tolerating oral fluids without nausea and emesis
 Pain controlled (pain score <5)
 Voiding trial complete
 Independent ambulation
 No signs of delirium (oriented to person, place, time, current events)
 Postoperative follow-up
 Assessment POD 1 Phone call from office nurses
 Home health if required (urinary retention, DVT prophylaxis)
Benefits of ERP-
Meta-analyses & RCTs of ERP pathways have shown benefit.1, 3-6, and 8.
• Improved routine postoperative care
• Reduction in length of stay, with no difference in readmissions.
• Significant reduction in postoperative morbidity and mortality
• Improvement or no change in rates of postoperative complication and readmission.
• A recent meta-analysis across variety of surgical subspecialties confirmed that ERPs are cost-effective.
• Data on patient satisfaction and quality of life are more limited, but the available information suggests a benefit to ERP.
• ERP is consistently associated with improvements in pain scores.
• Rapid return to baseline functional status.

• Improved symptom scores
• Decreased rates of fatigue
• Study of gynecologic patients found improvements in “autonomy”, “physical complaints” and “postoperative pain”

Conclusion-

Implementation of an ERP is difficult, not only due to the high degree of coordination that is required, but because many of these interventions run counter to the current practice patterns. Practice patterns can be ingrained and difficult to change. As such, auditing and monitoring ERP implementation is crucial to achieving success. Incidences of protocol deviation must be examined. Parameters audited should include protocol compliance and deviation, measuring clinical outcomes of ERP, and measuring the patient’s quality of life and satisfaction.

Future of ERP -

In a health care world that is increasingly focused on evidence-based medicine, resource use, and measuring the quality of delivered care, ERP seems a natural fit across the surgical specialties.The cost to implementation an ERP are few whereas the benefits are tangible. As we, move towards quality metrics, bundled payments, benchmarks, and pay for performance models, ERP is the future. The NHS Britain has embraced ERP as a quality improvement and service tool and considers it standard of care following surgery.

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Contribution ID: **12** Type: **Poster**

Laparoscopic Management of Ovarian Gangrene in MRKH Syndrome

Laparoscopic Management of Ovarian Gangrene in MRKH Syndrome
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Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome is characterized by congenital aplasia of uterus and upper part of vagina with normal development of secondary sexual characteristics and normal 46, XX karyotype. Women with this syndrome usually present at young age with primary amenorrhea as first sign.

Our patient (MRKH type 1) was married with no coital difficulty due to adequate vaginal length; patient did not report to hospital for treatment of primary amenorrhoea/ infertility, it was torsion of ovarian cyst which gave rise to chronic lower abdominal pain for which patient reported, at 34 years of age- rather late & uncommon presentation, which was managed successfully by laparoscopic route and ERAS protocol.

In MRKH the ovaries are normal, oestrogen-dependent pathologies such as leiomyomas, adenomyosis and neoplasms can develop in a rudimentary uterus or in Müllerian remnants. MRKH presenting with pelvic mass, differentials considered include masses arising from Müllerian remnants, ovaries (fibroma), gastrointestinal stromal tumour (GIST) of intestine and extravesical leiomyoma of urinary bladder.USG- Doppler & MRI has an accuracy of 100% in diagnosing Müllerian anomalies. In vitro fertilization with own oocyte and surrogacy can be offered to patient of MRKH desirous of pregnancy, hence individualise and treat conservatively.

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Contribution ID: **13** Type: **Poster**

Catch me if you scan – Ruptured Primary Ovarian Ectopic pregnancy : A rare case report

A case report of ruptured ovarian pregnancy misdiagnosed at ultrasonography came to emergency in haemodynamically unstable condition ,underwent exploratory laprotomy and proceed.

Primary author: Dr SINHA, snehil (CGMC5880/2015)

Contribution ID: **14** Type: **Paper**

Peripartum cardiomyopathy:an intriguing challenge

Peripartum cardiomyopathy is a rare life threatening disease affecting 1 in 1300 to 1in 15000 pregnancies and 0.2 – 3% of live births with literature quoting between 20 % and 50% mortality in the afflicted. This is a type of dilated cardiomyopathy and is defined as systolic cardiac failure (left ventricular ejection fraction <45%).The patient may present with apparently simple symptoms like fatigue , dyspnoea or may present dramatically with acute pulmonary oedema and sudden collapse necessitating immediate critical care and multidisciplinary intervention.
We present a patient with a completely normal antenatal course admitted at term for evaluation of fever ;had acute pulmonary edema during second stage of labour with systolic dysfunction . With multidisciplinary care we were able to revive the patient and she was discharged in 2nd week with a healthy baby.

Primary authors: Dr PRADHAN, Pragyan (Postgraduate student); Dr NAYAK, Prashant kumar (Associated professor); Dr BHARGAVA, Pavan (Post graduate studeb)

Contribution ID: **15** Type: **Paper**

A rare case of Vaginal Leiomyoma

Leiomyoma are benign smooth muscle tumors commonly occurring in the uterus and to some extent in the cervix followed by the round ligament, utero-sacral ligament, ovary, and inguinal canal. Vaginal leiomyoma are very rare with only about 300 reported cases. A 49 yrs old para 3 lady presented in the gynaecological outpatient department with complains of lower abdominal pain, polymenorrhagia, dysmenorrhoea, dyspareunia, urgency and frequency of micturition since 6 months. Medical and surgical history were not significant. On per speculum examination the vagina was occupied with a large mass arising from the anterior vaginal wall and cervix could not be visualised. On bimanual examination, a firm globular smooth surfaced mass 6x5 cm was felt arising from the middle third of anterior vaginal wall up to 3 cm from the introitus with restricted mobility and non-tender. MRI pelvis reported as diffuse adenomyosis and a well defined rounded mass lesion arising from anterior vaginal wall displacing the base of uterus anteriorly suggestive of vaginal leiomyoma. Transvaginal removal of mass by enucleation along with total abdominal hysterectomy with bilateral salpingo-oophorectomy was done and postoperative diagnosis was anterior vaginal wall leiomyoma which was supported by histopathology report.

Primary authors: Dr AGRAWAL, Ankita (MS Obstetrics & Gynaecology); Dr CHATURVEDI, Srishti (DGO, Secondary DNB OBGY Resident)

Presenters: Dr AGRAWAL, Ankita (MS Obstetrics & Gynaecology); Dr CHATURVEDI, Srishti (DGO, Secondary DNB OBGY Resident)

Contribution ID: **16** Type: **Paper**

Single Dose Intravenous Carboxymaltose Versus Oral Iron Therapy In The Treatment Of Anemia In Post Partum Patients In A Rural Area

Introduction
• Anemia after the Birth of a baby (postpartum anemia) is a common problem throughout the world and for most women is self limiting, resolving within a week (Atkinson 1994).
• FCM was developed for rapid IV administration in high doses for the treatment of iron deficiency and the rapid infusion of up to 1000 mg of FCM over 15 min has been shown to be well tolerated

Objectives
• To compare the efficacy of oral and intravenous administration of iron supplements(ferric carboxy maltose) for treating postpartum anemia.

Materials and methods
• The study group included 60 patients attending AVBRH between period of February 2016 to August 2016 diagnosed to have anemia in postpartum period.
• Patients were divided in two groups
Group A constisted of 30 women who were given the single¬dose of i.v. 500 mg ferric carboxy maltose.
Group B consisted of 30 women, who were given orally 400 mg iron (ferrous sulfate) daily for four weeks.
• Study-: randomized control trial

Result
Characteristic of study population
In this study,total no of patients were 60 , each group had 30 women, 14 were primigravida in group A and 16 were multigravida in group B, whereas in group B there were 13 primigravida and 17 multigravida. Mean age of population in both groups was 22.3. Mean weight in kg in group A was 45.8 and in group B was 46.7 respectively.
Response to oral and intravenous therapy
It was found that pre treatment Hb in group A was 8.3 and post treatment was 10.7 , whereas in group B pre treatment Hb was 8.2 and post treatment Hb was 10.2 respectively.
Number of patients achieved target Hb
Target was 17 in group A and 10 in Group B , in group A 13 failed to achieve target Hb whereas in group B 20 failed to achieve target Hb.
Type and prevalence of adverse reaction
In group A nausea , diarrhea , constipation and giddiness were more common, whereas in group B hypersensitivity rection was seen in 3 cases.

DISCUSSION
• Most of our patient were having Hb around 9% and wt of 50 kg so a single 500 mg ferric carboxy maltose will raise their Hb around 11%.This dose is insufficient as it does not replenish iron store but to some extent help to restore iron store in an anemic patient.

CONCLUSION
• Intravenous administration of carboxy maltose seems to be safe and it helps postpartum women to recover early from anemia.as compared to oral iron

Primary author: KHAN, Anam

Contribution ID: **17** Type: **Paper**

VAGINAL ATRESIA- ONE AMONGST THE MANIFESTATION OF RARE "CHARGE" SYNDROME

CHARGE syndrome is a rare genetic disorder caused due to mutation in CHD7 gene- an ATP dependant chromatin remodeler. CHARGE itself abbreviates its manifestation, C- Coloboma/ Microphthalmia, H- Heart defects, A-Atresia Choana, R- Retardation of growth, G- Genital abnormalities, E- Ear abnormalities. A 15yr old girl with primary amenorrhoea presented to OBG OPD in April 2019 with complaints of cyclical lower abdominal pain since 7 months. On GPE & systemic examination- 1. She had left microphthalmia with vision of only perception of light. 2. Characteristic LOP ear was noted with h/o reduced hearing since childhood. 3. Secondary sexual characters, however revealed Tanner Stage 3- normal for her age. 4. CVS revealed Atrial septal defect. After proper consenting from the guardians, local examination revealed Vaginal atresia. After CTVS consultation, she underwent ASD correction in May 2019. Further she was subjected to imaging studies like USG & MRI abdomen and pelvis, which revealed a normal uterus and adnexa with hematometra and cervix appearing quite small in size, also noticing a relatively small left kidney with mild pelvicalceal fullness. After all initial investigations, confirmation of diagnosis and pre anesthetic clearance, she was planned for Vaginoplasty after 3 months. On 7-8-19, she underwent Mc Indoe's vaginoplasty with hematometra being drained by hysterotomy & upper part of neovagina was anastomosed with cervical opening, a split skin graft harvested from the left thigh posterior aspect was used to create a neovagina. I want to present this case due to its rarity and successful management.

Primary author: N, Chaitra (AIIMS)

Contribution ID: **18** Type: **Poster**

SCAR ENDOMETRIOSIS IN PREVIOUS LSCS: A CASE SERIES IN A TERTIARY CARE HOSPITAL

Endometriosis refers to presence of functional endometrial glands and stroma lying outside the uterine cavity. Scar endometriosis is extremely rare and accounts for less than 1% cases of endometriosis. Aim was to to observe the presentation of scar endometriosis in patients coming to tertiary care hospitals and to evaluate and manage such patients. The 1st case was 27years, P2L2, previous 1 LSCS, with complaints of mass at scar site gradually increasing in size associated with pain, pricking sensation which increased during menses. She was diagnosed as a case of scar endometriosis by USG. The pain and swelling relieved on taking dinogest tablets for 6 months. 2nd case, 33yrs, P2L2, previous 1 LSCS, complaints of dysmenorrhea with pain over scar for last 6 months. Pain relieved on taking doxycycline, metrogyl and ovral L. 3rd case, 26 yr, P2L2, 2 Previous LSCS, complaints of pain at lscs scar site during menses since 2 years, not relieved on taking Tab Dinogest for 2 years. Excision of 4x5cm endometriotic tissue was done, adhered to rectus sheath and peritoneum. Diagnosis confirmed by histopathology. Thus, 3 cases have been managed by different methods and have been helpful in guiding further management of such cases.

Primary author: DAS, Esha (AIIMS, Raipur)

Contribution ID: **19** Type: **Paper**

ASYMPTOMATIC PLACENTA PERCRETA: A CASE REPORT

Placenta accreta syndrome is a spectrum of abnormal placental implantation and firm adherence which are classified according to the depth of invasion into the uterus. A 28 years primigravida presented to AIIMS OPD at 13+2 weeks of gestation with complaints of brownish discharge per vaginum. She had history of myomectomy 2 years ago. Ultrasonography showed subchorionic hemorrhage with placenta being fundoanterior. TIFFA at 19 weeks of gestation showed multiple fibroids, mostly on the anterior wall of uterus. Growth scan at 30+2 weeks of gestation was suggestive of placenta accreta. Also multiple fibroids were visualised. MRI was done which further confirmed the possibility of placenta percreta. Patient was admitted in labour room at 36+6 weeks of gestation with complaint of leaking per vaginum . Emergency caesarean section was done and after delivery of baby, placenta was found to be adhering to the fundal region. Atonic PPH developed. Manual removal, uterotonics administration, internal iliac artery ligation tried but failed. Thus, subtotal hysterectomy was done. Placental tissue was seen invading uterine myometrium at fundus and visible on the surface of uterus. Diagnosis of placenta percreta was confirmed on histopathology.

Primary author: DAS, Esha (AIIMS, Raipur)

Contribution ID: **20** Type: **Articles for Souvenir**

ELUSIVE HAPPINESS

"Happiness is of the soul. The soul can never be cut to pieces. Nor burned by fire, nor moistened by water or withered by wind." ~ Bhagavad Gita

There is only one goal in life, being happy. Success, prosperity, abundance are just by-products of it. Much like Einstein's theory of relativity, happiness is relative to every person. For example, a packet of chips may make a roadside beggar happy, but maybe not you. And there lies the problem. Happiness is all around us, if we choose to feel it. Yet we choose to be crushed down by our own sky high, sometimes unattainable expectations. We consider every negative turn in our lives as the end of the world. (Even I don't practice what I preach)

With India being the most depressed country in the world, with every sixth Indian suffering from some sort of depression, we need to re-evaluate our lifestyle. Are we overworked? Are we over-ambitious? Are we poor?

Let me start on why I chose to write this. A 14 year old girl was found dead in a school toilet, in June 2019, who had killed herself in a very brutal way with a 3 page long suicide note. There she had apologised to her parents for not being able to fulfil their dreams and that she was exhausted and she needed sleep. That bright and beautiful girl could have been saved. She may not have been an IAS/ Doctor/ Engineer, but she could have been an artist or a writer. We, as a society, failed her and many others like her. We shun the topic of mental disorders like its taboo. We ignore the first signs and symptoms of depression and so do our close friends and relatives. All she needed was some psychiatric help and maybe less pressure from her parents. As the new generation of parents, we must make sure that we and our children do not fall prey to such extreme circumstances. There is a long gap between depression and suicide, and timely intervention can turn your life around. I know this because I too was 14 once and used to sit in the same classroom as her and chose to visit a therapist when I noticed the symptoms. I was lucky that my therapist was so good that it took me 1 week of sessions with her to overcome all that stress. And on my 15th birthday, our school newspaper had published articles by me and her on the same page. We congratulated each other over chocolate.

Human emotions are like the ECG plots, sometimes up, sometimes down. Life throws challenges at us and we overcome some, we cannot overcome others. And its not our job to overcome each and every challenge. Sometimes we can sit back and let life win the challenge. We will experience grief, stress, elation, joy. However happiness is born out of our interpretation of each of these emotions. Close your eyes and evaluate the good and the bad of every situation and then focus on the positives. In the various shades of grey that our life passes through happiness lurks camouflaged in every shade waiting to be discovered.

Do not compromise on happiness. Be it a job, a place, a relationship, if it is not making you happy you either leave or you adjust. And there is ALWAYS an alternative. We are too lazy to find it. And when in doubt keep calm and trust your peers, they will give you the necessary cheers and say "This too shall pass." As a friend, relative, parent, it is very important to notice the signs and symptoms of depression and counsel our loved ones out of it or motivate them to seek professional help. There is light and dark in everything, choose light and choose to show light to those wandering helplessly in the dark.

"Those who realise the self are always satisfied. Happiness can only be found within self." ~ Bhagavad Gita

Primary author: DAS, Esha (AIIMS, Raipur)

Contribution ID: **21** Type: **Poster**

Conventional slow intravenous iron sucrose administration versus rapid bolus in iron deficiency anaemia in pregnancy in a rural setup

Conventional slow intravenous iron sucrose administration versus rapid bolus in iron deficiency anaemia in pregnancy in a rural setup

Aastha R.K. Bajaj
Datta Meghe Institute Of Medical Sciences, Sawangi, Wardha, Maharashtra.

The prevalence of iron deficiency anaemia in pregnancy in India is up to 50-60%. It has major ill effects on the health of the mother and the fetus. Anaemia correction in rural areas has always been a task for healthcare personnel in India. Some definite difficulties in carrying out the conventional regimens of anaemia correction like poor compliance owing to hospital stays lead to deficient treatment and maternal as well as fetal health compromise. A randomized control trial was conducted in a tertiary level institute on 100 pregnant women at 20-24 weeks gestation with iron deficiency anaemia who received 400 mg intravenous iron sucrose either by the conventional slow infusion; or by rapid bolus-push over 2-5 minutes. The iron was administered in two equal doses of 200 mg each, 7 days apart. Conventional slow intravenous iron sucrose administration showed an average increase of 1.9 g% in Hb concentration, whereas rapid bolus-push technique showed an increase of 2.1 g%, patient compliance being higher with bolus-push. Both, the conventional slow and the rapid bolus push have similar efficacy in correction of iron deficiency anaemia in pregnancy. But the bolus push technique represents a cost effective approach in low resource settings.

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Primary authors: Dr BAJAJ, Aastha (Third year PG resident); Dr DESHPANDE, Vivek (Professor)

Presenter: Dr BAJAJ, Aastha (Third year PG resident)

Contribution ID: **22** Type: **Paper**

Thrombocytopenia in pregnancy

Thrombocytopenia in pregnancy a case report

Taru Shikha, Pushpawati Thakur, Pavan Bhargav,
AIIMS RAIPUR

Thrombocytopenia or low platelet count (<1.5lacs/Ul) is second most common blood disorder In pregnancy prevailing 6.6-11.6% in 3rd trimester of pregnancy.Gestational thrombocytopenia Can lead to coagulation abnormalities and can result in placental abruption and PPH.It can also associated with episiotomy site hematoma,rectus sheath hematoma and fetal complications like Still birth,IUGR,meconium stained liquor,birth asphyxia and neonatal thrombocytopenia.Its evaluation and management can be challenging as there are myriads of causes -diagnosed or undiagnosed ,obstretic or non obstretic.Early detection ,prompt follow up,vigilant perinatal care are indispensable to achieve a successful pregnancy outcome.
We present a case of severe thrombocytopenia first diagnosed at term gestation with fetal doppler abnormality necessitationg immediate intervention. With vigilant and timely perinatal care we were able to not only avert possible dangers but also achieve successful outcome.

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Contribution ID: **23** Type: **Paper**

Early recovery after surgery (ERAS) in Ob-Gyn surgeries A prospective single-center pilot study

Early recovery after surgery (ERAS) in Ob-Gyn surgeries
A prospective single-center pilot study

Ritu V Jain
Consultant – Shri Mahaveer Hospital, Raipur,CG,India.
Assistant Professor- RIMS Medical College, Raipur,CG,India

ERAS programmes employed in elective colorectal, vascular, urologic and orthopaedic surgery has provided strong evidence for decreased lengths of hospital stay without increase in postoperative complications, our aim was to explore role/ benefits, if any, of ERAS in elective ob- gyn surgeries.

Type- prospective cohort ;T= 38 ,elective ob- gyn surgeries;C= 50 ,similar operations, without ERP.ERP included: early feeding, urinary catheter removal, mobilisation, intravenous line removal and optimal oral analgesia.Primary end-points- length of hospital stay, incidence of complications (Clavien-Dindo classification#).Test- t-test(unequal variances) .Statistical significance $p < 0.05$.

No. Parameters NON ERAS (n=50) ERAS (n=38) t-value P Value S/NS
1 Oral (Solid food) 1.57 1.13 5.24 <0.00001 S
2 Uri. Catheter removal 1.99 1.03 1.96 0.0268 S
3 MobilIsation(Out of Bed) 1.63 1.22 4.90 <0.00001 S
4 Iv fluid removal 1.72 1.14 7.002 <0.00001 S
5 Oral analgesics 1.8 1.37 4.531 <0.00001 S
6 Complications #
Gr1=16
Gr2=15
Total= 31
M=15.5 Gr1=11
Gr2=10
Total= 21
M=10.5 7.071 0.00971 S
7 Discharge 2.87 2.59 1.788 0.0386 S

Result-ERPs can be successfully implemented with significant shorter hospital stays without increase in postoperative complications.
Future study- Include emergency ob-gyn surgeries.

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Contribution ID: **24** Type: **Poster**

Congenital cervical incompetence and its Outcome

An incompetent cervix, also called a cervical insufficiency, occurs when weak cervical tissue causes or contributes to premature birth or the loss of an otherwise healthy pregnancy. Cervical incompetence may be classified into four types according to etiologic factors: 1. Acquired, 2. Congenital, 3. Physiologic or Dysfunctional, 4. Anatomic. In Congenita cervical incompetence a histologic defect is present although the cervix appears macroscopically intact. An incompetent cervix can be difficult to diagnose and treat, especially in case of primigravida. Elective and emergency encirclage can be done for inherited cervical incompetence. We are going to present two cases of inherited cervical incompitence .with successful pregnancy outcome. A 30year old G2P0A1 with 14weeks POG with cervical incompetence h/o previous inevitable loss and positiuve family history in sister,in which McDonald circlage was done and 22year old primigravida with 22weeks POG with USG s/o shortening of cervix (0.8cm) in which Emergency WURM'S rescue circlage was done . Encirclage can be done for inherited cervical incompetence.it needs high clinical prediction and suspicion in all antenatal women, leads to good pregnancy outcome.

Primary authors: CHANDRAWANSHI, Veena (AIIMS, Raipur, India); Dr THAKUR, Pushpawati (AIIMS. Raipur, India); Dr SINGH, Vinita (AIIMS, Raipur, India)

Presenter: CHANDRAWANSHI, Veena (AIIMS, Raipur, India)

Contribution ID: **25** Type: **Paper**

Autologous intrauterine Platelet rich plasma [PRP] Vs G-CSF instillation for enhancement of endometrial growth and vascularity in IVF Failure : Our Experience

Success of any IVF cycle depends on favourable interaction between healthy embryos and adequately thick, responsive endometrium.For staging the endometrium thickness optimum for implantation ,there is still no agreement or general concensus. Gingoldet al, 2015 mentioned that endometrial thickness should be more than 8mm for good pregnancy outcome.
Platelet-rich plasma (PRP) is prepared from fresh whole blood which is collected from a peripheral vein. Through activating platelets in PRP, cytokines and growth factors (GFs) become bioactive and are secreted within 10 min after clotting. These factors include vascular endothelial growth factor , transforming growth factor, platelet-derived growth factor and epidermal growth factor .They can regulate cell migration, attachment, proliferation and differentiation, and promote extracellular matrix accumulation. Nowadays, PRP has been widely applied in different clinical scenarios, such as orthopedics,ophthalmology and wound healing to improve the tissue regeneration. PRP in the treatment of thin endometrium .Intrauterine infusion of G-CSF has been studied but inconsistent results have been reported. Some researchers reported that G-CSF favors endometrial growth and pregnancy. G-CSF is a cytokine that stimulates neutrophilic granulocyte differentiation and proliferation, it may induce endometrium proliferation and growth, thus improve pregnancy outcome. GCSF stimulates the secretion of various endocrine pathways and various endogenous cytokines

Primary author: Dr DR SANJANA KHEMKA AGRAWAL, Dr sanjana (shree narayana hospital)

Contribution ID: **26** Type: **Articles for Souvenir**

Determinants of negative preference for female fetuses amongst women of reproductive age group at rural medical college

India is experiencing lowest child sex ratio of the world. The deficit of girl children has been progressively increasing, in spite of so many laws to favour them like Sharda act, act against dowry and law against female feticide, i.e. PC & PNDT. The present study attempted to explore the determinants of negative preference of female fetuses at rural setup and preferences for prevention of female foeticide. Female foeticide is still in practice inspite of awareness programmes and existing law. Main reason for it is societal need due to marriage related customs and cultures along with unethical practices by service providers. To increase in self-esteem of women can only reduce the volume of service receiver along with upliftment of moral and ethical values of service providers from the beginning of their medical training can prevent it to happen.

Primary author: KHEMKA AGRAWAL, Dr Sanjana (Cgmci/7500)

Contribution ID: **29** Type: **Lecture**

Introduction to the Workshop

Friday, 13 September 2019 09:00 (15 minutes)

Presenter: Dr LAL, Hasmukh

Session Classification: Workshop

Contribution ID: **30** Type: **Lecture**

Assessing & Managing Fetal Growth: An ultrasound approach

Friday, 13 September 2019 09:15 (45 minutes)

Presenter: Dr KHURANA, Ashok

Session Classification: Workshop

Contribution ID: **31** Type: **Lecture**

Surveillance & Delivery of Twin Pregnancies

Friday, 13 September 2019 10:00 (45 minutes)

Presenter: Dr RATHA, Chinmayee

Session Classification: Workshop

Contribution ID: **32** Type: **Lecture**

Clinical Evaluation of the Placenta

Friday, 13 September 2019 11:15 (45 minutes)

Presenter: Dr KHURANA, Ashok

Session Classification: Workshop

Contribution ID: **33** Type: **Lecture**

Decreased Fetal Movements in the Third Trimester

Friday, 13 September 2019 12:00 (45 minutes)

Presenter: Dr RATHA, Chinmayee

Session Classification: Workshop

Contribution ID: **34** Type: **Lecture**

Scar Thickness

Friday, 13 September 2019 12:45 (45 minutes)

Presenter: Dr KHURANA, Ashok

Session Classification: Workshop

Contribution ID: **35** Type: **Lecture**

Anomalies Management in the third trimester, Case Scenarios 1

Friday, 13 September 2019 14:30 (45 minutes)

Presenter: Dr KHURANA, Ashok

Session Classification: Workshop

Contribution ID: **36** Type: **Lecture**

Anomalies Management in the third trimester, Case Scenarios 2

Friday, 13 September 2019 15:15 (45 minutes)

Presenter: Dr RATHA, Chinmayee

Session Classification: Workshop

Contribution ID: **37** Type: **not specified**

Pelvic floor repair

Session Classification: Workshop

Contribution ID: **38** Type: **not specified**

NDVH

Session Classification: Workshop

Contribution ID: **39** Type: **not specified**

Vaginal Hysterectomy for Prolapse

Session Classification: Workshop

Contribution ID: **40** Type: **not specified**

Vulval Prolapse

Session Classification: Workshop

Contribution ID: **41** Type: **not specified**

VVF

Session Classification: Workshop

Contribution ID: **42** Type: **not specified**

SUI

Session Classification: Workshop

Contribution ID: **43** Type: **not specified**

Vaginal reconstruction

Session Classification: Workshop

Contribution ID: **44** Type: **not specified**

Anatomy for pelvic surgery

Friday, 13 September 2019 15:00 (20 minutes)

Presenter: Prof. WAZE, Dr. Ajit

Session Classification: Workshop

Contribution ID: **45** Type: **Lecture**

Selection of patient for Vaginal surgery

Friday, 13 September 2019 15:25 (20 minutes)

Presenter: Prof. SINGH, Dr. Abha

Session Classification: Workshop

Contribution ID: **46** Type: **Lecture**

Energy Sources

Friday, 13 September 2019 15:45 (20 minutes)

Presenter: Prof. MAHAPATRA, Dr. P. C

Session Classification: Workshop

Contribution ID: **47** Type: **Lecture**

Complications Prevention & Management

Friday, 13 September 2019 16:05 (20 minutes)

Presenter: Dr NAGAR, Oby

Session Classification: Workshop

Contribution ID: **48** Type: **Lecture**

HPV testing – Which test, when, interpretation of results

Saturday, 14 September 2019 09:00 (17 minutes)

Presenter: Dr MAHESHWARI, Amita

Session Classification: Lecture Session

Contribution ID: **49** Type: **not specified**

Video- Lap management of Ovarian Cysts

Saturday, 14 September 2019 09:20 (13 minutes)

Presenter: Dr MAHESHWARI, Amita

Session Classification: Lecture Session

Contribution ID: **50** Type: **Lecture**

Management of HPV Positives

Saturday, 14 September 2019 09:35 (13 minutes)

Presenter: Dr THAKUR, Pushpawati (AIIMS. Raipur, India)

Session Classification: Lecture Session

Contribution ID: **51** Type: **not specified**

Cervical cancer in Pregnancy

Saturday, 14 September 2019 09:50 (17 minutes)

Presenter: Dr NAYAK, Prashant kumar (Associated professor)

Session Classification: Lecture Session

Contribution ID: **52** Type: **not specified**

Panel on Preventive Oncology of Cervix including Vaccination

Saturday, 14 September 2019 10:10 (50 minutes)

Presenters: Dr TIBREWAL, Anuradha; Dr MOHTA, Arpan Chatur; JAIN, Asha (SriMaa Sarada Arogyadham Hospital); Dr NAYAK, Bhagyalaxmi; Dr MASIH, Phebe; Dr THAKUR, Pushpa; Dr SINHA, Sangeeta; Dr SAHU, Sarika; Dr RAJBHAR, Sarita; Dr JAIN, Shalini; Dr PUROHIT, Sushma

Session Classification: Panel Discussion

Contribution ID: **53** Type: **not specified**

HPV and Genital Cancers- All you want to know

Session Classification: Lecture Session

Contribution ID: **54** Type: **not specified**

Panel on Medico legal problems in Obst. & Gyn

Saturday, 14 September 2019 11:00 (1 hour)

Presenters: Dr DUBEY, Anil; Dr KUJUR, Avinashi; Dr KAUR, Gurpreet; Dr SHAH, Lalit; Dr PAHALAJANI, Neeraj; Dr AGRAWAL, Priti; Mrs AGRAWAL, Priya (Advocate); Dr NAGARIA, Sandhya; Dr DAS, Sanjay; Dr MAHOBIA, Swati

Session Classification: Panel Discussion

Contribution ID: **55** Type: **not specified**

Dr. Abha Singh Oration- “ The Journey of Cervical Cancer “

Saturday, 14 September 2019 12:00 (1 hour)

Presenter: Dr NAYAK, Bhagyalaxmi

Session Classification: Lecture Session

Contribution ID: **56** Type: **Lecture**

Key note – Adipocytes as a new endocrine organ

Saturday, 14 September 2019 13:00 (35 minutes)

Presenter: Prof. SINGH, Dr. Abha

Session Classification: Lecture Session

Contribution ID: **57** Type: **not specified**

Case based Gynac Panel Management of Itching & Discharge of Private parts

Saturday, 14 September 2019 15:00 (35 minutes)

Presenters: Dr CHOUDHARY, Anjana; Dr AGRAWAL, Geeta; Dr LAGOO, Jyoti; Dr GUPTA, Jyotsna Gandhi; Dr MANDAL, Nivedita; Dr PARAKH, Padma; Dr PARIDA, R; Dr VATS, Rashmi; Dr JOGI, Sangeeta; Dr GOENKA, Shreya; Dr SAHU, Tribhuwan

Session Classification: Panel Discussion

Contribution ID: **58** Type: **Lecture**

Chickenpox and TORCH infections in Pregnancy

Saturday, 14 September 2019 15:35 (15 minutes)

Presenter: Dr ARMO, Meena

Session Classification: Lecture Session

Contribution ID: **59** Type: **not specified**

Vaccinations in Pregnancy

Saturday, 14 September 2019 15:50 (20 minutes)

Presenter: Dr SATHYANARAYANAN, Sripriya

Session Classification: Lecture Session

Contribution ID: **60** Type: **not specified**

H1N1 in Pregnancy

Saturday, 14 September 2019 16:10 (20 minutes)

Presenter: Dr CHAUDHARY, Gopa

Session Classification: Lecture Session

Contribution ID: **61** Type: **not specified**

Hepatitis in Pregnancy

Saturday, 14 September 2019 16:30 (15 minutes)

Presenter: Dr PANDEY, Sandeep

Session Classification: Lecture Session

Contribution ID: **62** Type: **not specified**

UTI in Pregnancy

Saturday, 14 September 2019 16:45 (15 minutes)

Presenter: Dr CHELANI, Manoj

Session Classification: Lecture Session

Contribution ID: **64** Type: **not specified**

Obstetric Analgesia

Sunday, 15 September 2019 09:00 (15 minutes)

Presenter: Dr SUNDARANI, Om Prakash

Session Classification: Lecture Session

Contribution ID: **65** Type: **not specified**

Preventing Complication in Placenta Previa

Sunday, 15 September 2019 09:15 (15 minutes)

Presenter: Dr AGRAWAL, Priti

Session Classification: Lecture Session

Contribution ID: **66** Type: **not specified**

2nd Stage of Labour Decision making – V/F/CS(Difference between DTA & malrotation)

Sunday, 15 September 2019 09:30 (15 minutes)

Presenter: Dr DALLA, Tabassum

Session Classification: Lecture Session

Contribution ID: **67** Type: **not specified**

Breech presentation

Sunday, 15 September 2019 09:45 (5 minutes)

Presenter: Dr KUJUR, Avinashi

Session Classification: Lecture Session

Contribution ID: **68** Type: **not specified**

Shoulder Dystocia

Sunday, 15 September 2019 09:50 (5 minutes)

Presenter: Dr DAHARWAL, Abha

Session Classification: Lecture Session

Contribution ID: **69** Type: **not specified**

Cord Prolapse

Sunday, 15 September 2019 09:55 (5 minutes)

Presenter: Dr NAIK, Smrity

Session Classification: Lecture Session

Contribution ID: **70** Type: **not specified**

Inversion uterus

Sunday, 15 September 2019 10:00 (5 minutes)

Presenter: Dr GUPTA, Ruchi Kishor

Session Classification: Lecture Session

Contribution ID: **71** Type: **not specified**

Retained placenta

Sunday, 15 September 2019 10:05 (5 minutes)

Presenter: Dr EKKA, Suma

Session Classification: Lecture Session

Contribution ID: **72** Type: **not specified**

Panel- Case Discussion Situations Case as per Discretion Of Moderetor

Sunday, 15 September 2019 10:15 (45 minutes)

Presenters: Dr CHANDRASEKHAR; Dr RAMANI, Chetna; Dr BABBAR, Kavita; Dr JAIN, Meena; Dr AGRAWAL, Monika; Dr MAHAPATRA, Mrutyunjaya; Dr MADHARIYA, Nalini; Dr AGRAWAL, Neerja; Dr PANDEY, Shanti; Dr SINHA, Snehil; Dr AGRAWAL, Sunita

Session Classification: Panel Discussion

Contribution ID: **74** Type: **not specified**

Joyful Life after medical care of AUB

Sunday, 15 September 2019 12:00 (1 hour)

Presenter: Dr KANNAN, Jayam

Session Classification: Lecture Session

Contribution ID: **75** Type: **not specified**

Pre-term Labour

Sunday, 15 September 2019 15:00 (10 minutes)

Presenter: Dr PATHAK, Monika

Session Classification: Lecture Session

Contribution ID: **76** Type: **not specified**

Repeated Pregnancy Loss

Sunday, 15 September 2019 15:10 (15 minutes)

Presenter: Dr MAISKAR, Vinaya

Session Classification: Lecture Session

Contribution ID: **77** Type: **not specified**

Mental Health of Women

Sunday, 15 September 2019 15:25 (15 minutes)

Presenter: Dr D'SOUZA, Aparajita

Session Classification: Lecture Session

Contribution ID: **78** Type: **not specified**

Intra Pratum Fetal Surveillance

Sunday, 15 September 2019 15:40 (15 minutes)

Presenter: Dr YUEL, Veronica

Session Classification: Lecture Session

Contribution ID: **81** Type: **Lecture**

Imperforate hymen, Vaginal, Cervical agenesis/Septum

Saturday, 14 September 2019 15:00 (17 minutes)

Presenter: Prof. AGRAWAL, sarita (AIIMS Raipur)

Session Classification: Video Session

Contribution ID: **82** Type: **not specified**

Septate uterus- management by hysteroscopy

Saturday, 14 September 2019 15:20 (17 minutes)

Presenter: Dr SINGH, Vinita (AIIMS, Raipur, India)

Session Classification: Video Session

Contribution ID: **83** Type: **not specified**

Mayer Rokitanski Kuster Hausar syndrome

Saturday, 14 September 2019 15:40 (17 minutes)

Presenter: Dr KANOI, Sunita (CGMC- 3439/2011)

Session Classification: Video Session

Contribution ID: **84** Type: **not specified**

Bartholin abscess

Saturday, 14 September 2019 16:00 (17 minutes)

Presenter: Dr JAISWAL, Jyoti

Session Classification: Video Session

Contribution ID: **85** Type: **not specified**

Management of Leukoplakia

Saturday, 14 September 2019 16:20 (17 minutes)

Presenter: Dr MISHRA, Nalini

Session Classification: Video Session

Contribution ID: **86** Type: **not specified**

Vulval Biopsy & Simple Vulvectomy

Saturday, 14 September 2019 16:40 (17 minutes)

Presenter: Dr ROY, Mou

Session Classification: Video Session

Contribution ID: **87** Type: **not specified**

Vaginal Hysterectomy / NDVH: 1

Sunday, 15 September 2019 09:00 (10 minutes)

Presenter: Dr SAO, Rajni

Session Classification: Video Session

Contribution ID: **88** Type: **not specified**

Vaginal Hysterectomy / NDVH: 2

Sunday, 15 September 2019 09:10 (15 minutes)

Presenter: Dr SIRMOUR, Namrata

Session Classification: Video Session

Contribution ID: **89** Type: **not specified**

Vaginal Hysterectomy / NDVH: 3

Sunday, 15 September 2019 09:25 (15 minutes)

Presenter: Dr JAIN, Sapna

Session Classification: Video Session

Contribution ID: **90** Type: **not specified**

Vaginal Hysterectomy / NDVH: 4

Sunday, 15 September 2019 09:40 (15 minutes)

Presenter: Dr TIDME, Ajit

Session Classification: Video Session

Contribution ID: **91** Type: **not specified**

Take back control with TTCRF

Sunday, 15 September 2019 10:00 (15 minutes)

Presenter: Dr KADHI, Pooja

Session Classification: Video Session

Contribution ID: **92** Type: **not specified**

PRP and fillers in aesthetic and functional Urogynaecology

Sunday, 15 September 2019 10:15 (20 minutes)

Presenter: Dr GOSWAMI, Sebanti

Session Classification: Video Session

Contribution ID: **93** Type: **not specified**

Lasers in GSM

Sunday, 15 September 2019 10:35 (20 minutes)

Presenter: Dr BATTINA, Surakshith

Session Classification: Video Session

Contribution ID: **94** Type: **not specified**

Surgical Procedures in aesthetic and functional Gynaecology

Sunday, 15 September 2019 10:55 (30 minutes)

Presenter: Dr AJMERA, Sejal

Session Classification: Video Session

Contribution ID: **96** Type: **not specified**

Vault Prolapse

Presenter: Dr SHARMA, Pratibha

Session Classification: Video Session

Contribution ID: **98** Type: **not specified**

TOT

Sunday, 15 September 2019 15:30 (15 minutes)

Presenter: Dr TIDME, Ajit

Session Classification: Video Session

Contribution ID: **100** Type: **not specified**

SUI

Saturday, 14 September 2019 09:00 (20 minutes)

Presenter: Dr BAGDE, Nilaj

Session Classification: Video Session

Contribution ID: **101** Type: **not specified**

VVF

Saturday, 14 September 2019 09:20 (20 minutes)

Presenter: Dr BISWAL, Deepak

Session Classification: Video Session

Contribution ID: **102** Type: **not specified**

Perineal Repair

Saturday, 14 September 2019 09:40 (20 minutes)

Presenter: Dr RAM, Uma

Session Classification: Video Session

Contribution ID: **103** Type: **not specified**

Urogynecology relevant to Gynecologists

Saturday, 14 September 2019 10:00 (20 minutes)

Presenter: Dr SHAH, Lalit

Session Classification: Video Session

Contribution ID: **104** Type: **not specified**

Open House

Friday, 13 September 2019 16:00 (1 hour)

Chairperson: Dr. Lalita Rao

Session Classification: Workshop

Contribution ID: **105** Type: **not specified**

Medico legal Panel – Mandatory Govt.Compliances for Practice as a Doctor

Sunday, 15 September 2019 11:00 (1 hour)

Presenters: Dr GUPTA, Alka; Dr JAIN, Anil; Mr DEWANGAN (Zone Commissioner, Nagar Nigam Raipur); SAHU, E.E. M.K. (Electrical Seftey Officer); FIRE SAFETY, Expert for; Dr SINHA, Mahesh; Dr GAWRI, Palak; Dr SHARMA, Rajesh; Dr GUPTA, Rakesh; Mr DUBEY, Vipin (Expert - Rain Water Harvesting)

Session Classification: Panel Discussion

Contribution ID: **107** Type: **not specified**

Live Operative Session

Friday, 13 September 2019 08:00 (5h 30m)

Cases* :
Pelvic floor repair
NDVH
Vaginal Hysterectomy for Prolapse
Vulval Prolapse
VVF
SUI
Vaginal reconstruction

- Depends on availability of patients at Pt. JNM Medical College at the day of workshop

Presenters: Prof. SINGH, Dr. Abha; Prof. WAZE, Dr. Ajit; Prof. MAHAPATRA, Dr. P. C; Dr GIRI, Sushil

Session Classification: Workshop

Contribution ID: **108** Type: **Lecture**

Key Note -PCOS new Perspectives

Friday, 13 September 2019 17:00 (30 minutes)

Presenter: Prof. MAHAPATRA, Dr. P. C

Contribution ID: **109** Type: **Video Session**

Coring of Large Size Uterus

Saturday, 14 September 2019 13:40 (20 minutes)

Presenter: Dr NAGAR, Oby

Session Classification: Video Session

Contribution ID: **110** Type: **not specified**

Community Banking: A new approach to Stem Cell Banking

Saturday, 14 September 2019 13:35 (25 minutes)

Presenter: Dr VUPPU, Deepak

Session Classification: Lecture Session

Contribution ID: **111** Type: **Video Session**

Sling Surgeries

Sunday, 15 September 2019 15:00 (30 minutes)

Presenter: Dr PATNAIK, H.P.

Session Classification: Video Session

Contribution ID: **112** Type: **not specified**

Handling Mob Violence

Sunday, 15 September 2019 15:45 (15 minutes)

Presenter: Dr SURESH KUMAR, A

Contribution ID: **113** Type: **not specified**

Case Study of Erbium Lasers

Sunday, 15 September 2019 11:25 (30 minutes)

Presenter: Dr PANCHOLIA, Vidya

Session Classification: Video Session