ERODE OBSTETRICS AND GYNECOLOGICAL SOCIETY

BULLETIN MARCH - 2021

International Women's Day

"Cancer Cx Screening & Awareness Programs"

Dr. Nancy Thanu
President

Dr. Purnimaa Saravanan
Secretary

Dr. Vani Madhavan
Finance Secretary

Covid Warrior - Dr. Premakumari

Covid Warrior - Dr. Sri Devi & Team

Dr. Nithya - OG Topper

Culturals

Mom & Daughter

EOGS Doctors Group

Secretaries' Pride

Womens Day

ERODE OBSTETRICS AND GYNECOLOGICAL SOCIETY

Affiliated to FOGSI - Since 1986 | erodeogsociety.com | TN Societies Registration SI No 144/2018

Dear Colleagues ,

You are Cordially invited for the EOGS monthly CME Meeting (Physical)

DATE	TIME
27.03.2021, Saturday	6 to 8 pm

Venue

IMA Hall, Sampath Nagar, Erode.

TOPIC	SPEAKER
'Labour Analgesia' Breaking The Barriers	**Dr. Sekar Michael**, M.D., DNB Prof. of Anaesthesiology, HOD of Pain Medicine Sri Ramakrishna Speciality Hospital, Coimbatore.
Chronic Pelvic Pain in Women	**Dr. GP Kirupakaran** M.D Consultant Anaesthesiologist & Chronic - Pain Specialist Salem Pain and Palliative Care Clinic
Interesting Case Presentation	**Dr. Usha Sahadevan**, M.D., DGO., Fetal Medicine Specialist, Lotus Hospital, Erode

Followed by Dinner

Dr. Nancy Thanu	Dr. Purnimaa Saravanan	Dr. Vani Madhavan
President	Secretary	Finance Secretary

President's Message

Advance New year wishes for both Tamil& Telugu New years.

One long year since the cruel outbreak of Corona. We were much thrilled to see our friends during International Women's Day celebrations @ IMA hall after a very long Gap .

Women's Day events occupied the whole week starting from the submission of FOGSI Advocacy to JDHS, DDHS & District Collectorate . Our cultural program was a big success& entertaining. Participants from all walks of life from 3 years to >75 years absorbed the audience with their colourful performances. You can browse the photos in our website soon. Cancer screening& awareness programmes conducted in various places- IMA hall, Vellalar College for women, Nursing Homes of our EOGeans in and around Erode. Thanks to our Secretary Dr.Purnimaa for making all the events successful and beneficial to the community.

March is observed as the month of Endometriosis awareness, we have attended may webinars in Endometriosis . We are planning to conduct awareness programmes based on this in due course. Though physical meetings are connecting us with friends, webinars give wide spectrum of knowledge from International faculties. Last month CME on Zoom by Dr.Srikala Prasad was well attended with useful tips by Madam and Dr. Praveen , Urologist . Our first physical CME is on 27th March and expecting you all to come & grace the event with your presence.

Dr.Anuradha Manoharan's inspiring photos made us to arrange for a WALKATHON on 21st @ Dr.Tamilselvi's Farm near Pallipalayam. We sincerely thank Dr.Tamil & Dr.Masilamani for sponsoring the outing with sumptuous breakfast followed by Reflexology Therapy. It has initiated the plan to have 3rd week WALKATHON at various venues in future. I am so honoured to be the President of an enthusiastic society with members as Clinicians, Academicians, participants in Social Welfare activities and also in Sports& Cultural events, etc. So proud of you dear friends. Keep this spirit always to uplift our society .

Advance Birthday wishes to all April Birds. Convey our wedding day wishes to your spouse those having wedding days in April.

என்றென்றும் அன்புடன்

Dr. Nancy Thanu MBBS., DGO.,

President - EOGS

Rathnam Maternity Clinic

3-A, Kovalan St., Teachers' Colony, Erode - 11.

Secretary's Message

It Gives me immense pleasure in Writing this message as a Secretary of EOGS .

Happy and delighted to be a part of EOGS

Our First CME was a Great Hit with a Evergreen Topic with an Enthusiastic Prof . Dr. Srikala Prasad and our Young Urologist Dr.Praveen

Immeditely after taking Over as a New team we were given a huge responsibility to show our Unity for a Nation wide Relay Hunger Strike Organized by IMA Against MIXOPATHY

We Sincerely Thank all Our EOGS Members for a Overwhelming Response to show our Unity for a Noble cause , Heartfelt Thanks to Rajalakshmi Madam who stayed the whole day

EOGS Celebrated Womens Day in a Grand Way

1. Womens Day Celebration and Meeting on March 7 at IMA Hall
2. *Award ceremony

As a token of honouring the empowered talented successful women of the society,we are honouring three eminent persons in our medical field

1) Dr.Premakumari CCS&HOD of OG dept of Erode Govt HQ hospital. She has been awarded for her selfless services rendered by her during Corona pandamic.
2) Dr.Sridevi,HOD OG dept,Govt Erode Medical college IRT -PMCH perundurai has been awarded for her selfless services rendered by the Whole team And Conducted more than 350 Covid positive deliveries during Corona pandamic.
3) We Honoured Dr Nithya from PMCH for securing highest marks in OG and stood as class topper.

We Conducted FOGSI SCREENING CAMP in IMA HALL and screened Several Women for CA Breast and CACervix.

On March 8 / Womens Day

We gave Awareness talk to our Vellalar college Staff s and Students

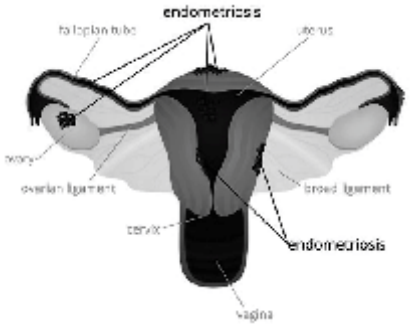
In all private hospitals And Govt Hospitals Conducted Free Screening Camp Conducted FOGSI Screening camp for the College Staffs for CA Breast and CACervix . All the list of Screened Patients have been attached through Google Sheet

On MArch 6 , Submitted the Advocacy to our Local Authorities

The District Collector / TheJoint Director of Health Services / The Deputy Director of Health Services . It Was very much Welcomed and showed their support for this Noble cause

Dr. Purnimaa Saravanan MD(OG)., F.MAS., F.ART
Abirami Kidney Care Dr. Thangavelu Hospital
No. 581, 582, Perundurai Road,
Near Ravi Theater, Erode - 638 011.

Endometriosis – What is new?



Endometriosis is a benign yet progressive disease of women. It rarely kills but can cause crippling pain and Childlessness.

March is observed as "Endometriosis Awareness Month"

Women have knowledge about Polycystic Ovaries as நீர்க்கட்டி. But even educated women dint have any knowledge about Endometriosis. Many celebrities like Marlin Manroe, Katrina Kaif , etc suffered from this silent killer disease. The morbidity & sufferings by women due to this dreadful disease is unmatchable .

The pattern in the diagnosis and management has attained a new shape due to the continuous research & management . Societies like SUED (Society of Endometriosis& Uterine Disorders); ESI (Endometriosis Society of India) with dedicated members making Awareness programs, Camps & CMEs to get a quality life for an Endometriosis affected women.

The major sequlae of Endometriosis are AUB, Pelvic pain & Infertility. Most of the women accept the pelvic pain as a normal phenomena and avoid/ postpone treatment. They land up for treatment very late and come for Infertility treatment. Previously Endometriosis is considered as the disease of the child bearing age group. But we are seeing pts in both extremes, in peri-pubertal as well as post menopausal age groups.

Endometriosis & adenomyosis go hand in hand in many pts.

Adenomyosis is a benign invasion of Endometrium into Myometrium causing myohyperplasia of uterine enlargement. It may be focal or diffuse. It is affecting the Junctional Zone which is 4-5 mm in normal women. In Adenomyosis it exceeds more than 10-12mm and easily diagnosed by USG.

The initial phase of adenomyosis can be diagnosed by 3-D USG. When all young women with dysmenorrhea & pelvic pain are screened by this 3-D USG, even the focal adenomyosis can be picked-up very early and treated medically thereby surgery can be avoided.

Gone are the days , that when Endometriosis is diagnosed, Surgery was the major option. As many of the pts are coming for Infertiliy treatment, our main aim is to conserve the uterus , preserve fertility to give Live birth.Adenomyosis has lower risk of successful Implantation; increased risk of pregnancy loss & reduction in live birth rate. This increase in Junctional Zone distorts the uterus and interfere with implantation.

Poor fertility outcome due to reduced receptivity at molecular level by:

- Altered endometrial steroid production & aromatase activity is increased locally;
- Altered receptor response; Increase in Macrophage &Natural killer cells locally.
- Increased production of Inflammatory mediators

All the above mechanism will affect the implanting embryo and causes miscarriages. It may cause II- trimester Abortions. In later dates it will impair the utero-placental Blood flow and leads to Small for dated babies, pre-eclampsia ,placental malpositions & Preterm labour.

Medical Management:

Both Adenomyosis& Endometriosis are with Hyper oestrogenism & progesterone resistance. Based on this various molecules are coming-up to fight the disease. Medical management has wide spectrum of drugs from Danazol ; Progesterones; GNRH Analogue; Dienogest; Aromatase Inhibitors; IUS with progestogens;

- Previously Pelvic pain was treated with NSAID & OCPs
- Danazol has lost its use because of its high Androgenic Effect
- **GnRH analogues :** They are in the field more than 30 years. GnRHa given for 6months will reduce the uterine volume & enhance fertility. Progesterone add-back is needed to prevent loss of Bone Mineral Density.
- **Dienogest:** very useful in Chronic pelvic pain, Dysmenorrhea& Dyspareunia. But less useful in menorrhagia and reducing the uterine volume.
- **Aromatase Inhibitor(Letrozole):** Reducing the volume (both adenomyosis& endometriosis)and improving the symptoms equalizing GnRHa when given for 8-12 weeks. Combined therapy of GnRHa & Letrozole reduces the adenomyosis volume to 60% when given for 8 weeks.
- **LNG-IUD(MIRENA):** Pain & menorrahgia can be treated with this. If treated with GnRHa & IUD removed after 6 months will give better pregnancy outome.
- **IUD releasing Danazol:** 400mg Danazol lasting for 6 months will reduce pain significantly with reduced androgenic effects. Danazol suppositories are under research.
- **Elagolix (GnRh Antagonist):** Very useful in Endometriosis associated Pelvi pain.Oral preparation. 150mg/day or 200 mg twice daily can be used for 24 months. Use of longer duration may suppress BMD. It is very costly and not available here.

Surgery can be reserved for Adenomyoma more than 5 cm; recurrent pregnancy loss & not responding to medical management. Surgery has its own limitations as Incomplete removal&

Recurrence, Uterine rupure during pregnancy,etc. For diffuse lesions Laparotomy is better. For focal lesions, laparoscopy can be done.

Recap:

- 3-D Ultrasound is the Gold standard in diagnosing early lesions to start medical management.
- Pain& Menorrhagia can be well treated with LNG-IUD
- Pre treatment with GnRha will improve fertility rate & Live birth rate.
- Suppress the disease with medical management and improve fertility.

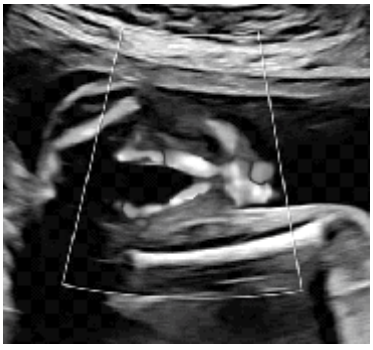
by Dr.Nancy Thanu
Excerpts from Webinars

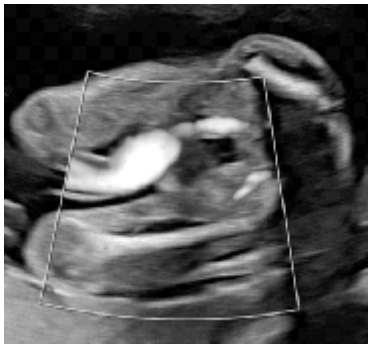
Single Umbilical Artery in Pregnancy – Significance

Dr.Madhu Preetha

The normal umbilical artery contains two artery and one vein. The umbilical arteries are routinely seen in mid-trimester scan as they skirt on either side of the bladder. Alternatively a transverse section of free loop of cord can demonstrate the finding.

Single umbilical artery is the result of atrophy or agenesis of one of the umbilical arteries. SUA is identified in mid-trimester scan as a part of anatomic survey.





INCIDENCE:

The incidence of SUA is 0.25-1% of all singleton pregnancies and upto 4.6% of twin gestation. It can be isolated or associated with other abnormalities.

Associated anomalies:

SUA is associated with other anomalies in 13-46% of fetuses. There is no specific pattern of malformation, however cardiac and renal anomalies are the most common.

Aneuploidy:

Isolated SUA does not appear to have an increased risk of aneuploidy. In fetuses with additional anomalies the risk of aneuploidy particularly Trisomy 13 and 18 is high.

Growth:

SUA has been linked to increased risk of growth restriction, stillbirth and preterm birth. This association has primarily been reported in non-isolated cases.

Outcome:

The outcome of foetuses with isolated SUA is good.

How to proceed?

A detailed anatomic survey is indicated with special attention to heart, kidneys and hands.

Invasive test like Amniocentesis is recommended in non-isolated cases.

Follow up scans to assess fetal growth is recommended.

Recurrence risk:

No increased risk of recurrence is seen in isolated cases.

பெண்

பிறந்த பொழுதிலேயே
பிறர்க்கெனவே நேர்ந்துவிடப்பட்டவள்.
பருவங்கள் மாறும்போது
பணிசெய்யும் இல்லங்கள்தான் மாறும்.

இளமையில் தாய் வீடு
இடையினில் புகுந்தவீடு
முதுமையில் மகன் வீடு
முடியாதபோது முதியோர் வீடு(விடுதி)

பாசம் தரும் பெற்றவர்கள்
இதயம் நுழைந்து பார்ப்பதில்லை
சொந்தம் கொள்ளும் துணைவர்கள்
சுதந்திரத்தைத் தருவதில்லை.

சிறகில்லாப் பறவைகளாய்
சிரிக்க மறந்த பதுமைகளாய்
மழலை தரும் மேன்மையராய்
மகிழ்ச்சி தரும் மனைவியராய்

கானல் நீரான வாழ்வில்
கற்பூரமாகிப் போனவர்கள்
.....பெண்கள்.....

“மங்கையராய்ப் பிறப்பதற்கே
மாதவம் செய்திடல் வேண்டுமம்மா”

“மாதர்தம்மை இழிவு செய்யும்
மடமையைக் கொளுத்துவோம்.”

மரு. நான்சி தாணு

PHOTO GALLERY

International Womens Day Celebrations

Dr. Kasthuribai

Dr. Chandrika

EOGEANS Family Members

Prabhu Devayinees

Chief Guest: Mrs. Barbara Lydia

PHOTO GALLERY

Advocacy submitted to JDHS, Dr.Gomathy

Advocay submitted to DDHS, Dr.Soundammal

IMA Hall

Vellalar College for Women

WALKATHON - March 2021

"Dr.Lakshmi with Ramani mam in Yuva Fogsi"

Dr.Renju with Dr.Shanthakumari ,FOGSI President Elect

Urinary Incontinence

– Dr. Srikala Prasad

Incontinence defined as involuntary leakage of urine. Estimates suggest 1/3rd of geriatric population are affected

Types

1) Stress Urinary Incontinence - involuntary leakage associated with raised intra-abdominal pressure
2) Urge Urinary Incontinence - Leakage of urine with urgency
3) Mixed Urinary Incontinence
4) Overflow Urinary Incontinence
5) Functional Urinary Incontinence
6) Transient Incontinence
7) Fistulas
8) Bedwetting

Reaching a diagnosis involves detailed history taking with relevant investigations.

Ask leading questions - Duration of leak, type of leak, amount of leak (trivial or significant), voiding pattern, urinary frequency during day and night

Obstetric and Gynaecological history adds value, especially h/o abnormal uterine bleeding or Postmenopausal bleeding.

Any Neurological Symptoms

Previous surgeries: Pelvic surgeries, previous incontinence surgery will help outline further treatment

Medication history - Urinary symptoms can be exacerbated by medicines - long-acting sedatives, loop diuretics, NSAIDS, Alpha blockers, Calcium channel blockers

Co-morbidities - Diabetes, hypertension, Dementia, previous radiotherapy

PHYSICAL EXAMINATON

General examination- Look out for any bladder mass (overflow incontinence), areas of tenderness

Genital examination-Look for urogenital atrophy, cystocoele, rectocoele, pelvic masses

Always examine the patient with full bladder

If leak present with empty bladder, points towards Intrinsic Sphincter deficiency

Rectal examination - Bulbocavernous reflex-30% have negative test in spite of normal neurological status

Examine sphincter tone

Rule out any rectal mass, impacted stool

Bladder Diary- a simple tool to ensure patient's intake/output

to be maintained for atleast 48 hrs

helps detecting precipitating factors

Scoring system - BOTHERSOME SCORE

Helps to determine the impact of leakage on patient's day to day activities

INVESTIGATIONS

1)Urine Routine and microscopy

2)Urine culture and sensitivity

3)Complete blood count

4)Renal function test

5)USG Abdomen : Important to note Postvoid residue

6)Cystoscopy : indicated in visible haematuria/microscopic haematuria
recurrent or persisting UTI suspected bladder mass

7)Urodynamics - Overactive active bladder

-Previous surgeries for SUI

-Obstructive LUTS

-Suspected neurogenic bladder

-Unclear diagnosis

TREATMENT

1)Lifestyle management

*Fluid intake - Adequate fluid intake

*Avoid dietary irritants - Caffeine, sugar substitutes, citrus fruits, tomato, spicy foods

*Bowel management- increase dietary fibre intake and avoid constipation

-Regularise bowel evacuation

*Regular exercise and weight reduction- 5 to 10% loss of weight can reduce incontinence episodes by 70%

*Reduce smoking

*Optimise medical issues like DM,HT,COPD

2) PELVIC FLOOR MUSCLE TRAINING

-1st line treatment for stress and mixed incontinence

-ideal for 3 months

3) Bladder training

MEDICAL MANAGEMENT

1)SSRI- Duloxetine 40 mg twice daily

2)Intramural debulking agents - retrograde injection, done cystoscopically

Agents include glutaraldehyde crossed linked collagen, silicon etc.,

Costly, may require repeated procedures, less effective than sling surgeries

SURGICAL MANAGEMENT

1)Midurethral Sling : retropubic or transobturator

2)Autologus rectus fascial slings : indicated for ISD or urethral hypermobility

3)Open Burch Colposuspension

4)TVT or TOT

MIXED INCONTINENCE

If Stress> Urge- treat surgically

If Urge> Stress - medical management

Along with Weight reduction, PFMT

Overflow Incontinence

- Look for treatable causes like Procidentia

Associated with Hypotonic bladder/Neurogenic bladder/Diabetes Mellitus

Treatment- Clean Intermittent Catherterisation

Indwelling catheter

Urge Incontinence

- Associated with increased frequency, nocturia, reduced volume per void Management

*PFMT

* Anticholinergics- oxybutynin, tolderodine, solifenacin, mirabegron

*Botulinum toxin

Gist of the presentation by Dr. B. Praveen Sundar

Take Home points

Elicit a focused history, followed by clinical Examination which should include a detailed pelvic exam with special tests when needed (Stress test, Stamey's Test, Q-Tip test and Pad test)

UTI/Genito Urinary TB must be ruled out, in patients with dysuria, fever, chills associated with incontinence

Do specific investigations like Cystoscopy, MRI, CT, Urodynamic Study when clinically indicated

Urodynamic Study can be of great help when diagnosis is in question

Always try to get a Urolog (Bladder Diary) filled by the patient, it gets us closer to the diagnosis

Never suggest surgery for Urge incontinence, conservative management is almost always successful

Weight loss and behavioural therapy (Pelvic Floor Muscle Training) greatly helps in managing non-severe SUIs

For SUI, Trans-Obturator Tape is a very safe and effective procedure. Chances of bleed, urinary tract injury are less

Post tape incontinence is difficult to manage, needs careful evaluation

Patient presenting with Recurrent UTI and dyspareunia post tape procedures, think of mesh extrusion into urethra, bladder or vagina

GUIDELINES FOR BLOOD TRANSFUSION

GUIDELINES

- Blood transfusion is a major procedure akin to surgery.
- Major share of blood usage is in Obstetric department.
- Special guidelines issued for rational use of Blood and blood components for Obstetrics.
- General guidelines for other departments.
- **GENERAL GUIDELINES**
- Transfusion is only a part of pt's management, it is not the sole management.
- Prescription based on Individual pt need.
- Blood loss should be managed to reduce the need of blood transfusion.
- Effective resuscitative/supportive management should be started while the need for transfusion is being assessed.
- Pt's Hb value alone should not be the deciding factor for transfusion.
- Clinical assessment to prevent morbidity& mortality is important.
- Risk of transfusion-transmissible infections should be kept in mind.
- Benefit to the pt are likely to outweigh risk.
- Reason for Transfusion should be recorded properly by the clinician.
- Adverse effects to be monitored by trained persons.
- Decision for Transfusion should be judicious.
- Minimum 3ml of blood sample required for grouping and cross matching (clotted/EDTA).
- Fresh sample is required after every three days from last Transfusion.
- Fresh sample is required if previous sample consumed for multiple unit cross-matching.
- Inspect Blood Bag before starting Transfusion.
- Never start blood in pre-existing IV line.
- No drugs should be given in the blood-line.
- No need to give routine Diuretics& Steroids.
- They can be given in associated conditions like failure or in Minor Transfusion Reactions.
- 1 amp(10ml) of Inj.Calcium Gluconate given for every 4 units of blood transfused.
- Do not warm blood prior to transfusion, except in exchange & massive transfusion (more than 6 units of blood)
- Warmed blood needed in:
- Large volume rapid transfusions-

  Adults >than 50ml/kg/hour

  Children > 15ml/kg/hour

- Transfusions to neonates
- Exchange transfusion in Infants
- Patients with clinically significant cold agglutinins

NOT TO WARM BY

- By placing it in a microwave
- On a heat source
- In hot water .
- SHOULD be warmed in BLOOD WARMER.
- They will have visible thermometer and an audible warning alarm.

GENERAL GUIDELINES

- Only one unit of blood should be released from blood bank at a time.(emergencies exempted)
- To minimize error vein-to vein identity should be maintained.(one person for one pt).
- No entity as 'Fresh Blood'; in exchange transfusion the freshest blood should not be more than 5 days.
- Blood should be indented as 'UNITS' , not as pints or bottles or bags.
- Blood taken out of Blood bank should never be returned if cold chain is breached.
- Reassess the need for single unit transfusions.
- Rpt platelet count after one hour & Hb after 48 hours of transfusion.
- Between two elective transfusions, there should be a gap of at least 48 hours.

Obs HEMORRHAGE CARE GUIDELINE

STAGE O	**Women in labour/risk assessed**	**Type & Crossmatch 2 units**
STAGE I	**Blood loss >500ml vaginal >1000ml CS HR>110 or BP 85/45 SPO2<95%**	**Active Heemorrhage Protocol; initiate preparations; Uterotonics**
STAGE II Focussed on medications& Procedures; mobilise help; blood bank support; keep sufficient blood and blood products.	**Continued Bleeding with total loss 1500ml**	**Notify blood bank; Bring 2 units of PRBC ,start transfusion FFP to be thawed. Determine availability for futher transfusion.**
STAGE III Focussed on massive transfusion protocol; Invasive surgical procedure	**Total loss >1500ml/ 2 units PRBC given/ vitals unstable/suspicion of DIC**	**Transfuse aggressively; massive trasfusion pack: near 1:1 PRBC and FFP 1 platelet for 6 units of PRBC After 10 units of PRBC and full coagulation replacement, consider rFactor VII**

TIME LIMITS FOR INFUSION

	Start Infusion	Complete Infusion
Whole blood/red cells	Within 30 mts ,removed from refrigerator	Within 4 hours(or less in high ambient temp)
Platelet concentrate	Immediately	Within 20 mts
Fresh frozen Plasma	Within 30 mts	Within 20 mts

MANAGEMENT OF TRANSFUSION REACTIONS

Mild:

- Stop the Transfusion; Maintain IV access
- Monitor the pt with Vitals
- Repeat clerical check of pt and blood pack
- Call medical staff for management
- Fever even <1.5 degree C will be considered moderate reaction-same bag should not be used.
- Even with mild reaction –same bag should not be used, return it to blood bank.

MODERATE REACTIONS

- Stop the transfusion Immediately
- Seek urgent Medical help
- Medical emergency Team(MET) support may be needed according to the situation.
- Maintain Venous access with 0.9% NS
- Repeat all clerical idendity of pt and pack.
- Inform the transfusion service provider(blood bank)
- Monitor the vitals
- Look for Haemoglobinuria
- Return the bag without contamination.
- Further Transfusion after getting consent from the Service Provider(Blood Bank M.O.)

MANAGEMENT OF DIC

- Treat the cause
- Give Uterine Stimulants to promote contraction
- Use Blood products to control hge
- (In many cases DIC prevented if blood volume maintained with RL)
- If needed for O2 perfusion give the freshest whole blood available or packed cells.
- Avoid Cryoprecipitate and platelet concentrate unless bleeding is uncontrollable.
- If blood components not available freshest whole blood to be given.

Dr. Nancy Thanu
Former Blood Bank MO, Erode GH.

Birthday & Wedding Days of April 2021

- 2nd April Dr.Veena Madhankumar
- 3rd April Dr.Geeta Raj
- 10th April Dr. N. Poongothai Palanisamy
- 11th April Dr.Dhanabagyam
- 11th April Dr.Rajeswari, Tiruchengode
- 18th April Dr.V. Meenakshi
- 20th April Dr.R.Malliga, Kangeyam
- 24th April Dr.Sucharitha ravindran
- 25th April Dr.Sivakumari, Gobi
- 27th April Dr.Sindhu Subramaniam
- 28th April Dr.Kasthuri Bai

Associate Members B'Day

3rd April Dr.Balasundaram, KG Hospital

21st April Dr. Ezhilventhan

Wedding days

6th April Dr.Jyothi Natarajan

8th April Dr.Nancy Thanu Ezhilventhan

9th April Dr.C.Kavitha Chandrasekar

10th April Dr.Sangeetha Karthikeyan

23rd April Dr.Shyamala Ramachandran

Editorial

Dear Friends,

Greetings. First of all I Want to thank Dr. Vanithasri for giving a nice article for march bulletin. Though we can browse internet for any topic, our personal experiences in the form of article will be useful to our friends. From this month onwards we have started a regional page for Tamil. Kindly send poems, writings or health Tips in Tamil for One Page.

Editor
Dr. Nancy Thanu
Mobile: 94430 22764, 90801 30756
Email:dhanuezhil@gmail.com

Associate Editor
Dr. Vanithasri
Mob: 9486709205

Dance Group Honoured

Womens Day Meeting

Cultural Participants with Parents

Prize Distribution by Dr. S.S. Sukumar, Past President, IMA-TNSB

Cancer Awareness Programme @ Vellalar College for Women

CRYOVIVA BIOTECH PRIVATE LIMITED

(FORMERLY KNOWN AS CRYOBANK INTERNATIONAL)

Premier Cord Blood Bank

Cryoviva Biotech Private Limited Founded in 2006 by RJ Corp. The company is focused on providing high-quality umbilical cord blood stem cell processing and storage for both private and Social banking. The company is committed to provide quality services in terms of providing high end processing and storage technology which are approved by International authorities.

WHY CRYOVIVA?

- Cryoviva is an indian's **only multinational cord blood bank**. We are operated more than 15 Countries. More than 5LAKH (Globally) parents choosing Cryoviva to stored their Baby stemcell.
- High trusted Financial Background- **RJ CORP**.
- Pan India tie-up with **CloudNine** and **Rainbow Hospital.**
- Cryoviva used to process a cord blood with fully automated **SEPAX Technology**. Sepax have highest quality standards such as **US FDA, AABB & FACT – Netcord.**
- Cryoviva stored baby's precious **umbilical cord blood** and **cord tissue stemcells.** Cord blood has a rich source of hematopoietic stem cell and cord tissue have rich source of mesenchymal stem cells.
- Cryoviva give a storage benefit of **99 years**.

CRYOVIVA – CLIENT BENEFIT PROGRAM "UNMATCHED BENEFITS"

- **20 LAKHS Financial Assistance (Cryo Specimen Assurance program) :** For the child , biological parent , biological sibling during the first 21 years to provide stemcell transplant expenses .
- **20 LAKHS Quality Guarantee :** Under cell safety program, if the store CBU are not viable for transplant due to any reason.
- **20 LAKHS Disaster Relief :** Provided at the time of retrieval, If the stem cells are lost/damaged due to natural calamities .
- **Free World Wide Shipment :** The stem cells are shipped to any part of the world if required for transplant without any cost to client.
- **Free Stem Cell Expansion:** Free expansion of stem cells to be provided if required for transplant (subject to ICMR guidelines).
- **Free HLA Typing of CBU:** At the time of storage & retrieval for the child and immediate family members.
- **Transplant Related Test:** Sample testing for transplant at no additional cost at the time of retrieval.
- **Highest Accreditations :** National and international Accreditations.

CRYOVIVA BIOTECH PRIVATE LIMITED,

43, Vamalai Street, 3rd Floor, Erode Fetal Medicine Centre Upstairs,
Brough Rd, Erode, 638001.

Mob: 9944458894, 8870188708, 8870388705, 8870288704, 8870988704.