



EOGS BULLETIN

JUNE 2019



Let us make Abortion safe and accessible



Dr Nandita Palshetkar,
FOGSI President



ERODE OBSTETRIC AND GYNAECOLOGICAL SOCIETY

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Office Bearers 2019 - 20



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Message from the President & Secretary

Dear Colleague,

Warm greetings...

Last CME was well attended and we thank you for your appreciations.

As suggested by many of you we will plan such programs in future also.

Arrangements for our trip to Vizag are being planned. We thank the members for enrolling in good numbers. With all your participation we are sure it will be a memorable trip.

Let us all maintain the records as suggested by our DD family welfare.

With warm regards...



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POST PARTUM HEMORRHAGE

Post partum hemorrhage is the most common type of obstetric hemorrhage and the world's leading cause of maternal mortality causing 24% maternal death annually.

Definition:

Clinically PPH can be defined as any amount of blood loss that results in hemodynamic instability.

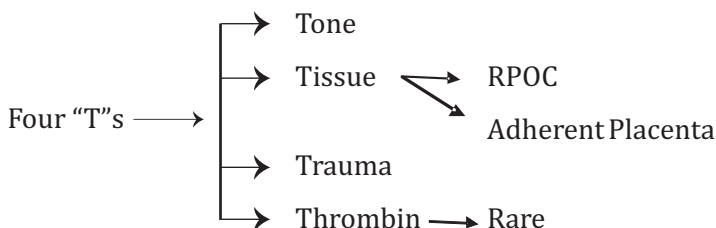
PPH defined as bleeding from the genital tract more than 500 ml in normal and more than 1000 ml in LSCS within 24 hrs of delivery.

Types:

Primary – This occurs within 24 hrs of delivery

Secondary – Hemorrhage occurs between 24 hrs to 42 days of post partum.

Causes:



Common cause is atony. Primary PPH occurs unpredictably in women who have no apparent risk factor.

Risk factors for atony:

Multiple pregnancy, fetal macrosomia, previous PPH, prolonged labour, general anesthesia, APH, anemia, BMI>35, Uterine abnormalities / fibroid.

Initial evaluation of PPH:

Atony is the common cause. To confirm the atonicity bladder should be emptied and a bimanual pelvic exam should be done. The uterus will be soft and feels boggy. Compression and massage of the uterus can reduce the bleeding.

In spite of these measures if bleeding persists other causes of PPH should be considered. The placenta should be inspected again for missing bits.

Uterine cavity should be carefully assessed to rule out retained placental bits (or) membranes and blood clots. Then the cervix and vagina should be visualized properly with the help of folded gauze in a sponge holding forceps to push up the cervix. Vaginal wall should be carefully inspected all the way up to the fornices.

Prevention of PPH:

- Proper AN check up to correct anemia.
- In labour AMTSL – Active management of third stage of labour include administration of oxytocin 5 units or 10 units following delivery of the baby, delayed cord clamping and delivery of the placenta by controlled cord traction followed by uterine massage.

Management:

- Call for help.
- Initiate steps of resuscitation immediately.
- Minor PPH – Blood loss of 500 – 1000 ml.
- Major PPH – Blood loss > 1000 ml with clinical signs of shock.

Minor PPH:

- IV line with a large bore cannula (16 – 18G) IVF NS (or) RL.
- Take 20 ml of blood for group and screen CBC, X match 2 units of blood.

- Coagulation screen including fibrinogen.
- PR, BP, RR, every 15 minutes.
- Stimulate the myometrial contraction with pharmacological and mechanical methods.
- Uterotonic oxytocin 40 IU in 500 ml crystalloid (NS (or) RL) 120 ml/hr unless fluid restriction is necessary.
- Methyl ergometrine 2 mg IV except in PIH and cardiac patient.
- Foley catheter application and monitor output.
- Uterine massage and bimanual compression.

Management:

If bleeding persists carboprost 25 mg repeated at the interval of 15 minutes maximum of eight doses.

Misoprostol 800 microgram rectally. Both should be avoided in asthmatic.

Major PPH:

- Blood loss > 1000 ml and ongoing hemorrhage (or) clinical shock.
- Start IV line with 14 G cannula – two line and draw 20 ml of blood for CBC, LFT, RFT, X match 4 units of blood.
- Coagulation profile including fibrinogen.
- Continuous monitoring of BP, PR, SPO2, RR, Urine output and temperature.
- Foleys catheter.
- Nasal oxygen 10 – 15 liter / min.

The cornerstones of resuscitation during PPH are restoration of both blood volume and oxygen carrying capacity.

The main therapeutic goals of the management of massive blood loss is maintaining

- HB > 8 gms
- Platelet count > 75000 / L
- Prothrombin time < 1.5 times normal
- APTT > 1.5 times normal

- Fibrinogen > 1 g / L

Fluid replacement:

Fluid replacement is a crucial component of PPH treatment although a dilutional coagulopathy may occur when large volumes of crystalloid, colloid (or) RBC used with insufficient transfusion of FFP and platelets.

Crystalloid	-	up to 2 liter isotonic crystalloid
Colloid	-	up to 1.5 l colloid until blood arrives
Blood	-	Initially transfuse 4 units of specific group

- If hemorrhage continues after 4 units, then check APTT, PT, fibrinogen levels. If PT (or) APTT are prolonged administer 12 – 15 ml / kg of FFP.
- If the haemostatic tests are unavailable then administer 4 units of FFP.

Platelet – Administer one platelet if bleeding is ongoing and platelet count less than 75000 / L

Cryoprecipitate:

Administer 2 pack of cryoprecipitate if bleeding is ongoing and fibrinogen is less than 1 g / L

Coagulopathies may evolve rapidly and repeated testing of APTT, PT, fibrinogen and platelet every 30 minutes during continued bleeding and observation of trends are more useful than single measurements.

Transfusion of FFP

The drawbacks of early FFP are that the majority of women with PPH will have normal coagulation at the time of administration and that it is associated with an increased risk of transfusion associated circulatory overload (TACO) and transfusion related acute lung injury.

- If no haemostatic tests are available early FFP should be considered for conditions with suspected coagulopathy such as placental abruption (or) amniotic fluid embolism (or) where

detection of PPH has been delayed.

- If the PPH is stopped and the PT / APTT is normal —> no FFP is required
- If the results of APTT / PT / fibrinogen level are not available and hemorrhage is continuing then after 4 units of RBC have been transfused, FFP should be infused at a dose of 12 – 15 ml / kg and 6 : 4 RBC : FFP transfusion maintained until tests available.

The routine use of rFVIIa is not recommended in the management of major PPH unless as part of a clinical trial.

- Continuous monitoring is necessary and recording of parameters overtime on a flow chart will help to re evaluate the women's physical condition even when the bleeding appears to have stopped.
- Once the bleeding is arrested and any coagulopathy is corrected chemical thrombo prophylaxis is administered as there is a high risk of thrombosis.

Surgical methods:

If the bleeding is not controlled with pharmacological and mechanical methods surgical interventions should be initiated sooner rather than later.

Intrauterine balloon tamponade is a first line surgical management. It is useful in uterine atony and placental site bleeding caused by placenta previa and placenta accreta.

Various types of hydro static catheters are

- Foley catheter
- Bakri balloon
- A condom catheters

A positive test (control of PPH following inflation of the balloon) indicates that laparotomy is not required.

A negative test (continued PPH following inflation of the balloon) is an indication to proceed to laparotomy.

Uterine artery clamp

- (a) In case severe hemorrhage uterine artery clamp applied intravaginally in lateral fornices to control the bleeding.

Haemostatic suturing:

In 1997 B Lynch described a haemostatic suture and is particularly suitable when the uterus has already been opened for a caesarean section.

In 2002 Hayman Et al described a modified compression suture which does not require hysterectomy and success in 10/11 women managed with this suture has been reported.

Double vertical compression sutures have proved effective in treating PPH due to atony and placenta previa. This may have dual action of reducing uterine blood flow and compressing the bleeding surface.

Compression of aorta :

It may be temporary but effective measure to allow time for resuscitation to catch up with the volume replacement and the appropriate surgical support to arrive.

Stepwise uterine devascularization and internal iliac artery ligation

Both uterine artery, then ovarian and lastly internal iliac artery ligation to control the bleeding.

Selective arterial occlusion or embolisation by interventional radiology

Selective arterial occlusion may also be effective after failed internal iliac artery ligation and it doesn't impair subsequent menstruation, fertility and obstetric outcomes.

Hysterectomy:

The decision for hysterectomy should be made by an experienced

clinician where all other measures are tried and failed where bleeding continues with a severely shocked patient. Subtotal hysterectomy preferable because it is quicker, simpler and safer.

PPH due to retained placenta:

The common cause for retained placenta is uterine atony. The risk of hemorrhage rises after 30 minutes. Intra umbilical vein injection of oxytocin 5U with saline 5 ml is offered to separate the retained placenta. If the placenta is not separated with the above measures then the placenta to be removed manually under anesthesia.

PPH due to placenta accereta:

Risk factor for placenta accreta is placenta previa. Previous caesarean section, previous myomectomy, Ashermans syndrome, sub mucous myoma.

Antenatal ultrasound and colour Doppler may be helpful in diagnosing placenta accreta and delivery can be planned in a tertiary centre. Uterine conserving options may work in small total accretas. But abdominal hysterectomy is usually the definitive treatment.

PPH due to Trauma:

1. Lacerations
2. Hematoma

Lacerations:

Subdivided into cervical, vaginal, uterine rupture. All tears should be identified and sutured properly.

Hematoma:

Small hematoma can be treated conservatively, but expanding one needs evacuation and bleeding points to be secured and dead space approximated with figure by eight sutures.

PPH due to coagulation defects:

Coagulation defects can occur with

- HELLP syndrome, placental abruption
- Prolonged IUFD, Sepsis



Dr Bindhu Menon



Dr Neetha George



Dr Aswath Kumar



Dr M Venugopal



Dr Fessy Louis

SPEAKERS AND PANELISTS



Speakers and Panelists of Preterm labour



Speakers and Panelists of Postpartum haemorrhage

SPEAKERS AND PANELISTS



Speakers and Panelists of Infertility



Entire team of Speakers and Panelists



Dr Rajasekar D/D family welfare



Dr Sri Revathy



Audience

- Amniotic fluid embolism

When coagulopathy is suspected appropriate testing should be ordered. When bleeding is uncontrollable infuse up to one liter of FFP and ten units of cryoprecipitate (two packs) may be given empirically while awaiting the results.

Secondary PPH:

PPH occurs after 24 hrs and within 42 days post partum.

Causes:

- Retained placental bits.
- Endometritis.
- Sub involution of the placental implantation site.

Management:

Clinical assessment and pelvic ultrasound, with colour flow Doppler may help in the diagnosis of pseudoaneurysms and arteriovenous malformations. High vaginal and endocervical swabs to be taken.

Treatment:

RPOC – surgical evacuation by senior consultant to avoid uterine perforation and Asherman's syndrome

Endometritis:

Ampicillin with metrogyl and gentamycin.

The PPH may be associated with Von willebrand's disease in 10 to 20 percent among adult women with menorrhagia. So proper testing to be done for these patients because the risk of delayed (or) secondary post partum hemorrhage is high among women with bleeding disorder.

Compiled by Dr Vasanthi Rajesh



EOGS – INFERTILITY PANEL - TAKE HOME POINTS

1. PCOS:

To make a diagnosis of PCOD 2 out of 3 following features need to be present

- ✱ Sonographic appearance – Follicle Number Per Ovary (FNPO) 20 follicles using Transvaginal probe of 8 MHz + Ovarian volume > 10 cc.
- ✱ Clinical feature of irregular cycles.
- ✱ Clinical or biochemical feature of hyperandrogenism (elevated free testosterone and Free Androgen Index)

Polycystic Ovarian Morphology should not be documented in young girls < 8 years post menarche using a Transabdominal USG.

- ✱ Letrozole is the first choice of ovulation induction for PCOS women.
- ✱ Metformin has its role in women with BMI > 25 and those women with other features of insulin resistance & high risk of metabolic syndrome.
- ✱ Inositol role as an insulin sensitizer is yet to be proven in Asian population.
- ✱ Life style changes play a major role in overcoming anovulation especially in obese PCOS (150 minutes of exercise / week) along with low carbohydrate and high fibre diet is advised.

2. ENDOMETRIOSIS

- ✱ In case of good ovarian reserve, even in the presence of an ovarian endometrioma, one can go ahead straight with Ovulation induction, provided tubal patency is assured.

- * Ovarian cyst excision is always preferred over Cyst drainage for an Ovarian Endometrioma to minimize the risk of recurrence.
- * Irrespective of the expertise of the laparoscopic surgeon Ovarian cyst excision would bring down the ovarian reserve.
- * Medical management of endometriosis would provide symptomatic pain relief but would not augment the fertility potential of the women.

3. IUI:

- * Stimulated IUI cycles always carry better success rate.
- * Letrozole along with Gonadotropins carry the best success rate.
- * Recombinant and Urinary Gonadotropins carry almost similar on par success rate in IUI cycles.
- * Ideal semen parameter for an optimized success rate in IUI is 10 million / ml – Total Motile Sperm Count.
- * Not just the sperm count influences the success rate of IUI but also the progressive motility determines the success rate of the cycle.
- * Round cells > 1 million / ml signifies infection, which has to be differentiated from immature sperm cells by peroxidase staining.
- * Red Flag signs to cancel IUI cycle:
 - 3 follicles > 17 mm
 - Serum E2 > 2500 pg/ml
- * Ideal Ovulation trigger: Urinary HCG / recombinant HCG.
- * But if serum E2 > 2500 pg/ml – HCG trigger avoided and GnRh agonist trigger preferred to avoid OHSS.
- * With GnRh agonist trigger, the chance of clinical pregnancy rate drastically drops down due to luteal phase deficiency.

✱ Favourable factors for a successful IUI:

- Age < 35 yrs , Duration of infertility < 4 yrs , Total Motile sperm count > 10 millions /ml , atleast 2 follicles > = 17 mm , Endometrial thickness > = 8 mm

4. ONCOFERTILITY:

- ✱ Oocyte freezing has become a common procedure in tertiary IVF units with a reasonable success rate off late with standardized protocols.
- ✱ The other alternative procedure available is Ovarian Tissue Freezing which is still experimental, but carries a better success rate of 37%.
- ✱ The added advantage of ovarian tissue freezing is that there is a tissue with multiple undeveloped follicles, so it allows multiple attempts of stimulation after transplantation.
- ✱ In cancer patients, ovarian tissue freezing can be performed immediately without delay of cancer therapy unlike Oocyte freezing which needs multiple days of hormonal stimulation.



- Compiled by

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Secretary EOGS



PRACTICE EMOTIONAL FIRST AID

BY GUY WINCH, TED TALK

Emotional Hygiene

Physical Health and Psychological Health

We all know how to maintain our physical health and how to practice dental hygiene, right? We've known it since we were five years old. But what do we know about maintaining our psychological health? Well, nothing. What do we teach our children about emotional hygiene? Nothing. How is it that we spend more time taking care of our teeth than we do our minds? Why is it that our physical health is so much more important to us than our psychological health? Favoritism we show the body over the mind.

We sustain psychological injuries even more often than we do physical ones, injuries like failure or rejection or loneliness. And they can also get worse if we ignore them, and they can impact our lives in dramatic ways. And yet, even though there are scientifically proven techniques we could use to treat these kinds of psychological injuries, we don't. It doesn't even occur to us that we should. "Oh, you're feeling depressed? Just shake it off; it's all in your head." Can you imagine saying that to somebody with a broken leg: "Oh, just walk it off; it's all in your leg?"

It is time we closed the gap between our physical and our psychological health. It's time we made them more equal, more like twins.

Loneliness

Loneliness creates a deep psychological wound, one that distorts our perceptions and scrambles our thinking. It makes us believe that those around us care much less than they actually do. It makes us really afraid to reach out, because why set yourself up for rejection and heartache when your heart is already aching more than you can stand?

But loneliness is defined purely subjectively. It depends solely on whether you feel emotionally or socially disconnected from those around you.

Loneliness won't just make you miserable; it will kill you. Chronic loneliness increases your likelihood of an early death by 14 percent. Fourteen percent! Loneliness causes high blood pressure, high cholesterol. It even suppresses the functioning of your immune system, making you vulnerable to all kinds of illnesses and diseases. In fact, scientists have concluded that taken together, chronic loneliness poses as significant a risk for your long-term health and longevity as cigarette smoking. Now, cigarette packs come with warnings saying, "This could kill you." But loneliness doesn't. And that's why it's so important that we prioritize our psychological health, that we practice emotional hygiene. Because you can't treat a psychological wound if you don't even know you're injured. Loneliness isn't the only psychological wound that distorts our perceptions and misleads us.

Failure

Failure does that as well.

In fact, we all have a default set of feelings and beliefs that gets triggered whenever we encounter frustrations and setbacks.

Are you aware of how your mind reacts to failure? You need to be. Because if your mind tries to convince you you're incapable of something, and you believe it, then you'll begin to feel helpless and you'll stop trying too soon, or you won't even try at all. And then you'll be even more convinced you can't succeed. You see, that's why so many people function below their actual potential. Because somewhere along the way, sometimes a single failure convinced them that they couldn't succeed, and they believed it. Once we become convinced of something, it's very difficult to change our mind.

Our mind is hard to change once we become convinced. So it might be very natural to feel demoralized and defeated after you

fail. But you cannot allow yourself to become convinced you can't succeed. You have to fight feelings of helplessness. You have to gain control over the situation. And you have to break this kind of negative cycle before it begins.

Our minds and our feelings — they're not the trustworthy friends we thought they were. They're more like a really moody friend, who can be totally supportive one minute, and really unpleasant the next.

Rejection

Especially after a rejection we all start thinking of all our faults and all our shortcomings, what we wish we were what we wish we weren't. We call ourselves names. Maybe not as harshly, but we all do it. And it's interesting that we do, because our self-esteem is already hurting. Why would we want to go and damage it even further? We wouldn't make a physical injury worse on purpose. You wouldn't get a cut on your arm and decide, "Oh! I know — I'm going to take a knife and see how much deeper I can make it."

But we do that with psychological injuries all the time. Why? Because of poor emotional hygiene. Because we don't prioritize our psychological health. We know from dozens of studies that when your self-esteem is lower, you are more vulnerable to stress and to anxiety; that failures and rejections hurt more, and it takes longer to recover from them. So when you get rejected, the first thing you should be doing is to revive your self-esteem, not join Fight Club and beat it into a pulp. When you're in emotional pain, treat yourself with the same compassion you would expect from a truly good friend. Protect Your Self-Esteem.

Rumination

We have to catch our unhealthy psychological habits and change them. And one of unhealthiest and most common is called rumination. To ruminate means to chew over. It's when your boss yells at you or your professor makes you feel stupid in class, or

you have big fight with a friend and you just can't stop replaying the scene in your head for days, sometimes for weeks on end. Now, ruminating about upsetting events in this way can easily become a habit, and it's a very costly one, because by spending so much time focused on upsetting and negative thoughts, you are actually putting yourself at significant risk for developing clinical depression, alcoholism, eating disorders, and even cardiovascular disease.

The problem is, the urge to ruminate can feel really strong and really important, so it's a difficult habit to stop.

Battle the Negative Thinking.

Heal your Psychological wounds & Build Emotional Resilience

By taking action when you're lonely, by changing your responses to failure, by protecting your self-esteem, by battling negative thinking, you won't just heal your psychological wounds, you will build emotional resilience, and you will thrive.

A hundred years ago, people began practicing personal hygiene, and life expectancy rates rose by over 50 percent in just a matter of decades. Our quality of life could rise just as dramatically if we all began practicing emotional hygiene.

Can you imagine what the world would be like.....

If everyone was psychologically healthier?

If there were less loneliness and less depression?

If people knew how to overcome failure?

If they felt better about themselves and more empowered?

If they were happier and more fulfilled?

And if you just become informed and change a few simple habits, well — that's the world we can all live in.





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