EOGS BULLETIN

October to December 2019

POWER TO DECIDE

Let us **EDUCATE ADOLESCENT GIRLS**
on health, hygiene and nutrition

Dr Nandita Palshetkar,
FOGSI President

WE FOR स्त्री
Safer •Stronger •Smarter

ERODE OBSTETRIC AND GYNAECOLOGICAL SOCIETY

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

Office Bearers 2019 - 20

Dr. E.S. Usha
President EOGS

Dr. Sri Revathy Sadasivam
Secretary EOGS

Dr. Dharani
Treasurer EOGS

Dr. E.S.Usha
Lotus Hospital,
90, Thayumanavar Sundaram Street,
Kollampalayam, Erode 638002
9952362196
esusha@gmail.com

Dr. Sri Revathi Sadasivam
Maaruthi Medical Centre and Hospitals,
564, Perundurai road,
Erode 638011
98651 96660
sada.reva.9.6.88@gmail.com

Monthly Bulletin of Erode Obstetric and Gynecological Society
Editors: **Dr. E.S. Usha & Dr. N. Poongothai**

EOGS Cordially invites you all for the Year End Get together

Date	:	**08.12. 2019, Sunday**
Time	:	**4.00 pm - 8.00 pm**

PROGRAM :

Pool side fun 4- 5 PM

High tea 5- 5.30 pm

Interactive games 5.30 – 6.00 pm

Stunning Gyne award 6.00 – 6.30 pm

DJ and Dinner 7.00 pm onwards

Dr. E.S.Usha MD DGO
Fellow in fetal Medicine, President EOGS
Lotus Fetal Medicine Center, Erode

Dr. N.Darani MS(OG).,CCIGDM.
Treasurer - EOGS
Jai Maruthi Hospital, Erode

Dr. Sri Revathy Sadasivam
MD, DNB, MICOG, MRCOG (UK)Master in Reproductive Medicine (UK
Secretary - EOGS, MMCH, Erode

FROM THE OFFICE BEARERS

Dear members,

As the year 2019 is coming to a close we thank all the members for their support in all our activities.

We are planning for a grand gala year end dinner and request everyone of you to participate.

We are planning to work on two areas which our FOGSI President Dr Nandhita has stressed namely educating adolescent girls and cancer screening.

We want all our members to conduct a meeting in few schools on adolescent health issues. The resource material will be provided by us. Together we can reach out to a large number of adolescent girls.

Same way we are planning to conduct screening camps for cervical and breast cancer.

Expecting all your support in the future activities also.

Wishing you all a Happy and Prosperous New year.

Dr. Sri Revathy Sadasivam MD (OG)., DNB (OG)., MICOG., MRCOG (UK)., Masters in Reproductive Medicine (UK)
Secretary EOGS

Dr. E.S. Usha MD., DGO.,
Fellow in fetal medicine
President EOGS

MAGNESIUM SULPHATE - CURRENT USAGE

Three roles for MgSo4 in obstetrics

- Tocolysis.
- Seizure prophylaxis.
- Fetal neuro protection.

MgS04 in Tocolysis:

- Widely used sometimes back.
- Dosage varied – no standard regime for tocolysis.
- Side effect varied.
- Results varied.

Difficulties of MgSo4 Tocolysis

- Dosing and administration very difficult.
- Monitoring – cumbersome.
- Why use such a tough drug when something better is available ?
- Magnesium Sulphate Tocolysis – Time to Quit.
  - ➢ *David Grimes & Nanda*

MgS04 in Seizure prophylaxis:

MAGPIE Trial

A randomized trial comparing magnesium sulphate with placebo for pre-eclampsia. Outcome for women at 2 years.

The reduction in the risk of eclampsia following prophylaxis with magnesium sulphate was not associated with an excess of death or disability for the women after 2 years.

In practice

- Pritchard's Regime - the loading bolus dose of 4 g of $MgSO_4$ is given slowly intravenously over 5-10 min and this is followed by 10 g given intramuscularly (5 g in each buttock). Subsequently, 5 g is given intramuscularly into alternate buttocks every 4 h.

- Zuspan's Regime - the loading dose consists of an initial intravenous dose of 4 g slowly over 5-10 min followed by a maintenance dose of 1-2 g every hour given by an infusion pump.

  For the 50% $MgSO_4$, 1 ml of the solution contains 0.5 g of $MgSO_4$,while for the 20% solution, 1 ml contains 0.2 g of $MgSO_4$

MgSo4 in Pre Eclampsia

- Because of high quality data and consistency of findings, the use of magnesium sulfate for maternal pre eclamptic seizure prophylaxis is its best established obstetric indication.

- A recent systematic meta-analysis of six well designed randomized clinical trials (n=11,444 pre eclamptic women) revealed a marked reduction in the recurrence of eclampsia (relative risk RR) 0.41, 95% Confidence Interval (CI) among treated women.

Current Evidence Hot from the Pot

- MgSo4 for 8 hrs instead of 24 hrs

BJOG

Magnesium Sulfate During the Postpartum in Women With Severe Preeclampsia (MAG-PIP)

Is there benefit to continue magnesium sulphate postpartum in women receiving magnesium sulphate before delivery? A randomized controlled study.

Women with severe pre-eclampsia treated with a minimum of 8 hours of magnesium sulphate before delivery donot benefit from continuing the magnesium sulphate for 24 hours postpartum.

MgSo4 for Neuro Protection

How did it start…?

- Nelson & Grether – Analyzing data on more than 150,000 children, followed through at least 3 years of age, they reported that only7% of very low birth weight children exposed ante-natally to magnesium sulfate developed cerebral palsy, as compared with 36% of randomly selected gestational age–matched, but unexposed, children.

PREMAG Trial

- 50073 women < 33 weeks randomly assigned to either Rx of a single 4g MgSo4 bolus vs saline Placebo.
- MgSo4 group had a reduction in gross motor dysfunction 7% compared to other group.
- Similarly, a trend toward reduction in cerebral palsy was observed among magnesium sulfate exposed children compared with controls.

MFMU Network

- 21201 women

- Rx Group received 6 gm MgSo4 bolus over 20 mins, followed by continuous infusion at 2g/hr. Control group received matching volumes of saline.
- For the outcome of moderate or severe cerebral palsy, a reduction among children of magnesium sulfate–treated women, compared with those receiving placebo, was statistically significant.

Cochrane review of MgSO4 for fetal neuroprotection concludes without equivocation that "the neuroprotective role for antenatal magnesium sulfate therapy given to women at risk of preterm birth for the preterm fetus is now established."

From Dr Palaniappan's talk.

The 7 Cs of Success

1. A clear **Conception** of what we want, a vivid vision, a goal strongly imagined.
2. A strong **Confidence** that we can attain our goal.
3. A focused **Concentration** on what it takes to reach that goal.
4. A stubborn **Consistency** in pursuing our vision.
5. An emotional **Commitment** to the importance of what we're doing.
6. A good **Character** to guide us and keep us on a proper course.
7. A **Capacity** to Enjoy the process along the way.

BREAKING BAD NEWS

What is 'Bad news"?

Any information which adversely and seriously affects an individual's view of his or her future.

Some examples:

- Blocked tubes
- Azoospermia
- Premature ovarian failure
- Baby with lethal anomaly
- Downs syndrome in the fetus
- Malignancy
- Intrauterine death

Why is this important skill?

- It is a communication skill.
- NOT taught in our formal training.
- Mostly learnt by watching our senior teachers / colleagues.
- Ethically imperative.

Physicians face great stress when they have to break bad news.

First reaction from patients:

- Shock.
- Disbelief.
- Anger.

We also have to handle their Despair and Guilt.

Reaction from the doctor

Panic – did I miss anything, how am I going to convey, will they blame me?

Don't panic instead concentrate on how to help the patient.

Breaking Bad news

The ABCDE mnemonic:

Advance preparation.

Build a rapport.

Communicate well.

Deal with reactions.

Encourage and validate emotions.

Advance preparation :

- Go through the details of the patient.
- Mentally rehearse words or phrases.
- Speak to a senior colleague and get advice on what to say.
- Arrange for adequate time and privacy.
- Prepare yourself emotionally.
- Greet them with a smile.

Build a rapport :

- Try to gauge how much the patient wants to know.
- Gently tell the patient that the news is 'not very good'.
- Have a support person with the patient.
- First talk to the couple alone.

SEPTEMBER MEET

Dr Gita Arjun

Dr Palaniappan

Audience

SEPTEMBER MEET

Panelists

EOGS members with Faculty

Lucky draw winner Dr Renju

NOVEMBER MEET

Dr Latha Janaki, Psychologist

Members Participation

NOVEMBER MEET

Active involvement of audience

EOGS members

- Do not exclude the patient from any of the conversations.
- Do not send the patient out while you have a discussion with the husband or family.

Communicate well:

- Ask what the patient already knows or understands.
- Body language: Lean towards the patient, make eye contact.
- Start with colloquial terms.
- Incremental addition of information.
- Keep language simple.
- Don't throw medical jargon at them.
- 'I' m afraid things are not all right'.
- 'The baby's heart beat is not heard and I couldn't see it on the scan either'.

In case of cancer

- 'The scan has shown a growth'.
- 'The ovary seems to have a tumour'.
- 'We need to make sure everything is alright with you'.
- 'Let us do some more tests to find out what it really is'.

Gestures make a difference – hands and arms folded gives them comfort.

Standing with hands crossed gives an impression that you are defensive.

Allow time for tears.

Be patient.

What to say ?

- It is difficult to give definite answers right now

- What is important to me?
- Do I neglect issues that matter to me because I am busy spending time on things that matter less?

Don't be a martyr...! Get help from others ; delegate work to others.

'US' time with husband and family is important.

Managing stress

- Have 'ME' time.
- Creatively visualize magical places.
- Get outside.
- Enjoy life – maintain a Joy journal.
- Plan for retirement.

As an obstetrician and gynaecologist - Give your heart and soul to your career also make sure your life is complete.

From Dr Gita Arjun's talk

ANAESTHESIA FOR THE PREGNANT PATIENT UNDER GOING NON OBSTETRIC SURGERY

The pregnant patient presents an unique two in one situation for the Anaesthesiologist.

Anaesthetic drugs and techniques affect both the uterus and placenta- the link between mother and unborn child. Anaesthetists play an important role providing anaesthesia and analgesia.

The difficulty rises when surgery has to be performed during the period of organogensis (13^{th} to 56^{th} day after conception). The commonest procedure are cerclage, acute abdomen, maternal trauma and correction of decompensating cardiac lesion. Major procedures like Craniotomy, Cardiac pulmonary bye pass have also been performed in pregnant women, with good out comes for mother and fetus.

Goals in Anaesthetic Management

Maternal Safety :

1. Good pre -operative preparation and evaluation.
2. Optimum Anaesthetic management.
3. Adequate analgesia during and after surgery without involving fetal depression.

Fetal Safety :

1. Prevention of pre-term labour.
2. Avoidence of terotogenic drugs.
3. Alowing optimum utero placental perfusion to prevent fetal hypoxia.

Anaesthetic Management involves both mother and fetus. Alteration in maternal physiology involve every organ but some are important to anaesthetic management.

Respiratory :

The Pregnant mother is prone to develop hypoxia so administer oxygen, monitor oxygen level by using pulse oximeter. Post- operative pain will cause rapid shallow respiration, which decreases o2 level hence the need for good analgesia without fetal depression.

Cardio Vascular :

Increase the blood volume, Aortocaval compression in supine position, dilutional anaemia and hyper coagulable state of blood are seen in pregnancy.

CNS :

The drugs used in anaesthesia most commonly are nitrous oxide and benzodiazepines.

The benzodiazepines are associated with ceft lip anomalies.

The inhalation agents, narcotics, IV agents, local are safe during pregnancy.

Prevention and treatment of pre term labour are the most difficult problems to overcome peri operatively. Pre - term delivery is the most common cause of fetal loss. If magnesium sulphate is used it interacts with muscle relaxants and cause CNS depression.

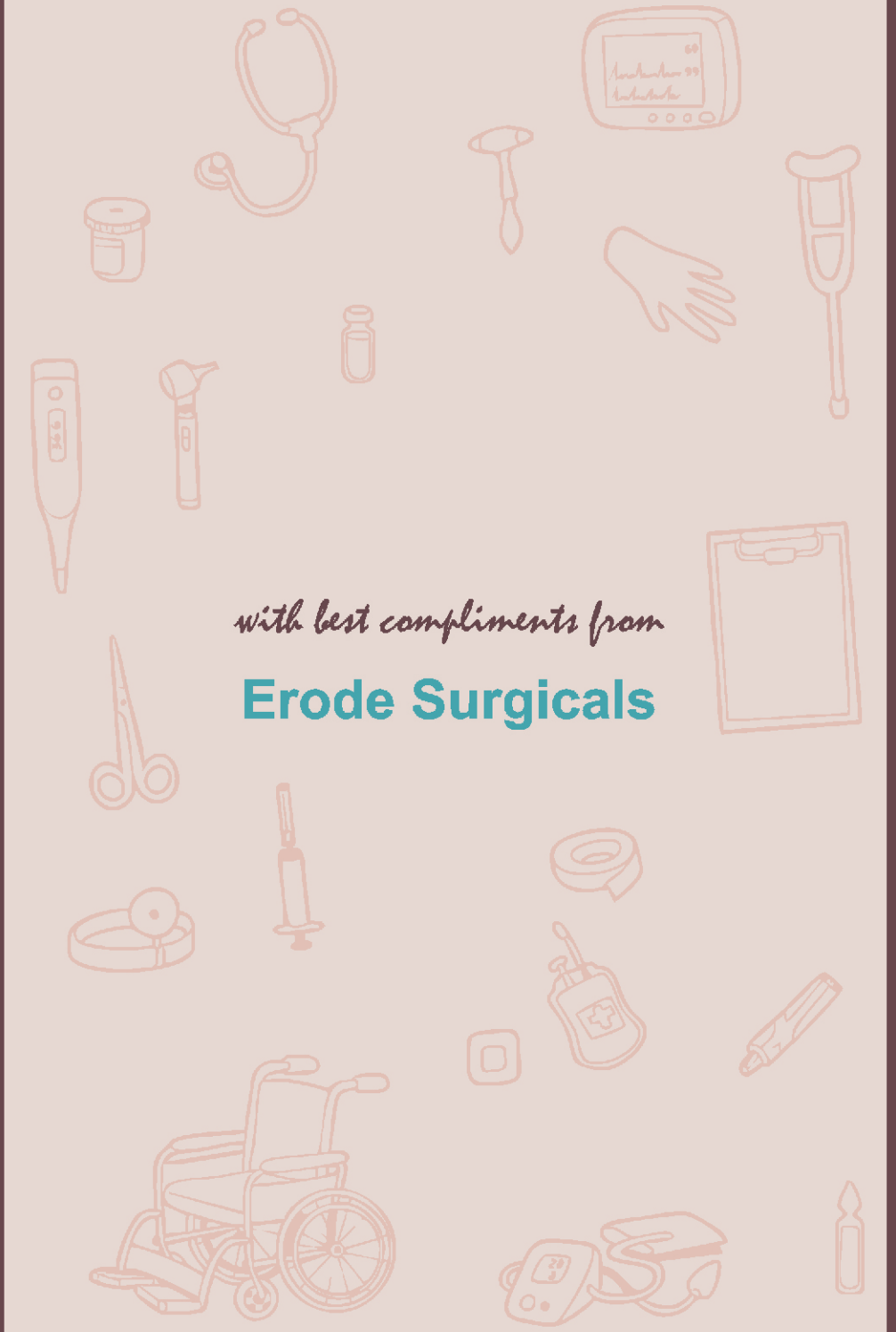
Recommended guidelines in the management of the pregnant patient for non - obstetric surgery.

1. As far as possible delay the proposed operative procedures till second or third trimester.
2. Risk of spontaneous abortions is high in second trimester.
3. To Promote fetal well being keep all the maternal physiological functions at optimum.
   a. Maintain blood pressure.
   b. Maintain acid base balance.
   c. Prevent uterine irritability.
   d. Prevent drugs causing fetal hypoxia.
   e. Postpone surgery until 2 trimester if possible.
   f. Counsel the patient pre operatively.
   g. Monitor and maintain oxygen, euglycaemia and normotension.
   h. Use regional when appropriate.
   i. Avoid nitrous oxide in higher concentration.

Laproscopic Surgery in Pregnancy :

It requires G.A and Co2 is insufflated into the peritoneal cavity. It carries additional risk to the fetus causing utero placental insufficiency and acidosis. Pneumo peritoneum pressure to be kept between 8 to 12 mm hg because above this range uterine flow is severely compromised.

Dr. Chithra Soundarraj



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