MAATRIKA

NEWS LETTER FROM THE OBGY FAMILY

Vol VIII : OCTOBER- DECEMBER,2018

EDITORIAL BOARD

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Dear Friends,

It is an immense pleasure to bringforth the 8th issue of our news letter MAATRIKA and we are glad to write this column.

Women empowerment is a much discussed issue always.

Female population makes for almost half of the world's population.It is of utmost importance that women also enjoy equal opportunities in all walks of life and have true freedom to make their own decisions,choices.

Women are known to have made their extraordinary contribution in making the world as we see today,be it mother Teresa, Marie curie,Rani Jhansi,to fought for their rights and stood up for their believes against all odds .

Despite all this,there are still women, who get so much caught up in their domestic lives that they forget about themselves and their dreams.

Be it cultural inhibitions,lack of financial support,lack of oppourtunities,gender based discrimination or personal responsibilities,women often give up on themselves,dreams and aspirations.

Women empowerment in society facilitates to bring equality fot both genders & helps women by providing them strength & courage to become decision maker of their own lives.

Women empowerment in india has gained strength with help of organisations working for welfare of women by providing them with all the needed support.They are trying to do so much..... let`s help them with some more.

QUIZTIME!!!!

1. Features of obstructed labour are all of the above except?

A) Hot dry vagina

B) Tonic contracted uterus

C) Foul smelling discharge

D) Unruptured membrane

2. Folds of hobokon are seen in?

A) Umbilical cord

B) Cytotrophoblast

C) Chorionic villous of placenta

D) Fetal sigmoid colon

3. Dystocia dystrophica syndrome is seen in?

A) Android pelvis B) Platypelloid pelvis

C) Anthropoid pelvis D) Gynaecoid pelvis

4. Thickness of endometrium at the time of implantation?

A) 3-4mm

B) 20-30mm

C) 10-20mm

D) 8-10mm

5. False regarding anencephaly?

A) 70% cases are males

B) Forebrain, midbrain are absent

C) Adrenal gland is diminished in size

D) Bulging eyes; short neck; large tongue are seen

Scientist

HOWARD ATWOOD KELLY

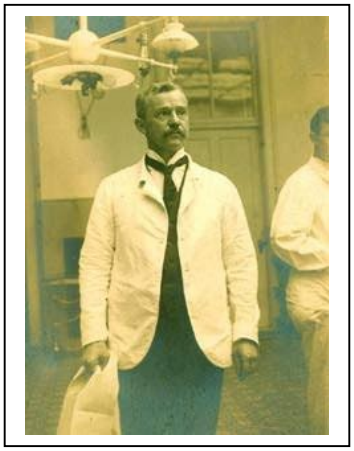
- He was an American gynaecologist.
- He was born in Camden;New Jersey on Feb 20, 1858.He was the 2nd of 9 children.
- Kelly entered the University of Pennsylvania School of medicine in 1873.
- He was the youngest of the BIG 4 – William Stewart Halsted, William Osler, William Welch –The founding chairs at johns Hopkins school of medicine and creators of Hopkins legacy.

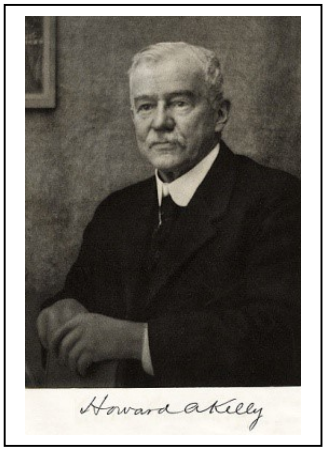
In the field of obstetrics and gynaecology –

1. He was a clinical innovator, performing the 1st successful caesarean-section in Philadelphia in 1888
2. He pioneered the use of radium in the treatment of gynaecological cancer and he is the one identified with the test- KELLY SIGN to find thee ureter by stimulating its peristalsis by touching it with forceps.
3. He created Kelly's stitch, a procedure to treat stress incontinence.
4. He invented Kelly speculum for rectal examination and Kelly's small cylindrical speculum a set of device for virgins.
5. He also invented Kelly's forceps, Kelly's clamp, curved haemostatic forceps.

Recognition and honours-

1. Honorary degree of "DOCTOR OF LAWS" from the University of Pennsylvania. Awarded ORDER OF LEOPOLD (Belgium), THE ORDER OF THE CROSS OF MERCY, CROSS OF CHARITY
2. Founding member of American college of surgeons
3. Honorary curator "At the University of Michigan
4. In 1943, a U.S Liberty ship was christened the Howard a Kelly





WHAT'S NEW

DILAPAN – HYGROSCOPIC CERVICAL DILATOR:

- It's a hygroscopic cervical dilator.
- It is made up of patented hydrogel [AQUACRYL]

- It is a rigid hydrophilic stick that increases in volume by absorbing fluids and comfortably dilates the cervix.

DEVICE DESCRIPTION:It consists of an active part made 0f AQUARYL 90,and a polypropylene handle attached to the active part by isocyanate adhesive & polyamide signal string.

Indications:

DILAPAN-S is for use wherever cervical softening and dilation is required.

USES:1. prior to labor inductionto improve bishop score.

2. cervical preparation prior to termination of pregnancy .

3. For instrumentation of the uterine cavity, etc.

Contraindications:

In clinically apparent genital tract infection.

Instructions for insertion:

1. Insert a bivalve speculum and prepare the vagina and cervix with an antiseptic solution

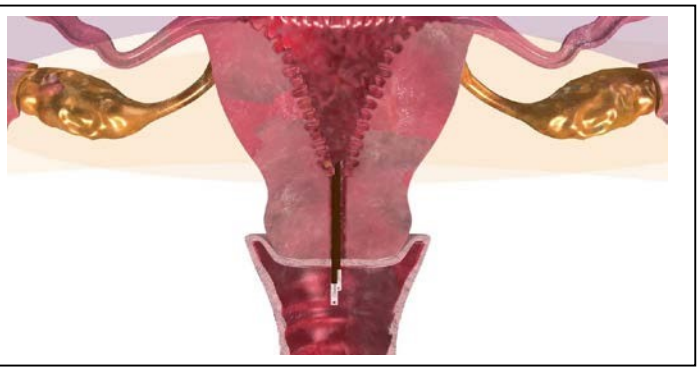
2. Remove the DILAPAN-S from the package using sterile technique.
3. Moisten with sterile water or saline to lubricate the surface prior to insertion.
4. Insert into the cervical canal gradually and without undue force. It should traverse the internal and external os.the border of the knob/collar

5. More than one DILAPAN-S may be inserted into the cervical canal. When using several dilators, repeat 2-4 steps.

6. Insert a gauze pad to help keep the DILAPAN-S in place, if needed.

Removal instructions:

1. Remove vaginal packing first, if used during the insertion procedure.
2. Carefully remove the DILAPAN-S by grasping the handle. Do not try to remove the DILAPAN-S using the string. Do not twist the DILAPAN-S during removal. Do not grasp the knob/collar with forceps.



ADVANTAGES:more rapid clinical effect on cervix with 1m rod resulting in 10-12.5 mm of dilatation.

One 4mm dilator allowing for completion of abortion at 16-18wks of gestation.

Appearance,insertion,mechanism of action is similar to that luminaria tents.

INTERESTING CASE IN THE DEPARTMENT

CORNUAL PREGNANCY

- A 33 year old G3P1D1A1 with 3 months of gestation with previous Normal vaginal delivery diagnosed as left cornual pregnancy referred from tadepalligudem to ASRAM for further evaluation and management.

At the time of admission:

No history of bleeding per-vagina
No history of pain abdomen.
Her LMP-17/10/2018
EDD-24/7/2019
POG-9wks 2 days

Obstetric history:

1st-Conceivedspontaneously, TERM, NVD, Still birth,13yrs back.
2nd-Tubal ectopic pregnancy, right salpingectomy done on 4/5/2018.
3rd- Conceived spontaneously, diagnosed by UPT at 2nd month of gestation.
During antenatal visits,scan advised, scan shows cornual pregnancy with no foetal cardiac activity same findings confirmed with MRI PELVIS.

Menstrual history:

AOM- 11yrs.
3-4days/28-30 days/regular/ normal flow/ no clots/ no pain

O/E:

At the time of admission vitals stable.

- **GYNAECOLOGY EXAMINATION**:

P/A: Spts +, soft no tenderness
PER SPECULUM:Cervix, vagina – healthy
No discharge, No bleeding.
PER VAGINUM: ut- bulky,8-10 wk size,mobile,fornices free.

- **MANAGEMENT**:

Patient was evaluated to confirm diagnosis.
USG was repeated at ASRAMS showed that-Molar pregnancy in left cornua
Patient was explained regarding planned for multi-dose MTX regimen

INVESTIGATIONS:

USG abdomen:

ET-11mm, RO-Not visualized, LO-4.6*3.7cms, e/o-Well defined hyper echoic lesion with solid and cystic spaces.
Vascularity on Doppler measuring 4.9*3.8cms in left cornua. No fetal pole.? S/O molar pregnancy in left cornua.

MRI Pelvis:

Uterus- Bulky, gestational sac with decidual reaction
IMP- Left cornual pregnancy with decidual reaction.

TREATMENT GIVEN:

Inj.MTX 4 doses on alternate days (1, 3, 5, and 7) with folinic acid (2, 4, 6days).

- Initial beta HCG- 25,839miu/ml (at the time of admission)

- After 4 doses- 11028miu/ml.
  - No side effects of MTX during the course, patient tolerated well, other than mild pain abdomen..Inspite of medical management with MTX, no satisfactory fall in beta HCG between day 4 and day 7.

  - USG repeated to measure size of gestational sac. No decrease in size, rather increase in gestational sac noted. So patient and attenders counselled regarding failure of medical management,& given an option of surgical management. After taking informed and written consent planned for hysterectomy.

INTRA OPERATIVE FINDINGS:

- ✓ Uterus of size 12x6x5cms
- ✓ Left cornual gross enlargement of size 5x5cms.gross enlargement of left cornua of uterus noted 5x5 cm.
- ✓ Right ovary adherent to posterior surface of uterus ,.right tube absent .
- ✓ Based on IOP findings proceeded for TAH and right oophorectomy

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SPECIEMEN CUT SECTION:(GROSS)

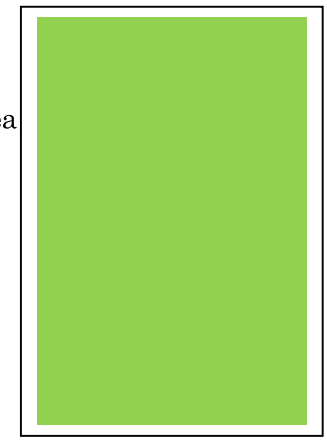
Myometrium thinned out at left cornua.
Products of conception seen filling left cornua.
Endometrial cavity normal,Endocervix normal.
Post-operative period uneventful. Suture removal done on 7th POD &discharged.

S.BETA-HCG ON POD-7:100miu/ml

HPE:

PLACENTA INCRETA
NON SPECIFIC PAPILLARY ENDOCERVICITIS
SECRETORY PHASE ENDOMETRIUM
FOLLICULAR CYSTS OVARY.

DISCUSSION:



- ➢ The term Cornual pregnancy used interchangeably with interstitial pregnancy.
- ➢ Incidence of7orneal pregnancies are 2-3% among tubal ectopic pregnancies.
- ➢ Previous ipsilateral salpingectomy is a specific risk factor for interstitial pregnancies.
- ➢ Usually delayed rupture following 8-16wks of amenorrhea than other sites as this area can accommodate the gestational sac enlargement due to presence of surrounding myometrium.

Diagnosis: by ultrasound -→empty endometrial cavity.
Gestation sac seen separate from endometrial cavity &.1cm away from lateral edge of uterine cavity.<5mm myometrial mantle surrounding in the sac.

INTERSTITIAL LINE SIGN– Extending from gestational sac to endometrial cavity most likely represent interstitial portion of fallopian tube and is highly sensitive and specific.

Other modalities :3d-ultrasound,mri,diagnostic laparoscopy.

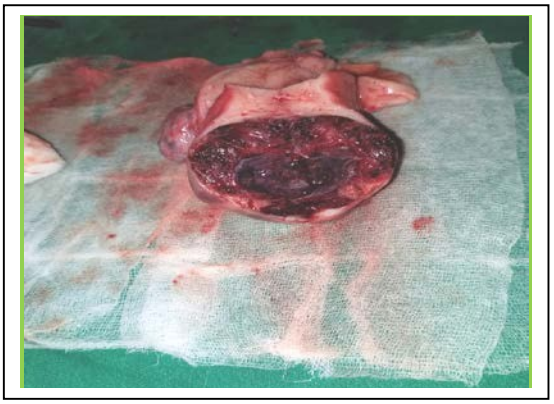
MANAGEMENT:

- ❖ medical management:**With early diagnosis conservative management may be considered.**

In Earlier cases either single dose/multi dose mtx regimen given.

- ❖ Surgical management : either **cornual resection** or **cornuostomy**may be performed via laparotomy/laparoscopy.

Beta-HCG levels should be monitored post operatively.

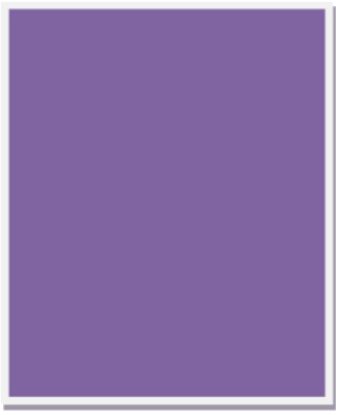


Followup: weekly sr.beta-hcg till it becomes undetectable.
Plan for elective caesarean section in next pregnancy.

ACADEMICS

GUEST LECTURE ON SURGICAL MANAGEMENT OF OVARIAN CANCER

October -29th



Dr.Kalyan Chakradhar
(Surgical Oncologist)

ROLE OF DOPPLER ULTRASOUND IN OBSTETRICS

November-11th

Dr.Rabiya
(M.D,Radiology)(ASST PROFF)

DECEMBER 6 TH

DR. SRINADH

FETAL MEDICINE WORKSHOP- BY Dr.SRINADH (M.D) Dr.I.GAYATHRI (M.D) ON DECEMBER 6TH 2018

- **Dr. Srinadh (consultant fetal medicine, AIFMR, KPHP, Hyderabad ,**
- **Dr.I.Gayatri , M.S.OBGY (consultant in lotus hospitals Kurnool) attended as the guest speakers for the interactive workshop on obstetric ultrasound being organised by our department of OBGY on 6th dec,2018.**

COLLEGE FEST VIBES

Dance competitions

Cooking competitions

BIRTHDAY CELEBRATIONS IN OUR OGBY DEPT:

Dr.Deepthi .M (2nd yr P.G)

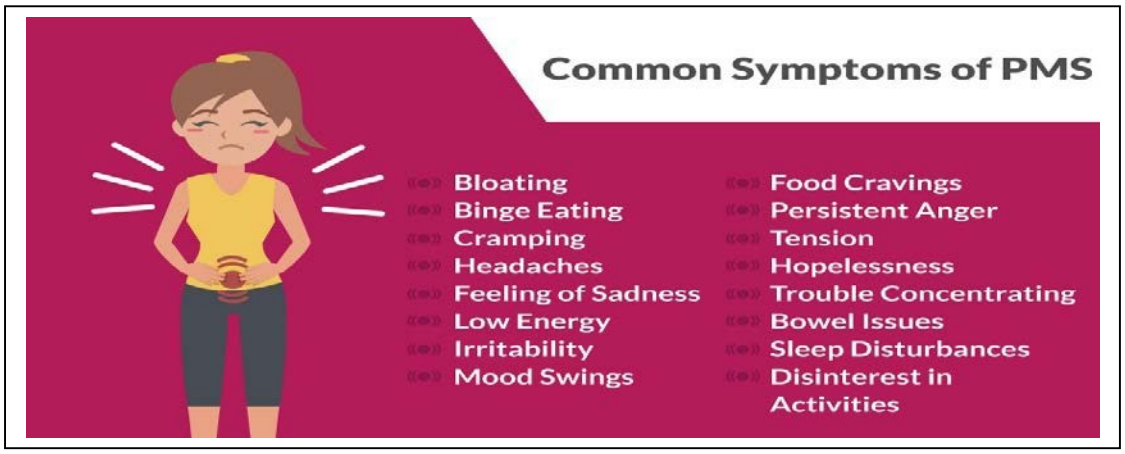
Dr.Anusha (1st yr P.G)

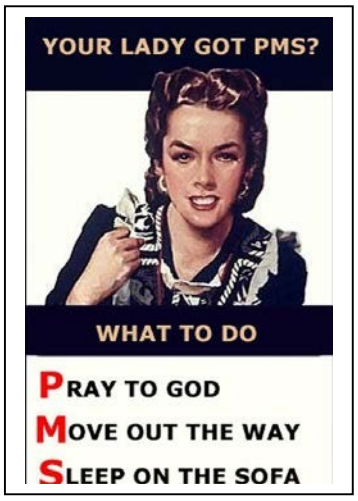
Dr.NAGA SUDHA (Final year PG)

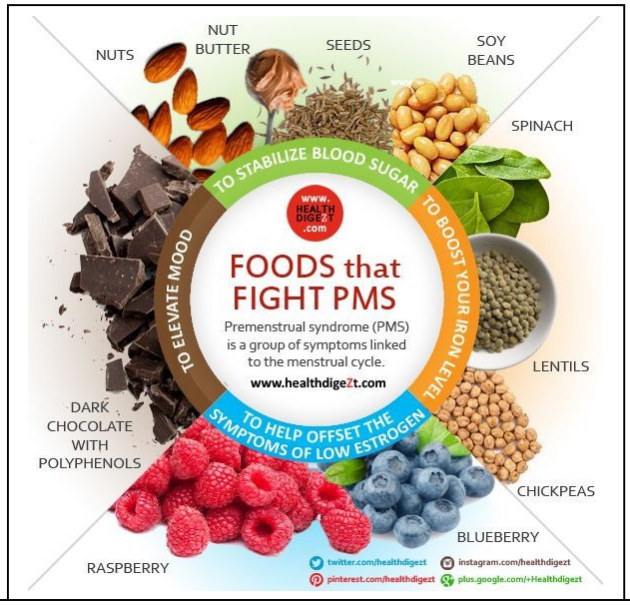
Dr.P.Ooha(1st yr PG)

HEALTH TIPS

Premenstrual syndrome:It is a symptom complex recognised primarily by cyclic changes Associated with ovulatory cycles.It occurs 7-14 days prior to menstruation &spontaneously resolves after menses.







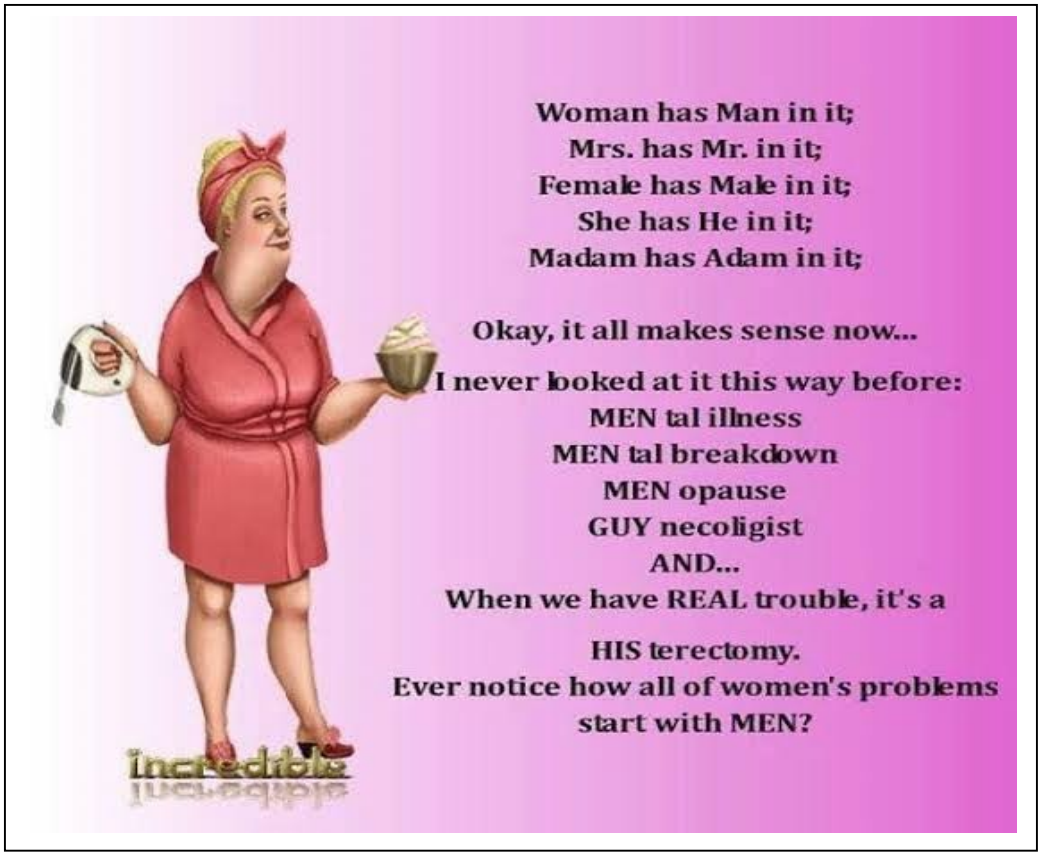
CAP-PRIZES & PRESENTATIONS:

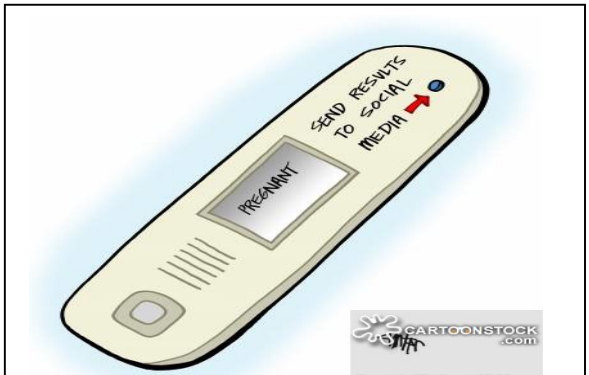
PRIZES:

- Dr.N.Divya- Won 1st prize for image of fort night-MENSTRUAL CUP

PRESENTATIONS:

- Dr.M.Deepthi parimala-scientist of the day-Dr.ROBERT GEOFFREY EDWARDS.
- Dr.M.Deepthi-Image of the fort night-VANISHING TWIN.
- Dr.V.Rajeevi-scientist of the day-Dr.ERNST WERTHEIM





FAREWELL TO Dr.HIMA SREE MAM

INTRODUCING NEW MEMBERS INTO OUR OBGY FAMILY

DR.K.KAVYA(ASSISTANT PROFESSOR)


OMG, Dr. where's the umbilical cord?
Wireless technology, sister...!