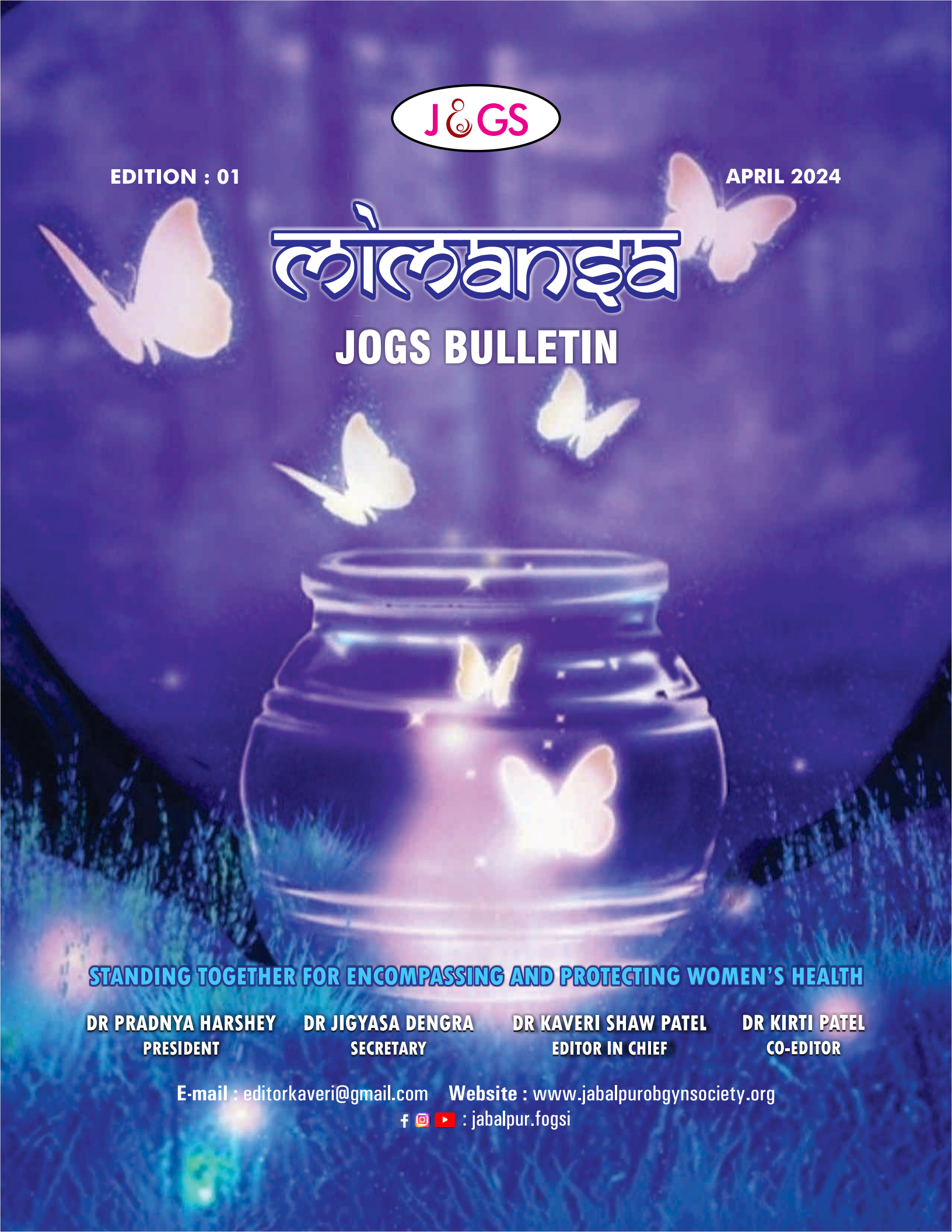

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JOGS BULLETIN

STANDING TOGETHER FOR ENCOMPASSING AND PROTECTING WOMEN'S HEALTH

DR PRADNYA HARSHEY
PRESIDENT

DR JIGYASA DENGRA
SECRETARY

DR KAVERI SHAW PATEL
EDITOR IN CHIEF

DR KIRTI PATEL
CO-EDITOR

E-mail : editorkaveri@gmail.com **Website :** www.jabalpurobgynsociety.org

: jabalpur.fogsi

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चिकित्सिका

परहित सुखाय मय ये जीवन अपना जनहित में जारी है !

जो बीत गई सो बात गई

जीवन जीते मधुशाला मय

तन-मन पर ले आघात कई

और धार ला रहे घिस घिसकर

कई पाठ पढ़े तो कई पाठ रचे

गिरे उठे थके ठिठके

पर भूले नहीं आगे बढ़ना भी अपनी जिम्मेदारी है

परहित सुखाय मय ये जीवन अपना जनहित में जारी है !

कितनी भी कठिन हो पगडंडी,

ढीली या कसी भी हो रस्सी

हम कुशल नट, पूरे जीवट, से पार पहुंच ही जाते हैं

हम प्रहरी, रक्षक, जनसेवक ऐसे ही नहीं बन जाते हैं

खुद तपकर भी कैसे छांव बनें, इतनी रखते तैयारी है

परहित सुखाय मय ये जीवन अपना जनहित में जारी है !

हम जात पात क्या धर्म प्रांत हर भेदभाव से ऊपर हैं

मानव सेवा के वचनब(, हर हाल काल में तत्पर हैं

हम फलदायी वो वृक्ष हैं जो पत्थर खाकर भी फूल झरें

कोई प्रशंसा, अनुशंसा, करता हो करे, या न भी करे

हम गीता ज्ञान के अनुयायी बस कर्म से सरोकारी हैं

परहित सुखायमय ये जीवन अपना जनहित में जारी है !

DR. SWATI VERMA JAIN
Damoh

From the FOGSI President's

Message

A big Congratulation to new team of Jabalpur Society.

We really admire society growing up with newer challenges coming in obstetrics and able to tackling them. The need of the society is to educate, eliminate and empower our womanhood which are really taken care by the Society continuously since last several years.

Our best wishes are always with so hardworking societies for putting milestones for others.

A growth of a society shows the positivity and unity in diversity.

I hope this year as well Jabalpur obstetrics and Gynae Society will come up with FOGSI vision Dr. Pradanya Harshey as president & dynamic Dr. Jigyasa Dengra as hon. Secretary will detinitely continue the newer JOBS assigned to them and will creat milestone acheivements. My best wishes are with them and new team.

I congratulate and expect the active support of dynamic team of managing committee members.

My good wishes to new editors Dr. Kaveri Shaw Patel and Dr. Kirti Patel that they will publish latest updates in their newsletter MIMANSA.

Looking for a bright future for FOGSI with JOGS with same motive and different vicinities.

DR JAYDEEP TANK

President FOGSI

From the FOGSI Secretary General's

Message

Dear Friends,

I bring greetings from the FOGSI!!

Dear FOGSIans and ICOGians,

Writing a blessing note is a pleasure for those whom we love.

It's a proud moment for me to write a blessing note for new team of Jabalpur Obstetrics and gynaecological Society as taking oath and responsibility for the new venture under leader ship of FOGSI President-Dr.Jaydeep Tank and Secretary General FOGSI Dr.Madhuri Patel. My blessings towards new president Dr. Pradanya Harshey as president & her sincere Secretary Dr. Jigyasa Dengra. I can say the team will definitely continue the newer jobs assigned to them and will make the tenure a successful one. I know team work is very important and we are working together, similarly I expect the active support of dynamic team members.

My good wishes to editors Dr. Kaveri Shaw Patel and Dr. Kirti Patel that they are going to update the newer things in obgy in their JOGS bulletin MIMANSA. May the tenure come with newer achievements in society.

Warm and personal regards,

M.A.Patel

DR MADHURI PATEL

Secretary General, FOGSI

Editor in Chief, JOGII

From the Chairperson ICOG

Message

It is indeed a pleasure to learn that a new team is taking over the reins of the prestigious Jabalpur Obstetrics & Gynec Society. I have always considered Jabalpur Society with high regards as one of the most active society of FOGSI. I have fond memories of my personal visits to Jabalpur for various workshops and the oration. I am very sure that, the able duo of senior and experienced Dr. Pradanya Harshey as president, & the energetic and dynamic Dr. Jigyasa Dengra as hon. Secretary will continue the legacy of outstanding predecessors and take the society to a level beyond, with the active support of powerful team of managing committee members and the editorial team of

Dr. Kaveri Shaw Patel and Dr. Kirti Patel.

With best wishes and regards

PARUL J. KOTDAWALA

Chairperson ICOG

From the JOGS President's Desk

Message

Greetings and Namaskar from JOGS 24 -25

Writing letter is expressing thoughts and wishes and words of encouragement to people we cherish . It's the beginning of journey of " Mimansa " the name as aptly says sincere deep thoughts coming together .I am extremely proud of our editor Dr Kaveri Shaw who is a visionary and Dr Kirti Patel who is sincere and silent co editor.They have worked hard to bring us articles from eminent writers,Dr Preeti Kumar Mam,Dr Parul Kotwala Dr Poonam Goyal . We are grateful to all stalwarts .Motherhood मातृ देवो भव is a blessing and we , as obstetricians play a pivotal role in helping mothers to be in their safe journey . Just like bud blossoms into flower , we are taking care of adolescents who become healthy and happy women . We as obstetricians are blessed to be a guiding candle to the mother to be and in our ways , we can help the society Dr Jigyasa ,my dynamic secretary and all members of safe motherhood committee have done excellent work in conducting safe motherhood programs .

I am thankful to President FOGSI Dr.Jaydeep Tank and Secretary General FOGSI-Dr Madhuri Patel for giving blessings for the book Mimansa .I also Thank Chairperson ICOG Dr Parul Kotdawala for sending Blessings for this new step of Jabalpur

DR. PRADNYA HARSHEY

Preident

From the JOGS Secretary Desk

Message

HELLO AND GREETINGS FROMS JOGS 2024-25

I would really like to appreciate all the efforts of yours for standing for protecting women's health

Human multitasking is the concept that one can split their attention on more than one task or activity at the same time and the best example of multi tasker is a gynecologist who deals with patients unable to conceive on one hand to patients who don't want pregnancy on other. One of important task for us as obstetrician is to have safe motherhood for all women which actually starts at adolescent in form healthy nutrition, anemia prevention and menstrual hygiene so that a women can enter into ante natal period in optimal condition, then comes her entire journey of motherhood and labor with our duty being taking her care throughout.

I am extremely grateful and thankful to President FOGSI; Dr Jaydeep Tank, Secretary FOGSI Dr Madhuri Patel, ICOG chair Dr Parul Kotadwala sir for giving their blessings to our newsletter 'Mimansa'.

We are blessed to have our writers who are all legends in the field. I thank them all

I also wish Dr Kaveri Shaw and Kirti Patel all the best.

THANKS, AND REGARDS

DR JIGYASA DENGRA
SECRETARY
JOURNAL JOGS 2024-25

From the Editor Desk

Message

Dear Readers

Greeting from Editorial Board

I do believe something very magical can happen when you read a good book.

"Mimansa" the name itself say sincere profound deep thoughts coming together "Here I congratulate all the reader for choosing this JOGS monthly bulletin as your choice and I can assure you that you will find it a best one.

A crisp update of recent advances with our own updates will be served you in attractive way.

This monthly bulletin will cover latest guidelines in gynecology, Articles based on researches by eminent writers of gynecology and regular quiz challenges to keep you thinking and learning.

We are here to keep all of us connected by academic feast monthly.

I am thankful to President FOGSI Dr. Jaydeep Tank and Secretary General FOGSI-Dr Madhuri Patel for giving blessings for the book Mimansa .

I also Thank Chairperson ICOG Dr Parul Kotdawala for sending Blessings for this new step of Jabalpur Society.I wish very Best for President Dr Pradanya Harshey and dynamic Secretary Dr.Jigyasa Dengra for a graceful tenure and believing in me for this valuable post of JOGS.

I know Dr. Kirti Patel my Right hand for this journey is always with me like a better half.

I thank you all my eminent writers for taking out time and giving society a wonderful article for knowledge.

I convey my love and regards to all my Seniors and wonderful readers, for their sincere contribution.

Regards

DR. KAVERI SHAW PATEL

Editor in Chief

JOGS 2024-25

From the Co- Editor Desk

Message

Hello every one

"There is no medicine like hope, no incentive so great and no tonic so powerful as expectation of something better tomorrow."

A women is the backbone of the society and her health is the prime responsibility of we obstetrician. safe motherhood is observed in India to raise awareness about importence of proper health care and maternity services for expectant mothers.This editorial is dedicated to four pillers of safe motherhood family planning antenatal care,clean safe delivery, essential obstetric care, basic maternity care.

So dear all let's pledge to save our mothers and children by providing them with best counselling, antenatal care and delivery services.

I would like to express my sincere gratitude to Dr Pradnya Harsey, Dr Jigyasa Dengra and DR Kaveri Shaw Patel to giving me this opportunity.

DR. KIRTI PATEL

Co-Editor

JOGS 2024-25

DIFFICULTY IN THE DELIVERY OF A BABY DURING LSCS

P. J. KOTDAWALA

Department of Obstetrics and Gynecology, V. S. General Hospital

& Smt. N.H.L. Municipal Medical College, Ahmedabad 380006, India

Kotdawala Women's Clinic, Ellisbridge, Ahmedabad 380006, India

e-mail: kotdawala@yahoo.com

M.J. PANDYA

Department of Obstetrics and Gynecology, AMC MET Medical College,

Sheth L. G. Hospital, Ahmedabad 380008, India

e-mail: munjal171184@yahoo.co.in

Introduction

Over the last three decades, there is a steady rise in cesarean sections globally [1]. This has mainly happened due to expanding indications for pri- mary cesarean section. We now perform elective CS in almost all breech pregnancies; preterm labor; various pregnancy situations such as asso- ciated medical problems, e.g., diabetes, hyper- tension, and immune problems; IVF pregnancies; advanced age pregnancies; and morbidly obese mothers. These higher rates of primary cesarean sections have led to very high repeat cesarean section rates! In almost all recent surveys for indications for CS, "previous cesarean section" has become the number one indication, contribut ing to almost 40–50 % of CS.

The various difficulties encountered during delivery of the baby can be listed as following:

1. Abdominal wall issues like previous scars, adhesions, and physical disability in the mother.
2. Problems of access to the lower segment like adhesions due to previous surgery, tumors like fibroid in the lower segment, or cancer of the cervix where trauma to the cervix may upstage the cancer. Uterine malformation, torsion of the uterus, and pre-labor CS where the forma- tion of lower segment is incomplete also con- tribute to the difficulties
3. A mal-positioned baby, fetus with high float- ing head or deeply engaged head may also pose problems in smooth delivery. Placenta previa, especially those located anteriorly, would make the delivery of the baby extremely testing!

Abdominal Wall

- Scars over the abdomen: Scars of previous cesarean section/sections or scars of laparot- omy may lead to extensive adhesions which can pose problem while entering the abdomi- nal cavity. Inflexible scar tissues may need a slightly bigger incision. Once an adequate sized scar is made, the delivery of the baby is not affected much.
- In general a vertical scar gives easy access to the upper parts of the uterus, but may make access to the extreme lower part of the uterus difficult, especially in an obese woman. A transverse scar gives an easy access to the

lower segment, but may not allow access to the upper segment easily. One may employ the incision according to the need of individual case.

- Adhesions: Adhesions due to previous surger- ies in the abdomen, due to endometriosis, or due to extensive pelvic inflammatory disease would cause problems to reach the lower uter- ine segment.
- Obesity
- Operative and postoperative complications among obese pregnant women include increased rates of excessive blood loss, operative time greater than 2 h, wound breakdown, infection, and endometritis. Sleep apnea occurring in this group of women may further complicate anes- thetic management and postoperative care.
- For obese women who require cesarean delivery, consideration should be given to using a higher dose of preoperative antibiotics for surgical prophylaxis than a normal-weight woman. Attempts to decrease the incidence of wound breakdowns and infections that have been studied include closure of the subcutaneous layers and the placement of subcutaneous drains. Although suture closure of the subcutaneous layer after cesarean delivery in obese patients may lead to a significant reduction in the incidence of postoperative wound disruption, postoperative place- ment of subcutaneous draining systems has not shown to be of consistent value in reducing post- operative morbidity. Prophylaxis against venous thromboembolism is vital in obese women due to higher risk, and the use of pneumatic compression, elastic bandages, and medical prophylaxis with unfractionated heparin or low molecular weight (LMW) heparin is indicated. Postpartum medical pro- phylaxis is recommended for patients who are at high risk of venous thromboembolism. As there is higher chance of emergency cesarean delivery and more complications, some resource planning like additional blood products, a large operating table, and extra personnel in the delivery is advisable. The type and placement of skin incision will also vary from routine low transverse incision, and at times one may need to consider placing the incision above the panniculus.

  The massively obese group was observed to be at significantly increased risk for delayed delivery and long operative time,prolonged delivery interval and blood loss >1,000 ml multiple epidural placement failures postoperative endometritis and prolonged hospitalization.

  Incision over the abdominal wall beneath the panniculus is avoided so as to prevent wound infection postoperatively. Instead, a supraumbili- cal approach would give entry to the uterus eas- ily, but cosmetically, it may not look good. The other approach is by lifting the panniculus by a Montgomery strap and putting an incision just above the pubic symphysis, which is cosmetically sound, but it makes access to the uterus dif ficult.

  Conventional wisdom dictated a low transverse incision after pulling up the panniculus by various means and performing the CS and to employ a ver tical incision if this was not possible. Both of these had a higher morbidity attached; the low trans- verse may not be adequate enough for intra- abdominal maneuvers for the delivery of the fetus. It also has a higher chance of post-op infection (due to overlying panniculus reducing aeration and less drying and irritation due to rubbing). The vertical incision has difficulty in accessing the lower uterine segment, higher rate of disruption, and hernia risk. Current experience has shown that a high transverse incision above the panniculus, after pulling it down as shown in the figure, may be the most appropriate in obese women. When the lower segment has not formed, preterm elec- tive CS, a deliberate transverse incision just below or above the umbilicus, and a fundal delivery of the baby would be the most appropriate. A lower incision and delivery through the lower segment is far more traumatic and risky in comparison to the marginally higher risk (2–3 %) of subsequent rup- ture. Several recent studies have concluded that if the lower segment seems inaccessible due to large panniculus, it is better to opt for a high

transverse incision with fundal delivery for better perinatal outcomes.

Lower Uterine Segment

- *Adhesions:* Adhesions covering the lower uterine segments, omental flaps extending over the fundus of the uterus, and the urinary bladder adhering high up to the upper uterine segment would cause difficulty in putting an incision over the lower uterine segment. A clear delineation of tissue planes is important for a safe delivery. In some cases where very low transverse incision was employed in a previous CS (Pfannenstiel), at times one may find direct contiguous adhesions between the uterus and the abdominal wall. Such adhe- sions require sharp dissection and may at times damage the bladder.
- *Tumors in the lower segment (fibroid, Carcinoma cervix, etc.):* Tumors/fibroid in the wall of the lower uterine segment along with its increased vascularity would prevent an easy entry through it. An incision just above the tumor may work well in accessing the uterine cavity and also for post delivery myo- mectomy if deemed fit. In a pregnancy with carcinoma of the cervix, one needs to be very careful.

Difficulties Encountered in Case of Deeply Engaged Head

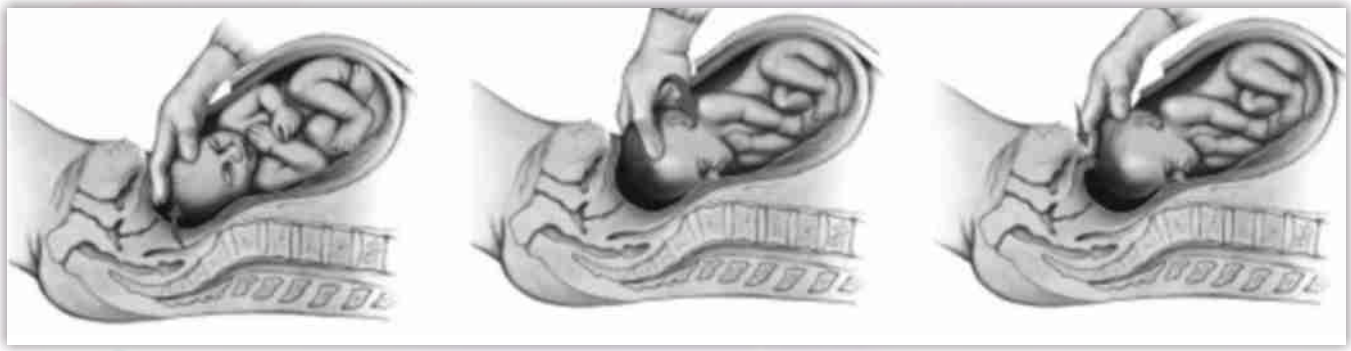
- *ERR sequence:* Outlined by Andrew Chao ERR sequence is an interesting maneu- ver for a safe delivery of the engaged head. Although this looks quite complex and a bit too intricate, it is well worth a mention here.

1. **Elevate**: Lock the fingers into a quarter- circle around the vertex. Apply traction out of the pelvis with the hand and the entire extended arm.
2. **Rotate**: Grasp the fetal head between the thumb and fingers and rotate it so the occiput faces the incision.
3. **Reduce**: Push the lower edge of the uterine incision down until it is posterior to the fetal head.

Too long trial Long trial of labor and failure of vaginal delivery would end up in a deeply engaged head, especially in deep transverse arrest. Baby delivery at cesarean in this situa- tion has difficulty in passing fingers below the head to disimpact and forward pull for deliv- ery. Here a forcible pushing of fingers and hand below the head may be very traumatic with lateral scar extensions and vertical tears toward the bladder. The following options may be employed to deal with this situation:

Push the head up from the vagina In this an assistant remains at the vaginal end between two legs. A Whitmore position is employed to increase the inlet dimensions to facilitate disen- gagement of a jammed head. As shown in the figure, Whitmore position leads to pressure on the acetabula and opening of the pelvic inlet. This is a modified lithotomy position where thighs are moderately abducted and flexed to approximately 135° relative to the trunk. The moderately abducted thighs would press the bilateral acetabula which results in more opening up of the pelvic cavity which can allow the push from below for delivering deeply engaged head. The vaginal hand pushes the head up out of the pelvis which can then be flexed and delivered by the abdominal hand (Fig. 34.7).

Intravenous nitroglycerin IV nitroglycerin bolus has been tried successfully to relax the uterus temporarily. Once the uterine muscle relaxes a little bit, one may be able to glide fin- gers below the head and dislodge it for a smooth delivery. An IV bolus of nitroglycerin (0.25–0.5 mg) will relax the uterus for approximately 20 s, long enough to pass fingers below the head. The anesthesiologist needs to be taken in to con- fidence as a short but steep dip in blood pressure is anticipated. Nitroglycerin does decrease the blood supply to the uterus, but the bolus dose has a transient effect which doesn't cause any fetal hypoxia. Intraoperative nitroglycerin application during cesarean section has no unfavorable effect on the condition of newborns <32 weeks or between 500 and 1,500 g. The incidence of intraoperative maternal blood loss >1,000 ml was not increased. Differences in the interval between nitroglycerin application and cutting of the umbilical cord have no clinically relevant effects on Apgar scores or arterial umbilical pH.



Pull from above Patwardhan described two maneuvers for different situations

1. *Back anterior:* If the back is anterior and the head is deeply engaged, one needs to deliver one hand and the shoulder out of incision, to be followed by the second hand and the shoul- der. Thereafter, the further pull in the grove of the abdomen will double up the child, and gradually the lower back, buttocks, and the legs will be delivered. Subsequent pull on the baby will bring out the head at last.
2. *Back posterior (reverse breech delivery/foot extraction method):* If the back is posterior and the head is deeply engaged, the feet are in the front. Passing the hand up from the abdo- men and pulling down the feet is easy, fol- lowed by the buttocks, and the head is delivered at the end.

Back lateral In almost a similar way, the opera- tor's hand is passed to the opposite side, and the foot is grasped and pulled down and out. The but- tocks, trunk, and the head will follow.

Pull vs. Push In general it has been found that a push from the vagina is more traumatic to the baby as well as to the genital tract. A pull from above, by pulling at the foot (reverse breech extraction), is safer for both the newborn and the mother. Several studies have confirmed this.

Floating head Difficulties encountered in case of floating head can be due to an elective pre-labor CS, too large head, preterm fetus, hydramnios, placenta previa, etc.

To ease up the head delivery, the first option is to induce uterine contractions to facilitate descent and expulsion. One should rupture the membranes and let the liquor drain out. The reduction in the volume inside the cavity will bring about uterine contraction. A simultaneous oxytocin infusion will help augment these con- tractions. A predelivery infusion of dilute oxy- tocin may achieve the same results, but care must be taken to avoid uterine hyperstimulation and resultant fetal compromise. Since the head is difficult to grasp and pull with a gloved hand, either pulling devices like vacuum extractor or obstetrical forceps may be employed.or the foot

extraction by reverse breech delivery may be employed. In case of foot extraction, one may need to act swiftly, and should not let much drainage of liquor, to allow the fetal somersault during the delivery!

Forceps/vacuum Both forceps and vacuum have been tried for delivery of a floating head.

Forceps: Short Simpson's forceps without a pelvic curve is the best suited instrument for head delivery.Generally the head will be in one of the transverse positions. Hence there will be a posterior and an anterior application. The anterior application can be difficult at times. The Barton's forceps with a hinged anterior blade is being proposed as a great tool to avoid this difficulty of application! The shank angling is also beneficial in easy applica- tion than straight shanks of a Simpson's forceps.

After application, one should rotate the face ante- riorly (occiput posterior) in a bid to reduce the transverse dimension of the head, and then pull out in a rotational arc toward the chest of the mother. Some colleagues rotate the face first to the anterior by inserting a finger in the mouth of the baby holding firm, and using a direct lateral application of the forceps blades on each side of the head! A direct pull out in transverse is also quite reasonable as

in routine CS the head is delivered in a transverse position.

Barton's forceps An effective aid in cesarean deliveries. The unique qualities of this classic medical instrument make it an effective, ergonomic option for cesarean deliveries involv- ing a high transverse position of the fetal head .

Vacuum Vacuum delivery of the floating head seems very plausible.But the correct application is very vital. Otherwise it may harm the fetus rather than facilitate the delivery. A correct application would be on the flexion point, the point at which the mento-vertical diameter crosses the sagittal suture, promoting flexion of the fetal neck. This will result in lesser traction force required to deliver the baby. A misplaced cup is the cause of majority of the complications. As most of the vacuum cups are designed for vaginal use have the pulling direction perpendicular to the device, their use during CS where the traction angle is almost a tangent, is ineffective. This leads to situations where the cup either slides over the scalp or it comes off due to the angle of the pull. To help an easy and optimally directed pull, spe- cial vacuum cups for CS are now designed. The Omni C is one such cup.

Malformed uterus Malformed uterus gener- ally leads to nonvertex presentations. So, very close deliberate examination to confirm not only fetal lie but position of the back and feet becomes vital in conducting delivery. A general rule of thumb of following foot and delivering the baby would be least traumatic to baby as well as to the uterus.

Overstretched Lower Segment (Bandl's Ring)

Due to extended labor and pro- longed drainage of liquor amnii, the upper seg-ment of the uterus retracts and thickens, leading to overstretching of the lower segment. This dif- ferential thickness is pronounced at the junction known as Bandl's ring. This narrowing leads to holding of fetal parts above it at the time of deliv- ery. A forcible delivery through this ring may produce trauma to the uterus. It is vital that either the ring is reduced by giving uterine relaxants like nitroglycerin, or the ring is deliberately cut at its anterior part for a safe delivery. Hence a lower segment vertical incision on the uterus extending and cutting through the ring is the most appropri- ate method of delivery during CS.

Summary

- Access to abdominal cavity has to be planned ahead in consultation with the patient.
- An inaccessible lower segment is not an end of the world situation. Upper segment C sec- tion can be a valid option & should be seriously considered, if serious harm is anticipated in accessing the lower segment.
- Floating head should be allowed to descend by letting the liquor drain and let the uterus contract by using oxytocin. A delivery by pulling at & delivery of the foot first, or use of vacuum/forceps will help.
- Deeply engaged head: A semi-lithotomy position, reverse breech extraction, use of I/V nitroglycerine, and use of disengaging devices are safer options.
- Obese women: A horizontal incision above the panniculus, at times going supra-umbilical will facilitate the smooth delivery. A fundal delivery of the baby may be considered.
- In cases of anterior placenta previa a detailed mapping of its margins will help decide the side where the membranes may be accessed with minimal separation of placenta & avoid incising the placenta.
- An emphasis on training the resident doctors for intra-partum C sections will increase their confidence and efficiency.

References

1. WHO Statement on Caesarean Section Rates WHO/ RHR/15.02 (www.who.int) & Ghosh S, James K. Levels and trends in caesarean births:

PRE-ECLMPSIA & ECLAMPSIA GUIDELINES (RECOMMENDATIONS)

DR. POONAM GOYAL
Chairoersin
Safe Motherhood Committee - 2024-2026

BACKGROUND

About 10% of mothers in Asia and Africa pass away due to high blood pressure during pregnancy. The most dangerous types are called pre-eclampsia and eclampsia, causing severe problems for both mothers and babies. However, most of these deaths could be prevented if women get the right care at the right time, based on proven methods. The incidence of pre-eclampsia in India varies from 5-15%and that of eclampsia is about 1.5%.

Government and other stakeholders should give due attention to early screening and treatment of hypertensive disorders in pregnancy. Community Based approach to diagnose and treat the problem are recommended.

CRITERIA FOR DIAGNOSIS OF PRE-ECLAMPSIA AND ECLAMPSIA [3]

PRE-ECLAMPSIA

Onset of a new episode of hypertension during pregnancy, characterisedby:

- Persistent hypertension (diastolic blood pressure >90mm Hg) and
- Substantial proteinuria (> 0.3g/24 hours).

ECLAMPSIA

- Generalised seizures, generally in addition to pre-eclampsia criteria.

RISK FACTORS

- Nulliparity
- Multifetal gestation
- Preeclampsia in previous pregnancy
- Chronic hypertension
- Pregestational diabetes
- Gestational diabetes
- Thrombophilia
- Systemic lupus erythematosus
- Pre pregnancy BMI greater than 30
- Antiphospholipid antibody syndrome
- Maternal age 35 years or older
- Kidney disease
- Assisted reproductive technology
- Obstructive sleep apnoea

SCREENING FOR PRE-ECLAMPSIA USING ULTRASOUND [2]

Which doppler index to use??

- The PI should be used for examination of uterine artery resistance in the context of pre-eclampsia screening.

First trimester

- Mean uterine artery PI should be the doppler index of choice for screening in the first trimester.
- Doppler examination of the uterine arteries at 11 to 13.6 weeks can be performed either transabdominally or transvaginally.
- Standardized methodology should be followed for assessment of the uterine artery doppler indices.
- If the uterine artery does not have notch PI should be < 1.0, if notch is present and PI is => 1.7 then we need to calculate NDI (Notch depth index) which should ideally be < 0.55.

Second trimester

- Doppler examination of the uterine arteries at the second-trimester scan can be performed either transabdominally or transvaginally
- Mean uterine artery PI should be used for prediction of pre-eclampsia.

Third trimester

- There are currently no randomized trials on the impact of the third-trimester screening for pre-eclampsia on maternal, feal and neonatal outcomes. Consequently, its implementation into routine practice cannot be recommended at present.
- Mean uterine artery PI should be used for prediction of pre-eclampsia, if this is offered in the third trimester.

Combined screening strategies

- A combination of maternal factors, maternal arterial blood pressure, uterine artery doppler and PLGF level at 11-13 weeks appears to be the most efficient screening model for identification of women at risk of pre-eclampsia.
- Given then superiority of combined screening, the use of doppler cut-offs as a standalone screening modality should be avoided if combined screening is available.

CLINICAL PRACTICE RECOMMENDATIONS FOR THE PREVENTION AND MANAGEMENT OF PRE-ECLAMPSIA AND ECLAMSIA[3]

DURING ANTENATAL CARE

PRACTICES RECOMMENDED

- Calcium supplementation during pregnancy in areas where calcium intake is low(< 900mg/day)
- Low dose aspirin (75mg) for the prevention of pre-eclampsia in women at high risk of developing the condition
- Antihypertensive drugs for pregnant women with severe hypertension.

In women with severe pre-eclampsia, if there is a viable fetus and the pregnancy is less than37 weeks of gestation, expectant management can be considered.

PRACTICES NOT RECOMMENDED

- Vitamin D supplementation during pregnancy
- Calcium supplementation during pregnancy in areas where calcium deficiency is not present.
- Individual or combined vitamin C and vitamin E supplementation
- Use of diuretics, particularly thiazides for prevention
- Advice to rest at home
- Strict bed rest
- Restriction in dietary salt intake.

PRACTICE IMPLICATION

- Provide calcium to all women with low calcium intake and low-dose aspirin to selected groups for the prevention of pre -eclampsia and eclampsia. While vitamin supplementation can be useful for other health conditions, do not provide vitamin C, D, E to pregnant women as a part of a strategy for prevention of pre-eclampsia and eclampsia.
- Give antihypertensive drugs, but not diuretics, to pregnant women with severe hypertension
- Do not advise rest or dietary salt restriction for pregnant women to prevent pre-eclampsia or its complications.

DURING LABOR AND BIRTH

RECOMMENDED PRACTICES

- Induction of labour for women with severe pre-eclampsia at a gestational age when the fetus is not viable or is unlikely to achieve viability with in one or two weeks.
- Expedited delivery for women with severe pre-eclampsia at term.
- Magnesium sulphate, in preference to other anticonvulsants, for the prevention of eclampsia in women with severe pre-eclampsia
- Magnesium sulphate, inpreference to other anticonvulsants, for treatment of women with eclampsia
- The full intravenous or intramuscular magnesium sulphate regimen for the prevention and treatment of eclampsia
- For women with severe pre-eclampsia or eclampsia, in settings where it is not possible to administer the full magnesium sulphateregimen, use the magnesium sulphate loading dose followed by immediate transfer to a high-level health care facility.

PRACTICE IMPLICATION

- Conduct an expedited delivery for women with severe pre-eclampsia remote from term, whether or not the fetus is viable.
- Magnesium sulphate is the anticonvulsant of choice for women with severe pre-eclampsia. If possible, give a full regimen of magnesium sulphate to women with eclampsia or severe pre-eclampsia. If the administration of a full regimen is not possible, these women should be immediately transferred to a higher-level health care facility for further management.

DURING POSTPARTUM CARE

RECOMMENDED PRACTICES

- Continued antihypertensive drugs during the postpartum period for women treated with antihypertensive drugs during the antenatal period.
- Antihypertensive drugs for women with severepostpartum hypertension.

PRACTICE IMPLICATION

- Treat women with antihypertensive drugs during the postpartum period if they

1. Have severe postpartum hypertension
2. Were treated with antihypertensive drugs during pregnancy.

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FOGSI'S MANYATA INITIATIVE - A NEED FOR PRIVATE HEALTH FACILITY


DR HRISHIKESH PAI


DR HEMA DIVAKAR


DR AMEYA PURANDARE


DR SAMITA BHARDWAJ


DR PRITI KUMAR


DR KAVERI SHAW PATEL

INTRODUCTION

WHO commends India for its ground-breaking progress in recent years in reducing the maternal mortality ratio (MMR) by 77%, from 556 per 100 000 live births in 1990 to 130 per 100 000 live births in 2016. India has experienced an estimated 4.7% annual decline in maternal mortality ratio and 3.5% annual increase in skilled birth attendance. Ninety-four percent (94%) of all maternal deaths occur in low and lower middle-income countries. India has consistently reaffirmed its commitment towards the eight development goals to reduce poverty and other areas of deprivation. In 2018, World Health Organization (WHO) congratulated India for great reduction in maternal mortality since 2005, especially in remarkable feat in contrast with the global maternal mortality reported decline of 43%, from which WHO and other international bodies concluded that India could not reach the Millennium Development Goals.

Private health facilities in India count for around 26% of institutional deliveries, (42% in urban 22% in rural). More than half of the deliveries take place in public health facilities. Government of India (GOI) has formed 'LaQshya Guidelines' for public facilities providing maternity and new-born care. These facilities have to upgrade the standards including clinical norms revolving around labour room and maternity OT through developed training processes in turn certification of labour room and incentives. The activities under LaQshya initiative are spread out in 4 phases spanning up to 18 months from intensive preparatory phase to evaluation phase.

In view to utilize the health care human resources efficientlyGOI in partnership with FOGSI and ICOG (Academic wing of FOGSI) had developed a program in 2006,with curriculum-based training and certification program which was successful during the implemented time period and GoI pursued to spread out the similar process in other disciplines.

Together launched **'Manyata'** – a nationwide initiative to improve the quality of private maternity care for women in low- and middle-income categories.FOGSI is a professional organization representing 35000 individual practitioners of obstetrics and gynaecology in India with 219 member societies spread over the length and breadth of the country. Manyata is not just a promise to expecting mothers for quality care, it is a reality. It is FOGSI's approval recognizing those who consistently deliver respectful and quality care during pregnancy and childbirth knowing that better, safer and respectful care will reach mothers.

Manyata Methodology : A set of 16 standards have been introduced as the standard practice which constitute the minimal essential care every woman must receive during her delivery.. The program promotes the adoption and practice of these 16 clinical standards based on World Health Organization's (WHO) standards, consisting of 5-6 sub criteria's to be assessed (Fig.1).

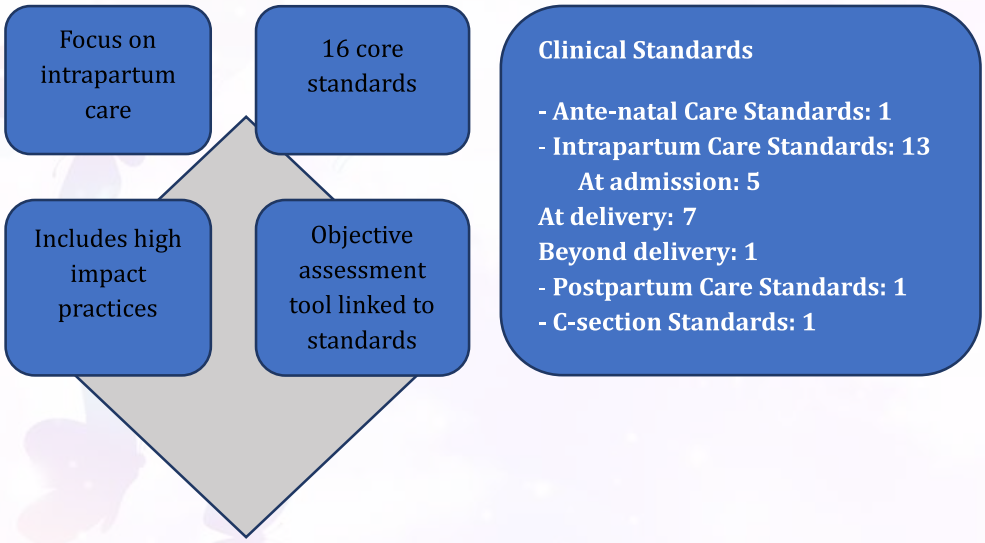
Standard number 6 is to Ensure respectful and supportive care.

Sr. No.	Clinical Standards
1	Provider screens for key clinical conditions that may lead to complication during pregnancy
2	Prepares for safe care during delivery
3	Assess all pregnant woman at admission
4	Conduct Per-vaginum (PV) examination appropriately
5	Monitor the progress of Labour appropriately
6	**Ensure respectful and supportive care**
7	Assist the pregnant woman to have a safe and clean birth
8	Conduct a rapid initial assessment and perform immediate newborn care (if baby cried immediately)
9	Perform Active Management of Third Stage of Labour (AMTSL)
10	Identify and manage Postpartum Haemorrhage
11	Identify and manage severe Pre-eclampsia/Eclampsia
12	Perform newborn resuscitation if baby does not cry immediately after birth
13	Ensure care of newborn with small size at birth
14	Adhere to universal infection prevention protocols
15	Ensure adequate postpartum care package is offered to the mother and baby at discharge
16	Review clinical practices related to C-section at regular intervals

Figure 1: Overview of 16 clinical standards

The 16 core standards are focussed on antenatal, intrapartum, and postpartum care with a guide to providers to perform the specific actions in each case in a timely manner (Fig. 2).

Figure 2 : Focused areas of clinical standards



The process for any private centre that gets enrolled in this initiative voluntarily starts with registration followed by self-assessment to be done. Further the facility will be assessed by the program teams on the self-assessed parameters, and the concerned healthcare providers will be trained on the 16 standards with an action plan developed for individual facilities accordingly. Post training the facility is assessed by the FOGSIs empanelled assessors on the 16 clinical standards through National Programme Management Unit (NPMU).On scoring over 85%, the hospital will be certified with the 'Manyata Seal of Quality' and shall officially be considered as a healthcare facility that provides quality maternal care (Fig. 3).

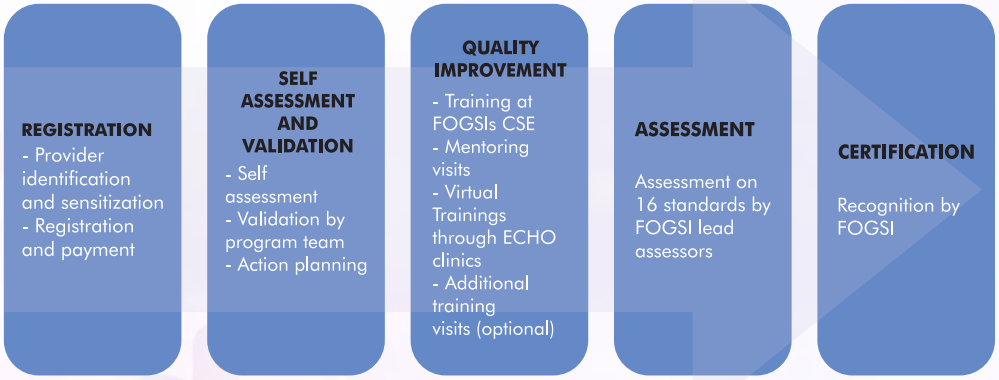


Figure 3: Process for Manyata registration to certification.

<u>Manyata training journey and impact:</u>

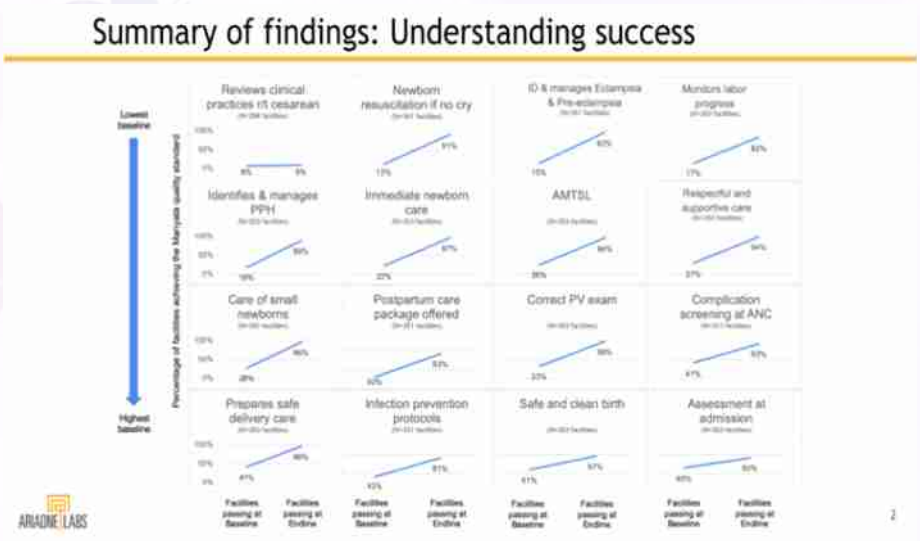
The program was initiated with Uttar Pradesh, Jharkhand and Maharashtra states spreading out to other 13 states of India. Before COVID – 19 the training and certification was implemented onsite. Due to COVID – 19, the whole system had been shifted to virtual platform bringing all the facilities together. The program has reached out to 2400+ centres in 3 phases pan India, with 1650+ certified onsite and further continuing it on virtual platform since April 2020. Online assessments until now are more than 1100 including the 185 assessments by Government of Maharashtra assessors . FOGSI has connected with hospitals/ FOGSI society to setup Centre for Skill Enhancement (CSE) to undertake trainings for the facilities enrolling for the Manyata program. One such is the Smriti Rainbow Hospital from Agra, Uttar Pradesh under the direct supervision of Dr. Narendra Malhotra and Dr. Jaideep

Malhotra. Dr. Hema Divakar's ARTIST for Her from Bangalore, Karnataka is another such CSE.

In these 1650 centres more than 10000 providers are being trained including the assistant doctors, staff nurses and housekeeping staff with more than 450000 deliveries impacted. The Indian government has, time and again, reiterated its commitment to Universal Health Coverage (UHC) or 'Health for All', with Ayushman Bharat as the primary conduit. The government is prioritizing UHC to ensure that every community in every corner of India has access to quality health care. Private sector efforts to improve the quality of their services are indispensable in universalizing quality health care in India.

Preliminary Evidence Generated by Ariadne Labs:) (Source: Program Data analysis)

The majority of Manyata doctors (95.6%) and nurses (87.2%) felt that Manyata improved the quality of care in their facilities and that they valued this more than any other aspect.



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LIST OF ABBREVIATIONS:

AMTSL – Active Management of Third Stage of Labour
CSE – Centre for Skill Enhancement
FOGSI – Federation of Obstetric and Gynaecological Societies of India
GoI – Government of India
ICOG – Indian College of Obstetricians and Gynaecologists
MMR – Maternal Mortality Ratio
MDG – Millennium Development Goal
NPMU – National Programme Management Unit
PwC – PricewaterhouseCoopers
RMC – Respectful Maternity Care
SDG – Sustainable Development Goal
UHC – Universal Health Coverage
WHO – World Health Organization

QUIZ

BY- MEDICOLEGAL COMMITTEE

DR ARCHANA SINGH

DR PRIYANKA GAUR

DR. BHOOMIKA TIWATI

DR SAKSHI MISHRA

RULES-

- Kindly share your answer on this email id. " editorkaveri@gmail.com".
- First three entries with maximum score will be the winners.
- Name of winners will be announced in our next bulletin.

1. When was the latest amendment done in MTP act 1971?

a) 2019 b) 2020 c) 2021 d) 2022

2. As per MTP Amendment act what is true for gestational age of pregnancy termination?

a) 20 weeks for all indications

b) Beyond 24 weeks for all indications

c) Beyond 24 weeks for substantial fetal abnormality

d) Beyond 24 weeks for rape survivors

3. As per MTP amendment act what is form E

a) Opinion form of registered medical practitioner.

b) Consent form

c) Certificate for approval

d) Form of application for the approval of a place

4. As per MTP Amendment Act form D is_____?

a) Opinion form of registered medical practitioner.

b) Reporting form

c) Report of medical board for pregnancy termination beyond 24 weeks.

d) Admission register

5. what are the consent forms in PCPNDT &MTP ACT

a) FORM G & C b) FORM F & C

c) FORM G & D d) FORM F & D

6. How many forms are to be filled under PCPNDT act?

a) 5 b) 6 c) 7 d) 8

7. Under PCPNDT ACT , form F is for_____?

a) Application for registration.

b) Certificate of registration.

c) Form of consent for procedure

d) Form for maintenance of records in case of prenatal diagnostic test/ procedure by genetic clinic/ultrasound clinic/imaging centre

8. When did POCSO act come into force??

a) 2011 b) 2012 c) 2013 d) 2010

9. What is a child as per POCSO act?

a) Anyone below 18 years of age

b) Anyone below 16 years of age

c) Anyone below 14 years of age

d) Anyone below 12 years of age

10. What is Section 376 of the Indian Penal Code?

a) Unlawful compulsory labour

b) Rape

c) Punishment for rape

d) Unnatural offences

HPV VACCINATION DRIVE



EXECUTIVE BODY MEETING




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HEALTH AWARENESS ON WORLD HEALTH DAY





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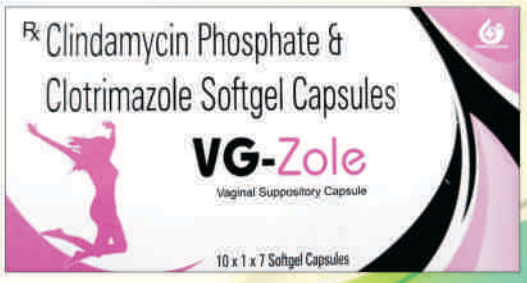

INDICATIONS :

- Candida Vulvitis
- Vaginal Candidiasis
- Vaginal Mycoses

- Candida Vulvitis
- Vaginal Candidiasis
- Vaginal Mycoses