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COGS NEWSLETTER

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FROM THE EDITORS' DESK:

DR PREMALATHA KRISHNA KUMAR AND DR SUDHA SUNDARAM.

Dear Fellow COGSIANS

Here we are with the very first eNewsletter from Covai Obstetricians and Gynaecologists Society. As a society with around 200 registered members this is a natural next step. We sincerely hope you will be stimulated by this edition and hope to receive support for continuation of this project.

In this issue we have included "Analysis of causes of Maternal Mortality in a Tertiary care centre" by Dr Murugalakshmi and Dr Devi Lakshmi, which is a published article from Coimbatore Medical College Hospital. Hope this article will stimulate young minds to formulate steps to reduce maternal mortality of any kind. Summary of 'FIGO consensus guidelines of placenta accreta spectrum disorders' which was published in 2018 will help to clarify in case of dilemma in anterior placentation in previous LSCS cases.

We have also included two interesting cases from Dr. Uma SenthilKumar and Dr Damodar Rao. In the recent years doctors are facing violence from general public. Our senior gynaecologist Dr Lalitha Vijayakrishnan explores ways and gives suggestions in reducing altercations and improving doctor- client rapport.

We are looking forward to your feedback and suggestions to move ahead.

President's address:

DR. CHITRA T V

It is indeed my great pleasure to initiate News Letters for COGS. Due to untiring efforts of our team with enthusiastic & persistent effort of Dr Premalatha KrishnaKumar & Dr.Sudha this is made possible.

Current topics of interest, recent guidelines, published articles by COGS members & achievements of COGS members and many more interesting things will be published. Proceedings of the previous month's conferences & meetings to be held will be notified.

This News Letter we hope will enlight us and key us updated. We hope & wish that everybody will participate and submit articles to this a successful endeavour.

I foresee great success for this New Letter

Dr.Chitra.T.V
President – Covai OG Society

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ANALYSIS OF CAUSES OF MATERNAL MORTALITY IN A TERTIARY CARE CENTRE

Dr. K.Murugalakshmi Md,Dgo1, Dr. A.Devi Lakshmi,Md{Og}2
1.Associate Professor,Dept Of Obstetrics And Gynecology,Coimbatore Medical College Hospital.
2.Assistant Professor, Dept Of Obstetrics And Gynecology,Coimbatore Medical College Hospital

Pregnancy and childbirth is a normal physiological process bringing a joyful experience to individuals and families. However, in many parts of the world, pregnancy and childbirth is a perilous journey, a risky and potentially fatal experience for millions of women especially in developing countries. The average maternal mortality rates in developed countries is between 10-15/100,000 live births while developing countries record rates 100-200 times this number. Maternal death is defined by the World Health Organization (WHO) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[1] The world mortality rate has declined 45% since 1990, but still 800 women die every day from pregnancy or childbirth related causes. According to the United Nations Population Fund (UNFPA) this is equivalent to “about one woman every two minutes and for every woman who dies, 20 or 30 encounter complications with serious or long-lasting consequences. Most of these deaths and injuries are entirely preventable.” [2]

I. Measurement

The four measures of maternal death are the maternal mortality ratio (MMR), maternal mortality rate, lifetime risk of maternal death and proportion of maternal deaths among deaths of women of reproductive years (PM). Maternal mortality ratio (MMR): the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period.[13] The MMR is used as a measure of the quality of a health care system. Maternal mortality rate (MMRate): the number of maternal deaths in a population divided by the number of women of reproductive age, usually expressed per 1,000 women.[13] Lifetime risk of maternal death: refers to the probability that a 15-year-old female will die eventually from a maternal cause if she experiences throughout her lifetime the risks of maternal death and the overall levels of fertility and mortality that are observed for a given population. The adult lifetime risk of maternal mortality can be derived using either the maternal mortality ratio (MMR), or the maternal mortality rate (MMRate). [13]
Proportion of maternal deaths among deaths of women of reproductive age (PM): the number of maternal deaths in a given time period divided by the total deaths among women aged 15–49 years.[14]
India contributes one-fifth of the global burden of absolute maternal deaths; however, it has experienced an estimated 4.7% annual decline in maternal mortality ratio (MMR) [1], [2], and 3.5% annual increase in skilled birth attendance since 1990 [1], [3]. While not on track to meet Millennium Development Goal number 5, India is making progress in reducing maternal mortality

- Direct deaths are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received. The major complications that account for nearly 75% of all maternal deaths are:3

Table 2:’ Among the gestational hypertension cases,neurological complications(65%) form the main cause,followed by pulmonary edema(14%),ARF(10%) and HELLP syndrome(7%).

Causes	Number	Percentage
Neurological(cva+cvt+ecl)	34	65
Abruption	2	4
Arf	5	10
Hellp	4	7
Pulmonary edema	7	14

●severe bleeding (mostly bleeding after childbirth)
●infections (usually after childbirth)
●high blood pressure during pregnancy (pre-eclampsia and eclampsia)
Indirect deaths are those associated with a disorder, the effect of which is exacerbated by pregnancy.{heart disease,anemia,other medical disorders}

II. Materials And Methods

Retrospective analysis of maternal deaths that occurred in Coimbatore Medical College Hospital during the last three years – 2013,2014 and 2015.During this period we had 131 maternal deaths out of 20147 live births.so the MMR in our hospital is 650 which is in par with that of our national MMR**.**

III. Observation

Table 1: Causes Of Maternal Mortality

Causes	Number	Percentage
Ght	52	40
Hemorrhage	12	9
Sepsis	10	8
Medical disorders	35	26
Others	22	17

Medical disorders	Total 35
Renal	1
Respiratory	7
Heart disease	9
Dm	3
Liver	7
Anemia	8

Others	22
Rta	3
Burns	5
Leukemia	1
Sol	1
Meningoencephalitis	2
Hiv	2
Pulmonary embolism	5
Amniotic fluid embolism	2
Anaesthesia complication	1

Gestational hypertension(40%) ranks first among the causes of maternal mortality followed by hemorrhage(9%) and sepsis(8%).Among the indirect causes,Heart disease stands first,followed by anemia,liver and respiratory illness.

Sepsis even in the era of antibiotics forms about ten percentage of the causes,mainly because of postabortal cases,revealing the pregnancy in late stages while sinking into a state of irreversible shock.All of them were unbooked, multigravidas ,illegal pregnancies which were diagnosed incidentally when they were admitted for some other illness.

Hemorrhage has come down with the advent of adequate conveyances for transport to tertiary care centres,availability of blood components at peripheral centres and liberalization of hysterectomy for saving the life of the mother ,sacrificing the uterus.

Anemia though an indirect cause forms a major bulk because of delayed booking and referrals,noncompliance of the patient,not revealing the pregnancy due to illegacy and illiteracy.
Among the Respiratory illnesses,pulmonary tuberculosis stood first..Due to the availability of ATT,patient survives upto the reproductive age group,but succumbs to the sequelae (fibrosis of the

.

SMILE OR CRY

Dr Lalitha Vijayakrishnan (obstetrician and gynecologist)

As India, I am also going to celebrate my 72nd birthday this month.
India needs 20 lakh doctors to keep the population in the pink.
But our number so far is half the required estimate.

Are the doctors happy?

Going through the news coming in the media day by day doctors are being beaten up, killed and destroyed emotionally.

We cannot change any government policy.

We cannot change the mob reaction.

All what we can do is change our self and adopt methods which will reduce the work stress and reduce the chance of litigation.

How is it possible?

We have decided to take up this profession because we love it.

First we, the doctors have to remove the mantle

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Table3: Age Wise Presentation:

Age	No.of deaths
<20	19
20-30	96
>30	16

Third decade death is more common,followed by second and fourth decade.

Table 4: Parity

Parity	No.of deaths
Primi	55
2-4	72
>5	4

Primi forms about 40% of cases and multi(2-4) forms about 57 % and grandmulti(>5) forms about 3%.

Table 5: Distribution Of Gestational Hypertension Cases Parity Wise

	Cva	Cvt	Hellp	Arf	Abruption	Pulm edema
Primi	13	10	2	2	0	2
Multi	5	5	4	1	2	3
Grand multi		2				1

In Primi,the main cause of death is the neurological complication of gestational hypertension which tells us that there is some underlying vascular pathology that also affects the central nervous system which usually runs in families.so a proper history taking at the booking visit may help us overcome this catastrophe.

Summary

From our study,it is obvious that gestational hypertension ranks first among the causes of maternal mortality..Hemorrhage and sepsis has come down in this era..

Among gestational hypertension the main cause in primigravidas,seems to be neurological complications, which tells us that there is some underlying vascular pathology that also affects the central nervous system which usually runs in families.so a proper history taking at the booking visit may help us overcome this catastrophe.

Anemia forms an indirect cause increasing the mortality rate of PPH and sepsis.

lung) of the disease.

Conclusion

The unacceptably high maternal mortality rate in India can be reduced by making concerted efforts along the following lines: -

Initiative from the government would be of paramount importance in this effort. This would include allocation of sufficient funds to all the health institutions including Primary Health Centers. Even more important is to ensure that the funds actually reach the users. Construction of better roads and transport facilities especially in the rural areas. Local dais and female health workers should be imparted periodic training and be incorporated as integral part of health care system.

Early registration of antenatal cases.

Health education of couples to make them understand the importance of antenatal check ups,hospital deliveries and small family norms.

Wide spread availability of Iron – Folic acid tablets and fortified food to the remotest of remote area Prevention and early treatment of infection,antepartum and postpartum haemorrhage. Treatment of concomitant illnesses like diabetes,tuberculosis and malaria. Emphasising the importance of observing proper aseptic measures while conducting deliveries.

Providing facilities for hospital deliveries for high risk cases like severe anaemia, diabetes and heart disease. Accountability in case of the unfortunate event of any maternal death. Taking appropriate remedial measures for preventing lapses noted in the management of these cases will be of immense value.

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FIGO Consensus Guidelines on Placenta Accreta Spectrum disorders:
Prenatal Diagnosis and Screening.

Eric Jauniaux et al. Intl J Gynecol Obstet 2018; 140:274-280

Abnormal placentation is a spectrum disorder that includes – abnormal adherence (placenta creta) and abnormal invasion (placenta percreta). These Placenta Accreta Spectrum (PAS) disorders largely remain undiagnosed before delivery with increasing risk of maternal morbidity and mortality.PAS disorders are a growing obstetric issue with global rise in caesarean rates. Although definitive diagnosis is done after delivery and with histological guidance, prenatal diagnostic techniques help raise suspicion of PAS disorders. There paucity of data and lack of universal terminology usage in screening techniques.

In an attempt to reduce errors due to the subjectivity involved in making this diagnosis and ensure that all operators are using the same description for the same sign,

of God/superman.


Make it known to the public/patient that we are only human being  with special training to understand human suffering and advise therapeutic measures which are commonly acceptable and recommended; that doesn't mean that everybody would respond to the therapy the same way. There can be variability in each individual.


Doctors cannot increase the longevity –life and death are not in doctor's hand.


What a doctor can do is improve the quality of life.

Be calm and humane while you are attending to the patient.

Be honest

Show empathy and Understanding.

Don't create an impression that you are mad after money. 

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the European Working Group on Abnormally Invasive Placenta **(EW-AIP**) recently proposed a standardized description and name for all the ultrasound signs used for the prenatal diagnosis of placenta accreta.

FIGO has put forward the following recommendations to help picking up PAS disorders in antenatal period.

Recommendations	Resource settings	Quality of evidence and strength of recomendation
Ultrasonography is a relatively inexpensive and widely available imaging modality and therefore should be the first line for the diagnosis of PAS disorder	All	High and Strong
Women diagnosed with cesarean scar pregnancy in the first trimester should be counseled regarding high risk of requiring a hysterectomy owing to PAS disorders. They should be followed up by the most experienced operator available, preferably one with expertise in diagnosis of PAS disorder.	All	High and Strong
At mid-trimester examination for fetal anomaly, all women should be asked if they have had a previous cesarean delivery. If so, this should prompt careful assessment of the placental implantation sire especially if it is anterior, low lying or previa.	All	Medium and Strong
Ultrasound signs observed for the diagnosis of PAS disorders should be described using standardized protocols.	All	Medium and Strong
The recorded presence or absence of each ultrasound sign will be influenced by the operator's interpretation of what constitutes that marker.	All	High and Strong
MRI is not essential for making a prenatal diagnosis of suspected PAS disorders but may be useful in evaluation the pelvic extension of a placenta percreta or areas difficult to evaluate on ultrasound	High income	Medium and Weak

A rare case of Ovarian ectopic pregnancy

Dr.Uma Senthil Kumar

Abstract

Background:

Ovarian pregnancy is a rare form of the non-tubal ectopic pregnancy. It ends with rupture before the end of the first trimester. Primary ovarian ectopic pregnancy is a rare type of ectopic pregnancy which has an estimated prevalence ranging from 1:7000 to 1:70,000 accounting for almost 3 % of all ectopic cases. It is usually terminated by a rupture in the first trimester and because of the increased vascularization of the ovarian tissue it leads to internal hemorrhage and hypovolemic shock status. The diagnosis is usually made by emergency laparotomies and histopathologic assessment.

Diagnosis is made using the Spiegelberg criteria which include:

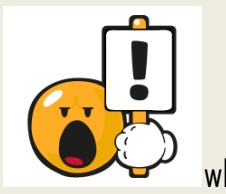
a. The gestational sac is located in the region of the ovary.
b. The ectopic pregnancy is attached to the uterus by the ovarian ligament.
c. Ovarian tissue in the wall of the gestational sac is proved histologically.
d. The tube on the involved side is intact.

Non-tubal pregnancies are the most common type of ectopic pregnancy and ovarian pregnancies are the second most common type; ovarian pregnancies are very common with intrauterine devices (IUDs). Surgical treatments are often performed in these cases because of the late onset of clinical symptoms which leads to late diagnosis. Methotrexate (MTX) treatment can be used for patients in the early phases if their

Join medical association 

and represent your grievances

to the authorities.

Don't do harthal/strike 

which definitely is not appreciated by the public.

Doctor has to make the public/patient believe that he/she is there to serve them 

and not to bargain.

May be to some extent we can prevent mob attacks and litigations.

This is just my loud thinking

Dr Lalitha Vijayakrishnan (obstetrician and gynecologis

condition is stable.

Case:
We report here one such uncommon case of primary ovarian ectopic pregnancy. Our patient is a 28 years old nulliparous woman with severe hypogastric abdominal pain with two weeks delay in menstruation and a positive urine hCG test. Ultrasound demonstrated a cystic lesion in the right ovary by transvaginal sonography . During laparotomy, ruptured ovarian ectopic pregnancy was diagnosed, and wedge resection of the ovary was only done. Histopathological examination confirmed it to be an ovarian ectopic pregnancy.

Conclusions
Ectopic ovarian pregnancy is a rare situation which requires quick and adept management. It should be diagnosed in its early stages otherwise it could be life-threatening and surgical treatment may be inevitable.

FOCAL ENDOMETRIAL HYPERPLASIA TREATED WITH MIRENA IUS

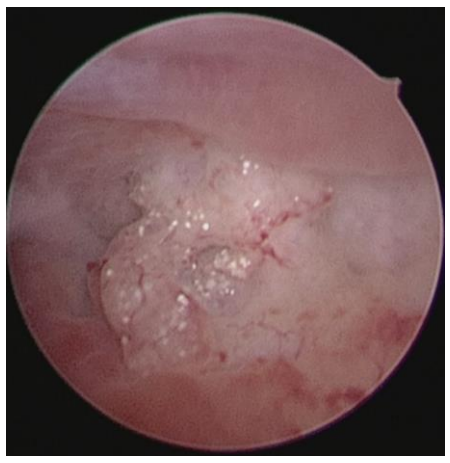
Dr Damodar Rao, Dr Preethi and Dr Asha Rao

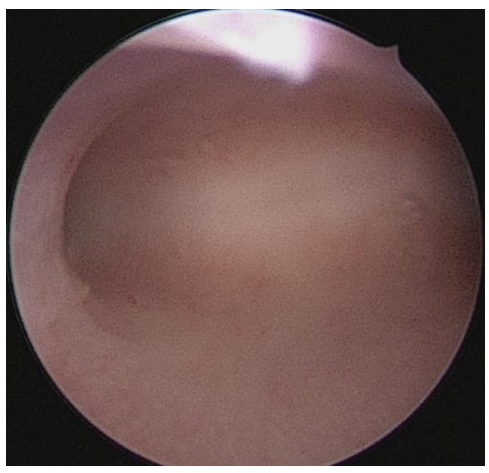
Mrs.A 30 year old female came to our OPD for Secondary Infertility with P1 L1 A1, LCB-6 years back with previous history of left salphingectomy for left sided ectopic pregnancy.

Patient is a case of PCO with irregular cycles had complaints of menorrhagia and dysmenorrhoea. Hence USG was taken on 08.08.16. which showed bulky uterus with features of adenomyosis with endometrial polyps, ET-13mm. For which hysteroscopy was done on 14.09.2016 which showed polypoidal endometrium and small echogenic calcified foci of 0.5 cm which was removed with grasper and scissors.

HPE shows → Polypoid area with focal hyperplasia crowded glands with mild atypia for which Mirena was inserted on 10.12.2016 and patient was advised to follow up every 6 months and patient lost follow up and she came back in Feb 2019 after 3 years and her USG was normal and she wants a second child and hence planned for Hysteroscopy guided Mirena removal and endometrial biopsy on March 2019. Her HPE of endometrial biopsy showed decidualised endometrium. Since patient is obese, she is advised weight reduction and planned for Ovulation Induction in Subsequent cycles.

Endometrial cavity before hysteroscopy and mirena insertion





Endometrial cavity after mirena insertion

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RECENT EVENTS

STAR ENDOGYN CONCLAVE 18-20 Oct 2019.

On behalf of Tamil Nadu chapter of Indian Association of Gynae Endoscopists conclave was conducted admirably by Dr Asha Rao, Dr Banumathy and team. There were 4 well attended pre congress workshops. Day 1 of the conclave saw live relay of 15 veritable gynae endoscopy surgeries operated by well known surgeons. Both Academic sessions on infertility and endoscopy on day2 were equally stimulating.

CME on "Oncology" by Coimbatore Medical College Hospital

CME conducted by CMC OBG on Gynecological malignancies advances and update on 28th Sep 2019.
Topics covered all gynaec malignancies from diagnosis, to recent advances in management
Event was well attended
Crisp and practical presentation by speakers
Interactive audience
Lot of take-home messages

Many of our COGSIANS took part in Coimbatore Marathon and ran 5km or 10 km.

Teachers day celebration gala at IMA hall in September. Dr Mohana Ramachandran was honoured.

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UPCOMING EVENTS