Royal College of Obstetricians & Gynaecologists

Issue 16 • February 2024 | Editor: **Dr. Lalitha N**

NEWSLETTER

India South
International Representative Committee

www.aiccrcogsz.com

Dear Colleagues and friends

I hope 2024 has been off to a good start for all of you.

I could not have asked for a better way to being the year. It was a humbling and emotional moment to take over the responsibility as the All India Chair of AICC RCOG from Bhaskar in Chennai at the SZ conference in Jan 2024. Thank you Bhaskar, for your cohesive leadership that raised the profile of AICC RCOG.

It was a proud moment since this is the first time after Dr Gunasheela that someone from the south has become the All India Chair. Since 2001, I have been inspired by many seniors and friends within AICC RCOG and it is hard to name all of them, a few however I need to acknowledge. Firstly, Dr Jaya Narendra who gave me the first academic opportunity and has since inspired me with her academic knowledge and gentle leadership. Dr Alokendu Chatterjee for his encouragement and for bringing in structure and laying down the protocols for the conferences. The past SZ chairs, Dr Moni Bansal, unfortunately not with us now, Dr Rekha Kurian and Dr Jaishree Gajaraj for their friendship and for always being there, from each of whom I have learnt different skills.

A special thanks to all my committee members, you have been a wonderful team to work with. It is really a warm feeling that the IRC India South is a cohesive and enthusiastic group and I am grateful to all of you for supporting me in all the activities we did.

During my tenure as All India Chair, besides the meetings and webinars, I aim to widen the engagement with community. This I hope to do by involving women's groups and initiating conversations that can guide us in terms of what women want. I also intend to reach out to underserved areas and support organisations working there with our time and skill. I would like those of you who would like to be involved in such projects to reach out to me and email me at **aiccrcogchair@gmail.com.** I look forward to taking these initiatives forward with the support of all of you.

I thank the college for the confidence they have in me, and I hope to do meaningful work taking the core values of RCOG forward.

Wishing Sumana and the SZ committee the very best for the next three years.

Uma Ram

Dr. Sumana Manohar

Dear Fellows, Members & friends

As I step into the role of Indian IRC South Zone chair, I feel it is a truly a privilege bestowed on me. When I started my career in Obstetrics & Gynaecology in England I was bowled over by the meticulous clinical guidance provided during the training & I always wanted to implement the same in my Country.

As Fellows & Members of RCOG, let us foster an environment of collaboration, knowledge sharing & continuous upliftment in women 's health care.

Key focused areas I would be giving due diligence to are midwifery education, workplace behavior & inculcating the transition of skill learning for budding obstetricians.

Course modules as South Zone Committee we are in the process of implementing Professional development in communicative skills as a Video webinar and Safe abortion care. In person course module on Advanced Obstetrics Skills in association with Critical Care Society & also on gynaecological emergencies.

We had an excellent South Zone Annual conference in association with ATNRCOG in the month of January & highlights would be shared by Dr Uma Ram as outgoing IRC SZ chair & incoming IRC All India Chair.

I look forward to the full-fledged support of all the five star states to carry forward my thoughts.

The traveling fellowships for South Zone 2023 were offered to

Dr Deepthi.R - Reproductive Medicine
Dr Josephine Rosy - Uro Gynaecology
Dr Priya Kannappan - Endo Gynaecology

Wishing you all a wonderful & fruitful year ahead.

Sumana Manohar

Cachar Cancer Hospital and Research Centre
Silchar, Assam

Padmashri Dr Ravi Kannan

Surgical Oncologist
Director-Cachar Cancer Hospital and Research Centre (CCHRC), Silchar
Recipient of Ramon Magsaysay Award(2023)
&
Dr Dharshana

ABOUT CACHAR CANCER HOSPITAL AND RESEARCH CENTRE

Cachar Cancer Hospital and Research Centre is a DSIR SIRO (Government of India) recognized comprehensive cancer centre situated on the outskirts of Silchar in the Barak valley of Assam on land provided by the Government of Assam. It was established (in 1996) and is administered by a nonprofit society registered in 1992 under the Societies Registration Act - The Cachar Cancer Hospital Society.

Public philanthropy from several organizations and individuals has helped the hospital grow from 20 beds and 23 staff to 146 beds and 450 staff, serving a population of about 10 million hailing from the four districts in southern Assam and the neighbouring states of Tripura, Manipur, Meghalaya, and Mizoram.

The hospital today treats over 5000 new and 25,000 patients on follow up every year. Over 75% patients receive low or no cost treatment, boarding and lodging in addition to being supported by several initiatives to ensure that patients accept and complete prescribed treatment.

Our Vision

We aim to become a state-of-the-art cancer centre that will ensure that no individual develops a cancer that can be prevented, that no patient is denied appropriate cancer treatment for want of resources, that no patient dies in agony and indignity and that no family suffers treatment induced poverty and grief.

Our Mission

We are a non-profit hospital that provides comprehensive cancer care to people in need – especially the underserved - through prevention, treatment, palliation, education and research.

Our Programs:

- Cancer awareness, prevention, and early detection
- Diagnostics – Pathology, Radiology and Molecular Diagnostics
- Comprehensive treatment – Surgery, Radiation, Chemotherapy and Palliative Care
- Cancer Research
- Cancer Education
- Counselling and Rehabilitation

Our Patient Profile

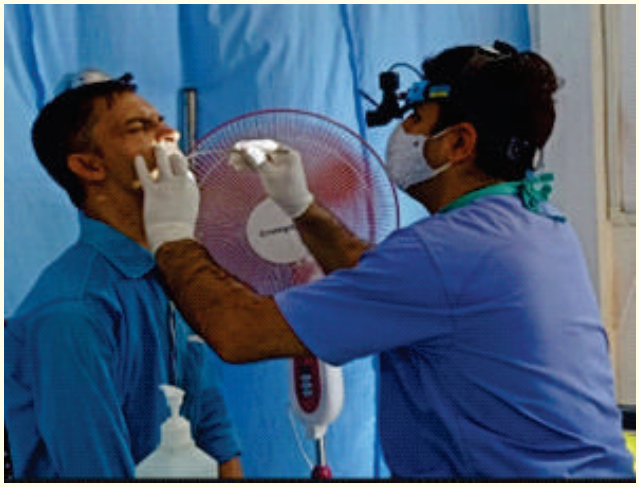
- At least 80% are daily wage earners or agricultural labourers – 59% of them earn Rs. 10,000 or less per month,
- 37% of the said 59% earn Rs. 6,000 or less.
- 80% of the patients come from families of 5 or more members and often with single bread-earners.
- 45% of them live in kaccha houses and have limited access to the basic necessities, let alone advanced treatment facilities.
- Poverty and lack of awareness has been noted as the primary reason behind the failure of cancer prevention or early detection of the disease.

Our Core Values:

HOME BASED PALLIATIVE CARE

A grant from the Indo-American Cancer Association in 2009, helped establish the department of pain and palliative care, a specialized unit that offers holistic care to patients who do not respond to curative treatment. Most of the cancer patients who seek treatment are in the advanced stages of the disease and so, curative treatment is not an option. Therefore, for such patients, providing palliative care services is crucial in order to relieve them of pain and to attend to symptoms, ensuring good quality of life and peaceful death.

It was very challenging to execute home visits, owing to the geography and hilly terrain, specially considering the fact that several patients lived in areas beyond rivers with no bridge, very bad road conditions, extremely remote areas that are inaccessible by an ambulance, areas with no electricity or mobile network. Currently, 1012 palliative care patients are in home care and are visited by hospital staff on a regular basis for pain relief and symptom control, and in 2022, the staff did 1685 home visits.



SATELLITE CLINICS

A critical link in the story is reducing time and distance of travel to the nearest treatment facility. This impacts on the indirect costs of care because of expenses related to travel, boarding and lodging and very importantly, loss of daily wages; all of which are disincentives to timely detection and completion of treatment.

In order to circumvent this, the hospital is creating a network of clinics catering to the needs of the population around a 20-60 km radius not needing to travel more than 2 hours for care. The most time and travel intense aspects of cancer care are evaluation and follow up visits, palliative care and chemotherapy all of which will be addressed through these clinics.

Breakup of Patients From Different States	%
Tripura	10%
Manipur	1%
Assam	85%
Meghalaya	1.2%
Mizoram	2.4%
Other Parts of India	0.4%

In addition, several of these clinics will also support patient and their family's rehabilitation and health promotion in the community. Cancer prevention involves cessation of tobacco, areca nut and alcohol use, adequate physical exercise, appropriate diet and prompt treatment of infections and inflammations.

For donating to us:

Name of the bank	:	SBI
Branch name	:	New Silchar
Account number	:	10390516728
MICR number	:	788002003
IFSC Code	:	SBIN0005922
Account name	:	Cachar Cancer Hospital Society
Savings bank account		

Screening for preterm birth in twin pregnancies

Introduction:

The incidence of multiple gestations is on a rising trend due to use of assisted reproductive technologies and advanced maternal age at conception. Twins represent 3.2% of all live births. However, they account for 20% of all preterm deliveries, 60% delivering <37 weeks, 10.7% <32 weeks with a 5 times higher risk of infant death.

Risk factors for preterm birth (PTB) include the history of preterm delivery, monochorionic twins, short cervical length, use of ART and cervical surgery. The adjusted odds of spontaneous preterm live birth were between 19- and 54-fold greater in twin pregnancies than in singletons. Twin pregnancies seem to have different pathways leading to extremely, very and late preterm birth as compared to singletons.

Despite the proven benefits of progesterone and cerclage in prevention preterm delivery in high-risk singletons, there have been no evidence of benefits of these interventions in twin pregnancies.

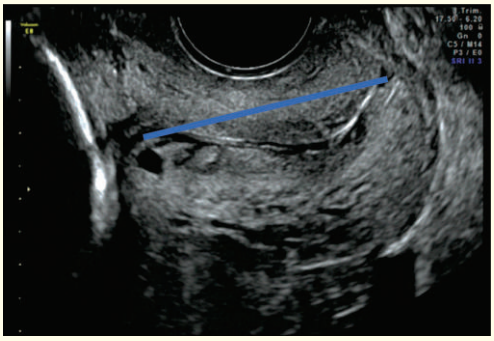
Screening:

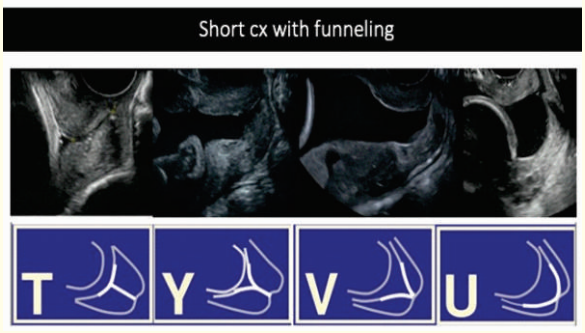
Cervical length measurement is the preferred method of screening for preterm birth in twins; 25 mm is the cut-off most commonly used in the second trimester(18-24 weeks).

Cervical length measurement-Technique:

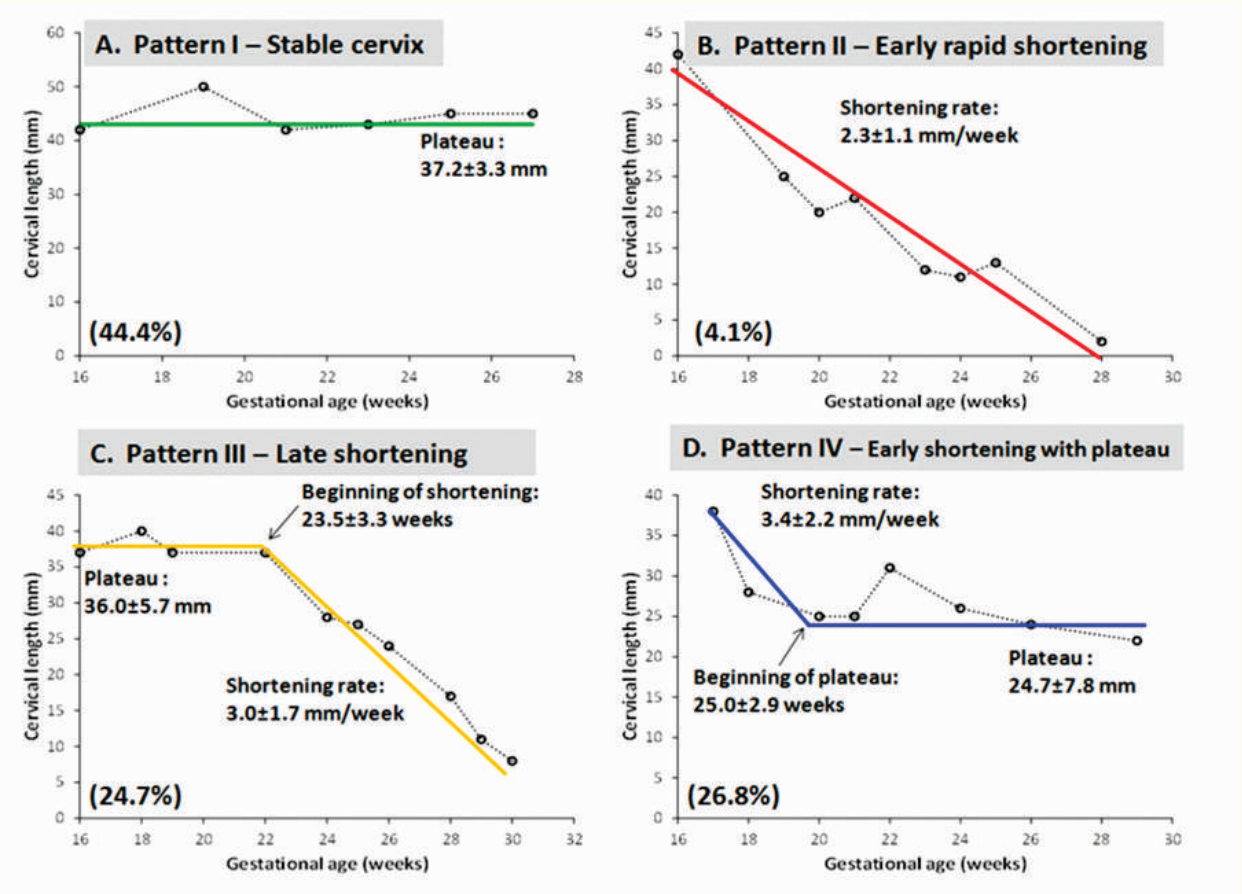
Steps	Recommendation
Pre examination	Maternal bladder empty
Transducer selection	High-frequency transvaginal
Introduction	Place probe at anterior fornix with longitudinal axis orientation for sagittal imaging
Required structures	Inferior bladder border, external os, endocervical canal and mucosa, internal os (limited by edge of mucosa)
Pressure	Least/no pressure- both cervical lips with same width
Magnification	Cervix to occupy 50–75% of screen
Measurement	Calipers between functional internal os and external os, obtaining a straight line between them
Repetition	Three distinct measurements Choose the shortest technically correct one
Additional findings	Funneling, amniotic fluid debris, sludge, membrane separation, vasa previa, low-lying placenta, abnormally invasive placenta
Pitfalls	Full bladder or excessive transducer pressure may elongate artificially cervical length Thickened lower segment or uterine contractions may mimic funneling
To avoid pitfalls	Identify cervical mucosa properly Avoid confounding cervical mucus with funnel by delineating course of membranes at level of internal os

If the cervix exceeds 25mm in length, it will be curved in more than 50% of cases. The standard method of measurement, using a straight line between the internal and the external os, will underestimate the cervical length in these cases. However, this is of little clinical significance as these patients are at low risk regardless of the exact measurement. In the high-risk group of patients with a cervical length <16mm, the cervix will always be a straight line.



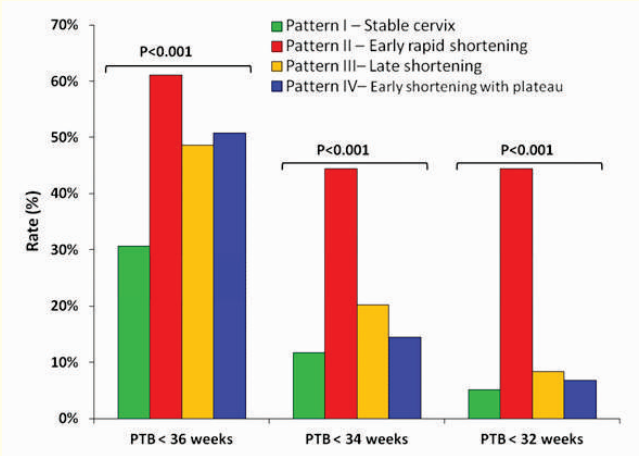


Melamed et al. studied 441 women with twin pregnancies - all women underwent serial measurements of cervical length every 2-3 weeks starting from 14-18 weeks and until 28-32 weeks of gestation. The parameters studied were baseline cervical length, onset of shortening, shortening rate and onset of new plateau(if any). They reported four distinct patterns of cervical shortening with prognostic significance for preterm birth.



The rate of PTB at <34 weeks was highest for women with Pattern II (44.4%) ($p < 0.001$), followed by Pattern III (20.2%), Pattern IV (14.4%), and lowest in cases of Pattern I (11.7%).

They concluded that the specific trajectory of cervical length shortening could be related to the risk of preterm birth.



Interventions:

Not beneficial:

* Routine hospitalization, discontinuation of work, bed rest/reduced activity, pessary, oral tocolytics
* Prophylactic use of progesterone (vaginal/ intramuscular) is not recommended for the prevention of PTB in unselected twin pregnancy
* History-indicated cerclage is not recommended in unselected twin pregnancy
* Prophylactic use of cervical pessary is not recommended in unselected twin pregnancy
* There are conflicting data on the effectiveness of cervical pessary in multiple pregnancy with a short cervix; therefore, its clinical use in these pregnancies is not endorsed

Intervention	Recommendation	Grade of recommendation/Quality of evidence
Activity restriction	Not recommended	1A, High
Tocolysis	Not recommended	1A, High
Intramuscular progesterone		
• **Unselected twins**	Not recommended	1A, High
• **Short cervix**	Not recommended	1A, High
• **H/O PTB**	Not recommended	2C, Low
Vaginal progesterone		
• **Unselected twins**	Not recommended	1A, High
• **Short cervix**	Consider 400 mg if CL< 25 mm	1B, Moderate
Vaginal pessary		
• **Unselected twins**	Not recommended	1A, High
• **Short cervix**	Conflicting results, Not recommended	1A, High
Cervical cerclage		
• **History indicated**	Not recommended	2B, Moderate
• **History indicated + H/O PTB**	Not recommended	2C, Low
• **USG indicated**	Not recommended	2B, Moderate
• **Physical examination indicated**	Recommended in twins with cervical dilatation>1 cm	1B, Moderate

Conclusion:

Transvaginal cervical length <24 weeks is the best tool to predict preterm delivery. Only vaginal progesterone in women with transvaginal cervical length <25 mm and physical exam indicated cerclage in women with cervical dilation > 1 cm have shown a significant decrease in PTB and improvement in neonatal outcomes.

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CONTRIBUTOR:

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QUIZ TIME!

CONTRIBUTOR :
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Consultant Gynaecological Oncologist
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1. A 35-year-old woman with a BMI of 28 kg/m2 presents with polymenorrhea and abnormal uterine bleeding. Analysis of a direct biopsy of the endometrium shows well-differentiated normal-shaped cells with an increased gland-to-stroma ratio. What is the most likely diagnosis?

   A. Endometrial hyperplasia with atypia

   B. Endometrial hyperplasia without atypia

   C. Adenomyosis

   D. Endometriosis

2. The risk of coexisting malignancy in a case diagnosed as Atypical Hyperplasia of Endometrium on Endometrial biopsy

   A. 1-2%

   B. 5%

   C. 15%

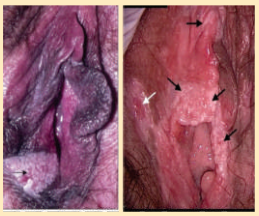
   D. 15-40%

3. What is the cervical screening test recommended by GOI for cervical screening in Basic setting?

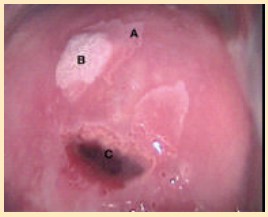
4. Give the commonest diagnosis

   What are the two commonest genotypes associated with this condition

   Give two topical therapeutic options?



5. What is the chemical reaction that occurs to give this reaction?



Answers in Page 14

ACTIVITIES

MRCOG Part 3 Revision Course

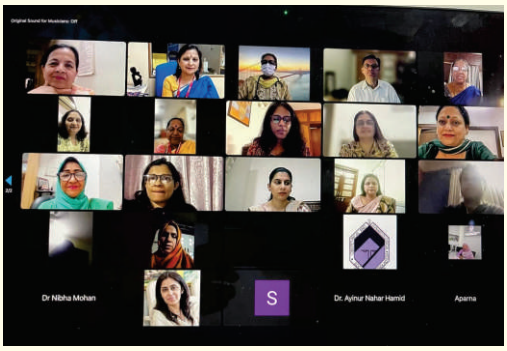
The Part 3 Revision course is a flagship event of the ATNRCOG and has been running successfully for more than a decade benefitting many aspiring candidates who are currently active members of the group .The Revision Course organized by the ATNRCOG was held on 13th and 14th of October 2023 in Chennai.

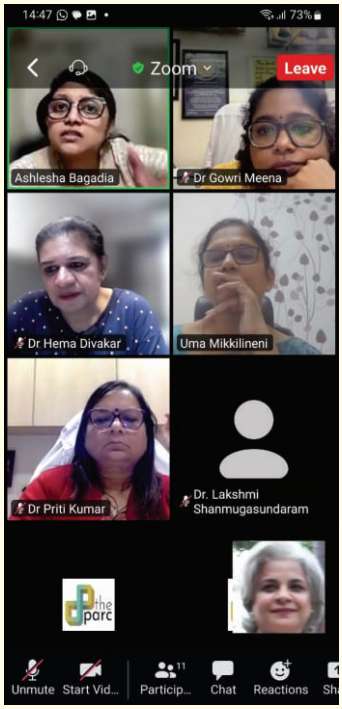
MRCOG Part 3 Exams

The MRCOG Part 3 exams were held at Kolkata and Mumbai on 1st & 2nd of November and 6th & 7th of November 2023 respectively.

Perinatal Mental Health

The perinatal mental health course was held online during 9th-10th of December 2023. This renowned short course for practicing obstetricians aims to improve understanding and identification of perinatal mental health issues and initiation of management and appropriate referral in complex cases. This edition had 25 delegates from all SAFOG countries and the plan is to extend the reach of the course to all the South Asian countries.





MRCOG Postgraduate Training Programme @ Aster Medcity Kochi

MRCOG Postgraduate Training Programme at Aster Medcity Kochi

Aster Medcity held the official launch of their MRCOG Postgraduate Training Programme on 7th January 2024 with Dr Mayadevi Kurup as the Program Director.

The programme was inaugurated by Dr Ranee Thakar, President, RCOG followed by a CME.

Dr. Azad Moopen (Founder Chairman & Managing Director Aster DM Healthcare), Dr. Geetha Philips (Director Academic Affairs & Lead Consultant, Internal Medicine), Dr. Uma Ram(All India Chair, AICC RCOG) Dr. Narayanan Unni (Advisor Academic Affairs & Lead Consultant, Nephrology) Dr. Gracy Thomas (President, Cochin O & G Society) Dr. Ajith S. (President, RCOG Kerala Chapter) Mr. Farhaan Yasin (Vice-President, Aster India Aster DM Healthcare) participated in the ceremony and offered their felicitations. This special event reinforced their dedicated pursuit of excellence in academics and training in Obstetrics and Gynaecology.

South Zone IRC conference 2024

The Annual Conference of the South Zone IRC for the year 2023 was held on 20th & 21st of January 2024 at the Madras Management Association Hall in Chennai. There were two workshops in the morning session on the first day - The Perinatology workshop (at MMA Hall) and the Vaginal surgery workshop at IOG Auditorium, Egmore.



The Scientific programme included a series of lectures, panel discussions, video demonstrations and dialogues by experts on topics in Obstetrics and Gynaecology with focus on presenting the latest evidence. The 4th South Zone oration was delivered by Padmashri Dr Ravi Kannan, Director- Cachar Cancer Hospital and Research Centre (CCHRC), Silchar on 20th January 2024.

The conference was formally inaugurated on 21st January 2024 by Mrs.Shilpa Prabhakar Satish IAS (Mission Director NHM TN). Dr. Sarala Gopalan and Dr.Jyothi Unni were the Guests of Honour. The conference also saw the formal installation of the Chairpersons of the AICC RCOG and the AICC RCOG South Zone. Dr Uma Ram took over as the All India Chair from Dr Bhaskar Pal and Dr Sumana Manohar took over as the Chair of the South Zone Committee.


Remembering Stalwarts : Dr Sulochana Gunasheela, Bangalore

Dr. Sulochana Gunasheela was a pioneer in South India in the field of Reproductive Medicine. After graduating from the prestigious Mysore Medical College, she went on to specialise in Obstretrics and Gynaecology in UK and further equipped herself in Assisted Reproductive Technology from Johns Hopkins Hospital in Baltimore, USA. She established the Gunasheela Fertility Centre in 1985 which was the first of its kind in South India at the time. The first IVF baby was born in the centre in 1988. She was the Chairperson of the All India Coordinating Committee of the RCOG. An academician of the highest caliber, her sincere commitment to reproductive medicine was truly a benchmark for the younger generation to emulate. Her intelligence, vision, organization, and caring for others were exemplary. She has authored several books on infertility and management of obstetrics and gynecological problems.

UPCOMING EVENTS

RCOG WORLD CONGRESS 2024

The RCOG's flagship event in 2024 offers O&G professionals from around the world the opportunity to learn about the latest developments in women's health

The event will be held from 15 - 17 October 2024 in Muscat, at the Oman Convention and Exhibition Centre. Find out more:

https://bit.ly/rcog2024

Early bird registration deadline:
Monday 15 July 2024

This is a fantastic opportunity for doctors at all career stages to reconnect, network and share the latest innovations.

https://bit.ly/rcog2024registration

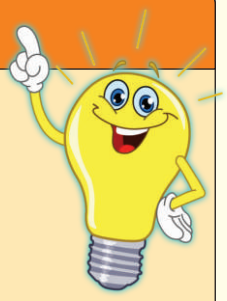
Abstracts now open!

Abstract submission deadline:
Monday 8 April 2024

Abstracts are an integral part of Congress and we encourage all O&G professionals, regardless of career stage or location, to submit their work.

There are 30 different categories to choose from, with the top 500 published in a Congress BJOG supplement and prestigious prizes available.

ANSWERS TO QUIZ



1. B

The gland-to-stroma ratio is increased to more than 50% in endometrial hyperplasia without atypia.
The glands may show mild crowding and cystic dilatation with sparingly seen outpouching and mitoses.
The gland-to-stroma ratio is increased further in endometrial hyperplasia with atypia.
Also, there is a disorganization of glands with luminal outpouching, cellular mitoses, and nuclear atypia.

2. D

3. VIA (VISUAL INSPECTION WITH ACETIC ACID - 3-5%)

Resource-based Cervical Cancer Screening Recommendations

	Good Resource Settings	Limited Resource Settings
Modality	HPV testing • Primary HPV testing • Co-testing (HPV & Cytology) Cytology Colposcopy and biopsy VIA	VIA Colposcopy ± Biopsy
Target Age Group (years)	25 - 65	30 - 65 (N.B.: In postmenopausal women, screening with VIA may not be as effective)

https://www.fogsi.org/wp-content/uploads/2017/12/FOGSI-GCPR-screening-management-of-CIN-HPV-vaccination.pdf

4. Vulval carcinoma. Unlike cervical cancers, 16 and 33 are the commonly associated genotypes

Imiquimod; Cidofovir

Ref:

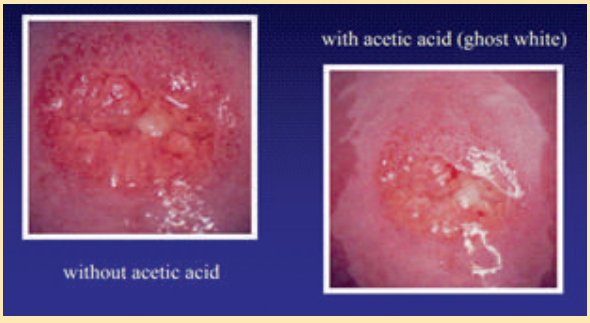
- Sutton et al (2008). Distribution of human papillomavirus genotypes in invasive squamous carcinoma of the vulva. Modern pathology. 21. 345-54. 10.1038
- https://www.cochrane.org/CD011837/GYNAECA_medical-and-surgical-treatments-usual-type-vulval-intraepithelial-neoplasia-uvin

Single genotype HPV infection		*Multiple genotype HPV infection*	
HPV type	*Cases (n = 67)*	*HPV types*	*Cases (n = 14)*
16	53	16 and 33	5
33	5	16 and 6	2
18	2	16 and 45	1
45	2	16 and 53	1
52	2	16 and 62	1
6	1	16 and 67	1
26	1	33 and 84	1
61	1	16, 33, and 53	1
		45, 52, and 62	1

Distribution of HPV genotypes in invasive squamous vulvar carcinoma cases

5. Acetowhite reaction – Addition of acetic acid causes a reversible coagulation of the nuclear proteins in the abnormal cells which causes a white patch or area (Protein + Acetic acid = White coagulum)

• Abnormal cells (dysplasia or cancer) have increased N:C ratio and hence increased protein content and turn white



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