Royal College of Obstetricians & Gynaecologists

India South
International Representative Committee

Issue 11, Jan 2022

Editor: Dr A Tamilselvi

NEWS LETTER

Dear Friends & Colleagues,

We are all social creatures. Relationships, interactions and concern for each other is at the very basis of all that we do. We looked forward to 2022 with hope that the world will open up and that we can increase our social interactions. However, the new year has dawned with us trying to understand antigen shifts, booster efficacy and the new covid strain. As we negotiate work with staffing shortages from people off sick, there is a certain tension that comes from uncertainty affecting many of us. At this time it is extremely important that we focus on the positives, keep abreast of evolving understanding of the pandemic and move forward supporting one another and the women we care for.

The south zone team took the lead wonderfully well and everyone from all over the country came together for the AICC RCOG conference in October which went remarkably well. With the same spirit and resilience, I am sure that 2022 will see some very good work to which more of you can contribute. We look forward to ideas from all of you with regard to programs and activities that we can do as a zone. You can email your thoughts and suggestions to chair@aiccrcogsz.com

On behalf of the SZ committee , I Wish everyone the best for 2022.

With regards

Uma

AN UPDATE ON HPV VACCINATION

Dr A Tamilselvi, Dr Anbu Subbian

Human Papilloma Virus (HPV) is a sexually transmitted virus causing anogenital and oropharyngeal diseases. Persistence of high-risk HPV genotypes has been directly linked in the causation of Cervical cancer. High risk HPV genotypes are associated with cervical, vulvar and vaginal cancer in females, penile cancer in males and anal and oropharyngeal cancers in both females and males. HPV 16/ 18 account for 66% of cervical cancers, and types 31, 33, 45, 52 and 58 account for about 15% of cervical cancers. Regarding Cervical Intraepithelial neoplasia (CIN 2), HPV 16 or18 associated with 50% of CIN2 or more, 23% by HPV 31,33,45,52 or 58. HPV types 6 and 11 are associated with 90% of anogenital warts

Availability of a vaccine against the high risk HPV genotypes, has provided an unique opportunity in the prevention of cervical cancers. The aim of HPV vaccine is to prevent future HPV infections and thereby reduce the risk of HPV associated cancers. Three types of prophylactic HPV vaccines are available, Bivalent against HPV 16,18 genotypes, Quadrivalent against 6,11,16,18 types and Nanovalent against 6,11,16,18,31,33,45,52,58 types.

HPV vaccination program was started in Luxembourg in 2008, with bivalent or quadrivalent vaccines with a three-dose schedule. Since then, the vaccination program has changed with availability of nanovalent vaccines, with availability of more data and effectiveness of the vaccines in different schedules.

Current recommendations by the World Health Organisation (WHO) and Advisory Committee on Immunisation Practices (ACIP) on HPV Vaccination and its rationale have been highlighted in this article.

1. HPV vaccine is recommended for routine vaccination at age 11 or 12 years. Vaccination can be started from the age of 9.

Rationale – Clinical trials have shown HPV vaccine is most effective prior to the onset of sexual activity, (i.e) prior to the exposure of Human Papilloma virus. None of the available vaccines can treat or clear a pre-existing HPV infection or disease. Vaccination starting at 9 years of age is expected to achieve higher on-time vaccination rates, resulting in increased numbers of cancers prevented.

What about vaccination for girls from the age of 13 years?

• Vaccination is recommended for all upto 26 years, who have not been adequately vaccinated.
• Vaccinationis not recommended foreveryone older than age 26 years. HPV vaccination of people in this age range provides less benefit, as most people in this age group have already been exposed to HPV.
• For adults aged 27 through 45 years, clinicians can consider discussing HPV vaccination with people who are most likely to benefit, such as those with a new sexual partner.

2. Dosing schedules for age groups below 15 years and for those above 15 years of age.

• For those starting vaccination before their 15th birthday a 2-dose schedule is recommended. Second dose to be given 6-12 months after the first dose (0, 6to12 months). Minimum interval between the 1st & 2nd dose should be 5 months.
• Those starting vaccination after their 15th birthday, a 3- dose schedule is recommended. In a 3-dose series, the second dose should be given 1–2 months after the first dose, and the third dose should be given 6 months after the first dose (0, 1–2, 6-month schedule).Minimum intervals are 4 weeks between the first and second dose.
• A 3-dose schedule irrespective of the age, is also recommended in those who are immunosuppressed such as those with HIV infection, autoimmune diseases and those on immunosuppressive therapy

Rationale: The reduced, 2-dose schedule has been shown to be as effective as the 3-dose schedule in those less than 15 years of age, with similar or greater immunogenicity than the 3 doses of older children. The 2 dose schedule in addition will make it easier to administer, with reduction in cost, without loss of efficacy which is particularly important for low- and middle-income countries.

FAQs on dose schedule:

• If a dose of HPV vaccine is significantly delayed, should the series be restarted again?
No. The balance dose or doses should be completed without starting over again

• If the interval between the doses of HPV vaccine is shorter (e.g. < 5 months between 1st& 2nd dose in a 2 dose schedule), should it be repeated?
Yes. The dose should be re-administered after another minimum interval has elapsed since the last recent dose. Evidence from RCT's show antibody responses were stronger with a longer interval (6 or 12 months) between the first two doses of HPV vaccine than a shorter interval .
•Is the dosage schedule same in all 3 types of HPV Vaccines (Bivalent, quadrivalent and Nonavalent)?
Yes. In all 3 types it is a two dosage schedule at ages < 15 years and 3 dosage schedule for those over 15 years of age.

3. Vaccination in special situations – Pregnancy, Breast feeding, Transgender and in those with same-sex sexual orientation.

• HPV vaccination during pregnancy is typically avoided and vaccination should be delayed until after pregnancy. Pregnancy testing is not required however, before vaccination. If HPV vaccine has been given inadvertently in an early pregnancy, there is no evidence that vaccination will affect a pregnancy or harm a fetus and pregnancy can be continued.
• Persons who are breastfeeding or lactating can receive HPV vaccine
• HPV vaccine is recommended for females and males regardless of their sexual orientation.
• Vaccination is also recommended for males aged 13 through 21 years. For males Quadrivalent and Nanovalentvaccines only are recommended. (Not bivalent)
• ACIP recommends vaccination of transgenders as per dosage schedule

4. Cervical Screening in those vaccinated should continue even after completion of their vaccination schedule.

• HPV vaccines do not protect against all HPV types that can cause cancer, Women who have been vaccinated are advised to follow the same screening recommendations as unvaccinated women. There could be future changes in screening recommendations for vaccinated women.

5. Choice of HPV vaccine

Current evidence suggests that from the public health perspective the bivalent, quadrivalent and nonavalent vaccines offer comparable immunogenicity, efficacy and effectiveness for the prevention of cervical cancer, which is mainly caused by HPV types 16 and 18

6. Vaccine administration and side effects

All three types of HPV vaccine are to be administered intramuscularly in the deltoid, using 0.5 mL of liquid suspension, The WHO Global Advisory Committee for Vaccine Safety (GACVS), states that available evidence did not suggest any safety concern regarding the use of HPV vaccines. Injection site related pain and erythema can occur whereas, rates of systemic events such as headaches, pyrexia, nausea, and fatigue are reported in around 55%

7. Contraindications to HPV Vaccine:

• A severe allergic reaction (e.g., anaphylaxis) to a vaccine component or following a prior dose of HPV vaccine is a contraindication.
• Nonavalent HPV vaccine is produced in Saccharomyces cerevisiae (baker's yeast) and is contraindicated for persons with a history of immediate hypersensitivity to yeast.
• Bivalent HPV vaccine should not be used in those with known latex allergy.
• A moderate or severe acute illness is a precaution to vaccination, and vaccination should be deferred until symptoms of the acute illness improve.

Conclusion

WHO recognizes the importance of cervical cancer and other HPV-related diseases as global public health problems. In 2020, all WHO Member States endorsed the Global Strategy towards the Elimination of Cervical Cancer with 3 measurable goals - "the 90-70-90" strategy.

• By 2030, 90% of girls should be fully vaccinated with HPV vaccine by 15 years of age;
• 70% of women should be screened using a high-performance test by age 35, and again by age 45;
• 90% of those identified with preinvasive or invasive cervical disease should receive appropriate treatment.

We as Gynaecologists have a pivotal role in achieving this vaccination strategy of 90%

Acknowledgement: Adapted from ACS and ACIP Recommendations

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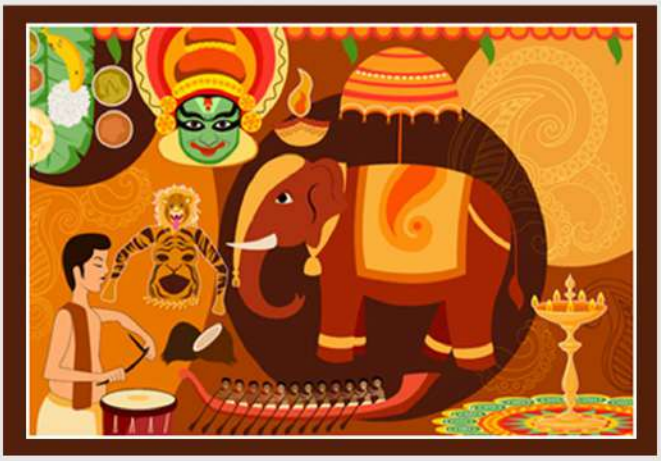
Dances of Kerala

Dr. S. Mayadevi Kurup

Kerala, the Southernmost State of India is popularly known as God's own country on account of its scenic beauty enriched with placid backwaters, lush greenery and beautiful beaches. Kerala is also rich in its cultural heritage which is centuries old. Kerala traces its non-prehistoric cultural genesis to its membership (around the AD 3rd century) in a vaguely defined historical region known as Thamizhagom — a land defined by a common Tamil culture and encompassing the Chera, Chola and Pandya kingdoms. At that time, the music, dance and language found in Kerala were all similar to that found in the rest of Thamizhagom (today's Tamil Nadu).



Dance and art forms are integral parts of a region's culture. Kerala is rich in various dance forms and is specially renowned for its two indigenous forms of classical dances 'Kathakali' and 'Mohiniyattam'. Some of the folk dances which are native to the state have gained popularity and are performed during temple festivals and other ceremonious occasions. These folk dances are unique in their presentation and involve perfect expressions performed by very fine class of dancers.

In Kerala, the folk dances are accompanied by splendid costumes and ornaments perfectly adorning the performers. There are nearly 50 dance forms performed in Kerala, out of which prominent ones are Thiruvathirakali, Oppana and Margamkali

Kathakali is a "story play" genre of art, but one distinguished by the elaborately colourful make up, costumes and face masks which the dancer wears. Globally Kathakali's magnificence has won great admiration for the state of Kerala. This renowned art form was originated over 300 years ago. It re-tells the great stories of the past, mostly from Indian epics, and leaves one spellbound at the various intricacies involved in the performance.

The costume is elaborate and the face is painted in vivid hues. The Vesham or make-up is of five types - Pacha, Kathi, Thadi, Kari and Minukku. Pacha Vesham or the green make-up portrays noble protagonists. Kathi Vesham portrays villainous characters. There are three types of beards or ThadiVeshams

.VellaThadi or White beard for superhuman monkeys like Hanuman. ChuvannaThadi or Red beard meant for evil characters. KaruthaThadi or Black beard for the hunter. Kari Vesham is used for she-demons. The "MinukkuVesham" is used for female characters and sages. A Kathakali actor enacts his ideas through "mudras", a systematic sign language based on Hastalakshana Deepika, a treatise on the language of hand gestures Kathakali orchestra is formed of two types of drums, the "chenda" and "maddalam", the "chengila" which is a metal gong and the "ilathalam" or cymbols. Kathakali training needs several years of hard work and dedication to master the art. The students need to undergo rigorous training replete with oil massages, exercises for eyes, cheeks, mouth, neck and lips along with lessons in abhinaya or expressions, the most important factor which helps the dancer communicate to the audience

Mohiniyattam meaning "dance of the enchantress" was initially known as "Dasiyattam" performed in temples by female devotees. Mohiniyattam developed further as a performing art during the 18th and 19th centuries with the initiation and patronage of a Maharaja of the Kingdom of Travancore - Swathi Thirunal, a poet and brilliant music composer himself. His contributions in this art lead to the eventual development and systematization of present dayMohiniyattam. In addition to that, a popular poet from Kerala, Vallathol played a pivotal role in popularizing this dance in the early 20th century. different rhythms and lyrics, while the music style is Carnatic. Instruments played during a Mohiniattam performance comprises of Kuzhitalam or cymbals, Idakka, Mridangam and flute.

Thiruvathirakali or Kaikottikali is a unique dance performed in Kerala on the auspicious day of Thiruvathira, the birthday of Lord Shiva. It is performed by women who seek blessings for eternal marital bliss. It falls in the Malayalam month of Dhanu. Now a days this dance has also become an integral part of "Onam", the festival of Kerala. Groups of up to 8 or 10 women are dressed in traditional Kerala

attire and dance in circles around a fully lit lamp. The graceful movements of the women in the white sarees, wearing jasmine flowers is both enchanting and elegant.

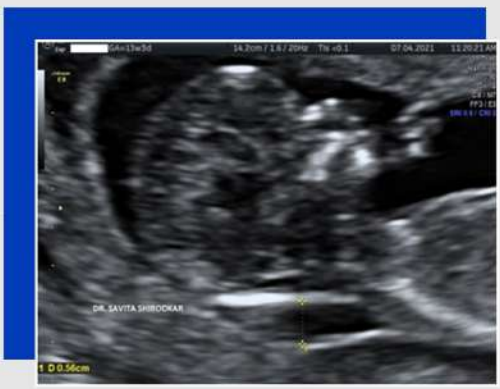
Oppana,which is a widely popular dance form among Keralite Muslims is native to Malabar. This dance form is a tradition of Muslim weddings and is generally presented by females. The bride is dressed in all finery, covered with gold ornaments and her palms and feet are adorned with an intricately woven pattern of Henna, and she sits amidst the circle of dancers. She is the chief spectator sitting on a chair, around which the singing and dancing take place. While they sing, they clap their hands rhythmically and move around, the bride using simple steps.

Margam Kali is one of the ancient group dance of Kerala practiced by Saint Thomas Christians. Typically, a dozen dancers sing and dance clapping around a lamp wearing the traditional costume called "Chattayum Mundum". The lamp represents Christ and the performers his disciples.

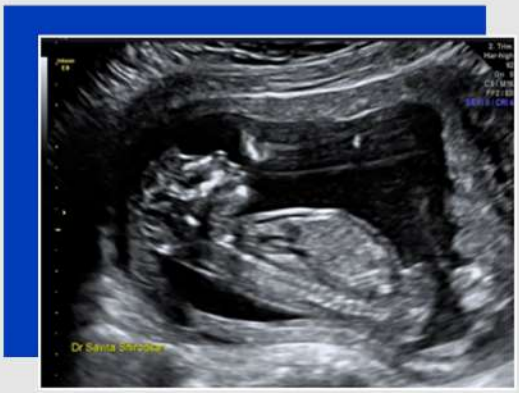
Among the various dance forms in Kerala, I have listed out only the most popular ones.I won't be able to finish this article without seeking the blessings of my Gurus,who have taught me.

Dr. S MayadeviKurup

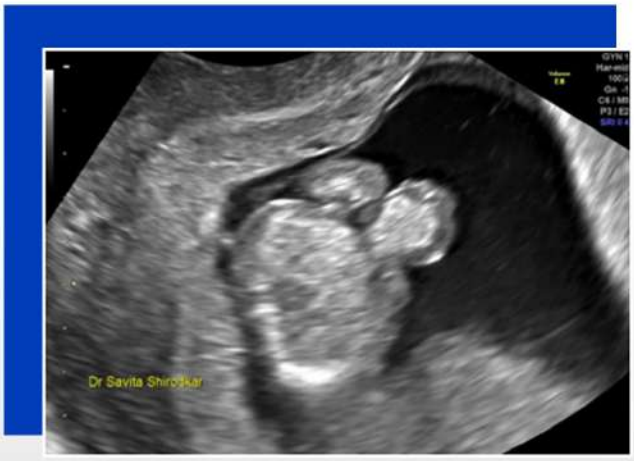
One minute Brain Teasers:



Pic 1 : Next step – Invasive or non-invasive testing?



Pic 2 : Identify the abnormality & its preventive strategy



Pic 3 : This fetus is growing at 98th centile, with polyhydraminos and this abnormality

Pic 4 : Do you know this person?

He was commissioned in Indian Medical Service & was Resident medical officer and surgeon at Eden and Presidency General Hospital in Calcutt

Clue – Inventor of instruments used in Caesarean

Pic 5 : Identify this person and the invention,who has a memorial at Westminster Abbey

Issue 11, Jan 2022

Screening For Gestational Diabetes

Dr Uma Ram

Gestational Diabetes (GDM) is defined as glucose intolerance first identified in pregnancy and includes a portion of women with pre-existing diabetes who are tested and identified for the first time in pregnancy. In India, the prevalence of GDM has increased and currently GDM is diagnosed in 15 to 20% of pregnant women. It is important to identify this problem because its impact on both the mother and the baby.

Maternal Physiology during pregnancy is primarily influenced by placental hormones. These hormones affect glucose and lipid metabolism and ensure that the fetus has an ample supply of fuel and nutrients at all times. This includes an increase in the lipolytic placental hormones as well as an increase in insulin resistance which causes a switch from carbohydrate to fat utilization. These changes are more pronounced in late pregnancy when there is increased fetal growth.In a normal pregnancy, theincrease in insulin production from the beta cells helps to overcome this insulin resistance. If a woman's pancreatic function is not able to overcome the insulin resistance it results in GDM.

Screening for GDM:

In countries where the prevalence of GDM is high, such as India, universal screening of all pregnant women is recommended. In countries where the prevalence is low, then risk factor based screening is followed. Across the globe, South Asian ethnicity is included in the criteria for universal screening.Current guidelines recommend that women are screened for gestational diabetes at booking and again at 24 to 28 weeks. Given that this is the commonest medical problem in pregnancy it is important that we understand the rationale behind the screening as well as the evidence supporting the different screening tests.

Insulin resistance in pregnancy increases more in the second half of pregnancy, hence traditional screening for gestational diabetes happens at 24 to 28 weeks. In general a single step test is preferred especially in countries of high prevalence. A single step oral glucose tolerance test (OGTT) in the fasted state is the test that is endorsed by FIGO, NICE, WHO, IADPSG and ADA. The ACOG and ADA continue to endorse a two step screening, where the first is a screening with 50 gm of glucose in a non fasted state to be then followed by OGTT. The DIPSI criteria is a single step screening with 75 gm glucose in a non fasted state.

Over time, different criteria have been applied to the OGTT result to diagnose GDM and this continues to create confusion among practitioners. The initial O'Sullivan Mahan (and Carpenter-Coustan) criteria are based on the woman's risk of developing diabetes subsequently. The older WHO (1999) criteria is based on the values diagnostic of diabetes in the non-pregnant population. None of these criteria are based upon actual pregnancy outcomes. Therefore there is currently no rationale or evidence to use these criteria for the diagnosis of GDM.

The landmark Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study was published with over 25,000 pregnant women from 9 countries who were screened for GDM between 24 to 32 weeks. This study illustrated that the association between glucose values and pregnancy outcomes was continuous and linear and that maternal hyperglycemia, which was less severe than overt diabetes was associated with adverse pregnancy outcome. The International Association of Diabetes and Pregnancy Study Group (IADPSG) consensus panel after reviewing the results of HAPO and other studies adopted the following guidelines for the diagnosis of GDM

They recommended thresholds for the diagnosis of GDM based on the odds ratio (OR) of 1.75 for the adverse outcomes. These thresholds after 75 gm glucose load were 92, 180 and 153 mg/dl respectively for the fasting, 1 hour and 2 hour values. While there have been some criticisms, these criteria are the only ones which are based on pregnancy outcomes. Since the publication in 2008 many international bodies have acknowledged and adopted the IADPSG criteria including FIGO,WHO and ADA.

The DIPSI non fasting 75 grams glucose challenge test is recommended by the MOHFW in India and endorsed by FOGSI. In this criteria, after 75 gm glucose load, irrespective of the last meal time, a 2 hour value of > 140 mg /dl is diagnostic of GDM. The non fasting test is easier to implement especially in suburban and rural India where women would find it challenging to reach a health facility in a fasted state for a glucose tolerance test. Studies however have shown that the non fasting test has a lower sensitivity in picking up GDM. This means that a percentage of women screen negative by the non fasting glucose challenge could still have glucose intolerance. It is a pragmatic screening test particularly helpful in situations where women would otherwise have no screening at all.

The rational of screening at booking is essentially to identify overt diabetics. When screening at booking, a fasting glucose of greater than 126mg/dl and HbA1C of greater than 6% is diagnostic of overt diabetes. There will be a group of women who have blood glucose values whichare lower than overt diabetes but would be above the cut-off used at the 24-28 week GTT. Women tend to have increased insulin sensitivity and lower blood glucose values, in early pregnancy. Therefore it was extrapolated that values which were considered high at 24 to 28 weeks would be high in early pregnancy as well and the same cut offs were applied. This diagnosis of early GDM or booking GDM is a space to watch for since we do not know yet whether treating these women actually improve pregnancy outcomes. There is at present a lot of interest and studies in this area.

In conclusion, all pregnant women at booking should be screened and those who have normal glucose values, should be screened again at 24 to 28 weeks.TheIADPSG criteria has the most evidence base and therefore endorsed by most international bodies. The DIPSI criteria are pragmatic and easily implementable in low resource settings. We should work together to look at outcome data in our own population, both in pregnancy

pregnancy and for subsequent diabetes in the mother and other neonatal metaboli outcomes to establish the evidence as to what is best for our mothers.

Suggested reading

1. Hyperglycemia and Adverse PregnancyOutcome (HAPO) Study: An Overviewhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628620/#

2. World Health Organization. Diagnostic criteria and classification of hyperglycaemia first detected in pregnancy. No. WHO/NMH/MND/13.2. World Health Organization, 2013.

3. The International Federation of Gynecology and Obstetrics (FIGO). Initiative on gestational diabetes mellitus: A pragmatic guide fordiagnosis, management, and care#https://pubmed.ncbi.nlm.nih.gov/26433807/

Quiz Contributors:

Dr Srimathy Raman
Bangalore

Dr Savita Shirodkar

Answers

Pic 1
Answer : *High NT can be a marker for genetic disorders that NIPT cannot identify. Hence invasive testing / micro array*

Pic 2
Answer : *Anencephaly; Folic acid supplementation*

Pic 3
Answer : *Omphalocele, Beckwith – Weideman syndrome*

Pic 4
Answer : *Vivian Bartley Green-Armytage / Green-Armytage forceps*

Pic 5
Answer : *Hugh Chamberlen& Obstetric Forceps*

AICC RCOG Southern Zone Travel Fellowship

The AICC RCOG southern zone launched the travelling fellowship for young Obstetricians and Gynaecology from Andhra Pradesh, Karnataka, Kerala and Tamil Nadu in 2015. Applicants should be Members/ Fellows of the RCOG UK

Applicants can apply for the fellowship, as an observer in designated centers for two weeks. They can select from the list provided according to their area of interest (e.g)- Fetal medicine, Urogynecology, Reproductive Medicine, Infertility , Gynaec Oncology or Endoscopy. Permission has been obtained by the committee from the concerned departments . Kindly refer the list of centers below

Upto a maximum of 3 candidates per year will be awarded in separate specialities per year
Applicants should satisfy following criteria:

1. Candidate should have obtained the MRCOG within the last 7 years of the application
2. Should be a member of good standing
3. Should not have any pending dues to RCOG or AICC RCOG
4. Should not have any disciplinary/criminal proceedings pending against him/her
5. Age should be < 45 years.

The applicant should send in their application by email to chair@aiccrcogsz.com, mentioning their speciality of choice
All applications will be reviewed by a committee constituted for this purpose by the SZ RCOG Rep Comm. Short listed candidates will be interviewed

A travel grant of up to a maximum of Rs . 25,000/- per selected candidate will be awarded towards travel and accommodation, on producing receipts. The final amount awarded will be decided by the Committee on an individual basis.
On completion of training the candidate will be required to

1. Send a report to the Zonal Chair
2. The candidate should make a presentation at the next Zonal meeting if required

Centers :

- Dr. Suresh S. Mediscan system, Chennai - Fetal medicine
- Dr.Lata Venkatraman. Rangadore Memorial Hospital, Bangalore - High risk obstetrics
- Dr. Evita Fernandez. Fernandez Hospital, Hyderabad - High risk obstetrics
- Dr. Rekha Kurian, Joseph Nursing Home, Chennai - Pelvic Endoscopy
- Dr. V P Paily - Vaginal surgery, Rajagiri Hospital, Kochi
- Dr. A Tamilselvi, IRM & WH, MMM Hospital, Chennai – Urogynecology
- Dr.Prathima Radhakrishnan, Bangalore Fetal Medical Centre - Fetal medicine
- Dr. Sheila Balakrishnan, Dept. of ObsGyn, S.A.T Hospital, Trivandrum Infertility
- Dr. S.Vani, Jananam Fertility Centre, Chennai - Infertility
- Dr Anbu Subbian, KMCH Coimbatore - Gynaec Oncology

AICC RCOG 2021 - Annual Conference 1 - 3 october