

METAMOMPHOSIS

The e-Journal of Perinthalmanna Obstetric and Gynaecological Society (POGS)

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Editorial

Dr Seneesh Kumar V



The second edition of metaMOMphosis is here and reaches you when the entire world is battling with the COVID pandemic. As a privileged community, I am confident that each one of us are prepared in this battle in advance and will guide others in the combat.

In this edition we cover some topics concerned with daily obstetric practice. Increased Nuchal translucency is a common scenario and not all fetuses are diseased. Dr. Rinshi Elayedatt, Fetal Medicine consultant from Amrita hospital has outlined the diagnostic workup for the same. This will be useful in counselling expectant couples as to 'what next'.

Cervical shortening is a major challenge in obstetric practice and the available management options includes cervical cerclage and progestogens. Dr. Vanitha, consultant Obstetrician from PG hospital, Nilambur has provided a synopsis of the recent evidence in this topic.

Dr. Shilpa and Dr. Vahab has written on an interesting case their team encountered at MES Medical College.

As usual a glimpse of the activities of POGS has been included.

Wishing all the POGSians a safe year ahead!

Seneesh

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President's Message

Dear POGSians,

It is with great pleasure we are bringing out the latest issue of our METAmomPHOSIS newsletter. We have actually planned almost our publications truly digital right from the day of inception of society. It has become very relevant in this period of COVID 19 pandemic. We had our last physical CME in the month of February. But as professionals in medicine, we cannot stop sharing knowledge and updating ourselves. So right from March itself we have converted all our CMEs to webinars. Our March webinar CME on endometriosis was the start of webinar fever right across all societies and ours was among the first few conducted. We plan to reach yet another milestone by organizing our first annual conference NOESIS as a completely virtual conference based on artificial intelligence and augmented reality, which is far superior and different from conventional webinars. This will be held on 8th and 9th of August 2020. More updates about the conference will reach you soon. In spite of social distancing issues we could observe all major days of public health importance as per FOGSI guidelines. The next important program for the members will be E-Layam, where we plan to have live entertained performance by members on 12th July on virtual platform. Our YouTube channel and Facebook page is ready for members to upload their individual academic and cultural activities and promote it to social media. This issue of the newsletter will come to you not only as a PDF but also as an E book which will be easy to handle and store. The most important part of this issue is that we have an important article on COVID 19 and pregnancy by Prof Ajith S, from Pariyaram Medical college, who have a vast experience of handling pregnant patients with COVID in this short period.

Wish you all happy reading #staysafe #stayhealthy

Dr Kunjumoideen K U
President, POGS



Secretary's Message

Dear POGSians

Warm greetings from the Secretary's desk.

At the outset I would like to thank our members for actively involving in all the society activities including academic and socio-cultural initiatives. The environment day and Yoga day observations have evoked a huge response from our members. The members are now actively involved in menstrual hygiene awareness classes. The NOESIS conference is going to be the first of its kind virtual event in our specialty in the country and it's the duty of each of the POGS members to make it a grand success. I request all the members to forward all the promotional flyers and videos of the conference to all your social media platforms and groups. We have a whole lot of varieties of activities getting shaped for you for the coming months. Wish you all happy reading and stay safe.

Best regards to all

Dr Abdul Vahab
Secretary General, POGS

COVID 19 & PREGNANCY

Dr Ajith S , MD,DGO,DipNB,FRCOG, HOD Dept of OBGYN, GMC Kannur, Pariyaram



COVID 19 is caused by Novel corona virus (SARS-CoV-2). The other human corona viruses include those causing mild to moderate upper respiratory tract infections like common cold, Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV).

The risk of infection in pregnant women is not greater than in the general population. However there are alterations in immune response to viral infections, especially in the third trimester. Hence, an increased severity of illness could be expected, if viral infections occur in pregnancy as earlier observed with H1N1, SARS and MERS. The morbidity and mortality were accentuated in these infections.

Fortunately, there is no evidence of increase in severity or mortality when Covid 19 occurs in pregnancy. Most of the Covid 19 infected pregnant women are either asymptomatic or present with mild flu like symptoms. Other symptoms seen are, fever, cough, breathlessness, headache, anosmia, loss of taste and diarrhea. In severe cases symptoms are not different in pregnancy.

According to a case series from New York, among 43 COVID 19 positive pregnant women, disease severity was mild in 86%, severe in 9% and critical in 5%. This seems no different from non pregnant cases. As per the UKOSS (UK obstetric Surveillance System) registry from 20th March to 11th May 2020, 427 Covid 19 positive pregnant women were admitted to UK hospitals – of these 9% required level-3 critical care, 4 (<1%) received ECMO (extracorporeal membrane oxygenation) and 5 women died. (Covid 19 associated maternal mortality of 5.6). Current MMR in UK is 9.2 (2015 -17). Again, it is unclear whether these deaths are the direct result of Covid 19. Median gestational age at hospital admission was 34 weeks, 42% of them discharged before delivery. The caesarean section rate among those delivered was 59%, in half of them indication was maternal or fetal compromise. 20% required general anesthesia in view of severe symptoms or urgency of procedure. The median gestational age at birth was 38 weeks. 27% had preterm birth: 47% of these were due to maternal compromise and 15% for fetal compromise. Six babies (2.5%) had a positive test for SARS-CoV-2 during the first 12 hours after birth; three of these were babies born by prelabor caesarean section.

There seems to be no increased risk of miscarriage or teratogenicity from the available evidence. The reports from China do not support the possibility of vertical transmission. Nevertheless, the emerging evidence from two reports from UK showing presence of IgM antibodies in neonatal serum at birth, suggests that it may be possible. IgM antibodies do not cross placenta; their presence in neonatal serum suggests an immune response to infection in utero; their importance to the neonate is yet to be defined. There has been no available evidence of virus in the mother's vaginal secretions or breast milk.

Antenatal care in Covid 19 pandemic

Antenatal care must be considered as an essential service, however unwarranted hospital visits must be avoided. Telephonic consultations should be encouraged. The recommended antenatal visits in low risk women are at 12,20,26,34 and 38 weeks. The ultrasound and investigations should be combined with the antenatal check up to avoid unnecessary travel.

All women coming to the hospital should be categorized to Non Covid, Covid suspects, Covid positives. The non Covid pregnant women can attend normal OP and routine care should be given. The suspects should be seen in triage and swab should be taken as per local guidelines. The antenatal check up may be deferred if possible, depending on the case. The health care workers should take all precautions while in contact with such patients.

The current recommendations for management of Covid 19 positive patients are based on a small number of cohort studies, experience based on treating similar pulmonary infections in pregnancy and expert consensus. This being an evolving scenario, recommendations may change frequently, hence regular updates are necessary.

The treatment is chiefly symptomatic and supportive. Oseltamivir should be considered in patients with respiratory symptoms considering the overlap with H1N1 infection. There is evidence for and against use of HCQS. HCQS acts as a broad-spectrum antiviral and has immunomodulatory activity. Clinical trials in China suggest it is effective in accelerating clinical, radiological and serological resolution. The recommended dose is 400 mg twice daily X 1 day followed by 200 mg twice daily X 4 days. Remdesivir is safe in pregnancy. Lopinavir – Ritonavir also can be used in pregnancy. Ribavirine and Baricitinib are contraindicated in pregnancy.

Antepartum steroids can be used to promote lung maturity and is recommended up to 36 weeks of pregnancy. Generally, it is better to plan delivery after swab is reported to be negative. Avoid induction of labour if feasible. Urgent delivery may be indicated in severe or critical cases or if there is an urgent obstetric indication. There is no contraindication for vaginal delivery. It is better to avoid prolonged labour. There are reports of fetal compromise, hence continuous electronic fetal monitoring during labour is recommended. Similarly, if urgent delivery is indicated because of disease severity or fetal compromise, caesarean section is recommended. The caesarean delivery may be needed in other obstetric indications as well.

For delivery and caesarean section, negative pressure labour room and operation theatre may be considered if available. Minimum staff and proper PPE are recommended while in contact with patients. It is better to avoid birth companion. Epidural labour analgesia should be considered. Entonox is not aerosol generating, can be used with single patient microbiological filter. The patient should wear a surgical mask. Regional anesthesia is the best for caesarean section, but general anesthesia may be needed in critically ill patients or in an emergency. The donning of PPE is time consuming and anticipate this possible delay in emergencies. The placenta must be considered as a biohazardous waste.

Pregnancy is a hypercoagulable state and emerging evidence states that Covid 19 infection also predisposes to a hypercoagulable state. Hence there is an increased risk of venousthromboembolism. Another risk factor is reduced mobility resulting from isolation and hospital admission. Hence DVT prophylaxis should be given. Low molecular weight heparin should be given unless birth is expected in 12 hours and continued for at least 10 days after discharge from hospital.

In patients with moderate or severe symptoms multidisciplinary team should be involved. Hourly monitoring of respiratory rate and oxygen saturation is required. The signs of decompensation are increase in oxygen requirement or $FiO_2 > 40\%$, respiratory rate >30 , decrease in urine output and drowsiness (even if saturation normal). Oxygen should be titrated to keep O_2 saturation $> 94\%$. Chest X-ray and CT should be done as for non-pregnant and should not be delayed for fetal concerns. (abdominal shielding may be used). The decision for delivery needs to be individualized. If urgent delivery is indicated, it should not be delayed for antepartum steroid administration.

In patients with chest pain, worsening hypoxia or in patients whose breathlessness persist or worsen after expected recovery from Covid 19, possibility of pulmonary embolism to be considered.

In women who have recovered from Covid 19, further antenatal check ups should be planned. These women should be offered a growth scan approximately 14 days following recovery. Although there is no evidence that FGR is a consequence of Covid 19, two-thirds of reported pregnancies with SARS were affected by FGR, hence the recommendation. However if there is an indication for an earlier scan it should be done.

There is only limited data on neonatal care. There is no need for early cord clamping and early cleaning of the newborn. The newborn should be tested by RT PCR. Individualized decision regarding breast feeding and mother and baby separation to be taken. The benefit of breast feeding outweighs the risk of viral transmission. The main concern with breast feeding is close contact between the baby and positive mother. The breast milk does not show viral particles as per the available studies. The mother should wear a face mask and strict breast and hand hygiene should be observed. If not planning breast feeding, either expressed breast milk or formula feed should be considered. A dedicated breast pump should be used, and proper cleaning should be done after each use.

Since it is a new disease and considering its rapidly evolving nature, most of the recommendations are not based on high quality evidence.

Reference – RCOG updates



SECOND TRIMESTER UTERINE RUPTURE: A CASE REPORT

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Dr Abdul Vahab K P, Professor and HOD, Department of OBG, MES Medical College



INTRODUCTION

Bicornuate uterus is a rare uterine anomaly that result from incomplete fusion of two mullerian ducts during embryogenesis. This leads to varying degree of separation between two assymetrical uterine cavities ranging from partial separation to complete separation with no communication between two cavities.[1,2] Bicornuate uterus is divided according to involvement of cervical canal –bicornate collis: two cervical canal, central myometrium extends to external cervical os and bicornate unicollis: one cervical canal; central myometrium extends to internal cervical os. Incidence of uterine malformation in general population is estimated to be about 3-5% and 5-10% in women with poor reproductive outcome.[3-5] Precise diagnosis requires diagnostic modalities like ultrasonography(USG), hysteroscopy and laparoscopy. Pregnancies occurring in malformed uterus are relatively rare and many of them are asymptomatic , but should be suspected in patients with recurrent miscarriage and malpresentations. Bicornuate uterus is associated with adverse reproductive outcopes and very rarely can lead to rupture uterus during pregnancy.[6] Herein, I report a case of G4A3 with second trimester rupture of bicornuate uterus. Bicornuate uterus with pregnancy in right horn was diagnosed at 8 week gestation by diagnostic laparoscopy.

CASE REPORT

A 25year old, G4A3, at 20 weeks and 2day gestation , presented to emergency department with complains of sudden onset abdominal pain and vomiting

She had underwent Diagnostic Laparoscopy at 8weeks and 2 days gestation for suspected right adnexal ectopic (fig 1) and was detected to have bicornuate uterus with pregnancy in right horn . She was counselled to continue the pregnancy after explaining possible risks of rupture. She had regular antenatal checkup from thereon.



Fig 1: bicornuate uterus with live embryo corresponding to 7weeks+1day in right adnexa

She was received in emergency department and was in hypovolemic shock.OE: patient conscious, oriented, pallor+++ .PR:120/, BP: 90/40mmhg .SPO2: 98%, with O2. RR-22/. PA: abdomen distended, tenderness +in all quadrants. 16G CANNULA secured on both hands. Catheterized, drained 15ml clear urine. Blood and blood products arranged.1unit PRBC transfusion started. Patient taken up for emergency laparotomy Gross hemoperitoneum present with clots. Bicornuate gravid uterus with ruptured right horn (fig 3,4) and placenta seen protruding through the rupture. Fetus was outside the uterus. Fetus along with placenta extracted. Ruptured right horn sutured. Around 2L blood loss estimated. 1unit PRBC & 2unit FFP given in immediate postop period. 3 more unit PRBC transfused on postop day-2,3 and 4. Patient recovered well and she was discharged on postop day 7 .



Fig:2: showing bicornuate uterus with ruptured right horn

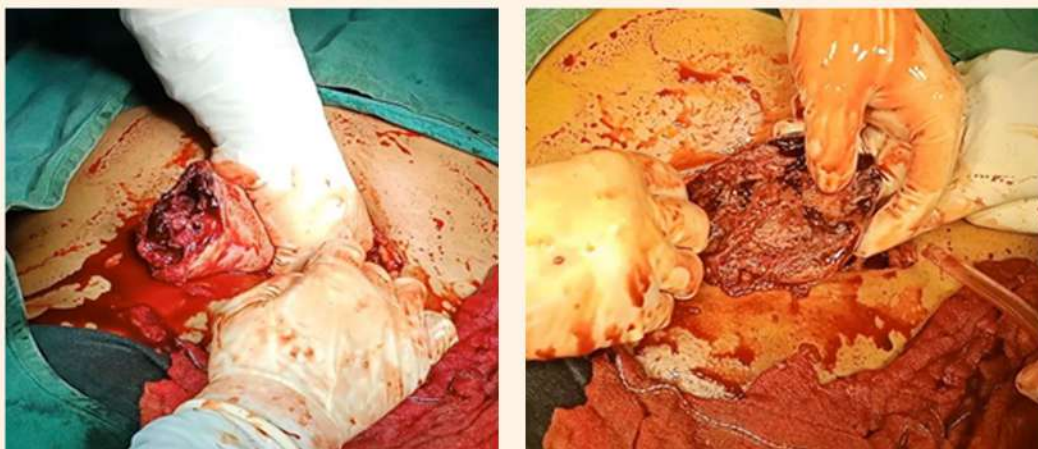


Fig 3,4: showing ruptured right horn

DISCUSSION

Pregnancy in a bicornuate uterus has a poor reproductive potential and requires close monitoring[1]The thin muscular wall of pregnant horn increases risk of horn ruptures.[7].In this case pregnancy in right horn was detected at 8th week of gestation. We had advised and counselled the patient to continue this pregnancy with regular followup after explaining all the risks including chances of uterine rupture.Termination of pregnancy was planned by cesarian section after attaining viability.The patient came with ruptured uterus with fetal demise at 20 weeks. But timely intervention could be done and patient could be saved because patient was counselled to immediately contact or reach hospital in case of any difficulty keeping in mind all the risks. Emergency laparotomy was done and right tube was obliterated so that pregnancy is less likely to occur in this horn later. Right horn was not resected as the supports on right side will be lost and the adhesions following this can also add to fertility issues. Subsequent pregnancy can be planned after one year as risk of rupture is high with uterine scar, and requires regular follow up with early termination.

CONCLUSION

Pregnancy in bicornuate uterus carries high risk of rupture and require regular follow up and close monitoring. But expandibility of uterine horn couldnot be predicted at early gestation even with good imaging techniques . Only by giving a trial and allowing the pregnancy to continue we could predict retrospectively that pregnancy in that horn could not be continued till viability.

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INCREASED NT WHAT NEXT ?

Dr. Rinshi Abid Elayedatt, Consultant in Fetal Medicine, Amrita Hospital, Kochi



ABSTRACT

Case of increased NT is a cause for obstetrician anxiety. This article would reveal to you a systematic and step-wise approach to solve the puzzle of a case of increased NT, from recognizing those that need an invasive testing and further follow up to those cases that will end up in spontaneous resolution of the raised NT. As more than 70% of the foetuses with increased NT > 3.5mm (99th centile) are likely to be live born and healthy, it is mandatory that every primary health care provider is aware of this fact even before they write-off these unborn.

INTRODUCTION- In the first trimester window of NT scan, a foetus is said to have an increased NT when the measured NT is beyond the 95th centile for that particular CRL. Yes, raised NT is a CRL dependent value with specific cut-offs (>95th centile) for every gestational age between 11weeks to 13 weeks 6 days. fig 1.1. Hence the term increased NT when used arbitrarily need not have an implication on the current management of the pregnancy unless, the NT is specifically beyond the actual cut-off at which termination is the only option. Thus an explicit knowledge of the algorithm in management of cases of increased NT deems mandatory.

MATERIALS & METHODS- NT between 11 + 13+6 weeks' gestation is an undisputed marker for aneuploidies.

The causes for increased NT varies & are:

- Chromosomal abnormalities
- Structural anomalies
- Genetic syndromes
- Structural anomalies
- Higher risk of miscarriage
- Risk of fetal demise
- Developmental delay
- Chromosomal abnormalities-

The prevalence of chromosomal defects increases exponentially with NT.

NT	Prevalence of chromosomal defects
5th- 95th centile	0.2 %
> 6.5 mm	65 %

- The incidence of chromosomal/ other abnormalities is related to the size than the appearance of NT. The most common chromosomal abnormality to be associated with increased NT is trisomy 21.
- In 75-80% of trisomy 21 fetuses the NT thickness is above the 95th centile of the normal range
- **Structural anomalies-** The most common structural abnormality associated with increased NT is congenital heart disease.
- Genetic syndromes
- **Fetal demise**

In chromosomally normal fetuses, the prevalence of fetal death is:

- 1% - NT between 95th - 99th centiles
- 20% - NT 6.5mm
- Majority die by 20 weeks after progression to severe hydrops.

Pathophysiology of high NT

- Cardiac defects / dysfunction (CHD)
- Venous congestion in the head and neck (CDH, Skeletal dysplasia)
- Altered composition of the extracellular matrix. (Trisomy, achondrogenesis, achondroplasia-II)

- Failure of lymphatic drainage (fetal akinesia deformation sequence, myotonic dystrophy, SMA);
- Hypoplastic lymphatics (Turner syndrome)
- Fetal anemia (α -thalassemia, Blackfan-Diamond anemia, congenital erythropoietic porphyria, dyserythropoietic anemia, Fanconi anemia)
- Fetal hypoproteinemia (congenital nephrotic syndrome)
- Fetal infection (Parvo virus B-19)

How to proceed further in a case of increased NT?

Answer the 3 basic questions when a case of increased NT reports in to your OPD:

- Is this NT taken as per FMF guidelines?
- Is the NT actually increased (beyond the 95th centile)?
- Is this an isolated finding?

FMF Criteria for measuring NT

- Neutral position (no hyperflexion/ hyperextension)
- Adequate magnification involving head & upper thorax.
- Mid sagittal view of face.
- Gain to be reduced.
- Widest NT to be measured.
- Rule out nuchal cord.

Increased NT- measurement >95th centile

- 95th centile at CRL-45mm 2.1mm.
- 95th centile at CRL-84mm 2.7mm
- 99th centile at any GA (11w-13w+6d) is 3.5mm(Snijders et al 1998)
- <http://fetalmedicine.org> calculator
- Associated findings

Additional aneuploidy markers

- a. unossified nasal bone b. tricuspid regurgitation c. ductus venosus 'a wave' reversal

Rule out structural anomalies.

Management of NT below 3.5 mm

- Combined test- gives a patient-specific risk for chromosomal abnormalities. It includes NT +serum free β -hCG and PAPP-A.
- A detailed scan at 11-13 weeks.
- Target scan at 20 weeks with fetal Echocardiography

Management of NT 3.5 mm or more

- Chorion villous sampling (CVS): fetal karyotyping/ array CGH
- Family history of genetic syndromes - DNA analysis.
- A detailed scan at 11-13 weeks
- An early target scan at 16weeks
- Target scan at 20 weeks- to rule out structural abnormalities, aneuploidy markers, subtle dysmorphic features.
- Fetal Echocardiography
- If structurally normal & NT has resolved, reassure survival and normal development.
- The chances that the baby will have a serious abnormality or neuro-developmental delay may not be higher than in the general population.
- Eg: When a cohort of 100 fetuses with increased NT >3.5mm (99th centile) at 12weeks of gestation are taken, it is seen that 20 (20%) are likely to be aneuploid on genetic testing (CVS). Out of the rest of the 80% euploid fetuses, 10 (10%) are likely to be diagnosed with a structural abnormality on

subsequent ultrasound examination and 2(2.5%) are likely to die in the subsequent weeks. Still 70% of the euploid foetuses are still going to be live born and healthy inspite of having an abnormal NT beyond the 99th centile.

Persistence of increased NT

- If in the absence of abnormalities, there is persistence of increased NT at 16 weeks, nuchal edema/ hydrops at 20weeks, rule out congenital infection or a genetic syndrome.
- Maternal blood should be tested for toxoplasmosis, cytomegalovirus, and parvovirus B19.
- Monthly follow-up scans to define the evolution of the edema.
- Consider DNA testing for certain genetic conditions, such as Noonan syndrome, even if there is no family history. There is a 10% risk of perinatal death/ birth with a genetic syndrome that could not be diagnosed prenatally in this cohort of babies. The risk of neurodevelopmental delay in the survivors is 3-5%.

Algorithm in the management of case of increased NT

CONCLUSION

- Increased NT is associated with trisomies, major chromosomal abnormalities, >50 fetal defects & genetic syndromes and fetal death.
- In the absence of structural or chromosomal abnormalities, NT resolves in majority of cases and they are born healthy and develop normally.
- Increased NT is not an indication for termination of pregnancy.
- The microarray can be performed as a first tier test in increased NT or as a second tier test when karyotype is normal. Microarray yields additional clinically valuable information over 5.0% in the above cases.
- In monochorionic twins, increased NT at the 11–14week is associated with a four-fold increase in risk for the subsequent development of severe TTTS syndrome -(Sebire et al., 1997c)



CERVICAL CERCLAGE AND PROGESTOGENS FOR PREVENTION OF PRETERM LABOUR

Dr. Vanitha, Consultant Obstetrician and Gynecologist PG Hospital, Nilambur, Malappuram



INTRODUCTION:

Preterm labor accounts to 5- 10% of deliveries and causes significant mortality and morbidity to women and babies. It negatively impacts the women and their family and cost of health care system.

CONDITIONS THAT INCREASE RISK OF PRETERM LABOUR:

1. Previous preterm delivery
2. Previous h/o PPROM
3. Midtrimester pregnancy loss
4. Congenital uterine malformation
5. Multiple pregnancy
6. Vaginal bleeding
7. USG showing short cervix
8. Previous cervical surgeries

CERVICAL LENGTH MONITORING BY TVS:

Among these risk factors, previous history of preterm labor is a strong predictor of recurrence in the subsequent pregnancy. So when there is a h/o of preterm labor how to manage her in next pregnancy? Here comes the transvaginal sonographic monitoring of cervical length between 16 to 24 weeks of pregnancy. There is good evidence that cervical length < 25mm strongly predicts preterm labor risk with positive predictive value of 70%. Cervical length should be measured by transvaginal ultrasound. In high risk women it is recommended to monitor cervical length between 16 to 24 weeks of gestation. Cervical length measured between <16 weeks or >28 weeks is less sensitive in predicting preterm labor.

ROLE OF PROGESTRONE AND CERVICAL CERCLAGE FOR WOMEN WITH PRETERM LABOUR RISK

Though many interventions are proposed for prevention of preterm labor, there is a good quality of evidence only for vaginal progesterone and cervical cerclage. Again, the question is whether to use progesterone or cerclage alone or should we combine both? Here are few studies regarding the same.

ROTE et al, 2009: it's a metaanalysis comparing progesterone with placebo in women with singleton pregnancy and previous h/o of preterm labor. It concluded that progesterone significantly reduces the risk of preterm labor <37 weeks.

ROMERO et al: metaanalysis comparing progesterone with placebo in asymptomatic women with short cervix and found progesterone reducing the risk of preterm labour.

There is a good evidence that both cervical cerclage and progesterone are useful in women with short cervix and h/o preterm labor.

But there is lack of good evidence comparing vaginal progesterone with cervical cerclage in preventing preterm labor in high risk women.

Compiling these evidences NICE (National institute of clinical excellence) UK has come up with clinical guidelines

NICE GUIDELINES:**VAGINAL PROGESTRONE OR PROPHYLACTIC CERCLAGE IS OFFERED....**

If a women has h/o preterm labor or mid-trimester pregnancy loss and cervical length measured between 16 -24 weeks showing cervical length < 25mm.

VAGINAL PROGESTRONE ALONE IS OFFERED

If women has a h/o preterm labor or mid-trimester pregnancy loss and her cervical length is normal when measured between 16-24 weeks. And in women with cervical length <25mm but without history of preterm labor. Vaginal progesterone should be offered between 16 to 24 weeks and continued till 34 weeks.

PROPHYLACTIC CERCLAGE

If there is h/o PPROM or cervical trauma and TVS showing cervical length <25mm.

CONCLUSION:

Any kind of medical intervention has its own complications especially surgical procedure like cerclage. Good quality evidence is yet to come comparing vaginal progesterone with cerclage in high risk women for preterm labor. Until then let us follow interventions which cause less harm to mother and the best one would be to do cervical length monitoring by TVS which can be done very easily in OPD and decide upon what to do for her following NICE GUIDELINES.



POGS ACTIVITIES

Inauguration of POGS & Hello Tomorrow CME- January 2020

The POGS was officially inaugurated on 12th January 2020 at function held at IMA Hall Perinthalmanna. Dr Aswathkumar, FOGSI Vice President South Zone was the chief guest. Dr Aswath Kumar installed Dr K U Kunjimoideen, as President and Dr Abdul Vahab as Secretary of POGS. Dr P Gopeenathan, KFOG President presided over the function. Dr Mumthaz, the treasurer of POGS welcomed the Guests and delegates. Prof VP Paily, the Convenor of CRMD project has inaugurated the website of POGS, which has the facility for online membership payment and member benefit pages. Prof PC Mohapatra was the Guest of Honour. Prof PK Sekharan officially released the E Journal of PGS named as METAmomPHOSIS. Dr M Venugopal, the Secretary General of KFOG felicitated the meeting and Dr Abdul Vahab did vote of thanks.

Inauguration function was followed by 'Hello tomorrow' CME. 112 delegates attended the CME. Prof VP Paily spoke on Cervical Cerclage, Prof Mahapatra- Lessons learned and Mistakes made and Prof Sekharan on 'Update on Gestational trophoblastic diseases. Dr Aswath Kumar and Dr Prameela moderated a panel discussion on Twin pregnancy. Dr Kunjimoideen and Dr Venugopal moderated a panel discussion on Infertility case scenarios. POGS New year family get together also was organized on the same day evening with variety entertainments and gala dinner.





FOGSI Oncology committee CME held at Perinthalmanna, Kerala on 23rd February 2020

FOGSI Oncology committee CME organised by POGS was held at Perinthalmanna on 23rd February 2020. The program was supported by the oncology committee of KFOG. The CME was inaugurated by FOGSI Oncology committee chairperson Dr Bhagya Laxmi Nayak from Cuttack. The inauguration was presided over by Dr K U Kunjimoideen, President POGS and Dr Abdul Vahab, Secretary of POGS presented the report of January Hello tomorrow CME. Dr Bhagyalaxmi Nayak spoke on Oncofertility. Dr Santosh Kuriakose from Kozhikode Medical College spoke on Update on Screening of Cervical Cancer and Dr Adarsh Dharmarajan from Malabar Cancer Centre, Thalassery delivered a lecture on Hyperthermic Intra peritoneal Chemotherapy (HIPEC) for Ovarian cancer. The sessions were followed by active interaction from all the delegates. 76 delegates attended the program.

The General body meeting decided to conduct the cancer screening (Breast and Cervix) program for the female members of Malappuram district police as per the guidelines received from FOGSI office under the directions of President Dr Alpesh Gandhi



POGS REPORTS - MARCH

Proud of Perinthalmanna and OUR OG society

COVID 19 Lock down days... Few positive thoughts

As we go through these hard days of lock down to break the chain of community spread of COVID 19 infection, I would like to pen down few of positive vibes and ray of hope which we could see around at my small town, Perinthalmanna.

We have kick started the POGS activities in the first week of March with lots of expectations and planning starting from Cervical and breast screening programs in a big way. Mr U Abdul Kareem, IPS, the SP of Malappuram District has inaugurated the month long multi centeric screening program organized by POGS. We had plans to screen 1000 women belonging to Police force and their family members. Eight hospitals from various parts of district started the activity with the aim of providing free pap smear examination to these 1000 women. By the time we completed 372 women across the district, the COVID 19 related restrictions came into force and we stopped all activities upholding the 'Social distancing' and 'Personal hygiene' slogan.

From then on I could see a huge response from the occupants of this municipality and the unlimited number of patients flowing to this hospital town. The famous religious places like

Thirumthaamkavu temple at Angadippuram, The massive Sunny masjid in the central Perinthalmanna and the various churches across the city, all were closed down as soon as the government declared 'Social distancing' strategies. This shows the flexibility and inclusivity of all religious institutions to raise to occasion aiming the benefits of manhood. We could see hand washing taps all around all bus stops and at the entrances of all major institutions.

Hospitals were screening the patients by taking their detailed past travel history and thermal screening measures combined with providing face masks and hand sanitisers which were indigenously prepared. The POGS has urged all its members to educate the staff and public in their locality regarding the facts and myths about COVID 19, to avoid panic. Our members have taken several classes and released videos regarding proper hand washing techniques and strict observation of lockdown policy. All the women healthcare teams have divided into teams and observing emergency duties by turn.

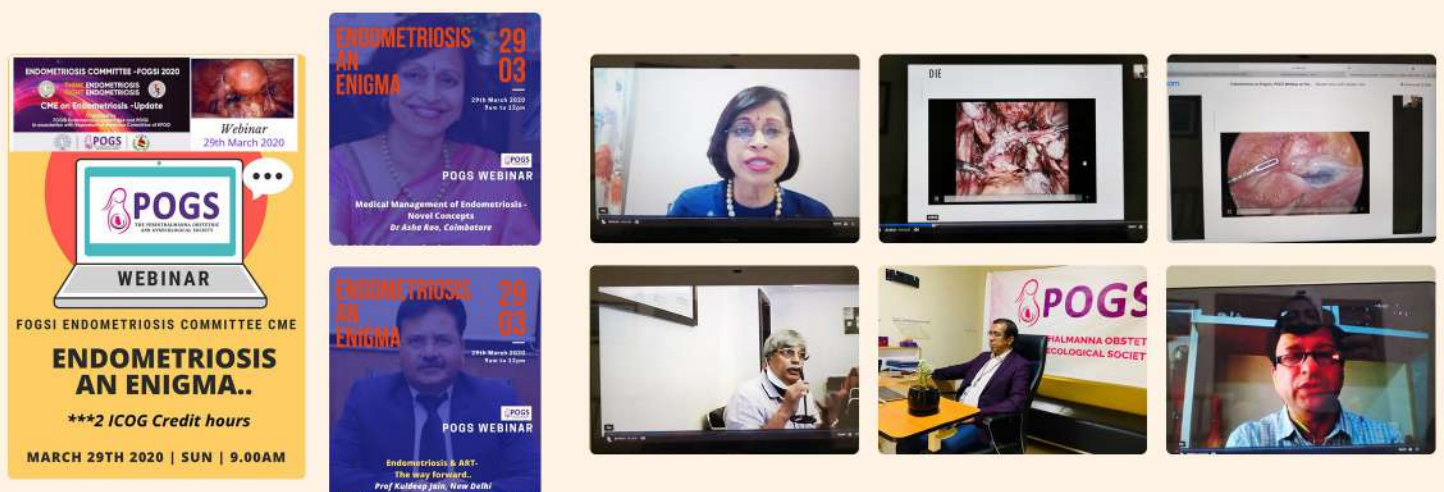
Academic activity is the essence of any medical professional's organizations. POGS is no exemption. We have planned a Webinar of 29th March Sunday and the CME is named as Endometriosis – An enigma.... This will help the members staying at home to divert their attention creatively from the scaring messages being forwarded in social media. Many senior national faculty will be joining this webinar from various parts of India.

The members are really engaged in various activities by sitting at home...

Really proud of this gang of our members and Perinthalmanna too..



Webinar POGS March 29th



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**8TH & 9TH
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