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The Mumbai Obstetric & Gynecological Society

MOGS MATTERS

30th June 2020 I Issue 2

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MANAGING COMMITTEE & YC REPRESENTATIVES 2020-2021

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President's Message

Dear friends,

It gives me great pleasure to present to you the second issue of MOGS Matters, our digital newsletter. We all have now become acclimatized to the new normal-the world of social distancing, virtual meetings and completely different lifestyles. What has not changed is, that learning continues-different subjects and types of learning, but all adding up to increased knowledge.

At the Mumbai Obstetric and Gynacological society we have been really busy with wonderful academic programmes-the Evolve conference, Focus on 1st trimester conference, Fresh viewpoints on infertility CME ,Outreach programmes etc. In august we have for the first time ever, Youngistan conference-by the young for the young at heart.

I hope you have enjoyed the Pearls of wisdom videos which we have been sending you-short videos by experts to update you in a few minutes.

This newsletter has been painstakingly put together by Dr Niranjan Chavan with his team of Komal Chavan, Rohan Palshetkar, Bhumika Kotecha and Deepali. They have really made an interesting mix of academics, fun, masti, fitness and a lot more, so do go through it and give your feedback.

We have launched the V Care & Share programme and are helping hundreds of healthcare workers and patients. Do contribute generously to this by paying online on our website or by NEFT transfer to MOGS -this is your time to give.

Our website has all the latest information so do log in to www.mogsonline.org

Thanks for all your support and do continue to be with your partner and friend-MOGS .

Take care-stay healthy .

Warm Regards

Rishma Dhillon Pai
M.D. , F.R.C.O.G (UK), D.N.B, F.C.P.S, D.G.O., F.I.C.O.G
President MOGS.
Asst. Treasurer - International Federation of Fertility Societies (IFFS)
President 2018-19 - Indian Society for Assisted Reproduction (ISAR)
President 2018-19 - Indian Association of Gynaecological Endoscopists (IAGE)
President 2017 - Federation of Obstetricians & Gynaecologists of India-(FOGSI)

From the Editor's Desk

"Success is not final, Failure is not fatal: it is the Courage to continue that counts" - Winston Churchill

Greetings dear friends and colleagues,

As vice president of MOGS, I present to you this unique e-newsletter "MOGS Matters". The year 2020 has been full of surprises and has taught us plenty of lessons. We are bringing to you this e-newsletter to keep up with the new normal era.

This edition features many articles from eminent gynaecolologists. The article on "Fertility After 40" by Dr Nandita Palshetkar, shows some very important but often ignored points. We have a focus on vaccines in this newsletter by our President Dr Rishma Pai - on Influenza vaccineand me, Dr Niranjan Chavan regarding HPV. We also have some insights on Telemedicine by Dr Rohan Palshetkar. These are some very important topics in this day and age and I'm sure all the readers will benefit out of them. The "48 Hours emergency duty in the life of an obstetrician at Sion Hospital, Mumbai in the Covid era" article from the residents of Sion Hospital is a picture of the ground reality that they are facing day after day and also a throwback of many memories for us seniors to look back on from our PG days! We have all realized the importance of a healthy mind and a healthy body in these trying times and Dr Aditi Tandon and Dr Komal Chavanhave highlighted the importance of fitness in their write-up. There are also a number of photographs from all our members showing off their new normal "fashion trends". For some leisure time, we have also added coloursudoku and more puzzles to be enjoyed by everyone.

We deeply mourn the loss of my beloved classmate Dr Parag Patil to COVID-19. He was a Corona warrior who was fighting courageously for the past 4 weeks. He was an active member of FOGSI, MOGS and Kalyan IMA. He was a leading consultant Obstetrician and Gynaecologist in Kalyan. He has left a legacy of teachings in the field of sexual medicine, adolescent health, MTP Law, PCPNDT Act and Nursing Home Issues.

This year we also lost our stalwart nonagenarian gynaecologist, a teacher to many of us, and the guiding light of MOGS - Dr Ajit Mehta. He was former Dean of Wadia Hospital.He had introduced a cervical typing score and a gestational calendar amongst innumerable other contributions to our field for which we will remember him for all eternity. He was a symbol of compassion and one of the greatest teachers that many of us have had the good fortune of learning from. We pray for the departed souls to attain eternal peace and for the families to get the strength to bear the irreparable loss.

I hope you all enjoy reading this edition as much as we have enjoyed putting it together. I encourage all the readers to stay safe in these difficult times and look out for one another, and help each other wherever possible.

Dr Niranjan Chavan
MD, FCPS, DGO, DFP, DICOG, MICOG, FICOG
Diploma in Endoscopy (USA), Prof. (Addl) & Unit Chief, LTMMC & LTMGH Sion Hospital
Vice President, MOGS (2020-21), Joint Treasurer-Elect, FOGSI (2021-24)

REPORT OF V CARE AND SHARE ACTIVITIES IN JUNE 2020

Dr Anahita Chavan
MD, DGO,DFP,FICOG
Former Prof and HOU Seth G S Medical College and KEM Hospital
Secretary MOGS
Second Joint Assistant Editor JOGI

This program was launched by the President Dr. Rishma Pai during her installation on 10th May 2020, and details were discussed in the first MCM on 20th May 2020. Conveners of the program are Dr. Hrishikesh Pai and Dr. Nozer Sheriar. Initially Dr. Hrishikesh Pai, along with Dr. Rishma Pai, asked all Heads of Departments of ObGyn in major public hospitals for their urgent requirements during the pandemic. After written replies were obtained, Dr. Nozer Sheriar, Dr. Jaydeep Tank and Dr. Atul Ganatra (who had informed us that he would be able to procure a good rate for purchase of equipment from vendors), were consulted.

It was decided to get quotations from various vendors and decisions for quantities and purchase were made in consultation with first the conveners and then the office bearers. PPE, N 95 masks, face shields, infrared thermometers, fetal dopplers and pulse oximeters, were items requested by all the institutes. A specific request was received from Nair Hospital for only an NST machine; being a covid centre, other equipment was available to them but they had no way of monitoring patients. Additionally, JJ Hospital did not have even BP apparatus and gloves, hence it was decided to provide them with the same.

MOGS purchased through its own funds: 1 NST machine, 500 PPE, 600 N 95 masks, 15 pulse oximeters, 6 BP apparatus, 16 fetal dopplers and 3 infrared thermometers.

At the outset, the program was kickstarted by a generous personal donation from Dr. Hrishikesh Pai and Dr. Rishma Pai. Our past member Dr. Shobhana Mohandas and Dr. Nandini Ram Babu also made contributions. We would like to place on record our thanks and appreciation to all the donors.

The first round of equipment was personally distributed on 2nd June 2020 by MOGS Secretary Dr. Anahita Chauhan, along with managing committee members Dr. Mansi Medhekar and Dr. Unnati Mamtora, and Youth Council member Dr. Medha Tankiwala, to the 6 major hospitals.

We had appealed to all our industry partners to help us in this program. Sun Pharma came forward with a substantial donation of PPE, N 95 masks, face shields, infrared thermometers and gloves which made it possible for us to honour requests from peripheral BMC hospitals as well.

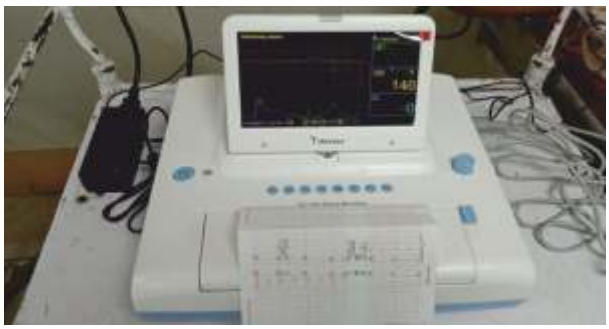
The second lot of equipment, including an NST machine to Nair Hospital, was personally distributed on 10th and 11th June 2020 by MOGS Secretary Dr. Anahita Chauhan, along with managing committee member Dr. Gaurav Desai, and Youth Council members Dr. Mohit Saraogi, Dr. Siddesh Iyer and Dr. Medha Tankiwala, to the 6 major hospitals as well as the 5 peripheral hospitals. The distribution is given below:

INSTITUTE	PPE	N 95 MASKS	FACE SHIELD	PULSE OXIMETER	FETAL DOPPLER	INFRARED THERMOMETER
KEM	100	100	50	2	2	2
SION	100	100	50	2	2	2
JJ	100	100	50	2	2	2
COOPER	100	100	50	2	2	2
WADIA	50	100	50	2	2	2
CAMA	50	100	50	1	2	2
BHABHA BANDRA	50	50	50	1	1	-
VN DESAI	50	50	50	1	1	-
BDBA KANDIVALI	50	50	50	1	1	-
MAGATHANE BORIVALI	50	100	50	1	1	-
BHABHA KURLA	-	100	-	-	-	-
NAIR	NST MACHINE					
JJ (ADDITIONAL)	6 BP INSTRUMENTS, 1000 PAIRS GLOVES					

We now plan to distribute the remaining PPEs and N 95 masks in the first week of July to other institutes in need. We are also exploring the possibility and feasibility of sending protective equipment to our members who are in need of the same, and some donors have come forward for this.

We have generated an online payment gateway for the same, which we have displayed on our website as well as in our online publications. We request you all to actively engage in fundraising activities among your friends and family, as well as volunteer to help senior members who may be unable to attend to their duties.

Our sincere thanks to our conveners, Dr. Hrishikesh Pai and Dr. Nozer Sheriar, past president Dr. Jaydeep Tank, Dr. Atul Ganatra and all the Office Bearers who wholeheartedly supported us.




Online payment gateway on MOGS website

http://mogsonline.org/vcareshare/

MOGS V Care & Share

MOGS extends a helping hand to our frontline healthcare workers and patients.
Support our efforts - contribute generously - if not now, when?

NEFT Details of MOGS

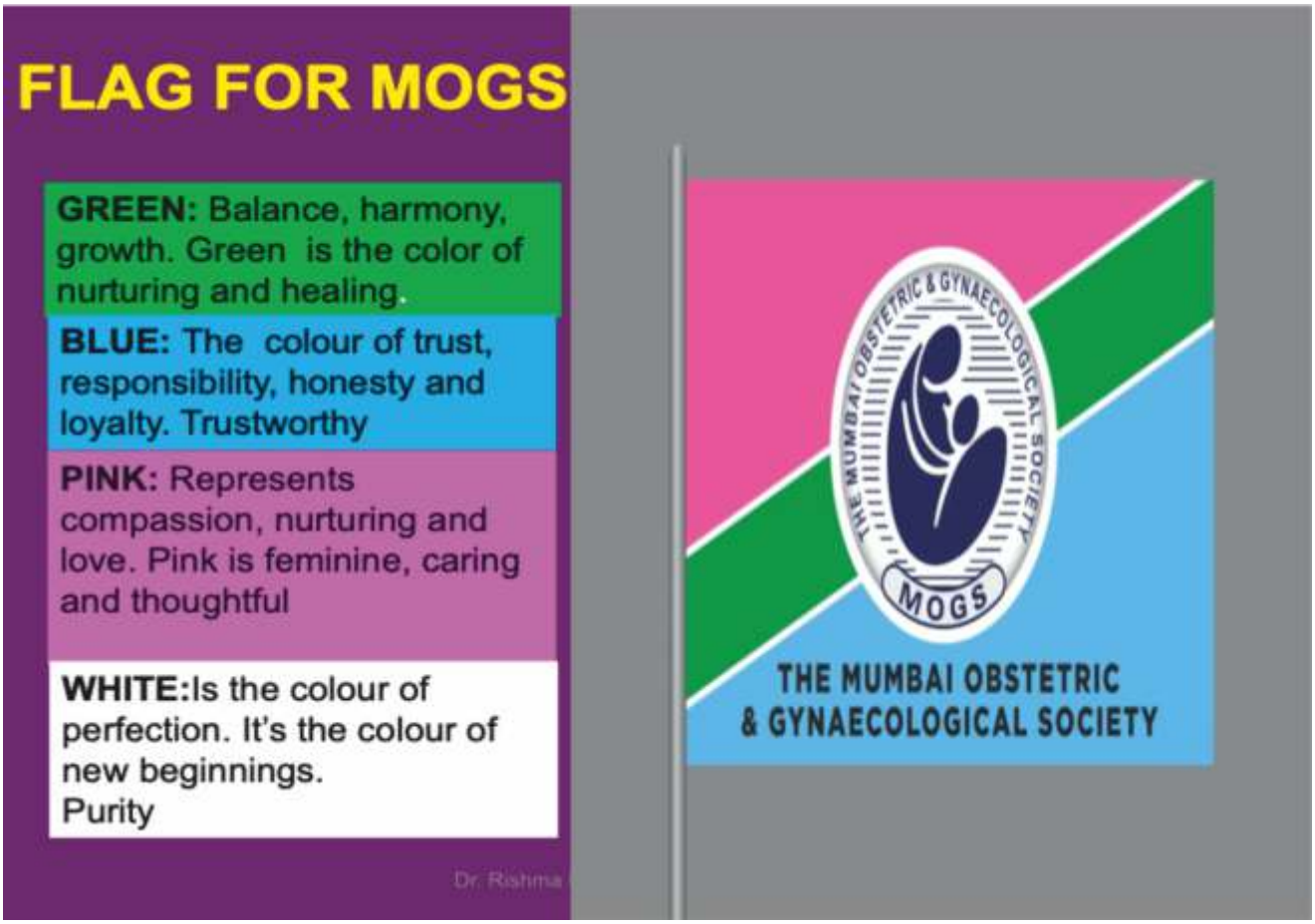
Name as per Bank Account	**The Mumbai Obstetric & Gynecological Society**	RTGS/NEFT/IFSC Code	**BARB0JACOBC**
Bank Account No	**24480100012858**	Gstcertificate	**27AAATT4562C1ZL**
Bank Name	**BANK OF BARODA**	Pan card	**AAATT4562C**
Bank Branch	**JACOB CIRCLE BRANCH, Mumbai 400 011**	SAC CODE	**998599**
MICR Code	**400012092**		

Click here for MOGS Twitter Handle :

https://mobile.twitter.com/mogshq

MOGS App

MOGS Flag

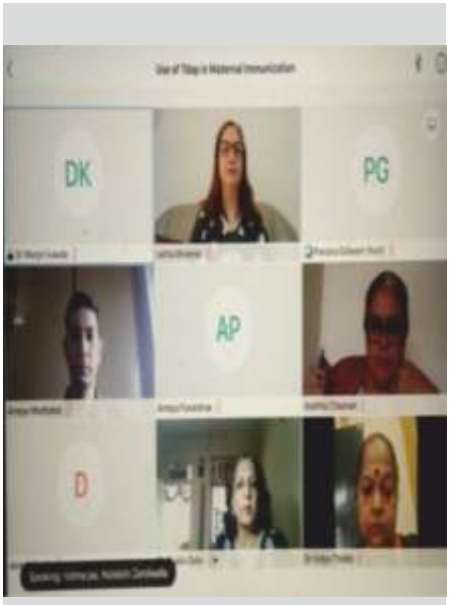


MOGS NEWS

1) Report of Webinar on the 20th May 2020, on "Abnormal Uterine Bleeding - Stop the glow - What to do and how"

The Mumbai Obstetrics and Gynaecological Society, in Association with the Indian Menopause Society(IMS) and the FOGSI Midlife Management Committee (Chairperson Dr Rajendra Nagakatti)& Association with the Indian College of Obstetrics and Gynaecology (ICOG-granted 1 ICOG Credit point) organised a Webinar on the 20th May 2020, on "Abnormal Uterine Bleeding - Stop the glow - What to do and how". The Webinar was also supported by the AMOGS Middle Management Committee (Chaiperson Dr.RajendraNagarkatti)and the AMOGS Adolescent Committee(Chairperson Dr. SupriyaArwari). There was elaborate discussion on topics relevant to the subject of AUB like adolescent AUB invaiorus age groups & novel treatment options..There were 1080 participants who logged in and also another 840 who came live on social media.

2) Report of MOGS webinar on Antenatal Care held on Thursday May 21st 2020 between 4 to 5.30 pm



The program was organised in association with Food n Drug committee FOGSI on 21st May between 4-5:30pm. Various topics relevant to prescriptions of medictaions ,their safety, vaccination were addressed in this webinar.Total attendance was 37.The Educational partner for this event wasGlaxoSmithKline.

3) Report of MOGS Live Webinar on 1st June, 2020 by Dr. NiranjanChavan

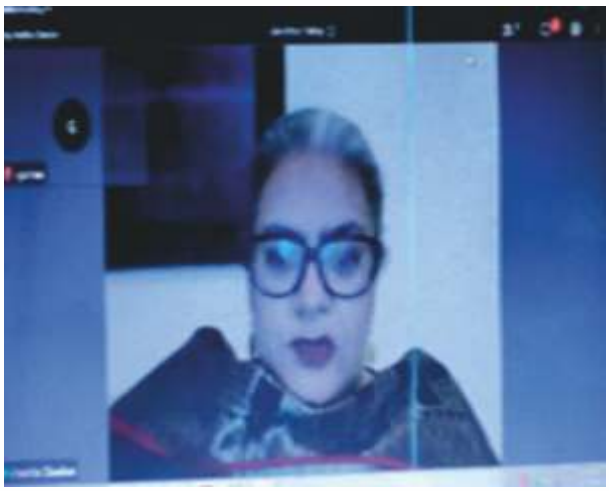
How to Start OPD & Routine Gynecological Surgeries Post COVID-19 Lockdown 4. in Association MOGS 1stJune, 2020.Total Attendees were 1504.This was a unique webinar with the practical tips for guiding the obstetricians and gynecologists for getting accustomed to the new normal professional practice in COVID pandemic.

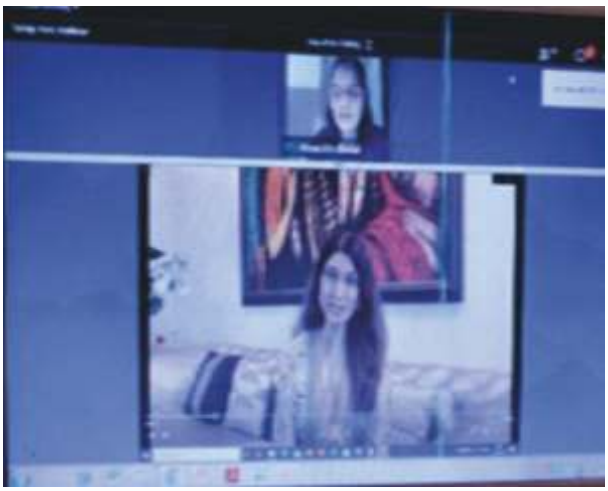
- **Video glimpse**

4) Report for outreach program on 13th June 2020

Dr Punit Bhojani
Consultant OBGYN,
Member, Managing Council,
MOGS,Youth Council Mentor, MOGS

The first MOGS outreach program, under the dynamic leadership of President Dr Rishma Pai, Secretary, Dr Anahita Chauhan and Treasurer, Dr Rajendra Sankpal, was unique with a live interactive webinar conducted on 13th June between 6 pm to 7.30 pm. Dr Purnima Satoskar, Dr Nagendra Sardeshpande, Dr Punit Bhojani and Dr Mansi Medhekar, were the conveners of the program. The program was well received and has an attendance of 85 members. Academic partners of this Web CME were Sun Pharma Spectra and the program was granted 1 ICOG credit point.





5) Report of "Focus On First Trimester" (F1stT) Conference

Dr. Purnima Satoskar
MD DNB FRCOG
Professor Seth G S Medical College
Head of Unit and Fetal Medicine
Nowrosjee Wadia Maternity Hospital
Consultant, Jaslok Hospital

The second MOGS Webinar "Focus on First Trimester" (F1stT) with an exclusive focus on issues in early pregnancy was held on Sunday, 21st June, 2020 from 10.00 am to 2.00 p.m. It was held in association with four FOGSI Committees-Midlife Management Committee, Foods & Drugs and Medico Surgical Equipment Committee Genetic &Fetal Medicine Committee & Imaging Science Committee. The program began with interesting Role Plays of Patient-Doctor Interaction by Dr. Mansi Medhekar and Dr. Ganpat Sawant discussing 'Common queries in first trimester' and Dr. Komal Chavan and Dr. Raju Nagarkatti discussing 'Minor ailments in pregnancy' which were very well enacted. Dr. Reena Wani elaborated beautifully on Teratogenicity, while Dr. Sujata Dalvi gave an interesting talk on Periconceptional Counselling. Dr. Vidya Thobbi and Dr. Samir Pradhan were the Chairpersons for this session. In the second session there were 2 keynote addresses. In his talk Dr. P.G. Natrajan emphasized the role of obstetricians in early detection of the carrier state of Thalassemia in pregnant women. Dr. Archana Baser explained the physiological basis and value of screening for Preeclampsia. International faculty Dr. Manjiri Khare, Consultant, Women and Perinatal Services, University Hospitals of Leicester, NHS, enthralled the audience by presenting her series of extremely interesting cases of genetic and teratogenic anomalies detected in first trimester. The Chairpersons were Dr. Mandakini Pradhan and Dr. Meenu Agarwal. The inauguration began with Dr. Rishma Dhillon Pai (President MOGS), addressing the delegates regarding the forthcoming programs, newsletter and Pearls of Wisdom videos that she has launched this year. A minute's silence was offered to honor MOGS member, Covid warrior Dr. Parag Patil, Dr. Rishma Pai welcomed and introduced the Chief Guest Ms. Sonali Kulkarni, an acclaimed and talented actress who has won several awards and has acted in many films with a social message. She spoke from her heart about her own experience with pregnancy and motherhood and appreciated the hard work done by doctors, stating that they are the real heroes. Dr. Anahita Chauhan then threw light on the 'MOGS V Care and Share' program which is convened by Dr. Hrishikesh Pai and Dr. Nozer Sheriar. She informed the audience that MOGS had utilized its own funds, along with generous personal donations from a few members, to donate necessary equipment to many municipal and government hospitals - PPE, N 95 Masks, face shields, thermal scanners and NST machine and acknowledged the generous contribution from Sun Pharma for the same. A special video prepared by Dr. Unnati Mamtora was shown, where Dr. Rishma Dhillon Pai has appealed to all members to help

MOGS in this noble cause by donating generously to V care and Share Fund which documented the equipment donated to various public hospitals. Dr. Shailesh Kore thanked MOGS for this venture and expressed his views on how this pandemic has helped us push our limits. All the municipal, government and peripheral hospital HODs and in-charges were honored by Dr. Ganpat Sawant as the real heroes in the pandemic. The inauguration was concluded by Dr. Rajendra Sankpal who thanked Ms. Sonali Kulkarni for her gracious presence. Dr. Rajendra Nagarkatti felicitated and thanked our Pharma Academic Partners.

A panel discussion of practical importance on 'Bleeding in first trimester' was moderated by Dr. Sarita Bhalerao and Dr. Purnima Satoskar. Panelists were Dr. P K Shah, Dr. Madhuri Patel, Dr. Raju Sahetya, Dr. Vandana Bansal, Dr. Rohan Palshetkar and Dr. Sachin Nichite.

The prestigious MOGS Dr. Dossibai J R Dadabhoy Silver Jubilee Oration for the first time in virtual format was brilliantly delivered by Dr. Asma Khalil, Professor of Obstetrics and MFM, St. George's University Hospital, London, who spoke in depth about first trimester ultrasound in twin pregnancy. Everyone enjoyed the academic and masti quiz held in between the sessions by Dr. Shrutika Thakkar and Dr. Mansi Medhekar. In sync with the MOGS mantra of the year 'FIT IS IT' and it being an International Yoga day, a short video on yoga by Dr. Komal Chavan was well appreciated. The program ended with vote of thanks by her. The office bearer in charge was Dr. Shailesh Kore. The conveners for the program were Dr. Purnima Satoskar, Dr.Rajendra Nagarkatti, Dr. Ganpat Sawant, Dr.Komal Chavan, Dr. Mansi Medhekar and Dr. Rohan Palshetkar. MOCs were Dr. Unnati Mamtora, Dr.Shrutika Thakkar and Dr. Aditi Tandon. Total registrations were 1000.

6) Report of MOGS Dr N A PURANDARE TEACHING PROGRAM - Webinar held on Saturday JUNE 27, 2020 by Bhatia Hospital, Tardeo, Mumbai

The Case presentation on "Fever in Pregnancy" was done by Dr Noopur Chawla from Saifee Hospital. The examiners were Dr Ajit Virkud / Dr Sujata Dalvi / Dr Ameya Purandare.The first talk session was chaired by Dr Reshma Rao / Dr Avan Dadina / Dr Tejas Purandare. Dr Madhuri Mehendale - briefly spoke on 'Donning and Doffing" followed by Dr Gita Nataraj(HOD Microbiology Dept - KEM Hospital) who very elaborately spoke on 'Laboratory Test of COVID 19' and answered many queries put up by the chairpersons / delegates. To observe condolences for the Death Dr Ajay C Mehta, Dr Ameya Purandare requested everyone to observe for 1-minute silence. He asked Dr Pranay Shah and Dr Ajit Virkud to pay tribute to Dr. A.C Mehta. Case presentation on 'Anemia in Pregnancy' was done Dr Rashmi Bhatsange from Saifee Hospital. The examiners were Dr Pranay Shah / Dr Sarita Bhalerao / Dr Priya Vora.

The second talk session was chaired by Dr Pragnya Parulkar / Dr Devika Chopra / Dr Kinjal Shah. Dr Anahita Chauhan gave an insight into 'Contraception - LARC / Implanon with video presentation' followed by Dr Nagendra Sardeshpande who spoke on 'Instrumentation in Laparoscopy'Total attendance was 120. This was a joint effort by Team of Bhatia hospital & MOGS.

7) Report of MOGS FRESHVIEW POINT CME Sunday, June 28, 2020 between 11-1 pm

Dr Sujata Dalvi

- Consultant Obstetricians & Gynecologist - Mumbai
- Assistant Editor of JOGI (Journal of Obstetrics & Gynecology of India)
- Member of Managing Council of Mumbai Obstetrics & Gynecological Society last 15 years
- First Joint Secretary AMOGS - Association of Maharashtra Obstetrics & Gynecological Society

Dr Sujata Dalvi invited the Chairpersons Dr Duru Shah, Dr Rishma Pai and Dr Bipin Pandit for Dr Subhash Penkar and Dr Marie Pereira Oration. This oration was delivered by the International Guest Speaker, Professor Neil Johnson - President of International Endometriosis Society from Auckland - New Zealand. He gave an elaborate oration talk on "Innovative Treatment of Endometriosis related Infertility". Professor spoke on the usefulness of Lipiodal - oil based dye as part of treatment for Endometriosis related Infertility with evidence based data with positive successful outcome. After the oration, Dr Subhash Penkar and Dr Marie Pereira expressed their gratitude to Professor Neil Johnson for delivering the oration and thanked him for the same. The digital plaque was displayed on the screen and read out by MOGS President Dr Rishma Dhillon Pai and then presented to Professor Neil Johnson.This was followed by MOGS Masti questions which were presented by Dr Sheetal Sawankar and contact no's of Dr Siddhesh Iyer and Dr Amruta were given to send the answers. Exciting prizes of Amazon vouchers were announced for the prize winners. Dr T Deepashree spoke on "Successful HSG - Case based study" and elaborated on usefulness of Lipiodal in diagnostic / therapeutic role in Tubal block / HSG / IU pathologies with various images and videos. Then, the Questions for Audience were displayed on the screen on the topics of the 2 talks that were given. This was followed by Fitness Video by Dr Priti Vyas keeping in mind the current year's theme of "FIT IS IT" to encourage all to remain fit and healthy.

Dr Sudha Tandon was the presenter of 1st case on Infertility with PCOD and the expert was Dr Jatin Shah. Dr Parikshit Tank was the presenter of 2 nd case on Infertility with Endometrioma with low AMH and the expert was Dr Sadhana Desai. Dr Pratik Tambe presented case of Unexplained Infertility and Dr Mukesh Agarwal was the expert and Dr Nagendra Sardeshpande presented the case of Infertility with Endometrial Hyperplasia -? Endometrial Carcinoma and Dr Asha Rao - FOGSI Endometriosis Committee chairperson was the expert. The Audience Poll results were displayed and read out by Dr Sujata Dalvi.The session of Questions and Answers was conducted by Dr Kundan Ingale - Chairperson FOGSI Infertility Committee and Dr Rakhi Singh - Chairperson FOGSI Endocrine Committee.

Professor Neil Johnson with all the faculty experts answered all the questions put forward by the audience.

MOGS Masti results were announced - Dr Mansi Medhekar in 1st masti and Dr Rajan Joshi from Godhra / Dr Sneha Venkeshwaran from Mumbai in 2 nd masti respectively won the prizes.

Total Registration - 1108

The educational partener for the programme was Medical Science Liaison, Guerbet, India.

MOGS MASTI

Dr Mansi Medhekar
Consultant Obstetrician and Gynaecologist
Gynaec. Endoscopic Surgeon. Member of Managing council MOGS

The Focus on First Trimester conference(F1T) geld on 21st June 2020 was an academic extravaganza with scientific content appreciated by all. To keep the online conference interesting and to stimulate the brain cells of the audience, Dr Shrutika Thakkar and Dr Mansi Medhekar hosted MOGS MASTI in between the sessions.

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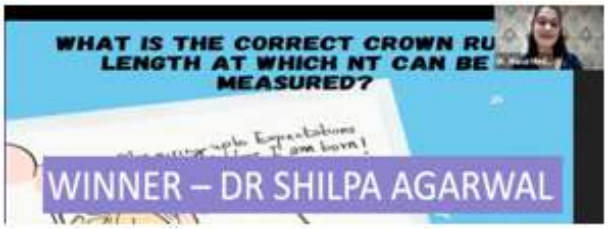
The MASTI question comprised of one academic and two fun questions. Prizes were won by fastest finger first. First registered delegate to send the correct answer were give surprise prizes. Winners won by minute margin.
Responses were received from all over India including Dehradun, Amritsar, Punjab, Tamil Nadu, Pathankot, Nagpur, Pune and many more cities.

It was fun and exciting to co-ordinate the prizes for MOGS and its members.
Many thanks to Dr Shrutika Thakkar for co-hosting the quiz questions. Our sincere thanks To Dr Rishma Pai, President, Dr Anahita Chawhan, Secretary and Dr Rajendra Sankpal, Treaurer MOGS for giving us the opportunity.

CORRECT ANS:- EAT PRAY LOVE



CORRECT ANS:- 45-84MM

CORRECT ANS:- PIPERS FORCEPS

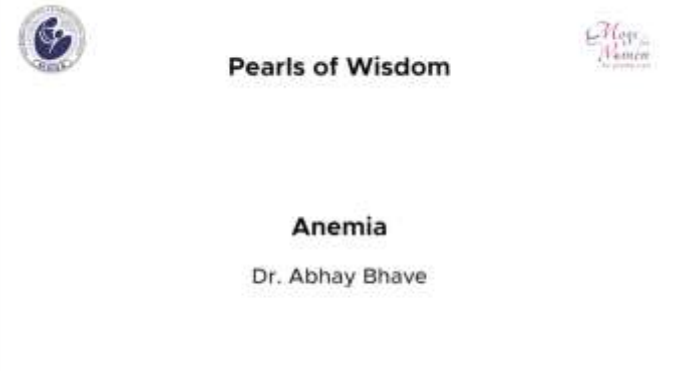
PEARLS OF WISDOM

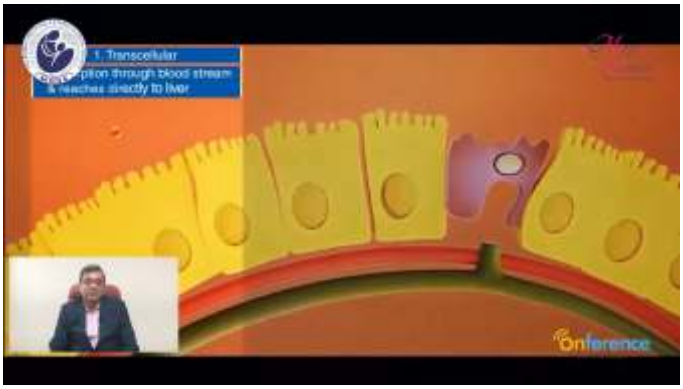
It gives us pleasure to present to you 'Pearls of Wisdom', a series of short videos made by experts on Obstetric and Gynecological topics of interest to you. As they are just about 5-7 mins long, you can watch these quick snippets anytime and stay updated.

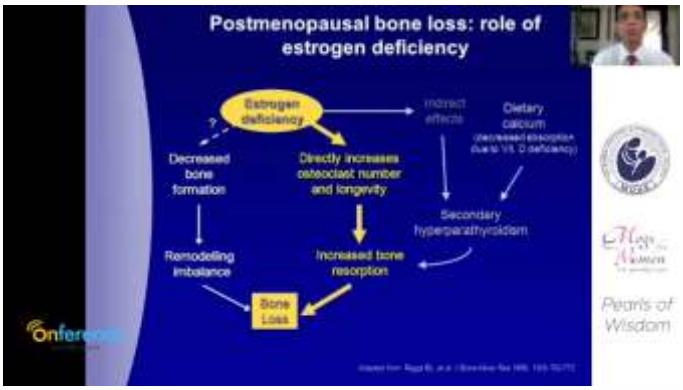
3 videos have been released till date and emailed to you all.

1. Conception to Lactation- Window of Opportunity- Dr Rishma Pai
2. Osteoporosis Prevention and Management- Dr Rajendra Nagarkatti
3. Anaemia - Dr Abhay Bhave

We hope you continue to benefit from these.







FORTHCOMING EVENTS - YOUNGISTAN CONFERENCE

Dr Bhumika Kotecha Mundhe
DGO, DNB (Ob/Gy), MNAMs
Trained in Advanced Minimally Invasive Endoscopy (Singapore)
Youth Council Member, MOGS

MOGS presents 'Youngistan Conference' on 19th July 2020. This is the first conference of its kind, wherein the organisers are the Youth Council Members of MOGS with a theme of;

"By the young, For the Young at heart."

This forthcoming event of MOGS will have interview, panel discussion, Yuva talent display and fitness program all amalgamated with a twist. The scientific committee invites you to participate in an innovative Slogan and creative E-poster competition.

Theme for Slogan- Save the Girl Child

Theme for E poster (creative) - Population Stabilisation

The entries to be submitted via email on- mogs2012@gmail.com

The last date for submission is 10th July 2020.

The winners of this competition will be declared during valedictory session of the conference.

IMPORTANCE OF TDAP VACCINATION DURING PREGNANCY

Rishma Dhillon Pai
M.D. , F.R.C.O.G (UK), D.N.B, F.C.P.S, D.G.O., F.I.C.O.G
President MOGS.
Asst. Treasurer - International Federation of Fertility Societies (IFFS)
President 2018-19 - Indian Society for Assisted Reproduction (ISAR)
President 2018-19 - Indian Association of Gynaecological Endoscopists (IAGE)
President 2017 - Federation of Obstetricians & Gynaecologists of India-(FOGSI)

Pertussis, or whooping cough, is a highly contagious respiratory infection, which is most commonly caused by the small, Gram-negative bacillus Bordetella pertussis.1 Transmission of the infection is via contact with airborne respiratory aspirates from symptomatic patients during coughing.Bordetella pertussis attaches to the cilia of respiratory epithelial cells2.It releases a toxin that leads to paralysis of the cilia and inflammation of the respiratory tract. This inflammation impedes clearing of the pulmonary secretions.2

Classical pertussis has 3 stages of clinical symptoms: catarrhal, paroxysmal, and convalescent. These stages are only seen in unimmunized toddlers and children.3The initial stage of the infection - the catarrhal stage- generally lasts 1-2 weeks and can be similar to a common cold with runny nose, sneezing, low-grade fever, conjunctivitis and development of a mild, occasional cough.2,3The disease typically progresses to the paroxysmal stageduring which the characteristic whooping cough appears and pertussis is suspected.2 The patient may experience bouts of rapid uninterrupted coughing while drawing a single breath as they try to expel mucus. This is often followed by a long respiratory effort accompanied by the high-pitched 'whoop', resulting from inspired air passing through the partially closed glottis.3 Patients can develop cyanosis and can become distressed. This stage usually lasts 1-6 weeks but can persist for up to 10 weeks.2

In infants younger than 3 months, the catarrhal phase usually lasts for a few days or is not recognized at all; the paroxysmal and convalescent stages are protracted.3 In the paroxysmal stage, young infants frequently present with gagging, gasping, choking, cyanosis, apnea, or an "apparent life-threatening event" instead of paroxysmal coughing; whooping is absent.3Infants <2 months of age are at particular risk of complications and high mortality, with the highest rates of hospitalisation (>90%), pneumonia (15-25%), seizures (2-4%), encephalopathy (0.5-1%) and death (0.5-1%).3There are also reports on pertussis as a significant cause of sudden infant death syndrome3.Where a source of infection can be identified in the domestic setting, siblings and adolescent or adult family members with unrecognised pertussis represent the primary source of infection to infants.4,5

High burden of pertussis still seen in infants, both in developing and industrialized countries.6Vaccination strategies to control disease in infants include "cocooning" and maternal immunization.6Pertussis vaccine suitable for adults is available in combination with tetanus and diphtheria(Tdap) vaccine as a reduced dose vaccine. Cocooning approach involves Tdap vaccination of parents and persons in close contact with the susceptible infants. However, multiple individuals need to be vaccinated in this strategy and has posed limitations. Results have been highly variable.6

Maternal immunization ie. immunization during pregnancy provides passive protection to the newborn via transfer of maternal antibodies through the placenta and indirect protection by preventing pertussis in the mother.7

Existing evidence has not demonstrated that pertussis vaccination during pregnancy is associated with any increased risk of serious maternal or perinatal complications such as hypertensive disorder, stillbirth, neonatal death or pre-term birth.7 Recent systematic reviews support the safety, immunogenicity and effectiveness of maternal Tdap immunization to reduce the morbidity and mortality associated with pertussis in infants before they receive their primary immunizations.6

Vaccination of pregnant women seems more effective than cocooning and is likely the most cost-effective strategy for preventing pertussis in infants too young to be vaccinated.8 WHO recommends that national programs consider the vaccination of pregnant women with onedose of Tdap (in the second or third trimester, preferably at least 15 days before the end of pregnancy) as an additional strategy when infant morbidity or mortality from pertussis is high or increasing.9

In 2011, the US became the first country to recommend pregnant women to be vaccinated with a pertussis-containing vaccine.10Advisory Committee on Immunization Practices (ACIP) first recommended that unvaccinated pregnant women receive a dose of Tdap.11 However, a rapid decline of pertussis antibody levels was observed in adults and postpartum women immunized with Tdap. This recommendation was thus updated in October 2012 to extend vaccination to all women during each pregnancy regardless of previous immunization status.10,12As per American College of Obstetricians and Gynecologists recommendation, women should be vaccinated preferentially between 27 and 36 weeks of pregnancy, and women not vaccinated during pregnancy should be vaccinated during the postpartum period.12Moreover, ACOG recommendations also state that in order to maximise the maternal antibody response and passive antibody transfer and levels in the newborn, vaccination should as early as possible in the 27-36 weeks gestational period.12More than 40 countries now have maternal immunization recommendations in order to reduce the burden of pertussis in infants too young to be vaccinated.

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FERTILITY AFTER 40

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Infertility affects approximately 13-14% of reproductive-aged couples. It is defined as the inability to conceive after 1 year of properly timed, unprotected intercourse. The number and quality of a woman's oocytes declines with age. The decline in the number of oocytes begins at 20 weeks' gestation when the female fetus has approximately 6-7 million oogonia (largest lifetime endowment). The number of oocytes decreases to approximately 2-3 million at birth and decreases again to 300,000 by the time of puberty.In the recent era, parenthood has taken a step back. Pursuing one's education, career or not finding the right partner are some of the reasons why childbearing may be delayed in some couples. But due to this declining oocyte reserve, there is difficulty in conceiving as a woman gets older. Besides this, as age increases, the quality of eggs continues to decline. Quality of eggs is an important factor for conception and a healthy pregnancy. This is irrespective of whether a couple is trying to conceive naturally or through fertility treatments. As age begins to increase, there is also a worry about chromosomal abnormalities in the offspring. This could lead to increased risk of miscarriage as well as birth defects.

POOR OOCYTE QUALITY AND CHROMOSOMAL ABNORMALITIES

Beyond the age of 40, the ability to get good quality oocytes reduces. As maternal age continues to increase, the number of normal oocytes that is available is only 10-20%. One treatment modality that is available is oocyte donation, which will result in younger eggs with good quality. This treatment modality not only improves the quality of eggs but also diminishes the chances of chromosomal abnormalities in the offspring.

Another treatment modality is the nuclear transfer of an oocyte into the cytoplasm of another enucleated oocyte. Zhang et al published a study in a patient with 2 failures. 8 out 12 patient oocytes were fertilised and 12 out of 15 donor oocytes were fertilized. The patient's pronuclei were transferred subzonally into an enucleated donor cytoplasm resulting in seven reconstructed zygotes. Five viable reconstructed embryos were transferred into the patient's uterus resulting in a triplet pregnancy with fetal heartbeats, normal karyotypes and nuclear genetic fingerprinting matching the mother's genetic fingerprinting. Fetal mitochondrial DNA profiles were identical to those from donor cytoplasm with no detection of patient's mitochondrial DNA. This report suggests that a potentially viable pregnancy with normal karyotype can be achieved through pronuclear transfer. Ongoing work to establish the

efficacy and safety of pronuclear transfer will result in its use as an aid for human reproduction. [1]

POOR OVARIAN RESERVE (POR)

It is the main factor to consider when considering women above the age of 40. There used to be a lack of universally accepted diagnostic criteria for POR. Various tests have been used to diagnose poor ovarian reserve. One of the earliest ovarian reserve tests used was FSH. An elevated FSH level is associated with poor response, however a normal FSH level did not exclude poor response. Also elevation of FSH occurs quite late in women with decreasing ovarian reserve. Therefore FSH isn't an ideal test to indemnify poor responders [2]. AFC and AMG are one of the most sensitive markers of ovarian reserve. Besides this they are ideal to set out stimulation protocols for each patient individually. Both AFC and AMH provide the clinical a reliable and accurate prediction of ovarian response.

Earlier there used to be a lack of universally accepted diagnostic criteria for POR. To overcome this limitation, there was a consensus meeting of "ESHRE working group on POR discussion" in 2011 [3]. They set out the Bologna criteria

Bologna criteria recommend the presence of at least two of the following three features for diagnosis of POR:

- Advanced maternal age (?40 years) or any other risk factor for POR
- A previous POR (?three oocytes with a conventional stimulation protocol)
- An abnormal ORT (i.e. AFC, 5-7 follicles or AMH, 0.5-1.1 ng/ml).

Two episodes of POR after maximal stimulation are sufficient to define a patient as poor responder in the absence of advanced maternal age or abnormal ORT.

Adjuvant therapy

Androgen supplementation in the form of oral DHEA or transdermal testosterone in poor responders has been explored as it is believed to improve the intrafollicular environment and follicular sensitivity to exogenous FSH. Meta-analysis by Naegels HE in 2015 suggested that pre-treatment with DHEA may improve LBR but however the quality of evidence was moderate and there was insufficient data to carry out a conclusion [4]. In patients with poor ovarian reserve, pre-treatment with testosterone gel prior to COS, resulted in higher number of oocytes, higher fertilization rate, more number of embryos and better implantation rate [5].

Growth Hormone is another adjuvant that may be used to improve the oocyte yield and pregnancy rates. A meta-analysis published in 2017 concluded that GH in COH reduced the duration of ovarian stimulation and also yielded in a larger number of oocytes. However there was no evidence of increase in live birth rates [6].

Co-enzyme Q10 (CoQ 10) is another adjuvant that is available for use. It improves oocyte metabolism, corrects mitochondrial function and spindle alignment. Higher levels of CoQ 10 have been associated with optimal embryo parameters and higher pregnancy rates [7]

Recently, melatonin is being used as an adjunct for patients with poor ovarian reserve. It regulates ovarian function by regulating gonadotropin release in HPO axis via its specific receptors. Besides this it also protects the ovary from oxidative stress. Studies have shown that melatonin improves yield & quality of oocytes and also improves fertilization rates. [8,9,10].

Pretreatment

As a strategy to improve follicular synchronisation, to prevent premature ovulation and also as a measure to schedule cycles, OCPs, pretreatment with OCPs, progesterone or ethanol estradiol may be used. Even though studies have shown that there is no difference in the pregnancy rates, the duration of stimulation may increase with the use OCPs [11,12]

Controlled ovarian stimulation for in vitro fertilization

In patients above the age of 40, due to the poor ovarian reserve, high levels of gonadotropins (300-450 IU/day) may be required to get a higher oocyte yield. In order to improve oocyte quality and consequently embryo quality, LH may be added in the early follicular phase. But the evidence available regarding the same is inconclusive [13]. Low-dose HCG supplementation or addition of pure HMG where HCG is the source of LH activity has shown some improvements in the oocyte yield[14,15]. Luteal start of FSH has been used to influence the recruitment of follicles without any reported clinical benefit.[16]

Agonists

In patients with poor ovarian reserve, agonists are widely used to prevent endogenous LH surge. Long agonist protocol increases both duration of treatment and total dose of gonadotropins necessary to effect follicular development in poor responders. However, agonists due to their initial flare effect may help in recruitment of the follicles. Hence, short agonist protocol where agonist administration is initiated in the early follicular phase before gonadotropin administration is one of the most widely used agonist protocols in poor responders.[17]. Some clinicians prefer microdose flare and ultrashort protocol in order to minimise the pituitary suppression, however they have not shown to improve clinical outcomes. [18,19]

Antagonists

Over the last decade, the antagonist protocol has been popular in the management of women with poor ovarian reserve. The antagonist protocol prevents the premature LH surge without increasing the duration of treatment. The antagonist protocol has similar pregnancy rates as the short agonist protocol. Two meta-analyses have not found any difference in the pregnancy rate between antagonist and short agonist protocols.[20,21]

Natural cycle in vitro fertilization

Clinician sometimes use this method as an alternative to the high dose gonadotropin

regimens in patients with POR. It may have improvements in oocyte quality and may also reduce the financial burden of high dose regimens [22,23,24]. Natural cycle IVF may be modified by the addition of antagonists and low doses of FSH [25,26,27,28]. Another modification that may be done is by minimal stimulation with either letrozole or clomiphene citrate with the addition of low doses of gonadotropins [29]. This may improve oocyte yield and quality at the time of oocyte retrieval. However the cancellation rate for natural cycles is as high as 50%. The pregnancy rates reported in natural IVF cycles is 8-18%. This protocol provides an alternate protocol for patients with POR when high dose FSH protocol is unsuccessful. [18,19].

Ovarian Rejuvenation

In 2010, phosphatase and tensin homolog (PTEN) enzyme inhibitors and phosphatidylinositol-3 kinase activators were used to activate the AKT pathway in dormant follicles in murine and human ovaries [30]. This suggested that patients with POR with residual follicles could be activated to develop follicles for oocyte retrieval [31]. After removing the ovaries, the residual follicles were activated in the laboratory using AKT stimulators. Post activation, there was ovarian tissue auto-transplantation. In 2016, Jun Zhai used the same protocol but improved the technique by grafting back fresh tissues. In six of the 14 patients (43%), a total of 15 follicle development waves were detected, and four patients had successful oocyte retrieval to yield six oocytes. For two patients showing no spontaneous follicle growth, human menopausal gonadotropin treatment induced follicle growth at 6-8 months after grafting. After vitro fertilization of oocyte retrieved, four early embryos were derived. Following embryo transfer, one patient became pregnant and delivered a healthy baby boy, with three other embryos under cryopreservation. [31]

Another modality used for ovarian rejuvenation is platelet rich plasma (PRP). PRP includes a number of soluble mediators which orchestrate complex immune responses and tissue regeneration [32]. PRP orchestrates a regulatory interplay of cellular migra- tion, extracellular matrix remodeling, cell proliferation, apoptosis, differentiation, and angiogenesis in response to widespread cell damage [33]. Following injury, platelets are among the first cells to arrive and following activation emit a multitude of biologically active mediators to rectify the injury [34]. The ovary is an organ which undergoes monthly injury and repair with each ovulation. A study published in 2018 by Scott Sills showed how intraovarian injection of autologous PRP affected ovarian reserve. PRP was obtained from 4 patients in patients with POR (Mean age = 42 +/- 4 years). 5ml Activated PRP was injected into the ovary. There was decreased FSH levels and increased AMH levels within 2 months. In each of the 4 patients, at least 1 blastocyst was formed which was suitable for cryopreservation [35].

Clinical use of platelet rich plasma (PRP) is perhaps best known for managing thrombocytopenia to improve hemostasis. However, PRP also includes numerous soluble mediators which orchestrate complex immune responses and tissue regeneration [1]. Closely

associated with inflammatory signaling, PRP figures prominently in tissue regen- eration and orchestrates a regulatory interplay of cellular migra- tion, extracellular matrix remodeling, cell proliferation, apoptosis, differentiation, and angiogenesis [2] in response to widespread cell damage. Following trauma or local ischemia as with myocar- dial infarction or stroke, platelets are among the first cells to arrive and, following activation, emit a multitude of biologically active mediators to rectify the tissue insult [3]. Notably, the human ovary is covered by an epithelial monolayer which sus- tains cyclic 'injury' and local tissue repair with each ovulation. While resident stem cells have been thought crucial for the regeneration needed for hemostasis and organ integrity here, the identity and mode of action for these cells remains incompletely characterized. Although recent research has opened a doorway into ovarian stem cell biology [4,5], clinical explorations in this field have thus far been limited.

Notwithstanding the now well-established surgical role of PRP in tissue repair, some researchers have suggested that platelets may contribute to overall organ function as well [6]. As a central problem in many clinical infertility presentations is ovarian sen- escence and an inexorable decline in oocyte endowment, it seems plausible to consider using autologous PRP in a reproductive context. Particularly since the concept of reduced (or entirely lost) fertility potential associated with ovarian failure is the focus of ongoing research, the possibility of PRP improving the ovarian microenvironment - and even interacting with putative ovarian germline stem cells (GSCs) - warrants serious consideration. Here, we report on autologous activated PRP as applied to human ovaries in an office setting, and provide the first clinical data on IVF cycle characteristics following this intervention.

Conclusion

Fertility after 40 is plagued by reduced size of primordial follicles and the resulting oocytes that are formed are likely to be of suboptimal quality. An early recourse to artificial reproductive techniques seems to be the only option with a reasonable chance of achieving pregnancy in women above 40. Currently there is no treatment besides egg donation to overcome the problem of poor oocyte quality. With newer interventions such as PRP and stem cells coming into forefront, there may be a way of overcoming this hurdle and give women an offspring with their own genetics.

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INFLUENZA AND PREGNANCY

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Influenza, also called flu or grippe, is an acute viral infection of the upper or lower respiratory tract that is marked by fever, chills, and a generalized feeling of weakness and pain in the muscles, together with varying degrees of soreness in the head and abdomen. Though a common viral infection, it can be deadly, especially in high-risk groups. Following respiratory transmission, the virus attaches to and penetrates respiratory epithelial cells in the trachea and bronchi. Viral replication occurs, which results in the destruction of the host cell. Virus is shed in respiratory secretions for 5-10 days; children shed it for longer duration than adults. The incubation period for influenza is usually 2 days but can vary from 1 to 4 days. "Classic" influenza disease is characterized by the abrupt onset of fever, myalgia, sore throat, nonproductive cough, and headache. The fever is usually 101°-102°F and accompanied by prostration (bedridden). The onset of fever is often so abrupt that the exact hour is recalled by the patient. Myalgias mainly affect the back muscles. Cough is believed to be a result of tracheal epithelial destruction. Additional symptoms may include rhinorrhea (runny nose), headache, substernal chest burning and ocular symptoms (e.g., eye pain and sensitivity to light).

Likewise, recovery is usually rapid, but some patients may have lingering asthenia (lack of strength or energy) for several weeks. The most frequent complication of influenza is pneumonia, most commonly secondary bacterial pneumonia (e.g., Streptococcus pneumoniae, Haemophilus influenzae, or Staphylococcus aureus). Primary influenza viral pneumonia is an uncommon complication with a high fatality rate. Reye syndrome is an uncommon but serious complication seen in association with intake of salicylates more common with influenza B.1

There are four types of influenza viruses: A, B, C and D. Influenza A causes the major epidemics and pandemics and causes disease in all age groups. Influenza A viruses are divided into subtypes based on two proteins on the surface of the virus: hemagglutinin (H) and neuraminidase (N). The type A influenza virus affects both humans and animals, and the subtypes H3N2 and H1N1 are the two main circulating strains.

While the type A virus affects birds, pigs (swine) as well as humans the type B influenza virus predominantly affects humans and, while it does not have subtypes, it is split into two lineages: B/Victoria and B/Yamagata. Influenza B can also cause major epidemics at least

every 2 - 4 years.A third subtype, type C influenza virus, is rarely reported in humans, and most cases are subclinical.1

Influenza viruses are change constantly and undergo antigenic changes which occurs in two different ways. Antigenic drift is alteration or small changes in the genes of influenza viruses that happen continually over time as the virus replicates. These small genetic changes usually produce viruses that are still closely related. Antigenic drift occurs with high frequency in both type A and type B influenza viruses. Viruses that are closely related to each other, share the antigenic properties and thus recognizable to an immune system exposed to a similar virus. (This is called cross-protection.)

But these small genetic changes can accumulate over time and result in viruses that are antigenically different. When this happens, the body's immune system may not recognize those viruses.2

These small changes in the virus structure via way of antigenic drift can accumulate over time to an extent that the once exposed immune system no more recognizes the virus. Genetic changes that result in a virus with different antigenic properties is the main reason why people can get the flu more than one time. This is also why the flu vaccine composition must be reviewed each year and updated as needed to keep up with evolving viruses. The other type of change is called "Antigenic Shift." Antigenic shift is an abrupt, major change in the influenza A viruses, resulting in new hemagglutinin and/or new hemagglutinin and neuraminidase proteins in influenza viruses that infect humans. Shift results in a new influenza A subtype or a virus with a hemagglutinin or a hemagglutinin and neuraminidase combination that has emerged from an animal population that is so different from the same subtype in humans that most people do not have immunity to the new (e.g. novel) virus. Such a "shift" occurred in the spring of 2009, when an H1N1 virus with a new combination of genes emerged to infect people and quickly spread,

causing a pandemic. When shift happens, most people have little or no protection against the new virus.2

While influenza viruses are changing by antigenic drift all the time, antigenic shift happens only occasionally. Type A viruses undergo both kinds of changes; influenza type B viruses change only by the more gradual process of antigenic drift.

Influenza can be spread directly- through virus laden droplets or indirectly- through contaminated surfaces.

Children are primary vectors and play an important role in spreading influenza in the community, including to high-risk populations.1,4

EPIDEMIOLOGY

In a 2008 World Health Organization estimate, the average global burden of inter-pandemic influenza may be in the order of ~1 billion cases, with ~3-5 million cases of severe illness and

290 000 to 650 000 deaths annually.[3]

AT RISK POPULATION

During annual epidemics, rates of serious illness and death are highest among the very young (children aged <2 years), the elderly (people aged ?65 years) and people of any age who have medical conditions that place them at increased risk for complications from influenza. Pneumonia (the most common complication of influenza) and influenza together are the seventh leading cause of death in the elderly.4

WHO labels the following at particularly high risk of getting the flu related complications and therefore must take higher preventive measures against influenza.5

- pregnant women at any stage of pregnancy
- children aged between 6 months to 5 years
- elderly individuals (aged more than 65 years)
- individuals with chronic medical conditions
- health-care workers.

PREVENTION AND RECOMMENDATIONS FOR VACCINATIONS

Preventive measure against acquiring flu include a good practise of hand hygiene, cough etiquettes, social distancing, and taking an annual seasonal shot of influenza. Vaccination against influenza is the most cost-effective preventive strategy. Two types of influenza vaccine are available. Live attenuated (given intranasally) and inactivated (given intramuscularly). Live attenuated vaccines are uncommonly used and have a potential to cause the disease. Thus live attenuated vaccines are contraindicated in pregnancy and people with weakened immune systems. Inactivated influenza vaccine on the other hand, is again of two types; trivalent influenza vaccine TIV (containing 2 A strains and only 1 B strain) and a quadrivalent influenza vaccine QIV (containing 2 A strains and 2 B strains). QIV provide wider protection against the influenza owing to an extra B strain.

WHO recommends seasonal influenza vaccination for: [5]

- Highest priority:
  - ~ Pregnant women
- Priority (in no particular order):
  - ~ Children aged 6-59 months
  - ~ Elderly
  - ~ Individuals with specific chronic medical conditions

Health-care workers

"FOGSI recommends influenza vaccine for women who would be pregnant in the influenza season especially in those who are at high risk of influenza-related complications. Influenza vaccination is recommended for mothers from 26 weeks onwards. In case of a pandemic the influenza vaccine can be given earlier to protect the mother"6

Vaccination in pregnant women, with a single dose of inactivated influenza shot in each and every pregnancy is recommended by all the global and local recommending bodies: WHO, CDC, American Academy of Pediatrics, Indian Academy of Pediatrics, American College of Obstetricians and Gynecologists, Federation of Gynaecologists and Obstetricians Society of India, Ministry of Health and Family Welfare.[5,6,7,8,9,10,11]

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VACCINATION AGAINST HUMAN PAPILLOMA VIRUS OR HPV FOR PREVENTION OF CERVICAL CANCER

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Cervical cancer is a major public health problem in India and is the second most commoncancer in women aged 15-44 years. Almost all cervical cancers are caused by persistentinfection with one of oncogenic high-risk types of humanpapillomavirus (HPV), with HPV types 16 and18 being most common (80-85%).India has a population of more than 436 million women aged 15 years and above who are all at risk for cervical cancer. In 2018an estimated96,922 new cases and 60,078 deaths accounting for almost 20% of the global burden of thiscancer was reported in India. More than 3/4th of these cases were diagnosed at a locallyadvanced clinical stage with poor prospects of survival.HPV infection is also implicated in a variable range ofcarcinomas of the anus, vulva, vagina, penis and the oropharynx. Inall of these sites HPV-16 is the predominant type.

Risk factors: The interval between the acquisition of HPV infectionand progression to invasive carcinoma is usually20 years or longer. The most important risk factor for development of cervical cancer is persistent infection with high-risk oncogenic serotypes of HPV (e.g. 16, 18, etc.). It is most common sexually transmitted viral infection and the lifetime risk of HPV infection for sexually active males and females is more than 50%. Other risk factors include

immunestatus (e.g. susceptibility is greater in persons who areimmunocompromisedor receiving immunosuppressivetherapy); co-infection with other STIs(herpes simplex, chlamydia and gonococcal infections) and tobacco smoking.

Prevention: Since cervical screening detects precancerous and cancerous changes only after they have occurred and therefore HPV vaccination can offer solution by prevention. The target population should be young adolescents (9-13?years of age) in order to ensure recipients, receive maximum protection as they are sexually inactive and can mount a better immune response. As prophylactic HPV vaccination is not effective against all oncogenic HPV types, regular cervical screening is still necessary. If a woman is currently infected with an oncogenic HPV type, she will still stand to benefit from vaccination against new infections with the same or different HPV types.

Vaccines:

Currently, effective and safevaccines are available to prevent HPV 16 andHPV 18 infection in HPV-naive women in the form ofbivalent and quadrivalent vaccines.The quadrivalent vaccine,

also prevents infections fromHPV types 6 and 11, which cause anogenital warts.While the bivalent vaccine, isdirected only against HPV 16 and HPV 18, itspotent adjuvant, adjuvant system AS04,accelerates a more sustained and strongerimmune response. In a head-to-head immunogenicity trialof the bivalent and quadrivalentvaccines, neutralizingantibodies against HPV-16 and HPV-18 were 3.7and 7.3-fold higher, respectively, for the bivalentcompared to the quadrivalent vaccine in women aged18-26 years at month 7 after initiation of the vaccinationcourse.

Vaccination Schedule:

Antibodies are an important corelate of long-term protection. It is believed that antibody levels that are consistently high over a period of time are likely to stay high, and will provide long-term protection against cervical cancer. The current evidence supportsthe recommendation for a 2-dose schedule withadequate spacing between the first and second dose inthose aged 9-14 years. This schedule also has costsaving may facilitatehigh coverage.A 3-dose schedule (0, 1-2, 6 months) should be used forall vaccinations initiated >15 years of age.

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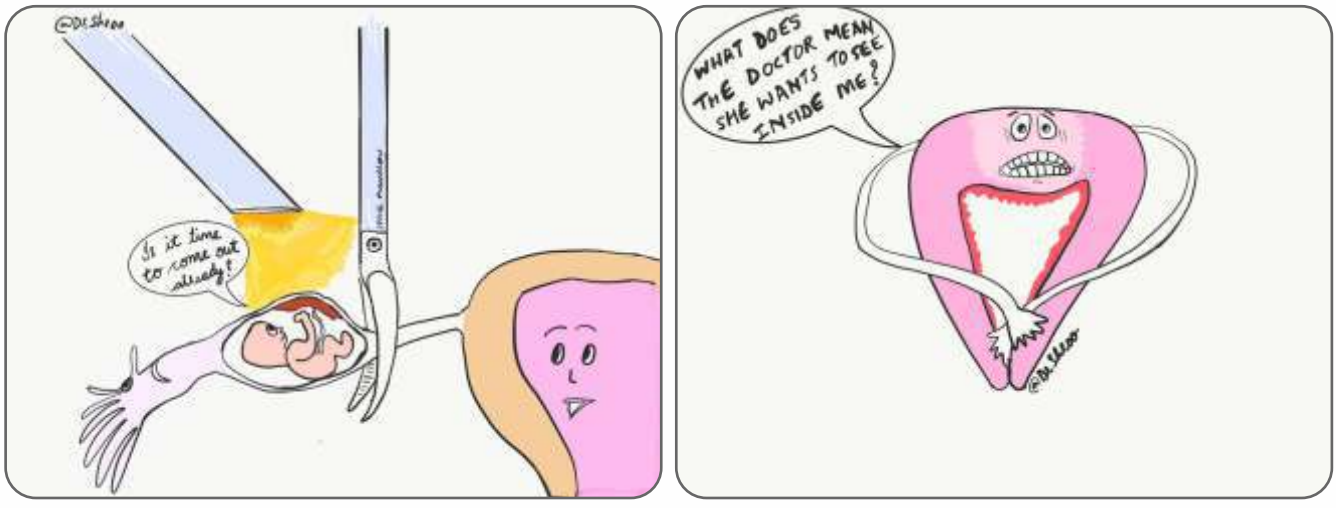

Doodle Art - Dr Shrutika Thakkar

VAGINAL PROBIOTICS-A NEWER TREATMENT APPROACH

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Background

Vaginal infections are extremely prevalent, particularly among women of reproductive age.These infections are associated with high levels of anxiety and reduction of quality of life.Treating aerobic vaginitis (AV) and bacterial vaginosis (BV) with antibiotics and chemotherapeutics is often ineffective and results in relapses and varies in efficacy. There are several unpleasant side effects and disadvantages associated with these therapies, including superinfections with pathogenic microorganisms, susceptibility of lactobacilli to clindamycin, high relapse rates. Moreover, vaginal pathogens, particularly G. Vaginalis and anaerobic bacteria, are showing increasing drug resistance to existing antibiotics. [1]

The emergence of microbial resistance to antibiotics &the difficulties in managing infectionrecurrences created the need for more effective local treatments modalities suchas vaginal probiotics, plant extracts etc. [2]

The loss of Lactobacilli Linked to Vaginal, Reproductive Health

A healthy vaginal microbiota is considered to be significant for maintaining vaginal health and preventing infections.Any disruption of this microbial barrier might result in a number of urogenital conditions including aerobic vaginitis (AV) and bacterial vaginosis (BV). If left untreated, vaginal infections can lead to various complications like pre-term delivery, pelvic inflammatory diseases, reproductive dysfunction, post-delivery infections, HIV and HSV transmission. [3]

In reproductive age women, bacterial vaginosis (BV) is the most common vaginal infection. BV has been linked to higher risk of developing infection like Human papilloma virus (HPV), Herpes simplex virus type 2 (HSV-2), T. vaginalis, N. gonorrhoeae and HIV. Also, BV is linked to low birth weight infants, preterm delivery, chorioamnionitis, post-hysterectomy cellulitis, post-surgical endometritis, endometritis following a vaginal delivery and pelvic inflammatory disease. [4]Abnormal vaginal microbiota may negatively affect the clinical pregnancy rate in IVF patients. [5]

Vaginal Probiotics

Probiotics have the capacity to restore and maintain the balance of the microflora at the intestinal and vaginal levels and to influence the immune system in situ. Probiotics have recently found its use in vaginal infections because without any adverse effects, it helps to maintain lactobacillus microbiota, which in turn produces lactic acid and protects from other pathogenic organisms and many studies have shown positive results stating that probiotics treat vaginal infections by altering the microbial composition. [6] In one study, ithas been shown that combining antibiotics with probiotics conferprotection from vaginal infections for long-term and it reduces theprobability of recurrence.[6,7]

Table 1: Advantage of Vaginal Probiotics over oral Probiotics [7,8,9]

Oral Probiotics	Vaginal Probiotics
1. Orally consumed probiotics are believed to ascend to the vaginal tract after they are excreted from the rectum 2. The time required to affect vaginal health is longer with oral than direct vaginal administration than, and it depends on viability of the strains as they pass through the stomach and gut 3. Less no. of lactobacilli that can be delivered by oral route reaches vaginal tract, clearly lower than via vaginal administration	1. Probiotic bacteria are directly introduced into the vagina 2. Vaginal administration allows for direct replacement of the probiotics for unhealthy vaginal microbiota 3. Less time required to affect vaginal health 4. Higher local (vaginal) lactobacilli concentrations achieved

Vaginal Probiotic Tablet

Probiotic vaginal tablets contain natural active ingredients to restore and maintain the delicate balance of the vaginal.This is an effervescent rapid-release vaginal tablet containing at least 109 viable lactobacilli (1 billion CFU). It contains3 different strains of viable lactobacilli: Lactobacillus brevis, Lactobacillus salivarius subsp. salicinius, &Lactobacillus plantarum. These 3 strains are normal inhabitants of the vaginal tract and were carefully and specifically selected for their characteristics.

L. brevis possesses strong adherence characteristics and as a virtue of its larger morphology size exerts competitive exclusion of vaginal opportunistic pathogens. L. salivarius and L.

plantarum produce high amounts of lactic acid maintaining a healthy vaginal pH which is inhibitory to growth of vaginal pathogens including HSV-2 and HIV-1.Peroxidase and halide ions are present in the vaginal fluid while L. salivarius and L. plantarum secrete H2O2 which has anti-bacterial and anti-viral properties.The probiotic lactobacillistrains in this vaginal tablet co-aggregates very efficiently with both Gardnerella vaginalis and Candida albicans, producing a strong microenvironment of inhibiting substances[10].

Lactobacillus brevis is rich in arginine deiminase, which uses this arginine as a substrate for the production of citrulline, thus preventing its use for the synthesis of polyamines [11].Polyamines like spermine, spermidine, putrescine and cadaverineaccount for transudation and exfoliation of the epithelial cells thereby causing copious discharge.Arginine deiminase can also act as anti-viral agent suppressing HIV-1 replication in CD4+ cells [12].

L. brevis contains high concentration of sphingomyelinase. Sphingomyelin present in the vaginal secretion can be metabolized by sphingomyelinase to generate ceramide. Ceramide inhibits viral infections by membrane-lipid rafts organization and structure [13]. This vaginal probiotic tablet therefore may prevent entry of HSV-2 and HIV.

Effectiveness of Lactobacillus-Containing vaginal tablets has been demonstrated in the Treatment of Bacterial Vaginosis, Vaginal Candidiasis and reproductive health. Studies demonstrates the effectiveness of vaginal tablets containing selected strains of lactobacilli in resolution of BV. An additional advantage of probiotic treatment was reduction of malodourous vaginal discharge, which is the primary symptom of women with BV. The effect on malodour could be ascribed to the enzyme arginine deiminase produced in high amount by L. brevis present in vaginal tablets. [1]

Conclusion

Probiotic vaginal tablets contain natural active ingredients with at least 109 viable lactobacilli: L. salivarius subsp. Salicinius, L. Plantarum, L. Brevis. These lactobacillus strains of probiotic vaginal tablets maintain healthy vaginal flora thereby preventing infection and colonization by vaginal pathogens like Gardnerella vaginalis, anaerobic organisms, chlamydia, HSV-2 and HIV-1. Also, these probiotic vaginal tablets strains may improve the fertility chances in a woman.

These vaginal tablets possess anti-microbial and anti-inflammatory activities. It is indicated to maintain normal vaginal flora and restoring healthy vaginal pH, treatment and prevention of relapse of common vaginal infections such as BV, to improve reproductive health: improve the fertilization chances, prevention of preterm birth, prevention of recurrent UTIs.

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LIST OF FORTH COMING EVENTS:

JULY 2020

19th July-'Youngistan' digital conference

2nd Online MOGS NA Purandare PG Training program

TELEMEDICINE IN INFERTILITY

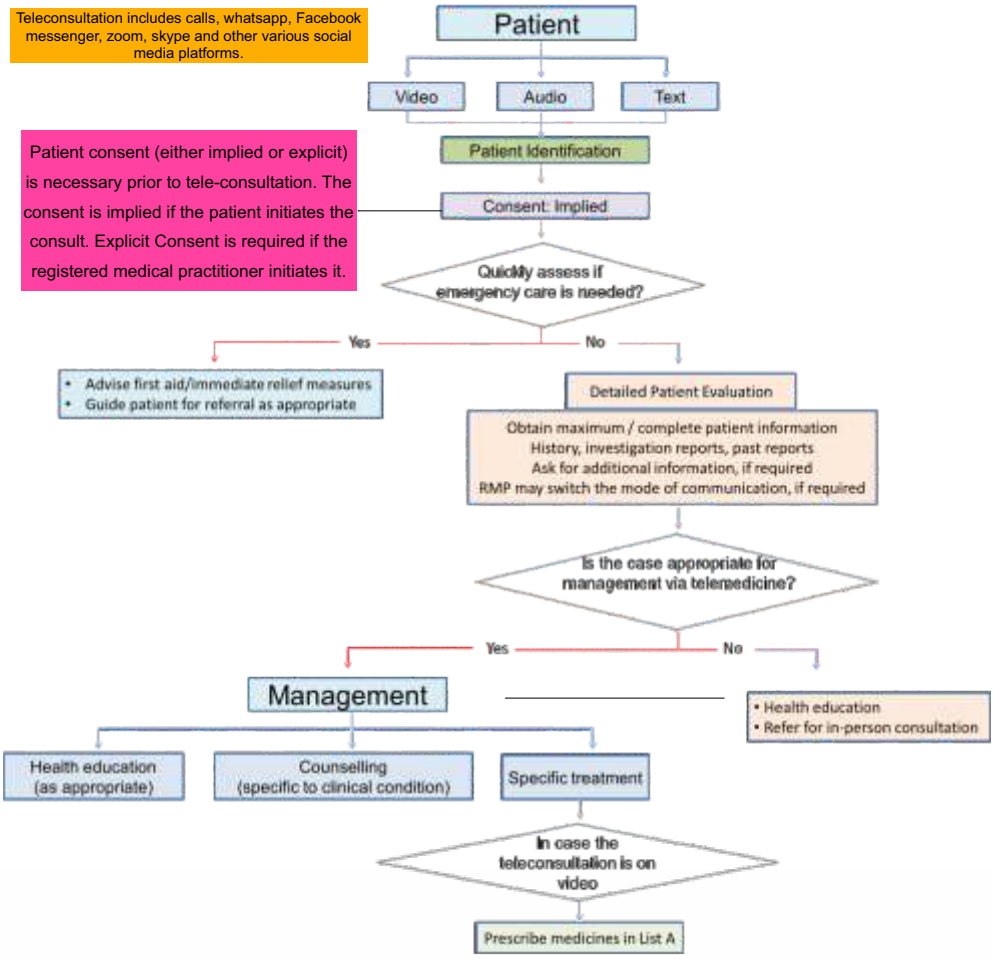
Dr. Rohan Palshetkar
MS OBGY, FRM

Dr. Amrita Tandon
MS OBGY, DNB,
MRM (London), FMAS

Dr. Aditi Tandon
MS OBGY

Teleconsultation includes calls, whatsapp, Facebook messenger, zoom, skype and other various social media platforms.

Patient consent (either implied or explicit) is necessary prior to tele-consultation. The consent is implied if the patient initiates the consult. Explicit Consent is required if the registered medical practitioner initiates it.



List of medicines

List O (Safe to prescribe in telemedicine)	Medicines which are used for common conditions and are often available 'over the counter'. Medicines such as paracetamol, ORS solutions, cough lozenges etc.
ListA (Prescribed during first consult which is a video consult or refill in case of follow up)	This would be an inclusion list, containing relatively safe medicines with low potential for abuse.
List B (Prescribe for follow up after in-person consult)	It is a list of medication which RMP can prescribe in a patient who is undergoing follow-up consultation in addition to those which have been prescribed during in-person consult for the same medical condition.
Prohibited List (cannot be prescribed via telemedicine)	Medicines listed in Schedule X of Drug and Cosmetic Act and Rules or any Narcotic and Psychotropic substance listed in the Narcotic Drugs and Psychotropic Substances, Act, 1985

It is important to document the tele-consult. Log or record the telemedicine interaction. Patient records, reports, documents, images, diagnostics, etc used during the consult should be retained by the practitioner.

Telemedicine consultations should be treated similar to OPD consults. Fees should be charged as per the physicians prerogative. A receipt or invoice must be provided.

THE pH ALARM....VAGINAL TEST GLOVE

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Rationale for testing vaginal pH

The vaginal milieu harbors many microorganisms. It's ecosystem has a delicate balance between the helpful lactobacilli and harmful pathogens depending on it's pH. The measurement of the pH-value in the vaginal secretions is one of the most important early diagnostic methods to recognize disturbances of the vaginal mucosa.

1. The loss of lactobacilli dominance is linked to bacterial vaginosis (BV), which is associated with an overgrowth of anaerobic bacteria, relatively high vaginal pH (>4.5), infertility, genital infections, and increased risk of sexually transmitted diseases. [1]
2. Assessment of aginal pH is a helpful, but frequently neglected, diagnostic procedure used to evaluate genital health. [2]
3. As the microscopic evaluation of vaginal secretions is prone to misdiagnosis, a simple pH determination assumes even greater importance with respect to Amsel's criteria which can be used to clinically diagnose bacterial vaginosis. [1]
4. Elevated vaginal pH has been correlated with adverse pregnancy outcomes, such as increased risk of preterm labor, low birth weight delivery and premature rupture of membranes (ROMs). Therefore, several studies have recommended screening for increased vaginal pH during pregnancy, and other studies have even shown its usefulness in lowering preterm birth rates. [3]
5. Vaginal pH tests have been found to be highly sensitive, simple to perform and cheap which readily indicates the presence of vaginal infection. [9]

Vaginal pH Test glove ...

Vaginal pH glove is an easy-to-use test for the measurement of vaginal pH values, identifying women at risk of vaginal infection, prompting early intervention.

- Index finger of gloves: It has an absorbing pad on the index finger of gloves to collect the vaginal fluid.
- Thumb: The pH indicator specifically located on the thumb to avoid the contact of any chemical agent with the vagina
- The pH indicator will change color when the index finger having absorbing pad is pressed against thumb for few seconds. [2,4]

How to test vaginal pH

Table 3. Use of vaginal pH in diagnosis[13]

3.5	4.0	4.5	5.0	5.5	6.0
The normal vaginal pH is between 3.8 and 4.5. An altered vaginal pH is indicative of vaginal infection					
pH	≤ 4.5	< 4.5	> 4.5	≥ 5.0	
Vaginal discharge	+/-	+ (white, thick, clumpy discharge)	+ (white/grey, thin, clumpy discharge)	+ (greenish-yellow, frothy discharge)	
Malodour	-	-	+	+	
Itching	-	+	-	+	
Burning	-	+	-	+	
	Normal	Candidiasis	Bacterial vaginosis	Trichomoniasis	

Interpretation of result :

1. Healthy Vaginal Ecosystem: pH between 3.8-4.5 in absence of any sign or symptom.
2. Candida Infection: pH between 3.8-4 associated with whitish discharge and symptoms such as itching, burning etc.
3. Bacterial vaginosis: pH > 4.5 associated with vaginal discharge malodorous or not.
4. Trichomonas Vaginalis: pH > 5 associated with vaginal discharge, itching, burning. [5]

USAGE:

For diagnosis of Vaginal Infections e.g. BV, Trichomoniasis, Vaginal candidiasis, HPV and genito-urinary tract infections. To identify those at risk of preterm birth, premature rupture of the membranes, amniotic fluid infections in order to prevent preterm labor. [4]

Clinical Evidence

Clinical studies in India demonstrated that Vaginal pH glove is a convenient and useful tool for screening women who experience symptoms indicative of a vaginal infection on outpatient basis. Vaginal pH detected by gloves (79%) reported high sensitivity than pH strips (72%) for

detection of bacterial vaginosis.[2]

Vaginal pH Gloves, being used for routine examination are themselves pH sensitive and no additional procedures need to be carried out. Further these gloves can prove handy in self-examination of vaginal pH and early detection of infections. [4]

Hoyme UB et al demonstrated that prevention of preterm birth is possible by vaginal pH screening. In this study conducted in Erfurt (Prematurity Prevention campaign 2000) pregnant women performed self-measurements of their vaginal pH by means of test gloves twice a week in order to screen for any disturbances in the vaginal milieu. [7] Self- assessment of vaginal pH is simple to use, cheaper and the results can be made available without any delay. The advantage of self-assessment is that women can carry out this test at times suitable for her. [8]

Conclusion

Vaginal pH Glove is a simple device to check the vaginal pH. Vaginal pH Gloves used for examination are themselves pH sensitive and no additional procedures need to be carried out. Further these gloves can prove handy in self-examination of vaginal pH and early detection and treatment of vaginal infections. It helps identify women at risk of miscarriage, premature labor, prompts early intervention.

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"48 HRS OF EMERGENCY DUTY IN THE LIFE OF AN OBSTETRICIAN AT SION HOSPITAL IN COVID ERA. " - *A TRIBUTE TO COVID19 WARRIORS.*

Inputs by - Dr. Dinesh Wade, Dr. Sneha Venkateswaran, Dr. Priyanka Sonawane, Dr. Hitendrasing Rajput, Dr. Hera Mirza, Dr. Shalini Mahapatra, Dr. Jui Ponkshe, Dr. Shikanshi, Dr. Niranjan Chavan, Dr. Faisal Shameel




Prologue:

A real time scene by scene description of 48 hours labour ward emergency duty managed by Dr. NNC Unit residents supervised/assisted by seniors on one of the Sunday, Monday at a stretch for 48 hours in the month of May 2020.

Scene 1:

Hello!

Good morning! Sorry, I am in a hurry, to let you know more about me at the beginning. By the end of the scene 1, you may get the answer for this question.

It was already 7:45 in the morning with sips of tea, I am fighting with the clock to lend me some more minutes to have breakfast but unfortunatelythe clock is not a good friend of mine nor of anyone else. So, with one slice of bread in hand, I left for the labour room, the place where we deliver happiness and give a warm welcome and loving care to upcoming future of our nation. Yes, I am a part of Sion Hospital.

The mighty Sion Hospital is bursting at the seams during this pandemic era and always a matter of discussion and criticism for some people in these days. Lokmanya Tilak Municipal General Hospital popularly known as Sion Hospital is Municipal Corporation's run civic tertiary medical college & general hospital which is catering to the "Corona capital" locality of Dharavi, the largest slum of Asia. Though task is not easy to take, but our institute has witnessed many more such seasons in the past and performed excellently. So dealing with the adversity is our passion and dealing with courage is our tradition.

Oops!!! I am 5 minutes late but I was talking with a patient's relative regarding her condition which Dr. Hitendra tallest JR-2 sitting in the receiving room (RR) informed me rounds in the morning. Actually as per our routine before we move out of the bed, we should receive informing from our efficient juniors and then we should take a opinion of the person whom I consider a director of this play which I am narrating now. Why director? Because you may not see his presence but his experience and words of instruction makes our decision and work more efficient. So after having a word with Dr. Hitendra, I took charge of labour room duty. The emergency morning usually starts with donning PPE due to pandemic protocol.

DONNING OF PPE https://youtu.be/iKLZ_YqjTI4

I don't ever wish any one would have the fate to don PPE because I know how it is painful to hold a bladder when it goes out of its capacity and hunger pang hammer"s your mind to show

some mercy on yourself. but I politely apologized to my mind and requested him, not disturb me as I am dealing with someone's life and it doesn't matter even if my own life is at risk.So we had two patients received in over from previous emergency duty as they were destined to deliver in my duty.

Dr. Jui a thin built girl, our JR-1, was in hurry to attend the patient who has delivered in ambulance while on the way to Sion hospital. With enthusiasm of all these people it is so difficult to guess their physical condition but I was sure she must have not taken breakfast. She was in Covid ward scheduled duty the previous night. Lunch might suffice the purpose of breakfast though Dr. Shalini our registrar on call has brought the breakfast for her but after donning PPE you can't eat nor can you pee. That's the irony of our situation!

In the morning, 6 patients were in active labour, 2 were in latent labour, I was going through all files of delivered and post op patients at around 8:30 am, suddenly there was thud on mydoor and I saw Dr. Hitendra attending this one patient lying on trollyaccompanied relative and doctor from 108 ambulance service.

Guess what it was? An obstetrician's worst nightmare, that was a case of right sided ruptured ectopic with haemoglobin of 6gm% referred from peripheral hospital. It gives me word of wisdom carried from many more generation that right things should happen at the right place,else life would be disaster. Dr. Hitendra called me and a junior resident for help. Anaesthesia team were also informed immediately. She was haemodynamically unstable, Dr. Jui drew her blood for CBC , PT INR, Blood grouping and cross matching and she herself ran for CBC counter as it was very important to know hemogram status of patient and at a same time she dispatched sample for blood grouping and cross matching. Though laws counts it as an abortion but it was loss of someone's motherhood . But being a doctor I need to be sure of my decision in the best interest of patient.

We then immediately prepared her for emergency exploratory laparotomy and shifted her in OT. Case was done by Dr. Hitendra and assisted by me, intraoperatively there was haemoperitoneum and 300gms of clots and evidence of right side ruptured tubal ectopic pregnancy. Right salphingectomy was done and peritoneal wash given and haemostasis was achieved, intraoperatively we transfused her 1 pint PRC and 2nd pint PRC post operatively. Patient withstood procedure well. By the time we finished with the case, Dr Jui came running and informed us that patient G2P1L1 with previous LSCS in active labour is having a pain over the previous LSCS scar so its was case of scar tenderness and we shifted her for emergency LSCS. Dr. Hitendra was assisted by me intraoperatively.We saw that her scar was thinned out and only serosa was intact which was separated only with artery forceps and baby was delivered with birth weight of 2.9kg and cried at birth. It was scar dehiscence. Haemostasis was achieved and patient withstood the procedure well.

During all this time, 4 patient were delivered vaginally and uneventfully as they were giving demo of normal labour to be well understood by budding obstetrician. One patient who was in active labour and fully dilated and fully effaced sincearound 1 hour and mother was totally exhausted by this time, though she was having good contractions and fetal heart rate started to drop, so the decision for forceps application was taken and we delivered her with help of forceps.Baby cried at birth.Both the baby and mother were stable post delivery. Two more emergency LSCS were done, one for meconium stained liquor with fetal distress done by Dr. Hitendra and other one was primigravida with cephalopelvic disproportion, done by first year resident and assisted by Dr Faisal, our lecturer on call who is always available at any time of night or day to helps us with difficult decisions and teaches the junior residents, basics fundaments of obstetrics and gynaecology which won't change ever. By the time my 8 hours shift ended I realised that we did 3 LSCS 1 emergency exploratory laparotomy 1 forceps application and 6 Normal vaginal delivery. But my lunch box was waiting for me but barrier of PPE made us far to approach.And here, I heard a voice from my colleague " Dr.Dinesh, now it's my turn to take charge so you may leave for scheduled rest time, see you soon." Dr.Sneha walked in to relieve me for next 12 hours.

Scene 2:

So, I am Dr.Sneha and my teammates Dr.Hera and Dr. Shikhanshi are here to take the calls for next 8 hours shift.Sunday afternoon, 3.45pm.We were all geared up, had lunch, emptied bladder as we knew we wouldn't be getting a chance for the same for next 8 hours. We rushed to labour room to relieve my colleagues, took over from them about every patient. They had worked tirelessly.Patients were coming continuously. 1 patient was already in SOTRR and another critical patient was to be shifted. Even after giving intravenous antihypertensive her BP was not getting controlled. Dr.Hera rushed to call a medicine resident for reference of raised BP. He came in immediately and advised to start nitroglycerine drip.

Patient was immediately given NTG drip and BP got controlled. Now she was stable enough to be shifted to SOTRR, She accompanied the anaesthesia resident with servants to shift the patient.They reached there and SOTRR beds were already occupied except for the one which was kept vacant for our patient. There was beeping sound of ventilator all around make us feel to fight of life with death is going on.., patient's relatives waiting and tirelessly praying for their beloved ones to win this battle. Our patient was now shifted from AMBU bag ventilation to Volume AC mode of ventilator and she was now maintaining her vitals. After thoroughly examining her for postpartum haemorrhage and collapse and completing my notes, we called the JR 1 to replace me here so that we could go down and look after the labour room. She immediately came. There were 3 patients in active labour out of which 1 was about to deliver.

I sat on a chair took a sigh of relief was just thinking that labour room is manageable and here came another patient on trolly with the relatives, all anxious to know what had happened to their patient. She had severe pain in abdomen. Abdomen being a pandora's box you never know how it surprises you. We rushed to the patient and quickly enquired about the history, took vitals .Fortunately, her vitals were stable. Anaesthesia team also came and started their preanaesthetic evaluation. She was a young 26 year old married lady. Her UPT came out to be negative. Clinically we could feel a cystic, tender mass of 8*5 cm in her left iliac region. We immediately shifted the patient to scan room. My Assist. Prof. Dr. FaisalShameel did the ultrasonography and we were right, it was left side ovarian cyst torsion.Dr. Hera was all prepared with consent for surgery in one hand and foleys catheter in another hand. Patient was fully prepared for surgery and shifted to labour OT. I assisted my senior to operate the case and managed her well. So here it proves that right thing should happen at right place at right time. Each day we get more experience and built up with evidenced based knowledge based on this clinical experience. It is well said that understanding medicine is not with reading book but more about witnessing clinical cases and emergency.

The rest of our shift was relatively manageable, and we successfully delivered 5 patients vaginally and 4 patients by LSCS and it halted at 12 AM when Dr. Priyanka relieved me. After going to our respective rooms for a shower and some rest, we got a call from the labour room at around 1:30 am. There was a call from the surgical OT as they were going to take the patient for exploration and wanted for obgy surgical standby. Labour room was still going busy and no resident was free to attend this call. Dr. Hera called me and informed me, that we will have to go for surgical standby. She also came running and we both went to EMS OT. We both changed into OT scrubs and again donned the PPE. Patient was taken in the OT. We got washed up for the case. Abdomen was opened by the surgeon and there was intraoperative findings of ileal perforation with findings of fecal peritonitis.There was no adhesion on the Uterus and it was bulky with no evidence of ectopic pregnancy. Bowel resection was done and double barrel ileostomy created and patient was shifted to SOTRR.

After informing the senior, advise was to continue their line of management and look for PV bleeding and cardiac activity after 2 weeks . By this time it was 4 'o' clock in the morning and we both were way too much tired. We immediately doffed and left.

DOFFING OF PPE https://youtu.be/wqnIqbpr9ec

Scene 3:

Hi! I'm Dr. Priyanka, didn't get time to introduce myself. Oops!! I Just did! I reached Sion Hospitalfrom my homeafter all the struggles of travelling in this lockdown period at 11.45pm. As I relieved Dr Sneha and Dr Hera, I saw there were 3 patients in active labour and one patient was referred from a peripheral hospital after a vaginal delivery due to uncontrolled PPH. Due to excessive bleeding, Dr. Shalini proceeded for vaginal exploration of a patient. Shalini, native of Orissa but for Post graduation, she came to Maharashtra and within couple of months after her joining, she learned Marathi so well, that she fluently was explaining patient's relatives about the patient's condition. Each doctor has multifaced personality and that makes their survival and work efficient. By the time Dr. Shalini was suturing the cervical tear, a patient came in trolley who had 5 convulsions. Before reaching, patient first came to EMS and was seen by medicine residents and was given stat dose of injection levipril to control convulsions and was transferred to labour room. Patient was taken up for emergency LSCS as patient was primigravida with term eclampsia with poor Bishops score after given loading dose of injection MgSo4 according to the Pritchard regimen.

Patient was operated by Dr Shalini and I assisted her and post operatively, patient was shifted to SOTRR (Surgical ICU) and Shalini accompanied the patient along with Anaesthesia resident, monitored her post-operatively for an hour and by that timewe had another patient referred from a peripheral hospital in view of sever preeclampsia. We informed the lecturer on call and we all were running with the speed of time to arrange blood reports and shifted the patient to OT for emergency LSCS for fetal distress with abruption with severe pre-eclampsia. These are the situations where senior's opinion saves time and timely efficient management of the patient. Their words of instruction make us feel his presence at all times.

Flashback:

During all this confusion and chaos of managing so many high risk patients, we suddenly got a call from Surgery OT to provide ObGyn standby for a 6 week ANC patient with massive abdominal distension, who was going to be taken for exploratory laparotomy. As neither me nor Dr Shalini could find time to leave the labour room premises to go to Surgical OT, we requested Dr. Hera and Dr. Sneha to attend this peripheral call. They immediately agreed and went to Surgical OT even though they had just left from their shift in the labour room.Labour room went all busy that night with 6 emergency LSCS and 8 vaginal deliveries.

It's Not the End, It's the Beginning:

Again, rotational shift repeated for next 24 hours and on Tuesday morning post 48 hours emergency duty, after handing over patients to next emergency unit, we took a off from labour room but not from our duties. Its not the end, Its the beginning. Post emergency, still we are with patients but no sense of tiredness ever bothered me and we are still continuing to smile through it all for our patients with this schedule.

We sometimes forget that a family is still waiting for us! Dr Pradnya Changede, senior Assist. Professor, our corona warrior walks in PPEs to asses the situation and advice us. Director Dr N. N. Chavan Sir, insists that only one JR1, JR2 and 1 SMO will be present for the grand rounds since the begining of lockdown and not all, as we have to maintian social distancing too while taking and presenting rounds and that has really worked wonders for us.

A dream does not become reality through magic; it takes sweat, determinationand hard work. And though this pandemic was destined in our path of success,we still continue to work hard as much as we can. We never get surprised by a thought of our non medico friends, who spend their night and day in a cozy bed due to lockdown and here we stand with PPE attire with sweat drenched body inside. It doesn't matter for others whether we get time for sleep or food but that doesn't matter for us because we have chosen this life. When all are busy in counting minutes of lockdown we are here to hold a count of your pulse and we promise, we won't let it go! And it's more adventurous on our part to deal with the game of life.

COVID or non-COVID, with courage, we work tirelessly for even 48 hours at a stretch and we continue to do that for 48 hours straight today also, every 6 weeks! I know no one can imagine this, but yes we are used to it. That makes us different from others.We budding obstetricians& gynaecologist are always at the peak of heavy duties which exhaust our soul physically and mentally too but we promise a million dollar smile to a parturient mother by gifting her safe motherhood. Till date our department of 6 units have delivered more then 300 Covid19 positive cases which is the largest number till date in India. It has a favourable outcome in terms of mother and babies. The heartening thing is that no vertical transmission has been found of Covid19 from mother to the neonate.

Epilogue:

We medics are never ever afraid of exams because it's a continuous process for each and every step of our curriculum but being a doctor, these emergency are like a real one time go exams for us.Unless and until we finish it successfully, I can't make myself comfortable. And now end of this pandemic, will soon make me comfortable and then only I will sleep with peace. Hopefully next emergency should not knock my door immediately. But I am always ready for all upcoming challenges. Thanks to my mentor teachers and seniors for gifting me this attitude. After all, medical institute has glorified tradition to pass on things from one generation to other. It may change a little bit but basic and fundamentals are all time constant. There is no limit to our efforts but people have unlimited expectations from us.We don't need page 3 cover media attention..We are the artists in gods play destined to servehumanity...Sometime, climax speaks for our efforts or sometime patient's happiness, but it will always be a suspense for everyone. Sometime's pastel colour may be less to decorate this canvas which we make beautiful with our tears and drenching sweat, in devotion of care for our patients.

Kudos to our department of ObGyn. faculty members and residents for tirelessly continuing all emergency work in these difficult times and ensuring safe motherhood.

CROSSWORD

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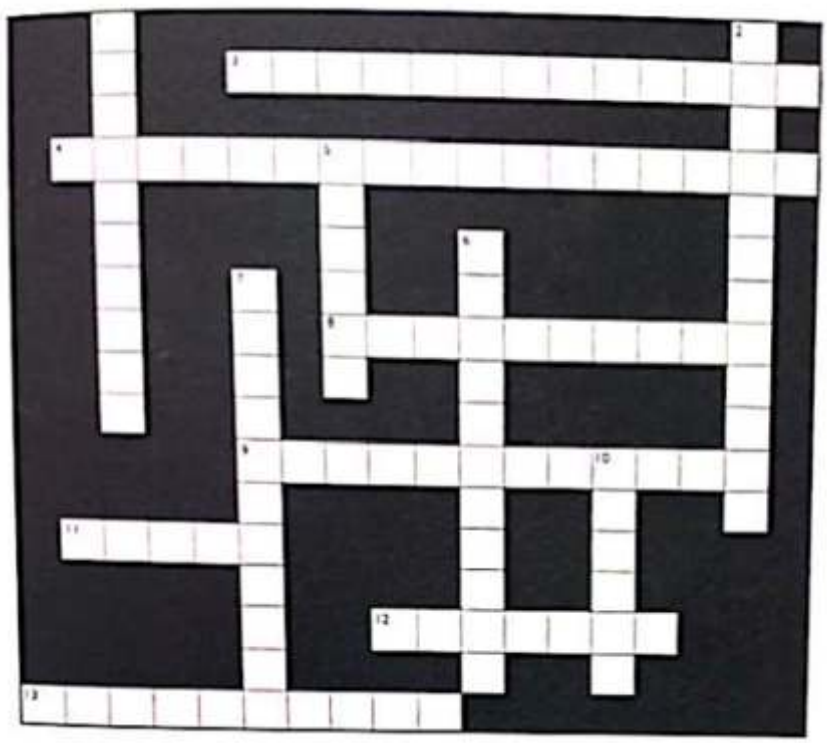
Senior Consultant Reproductive Medicine
Nova IVF Fertility Andheri ,Mumbai,



Across

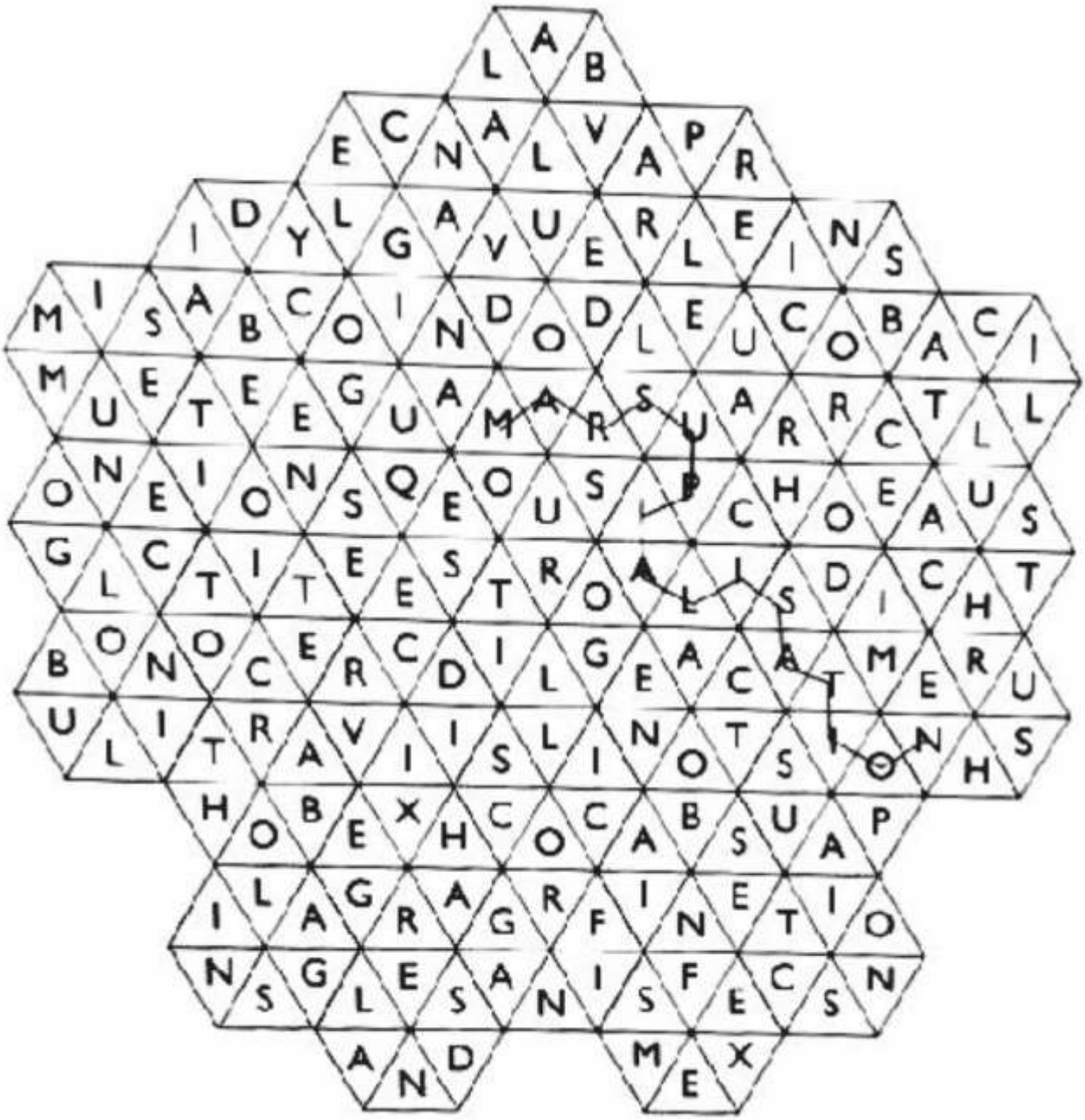
3. Medical management of incomplete miscarriage would also need this in vaginal pessaries(13)
4. A pre-existing condition that can cause recurrent miscarriage(10.7)
8. A big risk factor for miscarriage (10)
9. .....Of the uterus is a congenital risk factor for miscarriage (12)
11. How many miscarriages are needed to be called recurrent?(7)
12. Fetal genetic problems such as this can cause spontaneous miscarriage
13. Slight vaginal bleeding in early pregnancy with some pain but a closed os would indicate a miscarriage(10).

Down

1. Heavy vaginal bleeding with closed os would indicate this type of miscarriage(10)
2. This could be given in oral form as medical management of incomplete miscarriage (12).
5. A possibly fatal type of miscarriage that may have been caused by a criminal abortion (6).
6. The presence of gestational sac of >20 mmm with no yolk sac (11)
7. Heavy bleeding with pain and open cervical os would indicate this(11)
10. Even a healthy patient can suffer miscarriage due to this(6).

WORD SEARCH

This is a normal word search -except that the words do not have to be in a straight line! When you have found all the words, put the remaining letters together to spell out an important phrase…..
One word has been given to get you started. Good Luck!
Word list
Acid, Balance, Bartholin's glands, Diabetes, Discharge, Doderlein's Bacillus, Ectocervix, Glycogen, Immunoglobulin, Infection, Lactobacillus, Leucorrhoea, Menopause, Oestrogen, Organism, Secretions, Squamous, Thrush, Vagina, Vulva



Unscramble the Scramble

Each box contains the answer to each clue given. However each answer has a missing letter; solve each clue and together the missing letters make upa risk factor for placental abruption.

A	N	E
S	C	?
E	R	A

1. It may result in needing one of these?

	N	O
X	C	?
I	R	C
A	I	O
T	O	C
N		T

2. Causes a hard uterus

I	?	E
	P	D
L	R	A

3. Contraindicated pain relief

A	H	E
G	?	R
A	R	O
H	E	

4. Symptom?

I	F	T
S	N	
C	?	A

5. Will be seen in the placenta after delivery from a minor placental abruption

A		D
B	?	P
N	L	I
I	A	N
O		M

6. Symptom

COLOUR SUDOKU

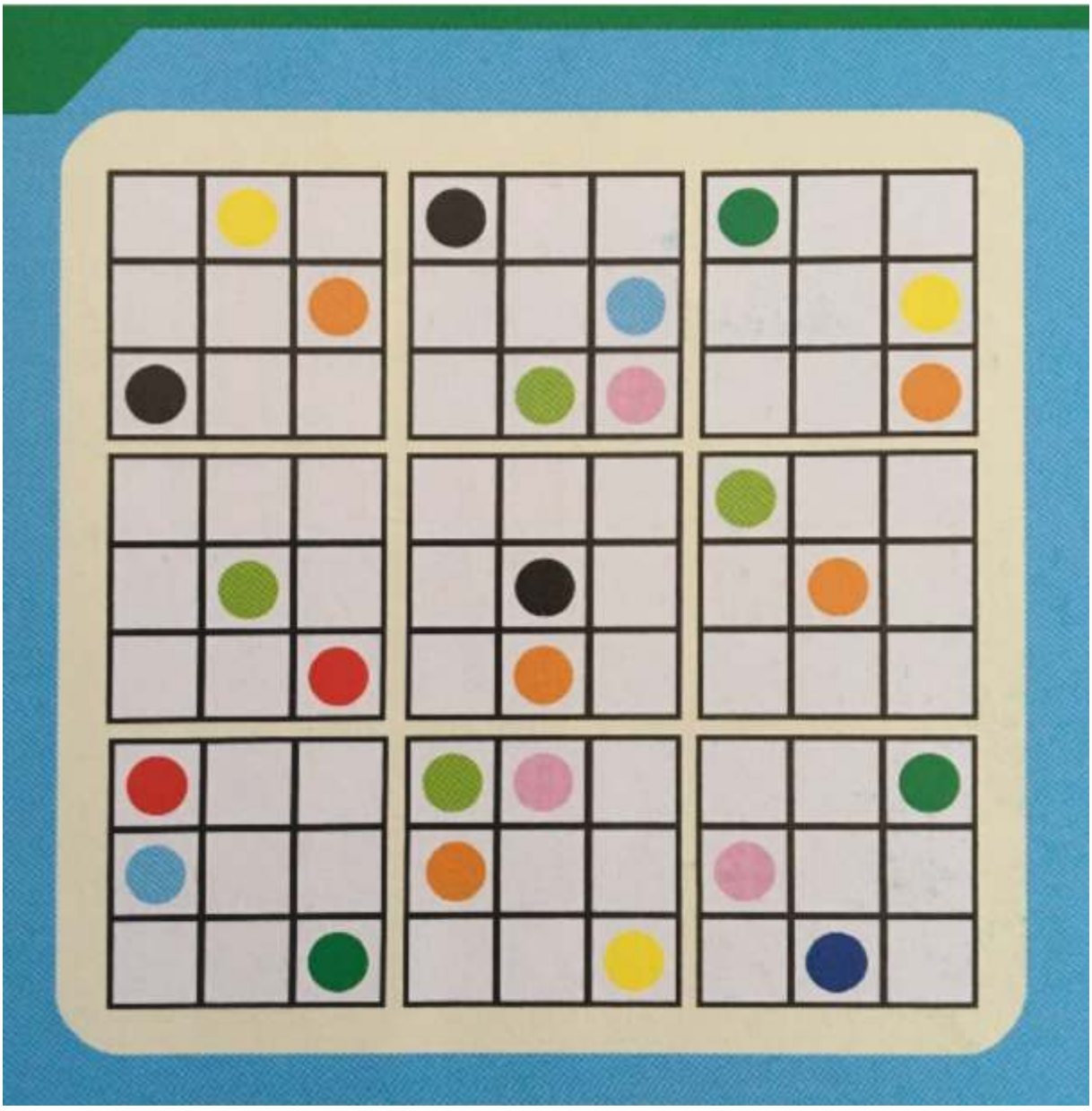
Dr Bhumika Kotecha Mundhe
DGO, DNB (Ob/Gy),MNAMs
Trained in Advanced Minimally Invasive Endoscopy (Singapore)
Consultant at Saifee hospital, Masina Hospital
& Wockhardt Hospital

Colour Sudoku

There 9 colours namely -Red, Orange, Yellow, Light green, Dark green,Light blue, Dark blue, Pink & Black to be filled in each box.

Mind you- No repetitions in each box/ column /row.

There you Go



FIT IS IT TEAM

Dr Rishma Pai,
President, MOGS.

Dr Anahita Chauhan,
Secretary, MOGS.

Dr Komal Chavan **Dr Madhuri Mehendale**
Managing Council Members, MOGS.

Dr Amrita Tandon **Dr Aditi Tandon**
Youth Council Members, MOGS.

Dr. Komal Chavan
performing Chair Yoga

Dr. Priti Vyas doing Yoga

DIET TRENDS

Dr Aalika Banerji Shah
(MBBS, Medical Nutritionist)
Consultant at Health Esthetics &
Lifestandards, Mumbai
+91 9819980566

With so many diets out there, literally a new one trending every other day, it can be challenging to know which is right for you. Of course what works for someone may not work for others, so technically speaking there's no winner. I'm Dr Aalika Banerji Shah and I'm here to decode some of the latest diet trends doing the rounds.

Of course there are a few things which make diets start 'trending' : faster weight loss, convenience, flexibility, long-term sustainability, inclusivity of more kinds of foods & not to forget celebrity influencers.

Patients out there today are so well informed & most of them already know what they want to follow before entering my clinic which makes it challenging to reset their minds. Most of them want to lose weight in the shortest time span and are willing to give up on a lot of essential nutritional requirements to get that 'summer body'.

For me, I believe in using food as a potent form of medication, to treat diseases from their root cause & help create balance. So naturally a good diet plan would include all the basic nutritional needs, maybe some supplementation & a variety of healing disease-specific foods.

If I had to list a few of my favourite diet trends for overall health, considering factors like short-term & long-term weight loss, nutritional completeness, and how easy the diet is to follow it would include some of these :

1. Mediterranean Diet

The Mediterranean Diet topped the list for the third year in a row as the report's best diet for overall health. It's also ranked No. 1 for best plant-based diet, best diabetes diet, and easiest to follow, plus a tie for first on the best diets for healthy eating list.

Based on the diets of Mediterranean countries like Italy and Greece, the focus is on whole-food ingredients, with an emphasis on fruits and vegetables, healthy fats like olive oil, and lots of omega-3 rich food like seafood. There's no calorie counting, but things like red meat and sweets are meant to be limited.

With the addition of prioritizing an active lifestyle and social relationships, this diet tackles overall health from every angle, which makes sense, considering much of the Mediterranean is considered a 'Blue Zone' a place in the world where people are the healthiest and live the

longest.

2. DASH Diet

The DASH Diet or "Dietary Approaches to Stop Hypertension" might be a new one for you. This diet is meant to combat the massive hypertension wave engulfing the world.

It's actually fairly similar to the Mediterranean Diet, with a focus on heart-healthy foods like whole grains, lean protein, and plenty of fruits and vegetables.

Since this diet places a particular emphasis on heart health, it also limits sodium, saturated fats, and sugar-sweetened drinks and sweets.

3. The Ketogenic diet

This diet has been all the rage due to its rapid weight loss results. It became very popular because you could eat saturated fats & supposedly indulgent foods like butter, cheese, cream, ghee along with meat, fatty fish, paneer & a few limited vegetables & still shed weight! Almost too good to be true.

This diet simply focuses on minimal carbohydrate intake, so the body starts burning its own fat stores for energy by a process known as ketosis.

It's strengths include : improvement in blood sugar levels, triglycerides, inflammation & improved mental clarity & sustained energy.

Some of its contraindications include : Patients with prior kidney or liver disease, hypertension, high uric acid levels etc

The debate still spilts everyone in the nutritional fraternity but I would suggest it has great benefits if done under supervision & with the right kind of foods for a short-term weight loss.

4. Volumetrics diet's

This diets approach is centered around understanding the food you're eating based on energy density and using that knowledge to make informed decisions about meals to keep you full and nourished.

Very low-density foods like nonstarchy fruits and vegetables such as spinach, cauliflower fall into Category One. Category Two includes low-density foods like starchy fruits and vegetables, grains, and low-fat meat. Medium-density foods fall in Category Three and include your meats and cheeses, sweets, breads, and so on. And Category Four is the high-density foods like chips, chocolate, cookies...you get the gist. The science is simple : calories in vs calories out & by maintaining a calculated deficit you end up losing weight.

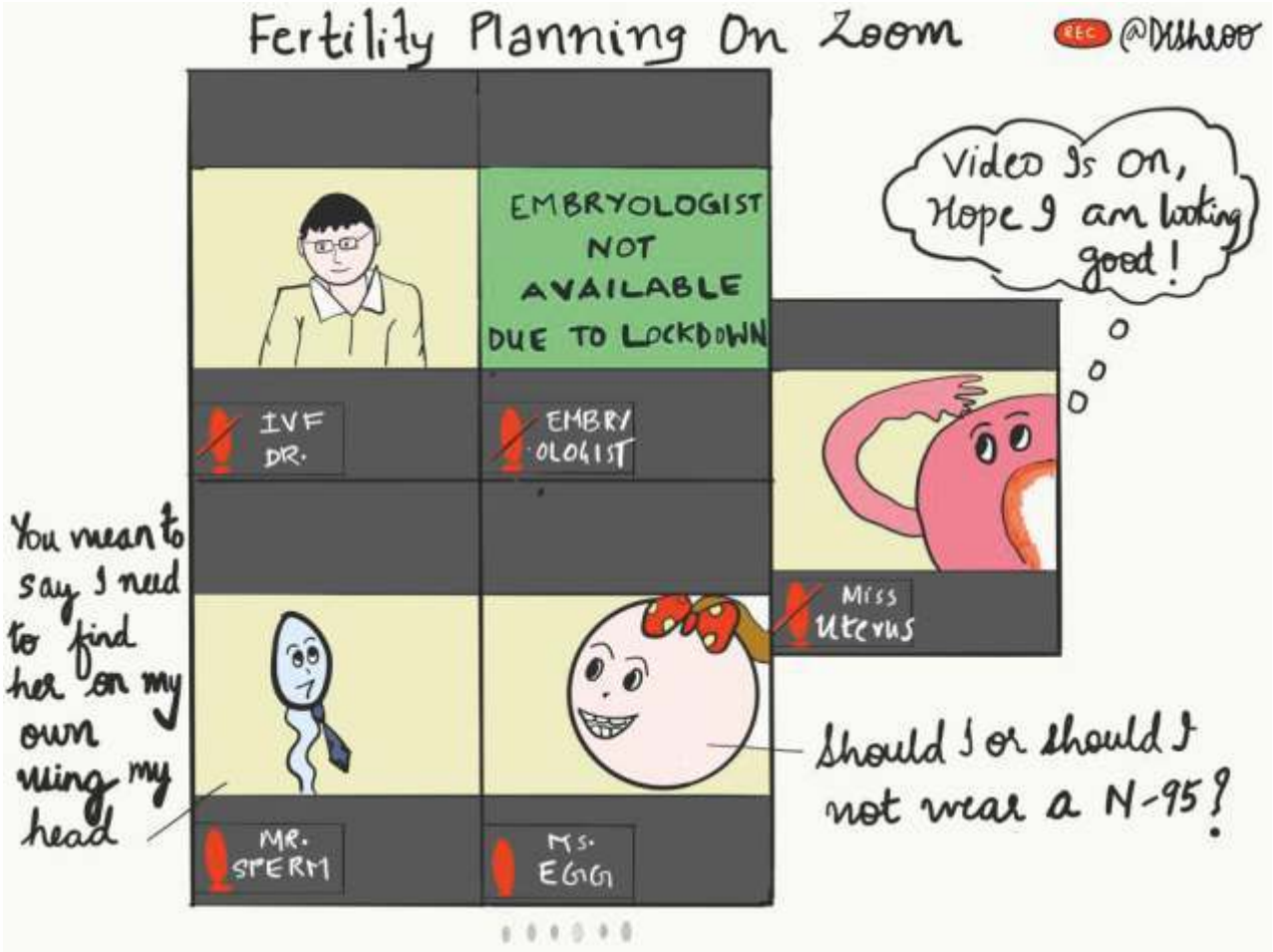
5. The Vegan Diet

And last but not least, is the new wave of Veganism taking over for health, compassion & environmental reasons : it basically means eating plant-based strictly.

Of course, just because you're not eating meat doesn't mean french fries and other meatless junk is off the table, so discretion is advised. If you're thinking of cutting out meat, you have to ensure you get your nutrients like protein, Vitamin B12, calcium, iron etc from the food you eat or from supplementation otherwise it is very easy to slip into deficiencies.

It has shown drastic improvements in reducing chronic lifestyle diseases as well as helping in weight loss but again only if done in the right manner.

So there you have it, a few of the noteworthy diet trends these last few years. With that said, we're all different with unique needs, so remember, what works for one person may not work for the next. But one thing is clear when looking at all these diets: We're continuing to move towards whole ingredients and healthy lifestyle changes overall, including more physical activity, which is something we should all definitely get behind.



FOOD FOR THOUGHT

WHOLE WHEAT VEGETABLE CHILLA

By **Dr. Leena Mishra**
MBBS, DGO, FCPS, DFP
Consulting Obstetrician & Gynecologist Malad ,Mumbai.

Ingredients:

1Cup whole wheat flour, 1/2 Cup Curd, 2 Medium chopped onions, 1 Capsicum finely chopped, 2 Tbsp Carrot grated, 4 Green chilly finely chopped, 3 Tbsp Coriander finely chopped, 1/2 Tbsp Ginger paste, 1/2 Cup water or as required, 1/2 Tsp Chaat Masala, 1/2 Tsp Red chilly powder, 1/2 Tsp Turmeric powder, Salt to taste, Oil for cooking

Steps:

Take whole wheat flour in bowl. Add curd, salt, red chilly powder,turmeric powder,chaat masala & ginger paste,mix them well. Add water as required to make lump free batter but thicker then dosa battar, cover & keep aside for 1 hour. Mix all remaining chopped vegetables,Mix them well again now batter is ready for chilla. Take tava/dosa pan & grease it with1/2Tsp oil. Spread the batter gently & don't spread too much. Cook the chilla for 2-3 mins on low medium flame &flip it cook on other side too. Serve it hot with green chutney or tomato sauce.

CARROT BURFI

By **Dr. Shruti Panchbudhe**
MBBS, MS, MRCOG, DNB, DGO
Assistant Professor, Obstetrics and Gynecology ,
SETH G S Medical College and KEM Hospital Parel, Mumbai

Ingredients-

4 cups,550 gm carrot, grated, 2 tbsp of ghee, 1 cup milk, 1/3 cup, 110 gm sugar or jaggery, ½ cup, 50 gm milk powder, ¼ tsp cardamom powder, 2 tbsp almonds / badam/pistachios chopped

Procedure-

Melt 2 tbsp ghee in a pan and add grated carrots to it. Saute the carrots on a low or medium flame till the color of carrots changes lightly and they shrink which takes 10 to 12 minutes. Now add in 1 cup milk, stir and boil for 5 minutes till the carrot turns soft. Stir occasionally, till the milk reduces completely and the mixture thickens. Now add in 1/3 cup of sugar or jaggery and mix well till the sugar or jaggery melts and the mixture further thickens. Add in ½ cup milk powder and give a good mix.

PTO

Make sure there are no lumps formed in the mixture and it separates from the pan and turns into a firm and dense consistency. Add in ¼ tsp cardamom powder and mix well and switch of the flame. Transfer the prepared mixture into greased plate lined with baking paper and smoothen the top part with spatula or spoon or alternatively prepare balls to prepare carrot ladoo. Set well forming a block. Now garnish with few chopped almonds or any dry fruits like almonds or pistachios and press slightly. Allow to set for 30 minute, or till it sets completely and now unmold and cut into square pieces for serving or store in airtight container and keep in the fridge.

HUMMUS WITH KUBOOS (CUISINE: LEBANESE)

By Dr. **Rana Choudhary**
(DNB, DGO, DFP, FCPS, FICOG, FICMCH, MNAMS)
Masters in Reproductive Medicine & IVF (UK), Diploma in Clinical Research, Youth Council Member MOGS

HUMMUS RECIPE

Ingredients
Chickpeas - 1 cup, Sesame seeds- 2 table spoons , Fresh lemon juice - 1 table spoon, Fresh garlic - 2-3 cloves, Olive oil - 2-3 table spoon, Salt to taste

Steps:
1. Boil the chickpeas. 2. Roast some sesame seeds and then once done grind it into a fine paste. You may add 1 teaspoon of olive oil to make the paste. 3. Now add the boiled chickpeas to this mixture. You may add 2 teaspoons or more of water along with olive oil to make a smooth paste. 4. Add the garlic, salt and lemon juice to it and continue grinding till it forms a pretty smooth mixture. 5. I sprinkle some periperi powder and olive oil on the top before serving.

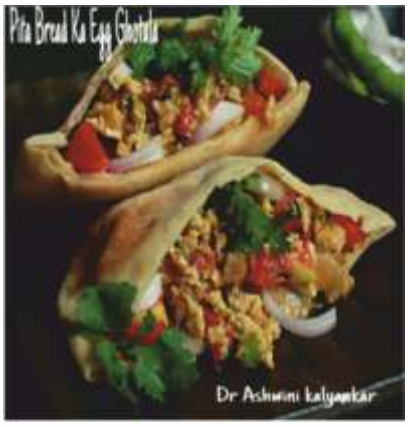
KUBOOS RECIPE / ARABIC PITA BREAD INGREDIENTS (SERVES : 5-6 PITA BREAD)

Ingredients:
Whole wheat (As its healthier than maida / all purpose flour) - 2 cups, Baking soda - 2 teaspoons, Salt to taste, Warm Water - ¾ cup, Olive Oil - 2 tablespoons, Ajwain (carom seeds) - 2teaspoons (I add it as it keeps the stomach health and reduces bloating).

Steps:
1. Mix the flour, salt, ajwain, baking soda in a bowl. 2. Add water and olive oil and knead into a soft dough. 3. Cover and let it rest for 10-15 minutes. 4. Now divide it into equal balls. 5. Take a ball, flatten it and roll it into thick round shape (similar to roti, but thicker). Poke some holes with a fork it. 6. Now cook over a hot tawa on slow flame till puffy and cooked from both sides. 7.Remove and serve with Hummus.
Enjoy the healthy and delicious version !

PITTA BREAD KA EGG GHOTALA

By **Dr Ashwini Kalyankar**
DNB, FMAS
Gynac Laparoscopic Surgeon



Excellent single dish meal with full of proteins floods th taste buds for Eggiterian.

Ingredients - 4 Servings:
12 eggs, 2 medium onion, 3 tablespoon chopped ginger, 2 tablespoon chopped garlic, 2 cup chopped coriander leaves, 2 teaspoon cumin powder, 2 tablespoon refined oil, 1 teaspoon chili powder, 1 teaspoon mustard seeds, 30 gm cheese, 1 teaspoon chopped green chili, 4 pinches Salt, 2 tablespoon of butter, 4 pita breads.

Steps
First of all boil 4 eggs. Next heat oil in a pan. Once hot ,add mustard seeds. Let them pop. Then add ginger, garlic, green chili and onions. Saute onions till oil leaves the sides. Add tomatoes to this. Lightly saute and then add pavbhaji masala, cumin powder, chilli powder, salt and turmeric powder. Once tomatoes soften break 4 eggs and scramble in this onion tomato masala. Now add chopped boiled eggs and grated cheese to this scrambled mixture. Top with coriander and toss in a non stick fry pan make 4 sunny side up eggs. 2cups of all purpose flour ,1/2cup of wheat flour, 1 teaspoon of salt and sugar. Add 1 teaspoon of activated yeast to a cup of water. Mix it well. Make a soft dove . keep it aside for 2 hrs. Make small balls of the dove and make thin chapattis . Pre-heat the tava and rost it. The soft two layered pita breads are ready. Now fill the egg ghotala in the pita breads and Ur tasty dish is ready to serve.

SALUTE TO OUR HEROS

Salute to Stalwart - Dr A. C. Mehta

We mourn the sad demise of our stalwart Dr. Ajit Mehta on 6/06/2020 at age of 90 years.

DrAjit Mehta was 25th President of Bombay Obstetric and Gynecological Society in late 70s."I treat each of my patient as a VIP and each baby that is delivered as a celebrity." That in a nutshell, is the credo of DrAjitChimanlal Mehta.

Hailing from an doctor family he was the only one amongst the three sons to persuade MBBS. He finished his MBBS from G. S. Medical College, Mumbai. In 1957 he obtained MD in Obstetrics nad Gynecology.

Dr Mehta held the post of Honorary Jt. Secretary of FOGSI from 1975-1982 and then Honorary Secretary General in 1983-1984.He was also assistant Editor of Journal of Obstetrics and Gynecology in India 1967-1968.

He used to describe himself as "adventurous" in his younger years. His early interest included "aquatics" for which he had earned trophies in school and college days.

Towards end he lived and practiced from his South Mumbai residence at Babulnath. He occasionally also used to write some very subtle poetry in his spare time. He has to his credit a collection of numerous poems.

True Stalwart ….!

Salute to the Covid Warrior - Dr Parag Patil

We mourn the passing of our covid warrior Dr. Parag Patil on 21st June 2020 at 6:30am. May God give his family the courage and the strength to bear this irreparable loss.

Dr. Parag Patil graduates from Seth GS Medical College and completes his post graduation from JJ Hospital Mumbai. He maintained closed ties with all his friends, batchmates, juniors and seniors. Dr. Parag Patil waspractising in Kalyan and helped bringing modern practices by organising various academic programs which we all looked forward to. He was very active in MOGS, AMOGS, FOGSI and IMA Kalyan. His programs would always include a unique form of Q&A's which would have the audience enthralled. He was the West Zone Co-ordinator of FOGSI Sexual Medicine Committee and he was the chairperson of AMOGS Sexual Medicine Committee.

For the last 4 weeks, he was fighting this dreaded disease and all of us were with you. During the lockdown, Dr. Parag Patil used to go to do COVID-19 duties at Bai Rukmini Bai KalyanMuncipal Hospital attending antenatal and gynaecological patients.

Dr. Parag was an advocate of women's sexual reproductive rights and adolescent health. He was very active in his crusade to make a better future for the youth of India.

He was a gentle, humble and hardworking soul who was always helping his colleagues and friends.

You will be missed.

LOCKDOWN CHUPARUSTOM

Dr Niranjan Chavan playing- Jane Kahan Gaye Woh Din on Harmonium
To Listen Click here on the link - https://www.youtube.com/watch?v=fBs-aqIaCaM

Physical & Mental fitness

Enjoying my husband & son's green thumb in my garden

Dr Anahita Chauhan

Dr Kedar Ganla

Dr Kedar Ganla

TRIPLE "E" BOOSTER

-Dr Suvarna Khadilkar

Health for all an unttained goal,
Years have gone, talking their toll.
Looking back, Here we stand
How can we offer helping hand?
Walk on this path for success of the Mission
Health for all through health for women
Healthy mother healthy wife
Healthy daughter leading healthy life
Wake up to the needs of Women of the day
Help them move, lead their way
From ignorance to knowledge,
From poverty to wealth,
From weakness to strength
And from ailment to health
Prevention is certainly better than cure

Use weapon of Triple "E" Booster
"Education, Employment, Empowerment"

"EVERY HALLWAY IS A RUNWAY"...
FASHION FUNDAS WITH NEW NORMAL...

Dr Amrita Tandon

Dr Pooja Batham

Dr Shreedevi Tanksale

Dr Tejal Poddar

Dr Deepali Kale

Dr Navneet Desai

Dr Komal Chavan

ACHIVEMENT BY OUR MEMBER

ARTS IN LOCKDOWN TIME

By Dr Asha Paranjpe

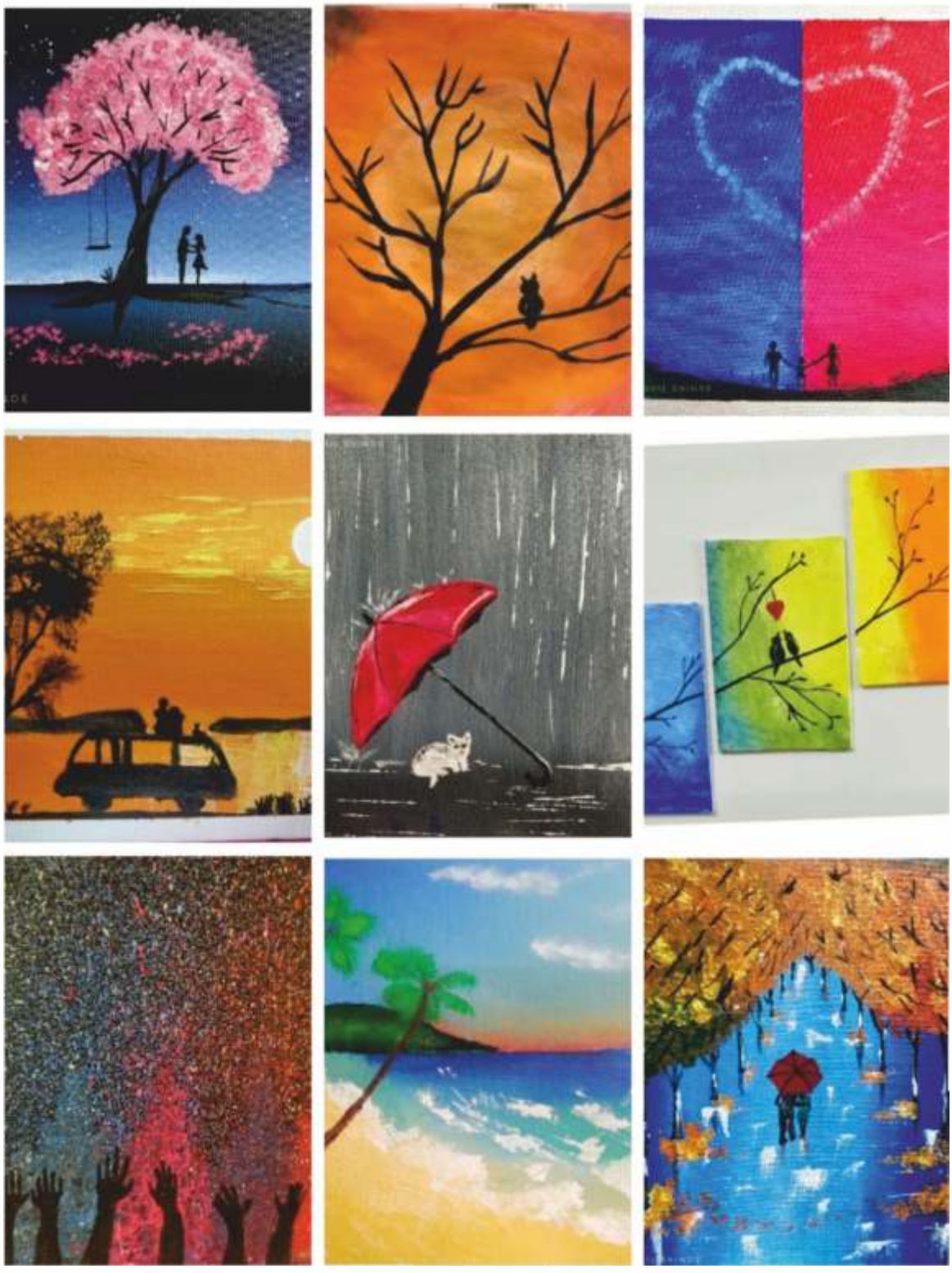
By Dr Pooja Batham

By Dr Deepali Kale

By Dr Deepali Kale

ACHIVEMENT BY OUR MEMBER

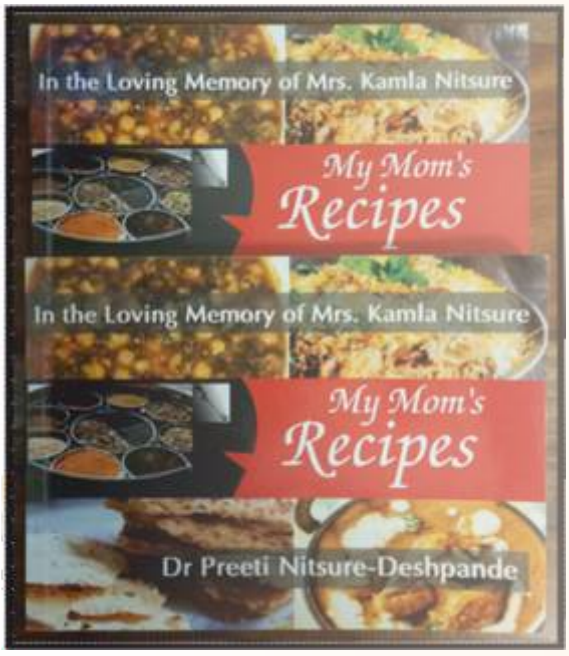
ARTS IN LOCKDOWN TIME



By Dr Sushil Shinde

The ability to provide patient-centred care within an ever-changing society requires excellent communication skills, creativity and flexibility of thinking, Dr (Mrs.) Pooja Batham, Obstetrician & Gynecologist demonstrates this thru her Paintings. While a career in medicine always appealed to her, art is yet another way of touching-life, she continues to enjoy this from a very young age, and overtime her paintings provides am immersive & satisfying feelings across the human endeavour.

ACHIVEMENT BY OUR MEMBER



Happy to announce release of recipe book of our own MOGS member **Dr Preeti Deshpande** on various recipes she learnt from her beloved Mom.

Dr Yash Sharma son of our MOGS member Dr Rajvi Chand & Dr Satish Sharma has secured 14 Gold Medals in MBBS course exams at Seth G S medical college.

Dr Sandeep Jeste is happy to share with us about his family members careers His daughter Mrunmayi Jeste UG from KEMH, DOMS, DNB(Gold medalist) doing super speciality in VITREORETINAL SURGERY from the esteemed Aravind Eye Institute Coimbatore .

His son in law Dr Shakti Singh MS ophthalmology from BJMC doing superspeciality in CORNEA from the esteemed Aravind Eye Institute Coimbatore. His son MohitJeste, Btech is doing Masters in computer science at University of Texas at Arlington with perfect GPA score, would be summer internship at KS Atlanta

It gives us immense pleasure to announce that our MOGS members can now share theirs or their family members achievments with us here in MOGS Newsletters.You can send an email for the same on following Email Id-mogs2012@gmail.com

A LIFETIME ODYSSEY !!

Dr. Priyanka. H. Vora
MBBS, DGO, FCPS, DFP, BIMIE, Masters In Reproductive Medicine & IVF (UK)

For on Doctors Day today,
I pen down my thought,
With God's grace we survived,
Although we went through a lot..

We the underdogs,
ever so underplayed,
Rose to the occasion,
even without your say..

Leaving our fears aside,
To stand as a rock by your side..

While you were worried,
Not to catch the infection,
No choice, we had
Normal delivery or Cesarean section..

While you chose to help us,
by staying at home,
Even though a few of us went back,
we were still HOME ALONE!

We saw the beautiful empty roads of Mumbai,
Nature at its best, no busy lives, no buzzing by the sides..
Yet in the silence which was so beautiful to endure,
Why did we miss the Mumbaikars - from our heart encore?

It is never too easy,
to live a day in a "DOCTORS LIFE" -
We speak.. only for your hope to channelize,
We sweat.. only in the PPE's for you to breathe a new life,
We treat.. only for your families to see you alive,
We dream.. only for YOU to have a happy and healthy life...

WE PRAY.. ONLY FOR THE ONENESS OF ALL HUMAN-LIFE!

Then why does your anger belittle us,as a shining armor in disguise?
It is never to easy to "LIVE A DAY" in a Doctors life!

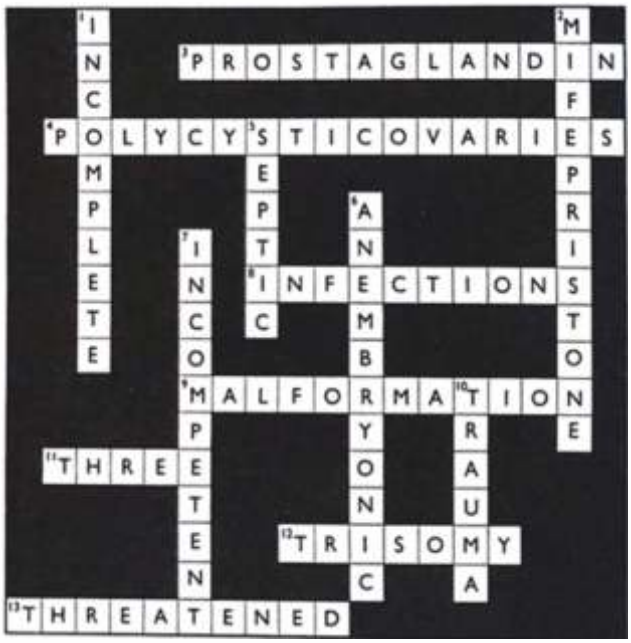
Relentless we have tried,
to flatten the curve,
It is only selflessly that we serve!!!
As our mind, body, heart and soul ,
knows of nothing else to embrace,
Even while all our lives we received ,
nothing but disgrace..

While the human in you,
did numerous things to keep us going,
Imagine how difficult it was for us to reap fruits in the soil,
that nature was sowing!?!?

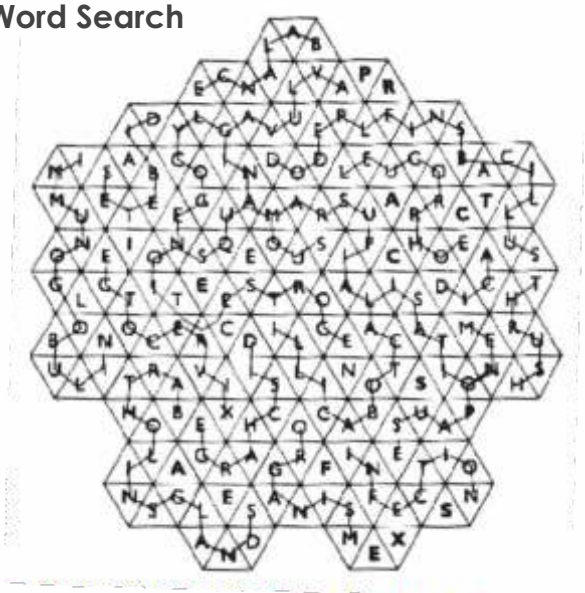
Just like yesterday, if not today, then tomorrow,
Things may change once again,
As thankless as our duties were,
The years of service may again turn sour,
But we will always remain where WE ARE,
FRONT LINE WARRIORS IN EVERY NEED OF THE HOUR!!!

ANSWERS

Crossword



Word Search



The remaining letters spell:
Practice safe sex!

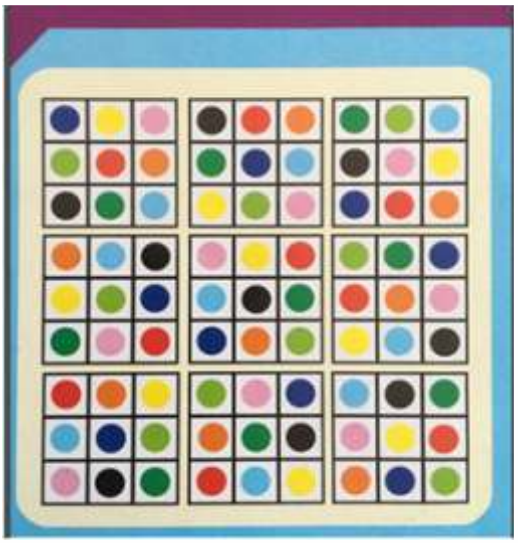
Unscramble the Scramble

1. CAESAREAN
2. TOXIC CONTRACTION
3. EPIDURAL
4. HAEMORRHAGE
5. INFARCTS

ABDOMINAL PAIN

The missing letters spell out TRAUMA.

Colour Sudoku



Boostrix has shown no vaccine related adverse effect on pregnancy or on the health of the foetus/newborn child[1]. In clinical trails mild or moderate pain(79%) was the most reported adverse event followed by injection site induration(12%), swelling (7.6%) and severe pain (2.6%)[1,3].

#Limited data indicate that maternal antibodies may reduce the magnitude of the immune response to some vaccines in infants born from mothers vaccinated with *GSK's Tdap vaccine* during pregnancy. The clinical relevance of this observation is unknown[1].

*FOGSI recommends Tdap vaccination should be administered during pregnancy in order to provide optimal protection to the baby during its first months of life. Strength of recommendation A. "A": Strongly recommended.

1. Boostrix Prescribing Information-Version BTX/PI/IN/2017/01 dated 04 Apr 2017. 2. FOGSI Good Clinical Practice Recommendations on PRECONCEPTION CARE 2016 - Available at:http://www.fogsi.org/gcpr-preconception-care/ accessed May 2018. 3. Petousis-Harris H, *et al*. Safety of Tdap vaccine in pregnant women: an observational study. BMJ Open.2016; 4. https://www.medicines.ie/medicines/boostrix-suspension-for-injection-31460/ Accessed May 2019.

For the use only of a Registered Medical Practitioner or a Hospital or a Laboratory

BOOSTRIX: Diphtheria, Tetanus and Pertussis (Acellular, Component) Vaccine (Adsorbed, Reduced Antigens Content) Ph. Eur.Name: Diphtheria, Tetanus and Pertussis (Acellular, Component) Vaccine (Adsorbed, Reduced Antigens Content) Ph. Eur. Composition: One dose (0.5 ml) of vaccine contains: not less than 2 IU (2.5 Lf) of diphtheria toxoid, not less than 20 IU (5 Lf) of tetanus toxoid, 8 µg of Pertactinbsed 8 µg of Filamentous Haemagglutinin & 2.5 µg of Pertactin adsorbed on aluminium hydroxide [Total 0.3 mg Al3+] & aluminium phosphate [Total 0.2 mg Al3+] Pharmaceutical Form: It is a white cloudy suspension for injection. Indications: It is indicated for booster vaccination against diphtheria, tetanus and pertussis in individuals aged 4 years and above who have previously completed primary vaccination with DPT. Posology: Single 0.5 ml dose of the vaccine is recommended. The use of BOOSTRIX may be considered during the third trimester of pregnancy. For the use of the vaccine before the third trimester of pregnancy, it should be administered in accordance with the official recommendations and/or in line with current medical practice concerning the use of vaccines containing a low (adult) dose of diphtheria, tetanus and pertussis antigens. BOOSTRIX may be administered to adolescents and adults with unknown vaccination status or incomplete vaccination against diphtheria, tetanus and pertussis as part of an immunisation series against diphtheria, tetanus and pertussis. Based on data in adults, two additional doses of a diphtheria and tetanus containing vaccine are recommended one and six months after the first dose to maximize the vaccine response against diphtheria and tetanus. BOOSTRIX can be used in the management of tetanus prone injuries in persons who have previously received a primary vaccination series of tetanus toxoid vaccine and for whom a booster against diphtheria and pertussis is indicated. Tetanus immunoglobulin should be administered concomitantly in accordance with official recommendations. Repeat vaccination against diphtheria, tetanus and pertussis should be performed at intervals as per official recommendations (generally 10 years). Paediatric population: The safety and efficacy of BOOSTRIX have not been demonstrated in children < 4 yrs of age. Method of administration: Deep I.M. inj. preferably in the deltoid muscle. Contraindications: Hypersensitivity to the active substances or to one of the excipients; Hypersensitivity after previous administration of a diphtheria, tetanus or pertussis vaccine. It is contraindicated if the subject has experienced an encephalopathy of unknown etiology occurring within 7 days following a previous vaccination with a vaccine containing a pertussis component. In this case, vaccination against pertussis will be postponed and vaccination against diphtheria and tetanus will proceed. It cannot be administered to subjects who have experienced transient thrombocytopenia or neurological complications (such as convulsions or an episode of hypotonia-hyporesponsive). following an earlier vaccination against diphtheria and/or tetanus. Administration should be postponed in subjects suffering from acute severe febrile illness. The presence of a minor infection is not a contra-indication. Special Warnings and Special Precautions for Use: If any of the following events has occurred in medical history after a pertussis vaccination and could be associated with it, the decision to administer a vaccination containing the pertussis component should be carefully considered: 1) Fever of ≥ 40.0°C occurring within 48 hrs of vaccination, not due to another identifiable cause.2) Collapse or shock-like state (hypotonic- areflexia episode) occurring within 48 hrs of vaccination; 3) Persistent, inconsolable crying lasting ≥ 3 hrs, occurring within 48 hrs of vaccination. 4) Convulsions with or without fever, occurring within 3 days of vaccination. There may be circumstances, such as during a pertussis epidemic, when the potential benefits of vaccination outweigh the possible risks. As with any vaccination, the risk/benefit ratio of performing or postponing a vaccination with BOOSTRIX in a child affected by severe neurological illness, new or progressive, should be carefully evaluated. As with all injectable vaccines, medical supervision and easy access to appropriate medical treatment are recommended in case of the occurrence of a rare anaphylactic reaction following administration of the vaccine. It must be administered with caution in subjects with thrombocytopenia or a coagulation disorder, as bleeding may occur in these patients during IM administration. Firm pressure must be exerted on the injection site (without rubbing) for at least 2 minutes. BOOSTRIX should not be administered intravascularly. A history of febrile convulsions and a family anamnesis of convulsions or of secondary reactions following DTP vaccination does not constitute a contraindication. Infection with HIV is not considered a contraindication. The expected immunological response may not be obtained after vaccination of immunosuppressed patients. Syncope (fainting) can occur after any vaccination, or even before, with adolescents in particular, as a psychogenic reaction to injection with a needle. This can be accompanied by several neurological signs such as transient disturbances in vision, paraesthesia and tonic-clonic movements of the limbs during the recovery phase. It is important that measures be set up to avoid injuries in the event of fainting. As with all the vaccines, a protective immune response cannot be obtained in all vaccinated subjects. Interaction with Other Medicaments: Concomitant administration 1) With a HPV vaccine does not lead to significant interference with the antibody response to any of the components of these vaccines. 2) With other vaccines or with immunoglobulins has not been studied but unlikely to interfere with immune responses. If, however necessary, the products should be injected at separate sites. 3) With an immunosuppressive treatment - patients receiving immunosuppressive therapy may not achieve an adequate response. Pregnancy and Lactation - Pregnancy: Safety data from a prospective observational study where BOOSTRIX was administered to pregnant women during the third trimester (793 pregnancy outcomes) as well as data from passive surveillance where pregnant women were exposed to BOOSTRIX or to BOOSTRIX Polio (dTpa-IPV vaccine) in the 3rd and 2nd trimester have shown no vaccine related adverse effect on pregnancy or on the health of the foetus/newborn child. The use of BOOSTRIX may be considered during the third trimester of pregnancy. Limited data indicate that maternal antibodies may reduce the magnitude of the immune response to some vaccines in infants born from mothers vaccinated with BOOSTRIX during pregnancy. The clinical relevance of this observation is unknown. Lactation: The effect of administration of BOOSTRIX during lactation has not been assessed. Nevertheless, as BOOSTRIX contains toxoids or inactivated antigens, no risk to the breastfed infant should be expected. The benefits versus the risk of administering BOOSTRIX to breastfeeding women should carefully be evaluated by the health-care provision. Undesirable Effects: Clinical Trial Data: The safety profile described below is based on data collected in clinical trials during which BOOSTRIX was administered to A) Subjects aged 4 - 8 years (N=839) : Very common: irritability, drowsiness, reactions at the injection site (such as redness and/or swelling), pain at the injection site, fatigue Common: anorexia, headache, diarrhoea, vomiting, gastrointestinal symptoms, pyrexia (fever ≥ 37.5 °C and up to > 39.0 °C), significant swelling of the limb where the injection was administered (sometimes including the adjacent joint) Uncommon: infection of the upper respiratory tract, concentration difficulties, conjunctivitis, skin rash, other reactions at the injection site (such as induration), pain B) Subjects aged 10 - 76 years (N = 1931) : Very common: headache, reactions at the injection site (such as redness and/or swelling), malaise, fatigue, pain at the injection site Common: dizziness, nausea, gastrointestinal disorders, pyrexia (fever ≥ 37.5 °C), reactions at the injection site (induration at the injection site, sterile abscess at the injection site) Uncommon: upper respiratory tract infection, pharyngitis, lymphadenopathy, syncope, cough, diarrhoea, vomiting, excessive perspiration, pruritus, skin rash, arthralgia, myalgia, joint stiffness, musculoskeletal stiffness, pyrexia (fever > 39.0 °C), influenza-like syndrome, pain Post-marketing surveillance: - Angioedema, allergic reactions, including anaphylactic and anaphylactoid reactions, episodes of hypotonia / hyporeactivity, convulsions (with or without fever), urticaria, asthenia. There might be a small increase in local reactogenicity (pain, redness, swelling) with repeated vaccination according to a 0, 1, 6 months schedule in adults (over 40 yrs of age) in subjects vaccinated initially with DPT in childhood, a booster dose could cause an increase in local reactogenicity. When vaccines containing tetanus toxoid are administered, very rare cases of undesirable effects on the central or peripheral nervous system, including ascending paralysis and even respiratory failure (e.g. Guillain-Barre syndrome) have been reported. Overdose - The undesirable effects due to the overdose were similar to those reported for normal administration of the vaccine. Excipients: Aluminium hydroxide, aluminium phosphate, sodium chloride, water for injections. Formaldehyde, polysorbate 80, glycine are present as residuals from the manufacturing process. Incompatibilities: It should not be mixed with other vaccines in the same syringe. Shelf Life - 36 months. Special Precautions for Storage: It should be stored at +2°C to +8°C. Store in the original package away from light.Do not freeze. Discard if the vaccine has been frozen. Protect from light. Keep out of reach of children. Instructions for Use / Handling: Shake well before use. Discard if for any foreign particulate matter and/or variation of physical aspect visually observed prior to administration. The vaccine should be administered immediately after opening the container (not later than 8 hrs after opening). Version: BTX/PI/IN/2017/01 v01 dated 25 July 2017. ***Registered medical practitioners can refer company website http://india-pharma.gsk.com/en-in/products/prescribing-information/ for full Productinformation. Please report adverse events with any GSK product to the company at india.pharmacovigilance@gsk.com***

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