Bangalore Society of Obstetrics and Gynaecology

News & Views

Vol.1 Issue 2 2013

Dr. Jyothika A Desai

From the President's Desk

Hi! Was it only in April that I took over the reins as President of BSOG? So much water has gone under the bridge since then. So many new experiences, new friends and new resolves. Life has not been the same ever since.

The scintillating Investiture ceremony laid the foundation for a series of Scientific sessions, where we attempted to explore hitherto untouched realms and the response from our members has been overwhelming. I am not going to delve into the details of the sessions as we have a separate report on them.

We started with a lot of lofty ideals about Community and Social service, but , I realized that the demands of the profession and the added position are such that I have not been able to do much in this direction. I sincerely apologize for this and hope to rectify it in the next few months.

I am proud to say that some of our members have brought laurels to themselves and to the society too. Dr Hema Diwakar has entered the soul of FOGSI members with her unstinted dedication to the women of India. She has also been instrumental in projecting Team Bengaluru to the whole of India. After Dr Kamini Rao, she has made BSOG a force to reckon with. Dr Sheela Mane, as the Vice President Elect, intends to reach out to the poorest and furthest of our women and to improve their lot. We have seen her work as the Chairperson of the Safe motherhood Committee in the past and know that she means business. We have Dr Padmini Prasad, Dr Chitralekha and Dr Prashanth Joshi winning awards both in India and abroad. Cheers to them. Not only our senior members, our young, fledgling members too, Dr Deepika & Dr Shetal have won in the FOGSI South Zone Quiz and will represent the South in Patna AICOG. A very healthy trend indeed!

The second issue of News and Views is bigger and better than our first, our maiden effort. It would be nice if we can have a feedback from you, our very own colleagues. All good things have to come to an end one day and I close expressing my gratitude to my team for their commitment and cooperation in all BSOG endeavours. We are putting in a lot of effort to make a difference and your cooperation in our endeavours will make all the difference. Yes, my dear friends, **"Together, let's make a difference"**

Great Thoughts by Great personalities!!

"Happiness is the meaning and purpose of Life, the whole aim and the end of human existence." – Aristotle

"The year you were born marks only your entry into the world. Other years where you prove your worth, they are the ones worth celebrating."

Floral Boat – Lalbagh, Bengaluru

Calendar of Events– BSOG 2013-14 (2nd Quarter)

1. BSOG IMS Meet on Hormones and the Breast- 11th August 2013, at Chinmaya Mission Hospital 10- 1pm
2. Indian Society of Transfusion Medicine Symposium on Antenatal screening protocols- 14th August 2013, at CMH Auditorium, 2-5 pm
3. BSOG-MSD Contraception Update at Hotel Atria, on 23rd August 2013, 1.30 - 4 pm
4. BSOG- Abbott Meet at Hotel Capitol, on 25th August 2013, 10.30 - 12.30 pm, Dr P.C Mahapatra
5. BSOG- Sagar Hospital Meet on Adolescence on 22nd September 2013, 10- 1.30 pm, Sagar Auditorium
6. BSOG- Mazumdar Shaw CME on Oncology on 25th September 2013, Hotel Le meridian

Forthcoming Events

1. FOGSI International conference on Endometriosis on 26th & 27th October 2013, at Golden Palms.
2. BSOG- Pediatric Society Meet on Lifespan approach to Disease Prevention on 17th November 2013, at BMC
3. AGM and scientific session on use and misuse of progesterone in obstetrics on 24th November 2013 at Hotel Capitol, 10.30-1.30pm
4. Gnanavarsha- 14th and 15th December,2013
5. BSOG- Rheumatology CME on 22nd December 2013, Hotel Atria
6. BSOG-Ramaiah CME on Cardia and Pregnancy 5th January 2014 at Ramaiah Medical College

Congratulations

Winners of BSOG-FOGSI Dr.Usha Krishna Quiz – Screening Round 28th July at BMC, South Zone Yuva Fogsi, Trichy

Dr.Devika Rani (top) , Dr.Shital Desale (bottom) from St.Marthas Hospital have won in the South Zone Yuva Fogsi Quiz and will be participating in AICOG Patna.

Awards Galore

Dr.Padmini Prasad awarded at International Conference on Erection Dysfunction held at Seoul, South Korea during May 2013

Dr. Chitralekha receiving the Dr. B.C.Roy Award (2013) from Justice Venkatachala

Dr. Prashant Joshi getting the IOG -STYA PAUL award for best review paper from Dr Philip Steer editor BJOG

"Never settle for less than you Deserve"

In

Conversation with

Dr.Prema Kulkarni

Madam, I bring you greetings from our president and society

My heartfelt thanks for taking time off to have this conversation and sharing your thoughts and memories with us.

Can you tell us about your student days?

I was born in Bijapur in a sportsman family .My father was a very learned man and a tennis player then. In fact two of my brothers were university tennis players. I was an athlete during my school and college days and a state and national level table tennis player and have won many accolades

Who/what inspired you to choose medical profession?

I wasn't inspired by anyone in particular; it was my own ambition to become a doctor.

What made you choose Ob/Gyn?

When I was an undergraduate posted in Ob/gyn department. I was fascinated by this subject and was greatly influenced by my teachers and thereby developed a keen interest. The joy and gratitude of the patient and attenders after the delivery gave me immense satisfaction and I decided to choose the same as my post graduate subject.

What about your career as an ob/gyn?

I have worked as a professor in most government colleges such as in Hubli, Bellary, Mysore and Bangalore medical college and also in private medical colleges in Mandya and Tumkur . I have been an UG and PG examiner for many years.

Which was the best period in your professional life?

The best period was when I worked in UK between 1973 -1978. There it's a very methodical approach. The practical experience I gained was enormous as I had the opportunity to perform variety of procedures apart from the excellent facilities.

What gave you the greatest joy in this profession? Teaching or surgery?

Of course it is a great feeling managing complicated surgeries successfully and it gives you an immense satisfaction nevertheless teaching also gives me immense pleasure. It gives me great joy to see my students excel in their respective fields not only in India but even abroad.

What about your hobbies?

My hobbies now are confined to playing scrabble, cards as I can no longer take part in any sporting activities considering my age.

Are you happy retiring from your profession?

In a way yes but I miss teaching and my students the most

What do you think has changed grossly from your practice days to the present one?

Nowadays young doctors don't have sufficient time to listen to the patient's problem and lack a good connectivity with the patient. The diagnosis and treatment is nowadays more dependent on laboratory/ radiological tools than history and clinical examination

What message do you want to give to all the students as well as practicing obstetricians?

Students should give equal importance to theory and bedside clinics. Nowadays students spend less time in wards interacting with patients. To the current lot of obstetricians I know all of you are good at your work but my suggestion would be that one should never neglect history and clinical examination and be more considerate towards your patients and develop a good communication skill.

Dr.Tejavathy

Speak the truth, even if your voice shakes. Tumbir

NEW REVIEW – DOODY'S BOOK REVIEW SERVICE UPDATE

Ramarajan_Severe Acute Maternal Morbidity

Jaypee Brothers Medical Publishers, 2011, $33.00

EDITORS

Ramarajan, Arulmozhi, MD, DGO, PGDMLE.,

REVIEWER'S EXPERT OPINION

Anthony Shanks, MD.,

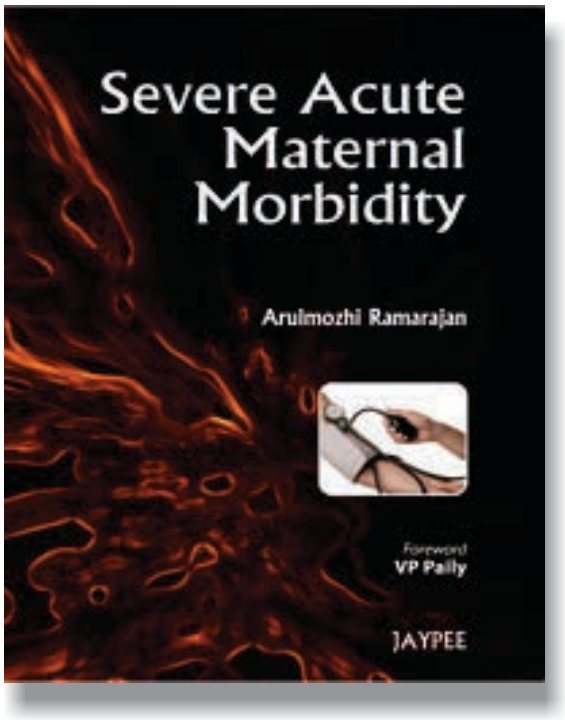
(Washington University School of Medicine)

Features

The book attempts to create a guideline for diagnosing and treating critical care patients who are pregnant. While reading it, I envisioned practitioners in less developed areas using it as a template to design their obstetrical ward.

The authors highlight the importance of the issue as well as what the wards should do. The topics the book covers are appropriate, and chapters on hemorrhage and eclampsia are well written (the entire book is very well written), but there are things some readers may find unnecessary. For instance, in one chapter, the authors describe how to turn on a tocometer machine and feed paper into it. It may not be necessary to cover such topics in more advanced books. The pictures depict worthwhile subjects, but many are out of focus and are of less than ideal print quality.

Another quibble is the use of a tamponade in cases of hemorrhage. Many books now detail using the Bakri balloon (or similar devices designed for this specific purpose) while this book discusses the use of a condom tamponade.



My darling Daughter

My luck was flying all time high
That day that moment is memorable
Gently when you came into my world
Every day that followed is unforgettable

Silently you changed me and my thoughts
And shaded my life in different colours
Through you I saw a different world
And experienced life's new flavours

Nothing is more powerful than your innocence
Sweetness of your voice is par excellence
I find myself under your influence
I am over-whelmed in your presence

For me you represent love and trust
You give me reason to be just
Quite unknowingly you inspire my deeds
And lead me to perform what is must

I enjoy the time when you are around
Your little demands are good as command
Carefully I listen when you talk
O little angle you are precious and grand

First Quarterly Report of Bangalore Society of Obstetrics & Gynaecology 2013-14

April – August 2013

1 **Installation Ceremony,**
Date: 21st April 2013
Venue: Hotel Atria

Office Bearers		Executive Committee
Dr. Jyothika Desai	President	Dr. Ashakiran
Dr. K.V. Malini	President Elect	Dr. Malathi T
Dr. Chandrika Muralidhar	Vice President	Dr. Mangala Devi
Dr. Shobha N. Gudi	Hon.Secretary	Dr. Prashant Joshi
Dr. Sheela C.N.	Joint Secretary	Dr. Savitha C
Dr. Jayanthi	Hon.Treasurer	Dr. Shailaja N
Dr. Vidya V Bhat	Imm. Past President	Dr. Shashikala Karanth
Dr. Susheela Rani	PG Forum Committee	Dr. Shirley George
Dr. Arulmozhi	PG Forum Committee	Dr. Tejavathy
Dr. Padmaja P	PG Forum Committee	
Dr. Kamini Rao	Invited Faculty	
Dr. Hema Divakar	Invited Faculty	
Dr. Sheela Mane	Invited Faculty	

Changing of Medallion

Dr. Evita Fernandes

Dr. Dhanya Kumar

We are glad to inform that our Investiture ceremony on the 21st of April 2013 was a grand success. Around 150 members attended the ceremony.

The first scientific session of the year featured OBGYN Watch, presented by Dr Narayanan. Dr Sheela V Mane, Vice-President Elect, FOGSI 2014, spoke next about the necessity of a Bangalore registry for SAMM and distributed the Proforma to Institutions and Private Hospitals. A SAMM Meeting would be held after 3 months, she said, to review the data. Invited speaker, Dr Evita Fernandez from Hyderabad, spoke on 'Ethics in Obstetric practice'. She stressed the importance of counseling before conducting investigations, procedures, etc. It generated a lot of interest and interaction. A panel on Fresh look at Fetal Growth Restriction, moderated by Dr Jyothika Desai, was conducted with panelists, Dr Uma Devi, Dr Shobha Gudi, Dr Susheela Rani and Dr Pratima Radhakrishnan. The Investiture started with the lighting of the traditional lamp, followed by a most soulful and melodious rendition of a prayer by Mrs Parimala Desai, Dr Mohini Prasad, was the master of ceremonies for the event. We were fortunate to have a Chief Guest as distinguished as Dr Dhanya Kumar, the Director of Health and Family Welfare Services, Govt of Karnataka. Dr Dhanya Kumar expressed his concern at the Maternal Mortality rates in Karnataka especially in the Northern districts and the increasing Cesarean Section rates. He offered his assistance to the Bangalore Society to decrease this unhealthy trend. Outgoing president, Dr.Vidya V Bhat addressed the audience next and gave an account of the programs and workshops during her tenure. It was a brilliant year indeed and Vidya surely raised the bar for subsequent years. It was time for the Medallion to change hands, from Dr.Vidya Bhat to Dr.Jyothika Desai. The incoming President, Dr Jyothika Desai addressed the gathering and expressed her proposals for the year and sought the cooperation of all to achieve the outlined goals. The logo for the year was presented as, "Together, let's make a difference". The Guest of Honour was our lovable and capable President of FOGSI, Dr Hema Divakar, who enthralled the audience as usual, with her speech.

On this occasion, we honoured our illustrious past presidents, Dr.Jaya Narendra and Dr.Pushpa Srinivas with the life time achievement award. We also felicitated Dr Kamini Rao, for being awarded the FIGO Best woman Obstetrician and Gynecologist award (2012) and the Medscape award for the same reason in 2013. Dr Sheela Mane, an enthusiastic FOGSIAN, was also felicitated for being elected as the Vice-President FOGSI, South Zone for 2014.

The Best Attendance awards were given to Mohini Jadwani, Dr.Lalitha Bhaskar, and Dr.Hansa Mehta. The much awaited BSOG Newsletter, "News and Views"," Tulanam", the Medicolegal newsletter and the calendar of events for the year were released and copies distributed amongst the members.

The Treasurer,

Dr Jayanthi

Thanked one and all

2 BSOG-FOGSI Key programme,

Date: 27th April 2013

Venue: Hotel Atria

BSOG along with FOGSI International Academic exchange committee organized a Key programme on Early Pregnancy Loss.

There was a lecture by **Dr. Howard Carp**, Professor, Obg Dept, Tel Aviv University, Israel. The programme was attended by 70 delegates.

Dr. Carp deliberated on Progesterone with emphasis on Immunomodulation & Recurrent Pregnancy Loss.

3 3.BSOG-RCOG Conference – A tribute to Late Dr.Sulochana Gunasheela

Date: 6th May 2013

Venue: Lalit Ashok Hotel

BSOG along with RCOG organized an interesting session on Dehydro-epiandrostenedione Sulphate in Diminished Ovarian Reserve with a talk by Dr Norbert Gleicher, Medical Director and Chief Scientist, CHR President, Foundation for Reproductive Medicine. A Memorial service to late **Dr. Sulochana Gunasheela** was also organized on the same day. BSOG members poured their heart out in memory of the doyen among gynecologists.

It was a memorable evening indeed. An Extra ordinary General body meeting was also conducted on the same day to express our solidarity and concern towards the ruling of the Karnataka Medical Council. It was well attended by 130 delegates.

Dr. Norbert Gleicher

3 Interface between mental health & obstetrics

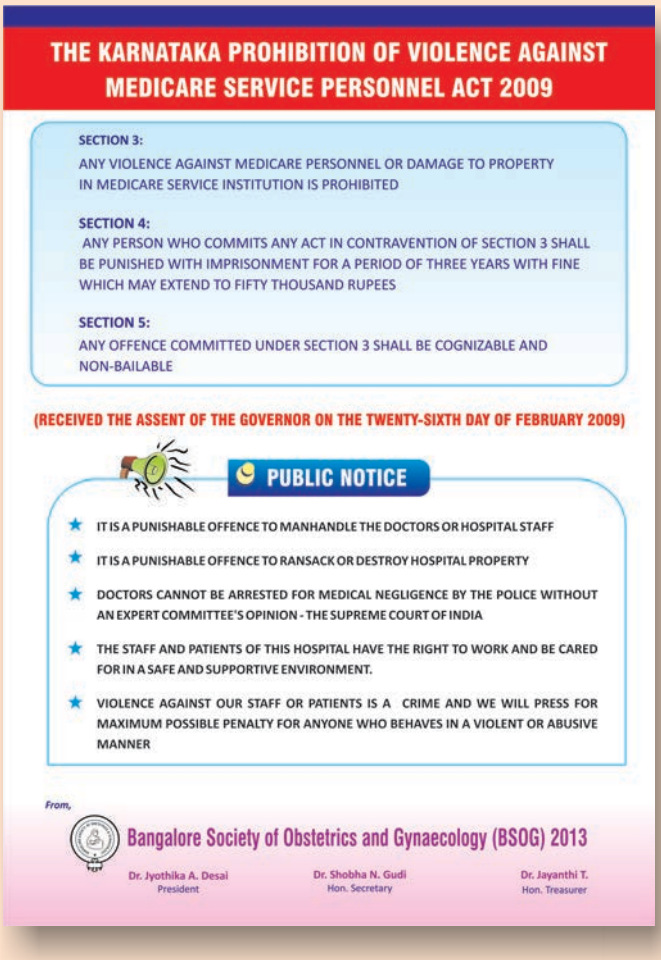
Date: 26th May 2013

Venue: BMC Alumni Auditorium

BSOG in association with NIMHANS organized a CME Interface between Mental Health and Obstetrics. Mental disorders during pregnancy and the postnatal period can have serious consequences on the health and wellbeing of the mother and her baby, as well as on her partner and the rest of the family. The CME was focused on psychiatric disorders in pregnancy and the puerperium. The knowledge of prediction, detection and treatment of mental disorders in women during pregnancy and the postnatal period (up to 1 year after delivery), remains elusive to most obstetricians. The CME was made interesting with role play by Interns & clinical discussions by experts with great scope for audience interaction.

The mental health experts, **Dr. Prabha Chandra**, **Dr. Santosh Chaturvedi, Dr. Geeta Desai & Dr. Veena Satyanarayana** from NIMHANS gave an insight into different aspects of psychiatric conditions in pregnancy.

It attracted around 90 delegates with good interaction. A Certificate of Attendance with 6 ICOG points was distributed to the attendees.



THE KARNATAKA PROHIBITION OF VIOLENCE AGAINST MEDICARE SERVICE PERSONNEL ACT 2009

SECTION 3:
ANY VIOLENCE AGAINST MEDICARE PERSONNEL OR DAMAGE TO PROPERTY IN MEDICARE SERVICE INSTITUTION IS PROHIBITED

SECTION 4:
ANY PERSON WHO COMMITS ANY ACT IN CONTRAVENTION OF SECTION 3 SHALL BE PUNISHED WITH IMPRISONMENT FOR A PERIOD OF THREE YEARS WITH FINE WHICH MAY EXTEND TO FIFTY THOUSAND RUPEES

SECTION 5:
ANY OFFENCE COMMITTED UNDER SECTION 3 SHALL BE COGNIZABLE AND NON-BAILABLE

(RECEIVED THE ASSENT OF THE GOVERNOR ON THE TWENTY-SIXTH DAY OF FEBRUARY 2009)

PUBLIC NOTICE

- IT IS A PUNISHABLE OFFENCE TO MANHANDLE THE DOCTORS OR HOSPITAL STAFF
- IT IS A PUNISHABLE OFFENCE TO RANSACK OR DESTROY HOSPITAL PROPERTY
- DOCTORS CANNOT BE ARRESTED FOR MEDICAL NEGLIGENCE BY THE POLICE WITHOUT AN EXPERT COMMITTEE'S OPINION - THE SUPREME COURT OF INDIA
- THE STAFF AND PATIENTS OF THIS HOSPITAL HAVE THE RIGHT TO WORK AND BE CARED FOR IN A SAFE AND SUPPORTIVE ENVIRONMENT.
- VIOLENCE AGAINST OUR STAFF OR PATIENTS IS A CRIME AND WE WILL PRESS FOR MAXIMUM POSSIBLE PENALTY FOR ANYONE WHO BEHAVES IN A VIOLENT OR ABUSIVE MANNER

From,
Bangalore Society of Obstetrics and Gynaecology (BSOG) 2013
Dr. Jyothika A. Desai, President
Dr. Shobha N. Gudi, Hon. Secretary
Dr. Jayanthi T., Hon. Treasurer

A Medico Legal Poster was released on this occasion. The poster was made available at the registration desk for all the members. The poster can be displayed at the reception of all the hospitals and clinics, in order to protect violence against medical practitioners and hospital staff.

4 Vision 2022

Date: 7th, 8th, & 9th June 2013

Venue: Hotel Lemeredian

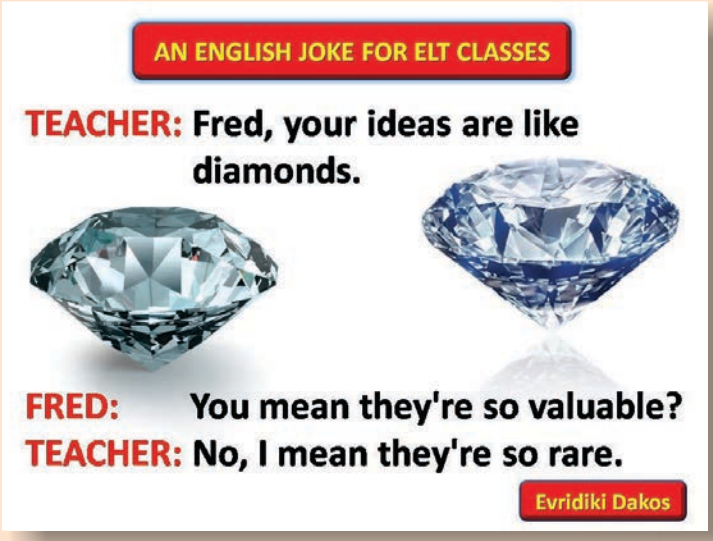
Vision 2022 was a FOGSI world congress in obstetrics and gynaecology, an international conference held on 7th, 8th & 9th of June 2013, at the Garden city Bengaluru.

Dr.Arulkumuran, Dr. Issac Manyonda, Dr. Issac Blickstein, Dr. Harshad Sanghvi, Dr. Mandeep Singh were the invited International faculty. The Scientific sessions involved 133 national faculty.

Conference had three pre congress workshops, USG – First things First, Endosutuing – Skills drills on Endo trainers, and Cancer Cervix workshop.

These workshops were held in parallel halls, on 7th June, from 9 am to 2 pm. All the halls were packed with delegates.

A FOGSI- Jhpiego meet was also organized, to discuss on the improvisations in the HMS Programme, with inputs from the Jhpiego team. The conference was well supported by BSOG and around 518 delegates participated. BSOG had organized a cultural extravaganza with Fancy Dress parade and Brides of India, which was much appreciated by



5 BSOG HCG CME on Advances in Oncology

Date: 16th June, 2013

Venue: Hotel Lemeredian




The CME was focused on advancements in the field of cancer screening, therapy and prevention. The CME dealt very effectively on breast cancer screening and advances in conservative treatment. A Panel Discussion on Cancer in Pregnancy moderated by **Dr.Sundari with Dr.Jyothika Desai, Dr.Malini, Dr.Shubha Rao, Dr.Rani Bhat and Dr.Kritika** as panelists was well received. The scientific content also included Young Talent Promotion with young gynecologists speaking on research in OBG and the now famous ObGyn Watchby **Dr .Narayanan**.

The CME included an invited lecture of **Dr .P K Sekharan** on Gestational trophoblastic disease. **Dr .Sekharan** spoke with clarity on the recent advances in the terminology and understanding of GTN. HCG Faculty kept the audience spellbound with their well construed lectures. The CME was attended by 150 members.

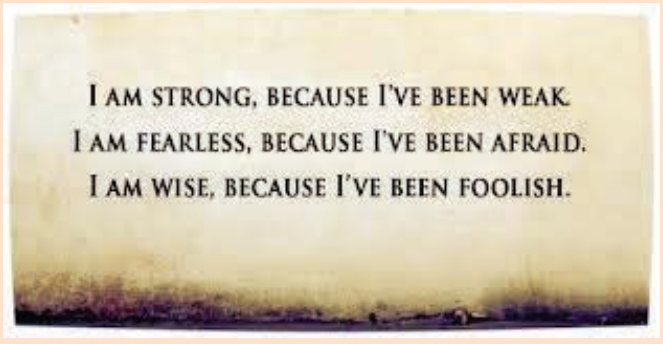
6 6.BSOG PG Forum CME for post graduates

Date: 20th, 21st, 22nd & 23rd of June 2013

Venue: API Bhavan


The immensely popular BSOG CME for post graduates had some new features this year. There was a Communications Workshop with Role plays and a CTG Workshop, apart from the hugely popular Drills. Renowned Teachers from all over the south were invited as faculty as in the past. We also had Dr Ashish Mukhopadyaya from Calcutta, **Dr. Pratap Kumar** from Manipal, **Dr. Ambarish Bhandiwad, Dr. Haresh Doshi** from Ahmedabad, **Dr.Sareena Gilvaz** to name a few. Case discussions, workshops on ultrasound, capsules on current issues, spotters, and SDPP and ward rounds were conducted as usual.

Students were trained in how to decrease maternal deaths due to PPH and Eclampsia by drills with an innovative birth simulator, 'Mamma Natelle ". **Dr Ramamurthy** was presented with the Teacher par Excellence Award during the current CME.



7 Live office hysteroscopy workshop : BMC auditorium

Date: 7th July 2013, 9am to 4.30 pm

Venue: Relayed from Rangdore hospital, Bangalore

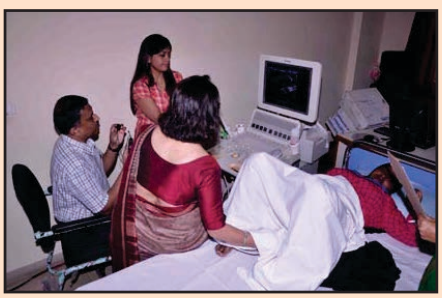
BSOG along with RCOG conducted a live workshop on Office Hysteroscopy. All cases which need Theatre Hysteroscopy can be tackled in the Office- was demonstrated by **Dr.Janesh Gupta** from UK along with **Dr.Ramesh**. The cases were contributed by Dr Vidyamani, **Dr.Malini, Dr Geeta Shanbagh** and **Dr.Latha Venkatram** with excellent support from the team from Rangadore hospital. **Dr.Janesh Gupta** also delivered lectures on the use of LNG IUS and the scope of office hysteroscopy. **Dr .Sheela Mane** and **Dr.Pratima Reddy** spoke on post-menopausal bleed and medical management of AUB respectively. The young talent promotion was in full swing with **Drs.Shashikala, Shefalika , Kavitha Reddy** and **Aruna Muralidhar** speaking on details of equipments, analgesia, guidelines and complications. The related topic of non resectoscopic endometrial ablation was jointly addressed by **Drs.Shobha Gudi** and **Parimala Devi**. About 100 delegates benefitted from this session, jointly organised by **Dr.Jyothika Desai** and **Dr.Latha Venkatram.**

8 Ultrasound in Gynecology Workshop

Date: 28th July 2013

BSOG conducted a very successful Workshop on Ultrasound in Gynecology on the 28th of July at the BMC Alumni Auditorium. As usual, the program started with 2 young speakers, **Dr.Asha Kiran** and **Dr.Nitya**, followed by the now famous Obg Watch delivered by Dr Narayanan in his impeccable style. After 2 very well spoken talks by **Dr.Supriya Seshadri** and **Dr.Chitra Ganesh**, the workshop commenced. The whole of Gynecology appeared to be there on that day. It was a veritable feast to both the 150 delegates and the sonologists, **Dr.Rammurthy, Dr.Preiti Venkatesh, Dr.Chitra Ganesh** and **Dr.Nitya Kalyani** from Mediscans, Chennai. All kudos to **Dr .Malini, Dr.Nagaratnamma, Dr.Shubha Rao, Dr.Jayanthi, Dr.Vatsala, Dr.Manjula, Dr.Sumitra** and **Dr.Geeta Shanbag** for getting 32 interesting cases for ultrasound. Just a word about the Audiovisual- it was simply superb. Dr Supriya Seshadri,BSOG wants to convey its gratitude to all, including the patients, who contributed in the dissemination of knowledge. The patients were given breakfast, lunch and a token amount to cover for their travel expenses. One observation was that even the patients appeared to be very happy at the end of the day, as they had been scanned by the very experts in the field. To top it all, **Dr.Venkatesh** had excelled himself in the choice and taste of the food provided. All in all, a very satisfying experience indeed.

The BSOG Round of the FOGSI Usha Krishna Quiz was also held on 28th July in the afternoon. A record of sorts was made when 53 postgraduates participated in the written Quiz on Reproductive Endocrinology. Apart from the 2 winners, **Dr.Devika** and **Dr.Sheetal**, both from Marthas Hospital, the rest of the postgraduates also were very happy because the President, **Dr.Jyothika Desai** had organized books and participation certificates for all the participants. The quiz questions and the answers key have subsequently been uploaded on the BSOG website for all interested.



9 CME on Breast & Hormones

Date: 11th August 2013

Venue: Chinmaya Mission Hospital Auditorium

BSOG in association with IMS Bangalore Chapter organized a half day CME on Breast and Hormones on 11th August 2013. Around 50 delegates participated. The CME was quite informative with added inputs from eminent faculty. **Dr.Somashekar, Dr.Mahesh, Dr.Arun Kekre, Dr.Poonam Patil, Dr.Niti Narang, Dr.Vadiraj** and **Dr.Sheela Mane** spoke on the occasion. The Panel Discussion on case scenarios of breast cancer was very brilliantly moderated by Surgical Oncologist, Dr.Somashekhar.


10 CME jointly organized by the Blood Transfusion Society of India and BSOG

Date: 14th August 2013

Venue: 10.Chinmaya Mission Hospital Auditorium , 2 pm to 5 pm

Dr Shivaram, Dr Joshua Daniel, Dr Sabita and Dr Seetalaxmi deliberated on the need for testing Red cell Antibodies routinely in pregnancy along with Thalassemia screening. Protocols for Massive Blood Transfusion were discussed and debated over. The exchange of views between the two specialties generated a lot of debate.


14th August was also celebrated as it was the day BSOG was founded 45 years back. Senior members – Dr Sita Bhatija, who is the sole surviving Founder member, Dr Pushpa Srinivas, Dr Jaya Narendra, etc who had been specially invited were requested to cut a cake wishing BSOG a long successful innings. Dr Hema Divakar, President FOGSI also participated in this joyous event


11 Contraception Update jointly organized by BSOG – MSD

Date: 23rd August 2013

Venue: Hotel Atria, 2-5 pm

An afternoon session on a Friday was surprisingly very well attended by 90 members. The session started with an interesting talk by Dr Vidyamani on RCOG Guidelines for unscheduled bleeding while on contraception. Dr Sheela Mane next spoke at length on the current concepts on Progesterone in COCs. The session ended with a Panel Discussion on WHO-MEC Clinical scenarios, moderated by Dr Jyothika Desai with the panelists being Dr Shobha Gudi, Dr Narayan Swamy, Dr Gangarani and Dr Aruna Muralidhar. With audience participation at its maximum, the discussion was very well appreciated by all.



"The Door Step to the Temple of Wisdom is a Knowledge of your own Ignorance" – Benjamin Franklin

12 BSOG CME

Date: 25th August 2013

Venue: Hotel Capitol, 10.30 to 1.30 pm

This was a totally different CME. We had a Dermatologist, Dr Shenoy, speaking on PUPPP, followed by a Gastro-Enterologist, Dr Dinesh Kini, speaking on Intrahepatic Cholestasis of Pregnancy. The two speakers were excellent orators and the Intricacies of these two conditions were beautifully unraveled by them. There was understandably a lot of discussion. The icing on the cake was provided by Dr P.C Mahapatra, who kept the audience Spellbound by his erudite rhetoric on Maintenance of Pregnancy- Current Concepts. There was an eruption of a volley of questions after the talks, which were answered by Dr Mahapatra with his inimitable style. All in all, a very satisfying meeting indeed.





13 CCCIP, 1st session in KIMS on 25th August 2013 Regional Faculty Dr Gomathy, Dr Jayanthy

Date: 25th August 2013, Venue: KIMS Auditorium

National Coordinator- Dr Shobha Gudi. Chief Guest Dr Sheela Mane, Guest of Honour – Dr Jyothika Desai.

Around 26 delegates participated.



13 Symposium on bridging the gap and optimizing oral contraception usage.

Date: 31st August

Venue: Fortune Park

Dr. Anitha Nelson Harbor UCLA, Medical Centre

Dr.Anitha Nelson

Purely Business

Dad: I want you to marry a girl of my choice.
Son: No!
Dad: The girl is Bill Gates' daughter.
...Son:Then okay.
Dad goes to Bill Gates.
...Dad: I want your daughter to marry my son.
Bill Gates: No!
Dad: My son is the CEO of World Bank.
Bill Gates: Then okay.
Dad goes to the President of the World Bank.
Dad: Appoint my son as CEO.
President:No!
Dad: He is the son-in-law of Bill Gates.
President:Then ok.

Bechara Kameena

15 CME on Adolescence

Date: 22nd September

Venue: CD Sagar Hall, Sagar Hospitals

BSOG in association with Sagar Hospitals organized a CME on Adolescence on 22nd September 2013 at CD Sagar Hall, Sagar Hospitals, Kumaraswamy layout, Bangalore.

As gynaecologists of this fast growing, economically unstable

in adolescent health care. Adolescence is a time of major transition, several positive and negative lifelong behaviors are established during adolescence including diet and exercise, sexual conduct, practices related to oral health, smoking, drinking, and the use of illegal substances. These complex issues were discussed during this CME. Dr.John Vijay, Dr. Preeti Galigali gave lots of information on Pshyco social issues and life skills. Young doctors of CSI hospital performed a role play on sexual assault, one of the main issues the country is facing today.

Other topics like PCOS in adolescence, managing menstrual problems in adolescence, teenage pregnancy, vaccination and contraception in adolescents were also been discussed.

The CME was attended by 50 delegates. It was well organized by Sagar Hospitals and relentlessly progressive nation we need to improve our skills

PROGRAMME

9.15 am	Invocation – *Ms. Saraswati (Sagar Hospital)*
Welcome	*Dr. Shobha Gudi (Secretary BSOG)*
9.30-11.45 am	"The Elixir of Youth"
	Chairpersons: Dr. Chandrashekhar M.R., Dr. Sheela Mane
9.30-10 am	Young Talent Promotion:
	Sexual Assault- Role Play - *Dr. Nitya, Dr. Meenakshi, Dr. Venu and Dr. Sindhu* from CSI Hospital - 10 mins
	Talk on Sexual Assault - *Dr. Namrata*, CSI - 10 mins
	A case of Hirsutism - *Dr. Nisha Manjal*, Sagar Hospital - 10 mins
10.00-10.20 am	Psycho-social issues in Adolescents - *Dr. K John Vijay Sagar*
10.20-11.00 am	Life Skills in Adolescents (with Role Plays) - *Dr. Preeti Galgalli*
11.00-11.15 am	Interaction
11.15-11.30 am	Vaccination in adolescence— *Dr. Gayatri Kamath*
11.30-11.45 am	Tea Break
11.45 am-1.30 pm	"The Bane of Youth"
	Chairpersons: Dr. Jyothika Desai, Dr. Thejavathy
11.45-12.00 noon	PCOS in Adolescents by *Dr. Anuradha* (Paediatric Endocrinologist)
12.00-12.20 pm	Managing Menstrual Problems in Adolescents – *Dr. Chandrika Muralidhar*
12.20-12.40 pm	Teenage Pregnancy - *Dr. Malini*
12.40-01.00 pm	Contraception in Adolescents - *Dr. Shobha Gudi*
01.00-01.30 pm	Interaction
Vote of Thanks	*Dr. Jayanthy, Hon Treasurer, BSOG*
National Anthem followed by Lunch	

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BSOG-MSCC CME on Oncology

Date: 27th September 2013

Venue: Hotel Lemeredian Bangalore

BSOG joined hands with Mazumdar Shaw Cancer Centre to present an interesting array of hitherto less explored areas in Gynec Oncology. It was an enriching experience to tackle better the deadly scourge of cancer. Invited faculty Dr. Bafna, Dr. Anuradha Kannan, Dr.Suchitra Rao and Dr.Vani Kumar spoke very well at the CME. Delegates who attended, were of the opinion that CMEs of this type were more interesting and informative and they would look forward to more such CMEs. Inspite of a short notice, around 85 delegates attended the CME


BSOG-MSCC CME on Oncology
on Friday, the 27th of September
@ Le Meridian

TIME	TOPIC
1.30 - 2.30	Lunch
2.30	Welcome by Dr Shobha Gudi (Hon Secretary) Chairpersons Dr Padmini Isaac, Dr Shakuntala Baliga, Dr. Jyothika Desai
2.30 - 2.45	The dilemma of Endometrial Ca in a young nullipara Dr. Suchitra Rao
2.45- 3.00	Ovarian cancer and Fertility treatment- Is there a connection? Dr. Anuradha Kannan
3.00 - 3.15	Can Laparoscopy be the primary mode of surgery in Genital cancer? Dr. Bafna
3.15 - 3.30	Feasibility of LBC as a primary screening modality for cervical cancer. Dr. Vani Kumar
3.30 - 3.45	Biomarkers in Gynec Malignancy - How relevant? Dr. Bafna
3.45 - 4.00	Hope of Fertility in cancer survivors Dr. Devika Gunasheela
4.00	Vote of Thanks, Dr. Jayanthy National Anthem Hall Coordinators...

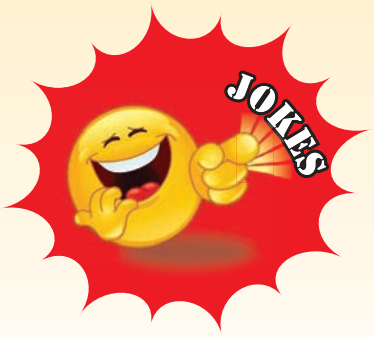
Venue: Le Meridian
Address: 28, Sankey Rd, Vasanth Nagar, Bangalore, KA 560052
Contact No: RSP - Suresh : 9845382072
Call to Coordinate : Dr. Manjula J.V

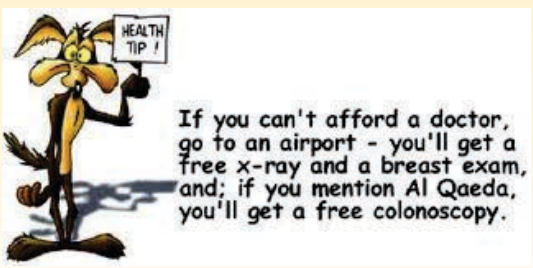
VISION 2022 – CULTURAL GALA

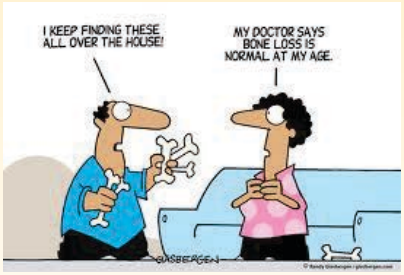
VISION 2022 – CULTURAL GALA











Stress Management by **Dr Thimmapa Hegde**

Managing stress is all about changing your thoughts.

Gautama Buddha had said.

"Watch your thoughts, they become words.

Watch your words, they become actions.

Watch your actions, they become habits.

Watch your habits, they become character.

Watch your character, for it becomes... your destiny."

So change your thoughts, change your destiny.

Become aware of the source of stress in your life

To identify your true sources of stress, look closely at your thoughts and attitude. Until we accept responsibility for the role we play in creating or maintaining it, our stress level will remain outside our control.

"I am the problem, I am the solution."

Maintain a Personal Log and look at how you currently cope with stress

This will help us identify the regular stressors in our life and the way we deal with them. Each time we feel angry or upset, keep track of it. As we keep a daily log, we will begin to see patterns and common themes. Note the following:

What caused our stress? How intense was our feeling? How did we react or respond and how quickly did we recover?

Are our coping strategies healthy or unhealthy, helpful or unproductive? Unfortunately, many people cope with stress in ways that compound the problem.

Unhealthy ways of coping with stress

These coping strategies may temporarily reduce stress, but they cause more damage in the long run:

Smoking, drinking too much

Overeating or under eating

Spending hours in front of the TV or computer

Withdrawing from friends, family and activities

Using pills or drugs to relax. Sleeping too much

Procrastinating

Filling up every minute of the day to avoid facing the problem, taking out your stress on others (lashing out, angry outbursts, and physical violence)

Learning healthier ways to manage stress

We can either change the situation or change our reaction. When deciding which option to choose, it's helpful to think of the four "A"s avoid, alter, adapt, or accept.

Since everyone has a unique response to stress, there is no "one size fits all" solution to managing it. No single method works for everyone or in every situation, so experiment with different techniques and strategies. Focus on what makes you feel calm and in control.

Stress management strategy #1: Avoid unnecessary stress

Not all stress can be avoided, and it's not healthy to avoid a situation that needs to be addressed. You may be surprised, however, by the number of stressors in your life that you can eliminate.

Learn how to say "no" cheerfully and firmly – Know your limits and stick to them. Whether in your personal or professional life, refuse to accept added responsibilities when you think you cannot take it. Taking on more than you can handle, is a sure recipe for stress.

Avoid people who stress you out – If someone consistently causes stress in your life and you can't turn the relationship around, limit the amount of time you spend with that person or end the relationship entirely if possible.

Cut down your to-do list – Analyze your schedule, responsibilities, and daily tasks. If you've got too much on your plate, distinguish between the "shoulds" and the "musts." Drop tasks that aren't truly necessary to the bottom of the list or eliminate them entirely.

Stress management strategy #2: Alter the situation

If we can't avoid a stressful situation, try to alter it. Figure out what we can do to change things so the problem doesn't present itself in the future. Often, this involves changing the way we communicate and operate in our daily life.

Express your feelings instead of bottling them up.

Be willing to compromise.

Be more assertive.

Manage your time better.

Stress management strategy #3: Adapt to the stressor

If we can't change the stressor, change yourself. We can adapt to stressful situations and regain our sense of control by changing your expectations and attitude.

Reframe problems. Try to view stressful situations from a more positive perspective.

Look at the big picture. Take perspective of the stressful situation. Ask yourself how important it will be in the long run. Will it matter in a month? A year? Is it really worth getting upset over? If the answer is no, focus your time and energy elsewhere.

Adjust your standards. Perfectionism is a major source of avoidable stress.

Focus on the positive. When stress is getting you down, take a moment to reflect on all the things you appreciate in your life, including your own positive qualities and gifts. This simple

strategy can help you keep things in perspective.

Stress management strategy #4: Accept the things you can't change

Some sources of stress are unavoidable. You can't prevent or change stressors such as the death of a loved one, a serious illness, or a national recession. In such cases, the best way to cope with stress is to accept things as they are. Acceptance may be difficult, but in the long run, it's easier than railing against a situation you can't change.

Don't try to control the uncontrollable

Share your feelings. Talk to a trusted friend.

Expressing what you're going through can be very cathartic, even if there's nothing you can do to alter the stressful situation.

Learn to forgive. Accept the fact that we live in an imperfect world and that people make mistakes. Let go of anger and resentments. Free yourself from negative energy by forgiving and moving on.

Stress management strategy #5: Make time for fun and relaxation

Beyond a take-charge approach and a positive attitude, you can reduce stress in your life by nurturing yourself. If you regularly make time for fun and relaxation, you'll be in a better place to handle life's stressors when they inevitably come.

Healthy ways to relax and recharge

- Go for a walk.
- Spend time with nature.
- Call a good friend.
- Write in your journal.
- Take a long bath.
- Watch a comedy.
- Play with a pet.
- Work in your garden.
- Get a massage.
- Read a good book.
- Listen to music.

Don't get so caught up in the hustle and bustle of life that you forget to take care of your own needs. Nurturing yourself is a necessity, not a luxury.

Set aside relaxation time. Include rest and relaxation in your daily schedule. Don't allow other obligations to encroach. This is your time to take a break from all responsibilities and recharge your batteries.

Connect with others. Spend time with positive people who enhance your life. A strong support system will buffer you from the negative effects of stress.

Do something you enjoy every day. Make time for leisure activities that bring you joy, whether it be stargazing, playing the piano, or working on your bike.

Keep your sense of humor. This includes the ability to laugh at yourself. The act of laughing helps your body fight stress in a number of ways.

Stress management strategy #6: Adopt a healthy lifestyle

You can increase your resistance to stress by strengthening your physical health.

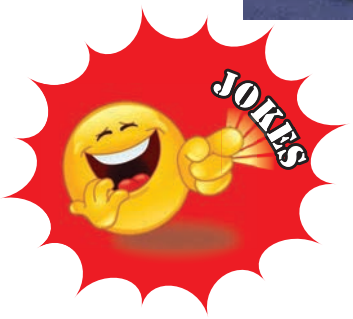
Exercise regularly. Physical activity plays a key role in reducing and preventing the effects of stress. Make time for at least 30 minutes of exercise, at least three times per week.

Eat a healthy diet. Well-nourished bodies are better prepared to cope with stress, so be mindful of what you eat. Start your day right with breakfast, and keep your energy up and your mind clear with balanced, nutritious meals throughout the day.

Reduce caffeine and sugar. The temporary "highs" caffeine and sugar provide, often end in with a crash in mood and energy. By reducing the amount of coffee, soft drinks, chocolate, and sugar snacks in your diet, you'll feel more relaxed and you'll sleep better.

Avoid alcohol, cigarettes, and drugs. Self-medicating with alcohol or drugs may provide an easy escape from stress, but the relief is only temporary. Don't avoid or mask the issue at hand; deal with problems head on and with a clear mind.

Get enough sleep. Adequate sleep fuels your mind, as well as your body. Feeling tired will increase your stress because it may cause you to think irrationally.



Great Thoughts by Great personalities!!

"This History of the World is but the Biography of Great Men"

- Thomas Carlyle

Herlyn WernerWunderlich syndrome - A diagnostic dilemma

Dr. Nageshu S. (Associate Professor),

Dr. Krishna K. (PG),

Dr. Lingegowda K. (Professor),

Dr. Bhat B.S. (Professor),

Dr. Kulkarni N. (Assistant Professor)

Dept of Obstetrics & Gynaecology, PESIMSR, Kuppam

INTRODUCTION

EMBRYOGENESIS

Herlyn-Werner-Wunderlich (HWW) syndrome is a very rare congenital anomaly of the urogenital tract involving Müllerian ducts and Wolffian structures, and it is characterized by the triad of didelphys uterus, obstructed hemivagina and ipsilateral renal agenesis. According to the American Society for Reproductive Medicine (ASRM) classification, HWW syndrome appears to include the addition of III uterine anomaly to Ia vaginal anomaly and renal agenesis. The incidence is approximately 1/2,000 to 1/28,000, and it is accompanied by unilateral renal agenesis in 43% of cases. 1 HWW syndrome represents a type of Müllerian duct anomaly (MDA) associated with mesonephric duct anomaly. The exact cause, pathogenesis and embryologic origin of HWW syndrome are unclear and remain a subject of discussion. The Wolffian ducts, besides giving origin to the kidneys, are also inductor elements for adequate Müllerian ducts fusion. Therefore the developmental anomaly of the caudal portion of one of the Wolffian ducts may be the cause of unilateral renal agenesis associated with imperforate hemivagina .On the side where the

Wolffian duct is absent the Müllerian duct is displaced laterally so it cannot fuse with the contralateral duct, resulting in didelphic uterus,and cannot come into contact with the urogenital sinus centrally. The contralateral Müllerian duct gives rise to a vagina while the displaced component forms a blind sac—an

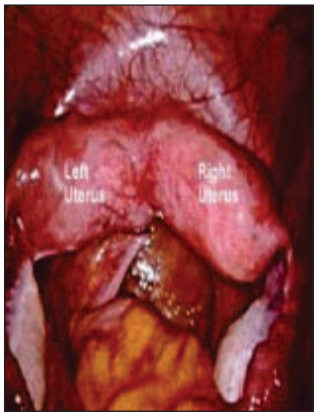
Imperforate or obstructed hemivagina. The vaginal introitus is not involved because of its origin from the urogenital sinus. 2-5

EXAMINATION

An adolescent girl aged 15yrs came with complaint of lower abdominal pain for last three months. Lower abdominal pain was present on right side, spasmodic type, progressive, intermittent, radiating to low back,not relieved after taking medication, associated with sensation to defecate. She attained menarche at 13yrs. Cycles were regular 3-4 days in 28-30 days, normal flow, and spasmodic dysmenorrhea was present. Vital parameters, general physical and systemic examinations were normal. Abdominal examination revealed a tender mass of 5×5 cm in the right iliac fossa, smooth surface, and restricted mobility with ill-defined borders. On percussion dull note was heard over the mass. On local examination - External genitalia were normal and hymen was intact, perforated. On Per rectal examination - A firm mass was felt filling the vagina in continuity with the abdominal mass. Uterus was not felt separately.

INVESTIGATIONS

USG abdomen and pelvis showed theabsence of right kidney and the possibility of uterine anomaly. MRI imaging showed a uterine-vaginal anomaly consisting of didelphys uterus and double vagina, one of which was obstructed, consequently there was accumulation of fluid exhibiting hematometra, right hematosalpinx, enormously enlarged the right obstructed vagina and absent right kidney. MANAGAGNOSIS



MANAGEMENT

Diagnostic laparoscopy was followed by right sided laparoscopic total salpingectomy, excision of transverse vaginal septum on right side and drainage of haematocolpos followed by vaginoplasty.

Intra operative findings

- Uterus didelphys

- Transverse vaginal septum on right side

- Right sided hematocolpos, haemotometra and hematosalpinx.

DIAGNOSIS

Uterus didelphys with right sided obstructing transverse vaginal septum with right hematocolpos , hematometra and hematosalpinx with absent right kidney.

DISCUSSION

Delay in diagnosis has been attributed to regular menstruation in the context of an incomplete vaginal outlet obstruction and slow extension of hematocolpos. Delayed diagnosis can lead to complications that include endometriosis, adhesions, infertilit y and infectious complications arising from chronic cryptomenorrhoea.

The diagnosis should be suspected in cases of women presenting with pelvic pain and a pelvic mass with ipsilateral renal agenesis. Systematic analysis of the literature suggests management of these cases consist mainly of vaginoplasty with excision of the vaginal septum in order to prevent the long term complications.6

CONCLUSION

It could be desirable to achieve an early diagnosis and treatment of HWW syndrome, in order to relieve acute symptoms, preserve normal fertility and prevent several medical complications. Unlike an isolated transverse vaginal septum, the vaginal septum with HWW syndrome is parallel to the patent vaginal canal, less pliable, and closer to the cervix. These anatomical differences result in pronounced distortion with significant diagnostic and surgical challenges.

UTERINE ARTERY EMBOLISATION: AN EFFECTIVE METHOD FOR TREATMENT & PREVENTION OF POSTPARTUM HEMORRHAGE

Dr. Sunil Tambavekar,
Dr. Shobha N. Gudi, Dr.Shylaja .A.S.,
Department of Obstetrics & Gynaecology,
St. Philomena's Hospital, Bangalore

This retrospective study was conducted to evaluate the

Efficacy of Uterine Artery Embolization for control of intractable postpartum hemorrhage & its role as a prophylactic measure to prevent anticipated postpartum hemorrhage.

The maternal mortality in India shows a national average of 212 per one lakh live births1. These figures are much higher than the developed countries and far out of proportion to the industrial and technological development that this country has shown, reflecting the inadequate preparedness of our healthcare system for tackling Obstetric emergencies. Obstetric hemorrhage is an important cause of maternal mortality responsible for approximately 25%of all deaths. Primary atonic postpartum haemorrhage is the commonest cause of such mortalities. The Conservative methods for managing primary PPH areuterotonic agents, uterine massage, brace sutures, uterine packing and transfusion. For those refractory to conservative treatment hysterectomy becomes mandatory. Since the past 2 decades, pelvic arterial embolization (PAE) has been shown to be an effective alternative to surgery. Uterine Artery Embolization was introduced as a treatment for PPH in 19793; high technical success rates and good clinical outcomes for the treatment of primary and secondary PPH have been reported since then4

Between June 2010 to May 2011 total 7 obstetric patients underwent embolization techniques at St. Philomena's Hospital. Three women underwent therapeutic embolization to control intractable PPH namely Primary atonic PPH, Primary Traumatic PPH and Secondary PPH in presence of warfarin toxicity in DVT. In 4 selected women prophylactic UAE was planned. Among these, only one woman actually underwent UAE as PPH was encountered, a case of Placenta accreta with previa with previous caesarean scar.

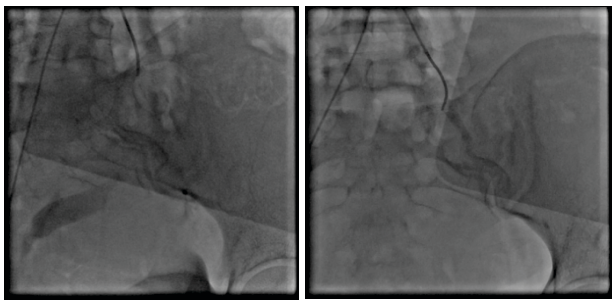
Method used: Contrast angiography in Cath lab by interventional radiologists. The dye used was non ionic contrast media; Inj. Ioversol 4 to 6 Fr.Catheters were inserted with help of guide wire in a retrograde fashion through the femoral artery.

For embolization Poly vinyl alcohol (PVA) particles, 300-500 mcg size, averagely one million in number were used; except in one case where Gel foam particles were used.

Case scenarios:

25 years old P2L2 referred in view of traumatic PPH at 5 hrs after instrumental vaginal delivery in a state of shock, with vaginal pack in situ. She was admitted & resuscitated in MICU.

On vaginal exploration, tear on left lateral wall & fornix noted, which could not be adequately sutured even under general anesthesia and bleeding continued. On exploratory laparotomy no intraperitoneal bleeding found and the uterus was well contracted. Pelvic angiography was done and left uterine artery embolization performed after knotting extravasation from descending vaginal branch of left uterine artery.



In this case of primary traumatic PPH, there was an estimated loss of 2000ml of blood, transfusion was of 8 units PRBC and 2 units FFP, optimal control of blood loss was achieved and recovery uneventful. On follow up, menstruation returned after five months of lactational amenorrhea, was on barrier and calendar method of contraception and conceived after 8 months with failure of contraception.

33 years P2L2, presented with profuse PV bleeding, on day 40 after FTVD.

She was on Warfarin therapy for deep vein thrombosis since 1 month. The peripartum history was of a FTVD on 06/06/2010, was detected as left lower limb DVT after 1 week. She was sent home on T. warfarin 7.5 mg OD.

She did not maintain follow up for monitoring of PT INR

and presented with secondary PPH with an involuting uterus but severe bleeding. Resuscitation & stabilization done in MICU. A diagnosis of Warfarin toxicity was made with an estimated blood loss of 2500 ml requiring transfusion of 13 units FFP, 6 units WB, 7 units PC .Left Internal iliac artery embolization performed after confirming the extravasation of blood. There was adequate haemostasis and she recovered well. She regained cycles after 5 months and is on barrier contraceptives and regular follows up with the physician.

30 years old primi had primary - atonic PPH after full

term normal vaginal delivery. She did not respond to medical management. After counseling for laparotomy – brace suture / hysterectomy vs uterine artery embolization, patient agreed for the latter.Bilateral uterine artery embolization performed. This case had an estimated loss of 1500 ml and received 3 unit's whole blood and 3 units of PRBC. She recovered well and has been on barrier contraception for one year, regained menstruation after 7 months of lactational amenorrhea.

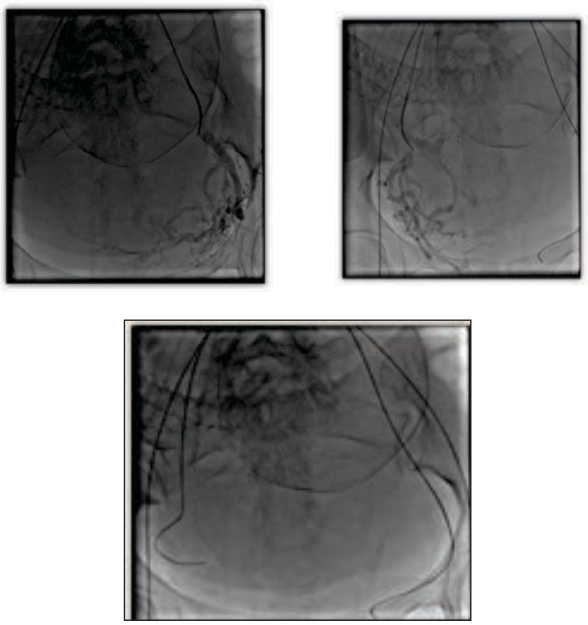
1. G2P1L1, 36 weeks, Placenta previa with previous caesarean scar.

2. Primigravida, 35 weeks, complete placenta previa.

3. G2P1L1, 37+1 week, Placenta accreta with previa with previous caesarean scar with breech presentation with Rh Negative pregnancy.

4. G3P2L2, 36 weeks, Placenta previa with previous caesarean scar.

In all the above cases planned Caesarian section was scheduled. Preoperatively, the women were taken to Cath lab and guide wires kept in place in the uterine vessels after angiography. In three of these cases, no further intervention was required as intraoperative blood loss was not severe and the guide wires were removed few hours after surgery. In the third case, 25 years old, G2P1L1, 37+1 weeks, Placenta accreta with previa with previous caesarean scar with breech presentation with Rh Negative pregnancy during the elective LSCS, it was found that LUS was thinned out with tortuous vessels. After placental extraction, severe PPH was encountered, from the placental bed along with atonicity, interventional radiologists were then able to visualize the bleeding vessels under C arm guidance, as the guide wires were already in place, a quick injection of gel foam particles could achieve hemostasis, which was also evident in the surgical field. There was an estimated blood loss of 1500ml and transfusion of 4 units of PRBC was done. The patient recovered well except for on the 6th post op day manifested with left lower limb DVT and was treated with anticoagulants.



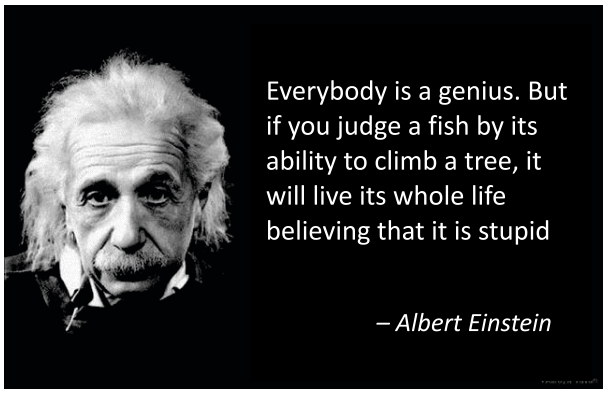
On follow up regained regular cycles with normal flow after 6 months of lactational amenorrhea later underwent sterilisation.

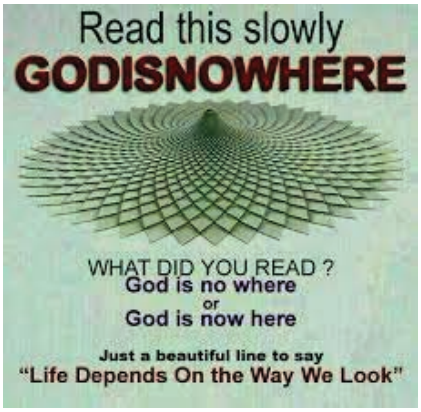
Conclusions:

- In all cases optimal bleeding control was achieved. No failure of embolization noted.
- Hysterectomies were prevented. Post procedure morbidities & duration of hospitalization were less.
- No severe complications noted; one patient who developed transient ischemic pain & DVT in lower limb, treated & resolved.
- No alteration in menstruation pattern or flow noted.
- One patient conceived spontaneously after 8 months, others are on contraception. Control bleeding in intractable PPH of any etiology.
- The high success rate, low morbidity rate, less rate of blood transfusions & preservation of reproductive function makes UAE highly

effective therapeutic &prophylactic measure to control bleeding in intractable PPH of any etiology.

- The method is underused. If promoted, it'll help to reduce maternal morbidity & mortality.
- Higher usage of the method will allow us to evaluate the





PAPERLESS PARTOGRAM

Dr A K Debdas Rajkumari Foundation, Jamshedpur, India, debdas2000@gmail.com

It is a simple three (3) step system of management of labor recorded in a simple 'at a glance' SINGLE sheet with a warning system by a red circle. It is actually a no fuss Graphless system but it is popularly referred in the net as the 'Paperless Partogram'

The 3 Steps:

Calculation of two 'ETD's (the Expected 'Time' of delivery) –

This is a split- second mental job-see below. These time figures are then to be written down in front of the case sheet in BIG BOLD letters-which instantly and effortlessly programmes the labor by pronouncing the reasonable 'time-END POINT' of labor- -say 8 PM.

Three (3) subsequent PVs at roughly 2- 3 hourly interval

Following the rule of 7 - for the management of slow labors & tracking of simple 3 Cs and 3 Ds for ensuring total safety and documentation

I- Calculation of two ETDs - This is to be done at the very first PV in the 'active phase' of labor when the cervix is at least 4 cms dilated – by application of the Friedman's

Formula of average rate of cervical dilatation in labor of 1 cm/hour.

Here is an example as to how to calculate the ETDs: Suppose a patient has come at

2 PM and on PV her dilatation at that point of time was found to be 4cm-then her first

ETD-the 'Alert ETD' would work out as 2PM+6 hours = 8 PM (this 6 hours is for the remaining 6cm that she has to dilate to become 10cm or fully at 1cm/hour) Just

mental addition of 4 hours to the Alert ETD would give the 'Action ETD' (8PM+4 hours =12 midnight).

As mentioned above, these two time figures are to be written in BIG bold letters infront of the case sheet for everyone to notice and work towards it, which thereby would totally eliminate prolonged and obstructed labor with no botheration or time expenditure or cost.

Moreover, this mental tool also ensures

'a) Transparency' of labor management, 'Easy and frank counseling' of the patient and her relations because everybody understands time, not graphs and also c)'timely transfer' of slow cases from remote rural centres to higher centres. This way, there would still remain four hours in hand (to the 'Action ETD' time point) to cover long distances and bad roads. Stamping ETDs also instills mental peace to the mother and all concerned by easing the uncertainty.

Working significance of the two ETDs

Alert ETD-Pt has reached her Alert ETD and not delivered yet-Get Alerted

Action ETD- Pt has reached her Action ETD and delivery is not imminent-Get active II- Three (3) subsequent PVs at roughly 3 hourly interval –Besides the 3 classical Ps (see below), in these examinations one has to particularly check whether the dilatation is occurring at –

The average rate of 1 cm/hour (ranging from 0.5-1.5 cm/ hour) or

At a much slower rate or

Not at all.

How to manage the slow cases: Determine the cause of slowness which has to lie in one of these 3 'P's – the power, passage and passenger or their combination and treat the cause so as to deliver by at least the 'Action ETD time'.

Simple management guideline for slow dilators-Formula of seven (7):

- Slow dilatation between 4-7 cm - it indicates probable power failure-Augment after exclusion of any mechanical problem..

- Slow dilatation between 7-10 cm – indicates probable mechanical problem e g

Deflexion, OP position, Malpresentation, CPD. Such cases need Specialist's evaluation and suitable action.

NOTE: According to literature “cervical dilatation is the only exact arbiter of progress in labor” (Studd, Cardozo and Gibb, 1982).

Scope of ARM -It may be done at any dilatation in the active phase of labor I e., from 4 cm onwards (WHO, 1994).

III- Tracking of 3 Cs and 3 Ds by the Nurses and charting the findings on a conventional chart paper in the usual longitudinal manner 'in numbers & words' (not in graphs which often staff-both doctors & Nurses hate to make in India) (No counting of tiny boxes. No dotting. No graphing. No wasting of time in maintaining such a chart)

C-1: Care of mother - T/P , BP

C-2: Care of fetus- FHR & Meconium

C-3: Care of contraction - how many per 10 minutes

D-1: Drugs

D-2: Drip

D-3: Drainage of urine

NOTE

1. No special training is required to maintain this kind of so called 'graphless' partogram.

2. The system is particularly useful for rural and poor resource places manned by less skilled staff.

3. It is also ideal for busy Teaching Hospitals and District hospitals where labor room remains full all the time and it is often difficult to know who is in labor for how long. Making an ETD list and have it hanging in the labor room notice board makes the management so much infinitely easier and safer.

ETD list

Bed No.	Name	Alert ETD
1.	Namita	11.30 AM
2.	Lipi	1. 45 PM
3.	Sajida	2. 00 PM

4. Private practitioners have always used this system but have been afraid about boldly writing it down and announcing it.

Reg No.

Date- Name-

Smart Birth Sheet

For *instant* ***'at a glance'*** assessment

GRAPHLESS PARTOGRAM

Age- Para- Wks of Gestation-

Alert ETD

Any **RISK FACTOR?**

ACTION ETD - (4 Hours)

PELVIS- Adequate/Borderline/Inadequate

C-1 Care of mother | **C-2** Care of fetus | **C-3** Care of Contraction | **C-4** Care of progress - do 3 hourly PV – check 3 Ds

NURSES SECTION											DOCTORS SECTION-D1,D2,D3				
Time (Check hourly)	T/P	BP	I V s	Urine output	FHR	Mec	Time of Ruptre Memb	No.of Contrn ***per 10 min***	Oxyto cin dose	Anal-gesic given (time)	**Time of PV**	**D-1 Dilatation** in cm			**D-2 Desc ent** in cm	**D-3 Depth of Caput** in cm
												Expected	Actual	**LAG in dil**		

Circle anything abnormal in RED to serve as a visual warning

Kumari Krithika Radhakrishnan, daughter of **Dr Pratima Radhakrishnan** and granddaughter of **Dr Jaya Narendran**, disciple of **Smt Sumitra Nitin** performed her Bharatanatyam Rangapravesham on 23rd June 2013 to a

M.SATVIK, s/o Dr Chandrika Muralidhar, 15 yrs old, 10th standard student of Poorna PrajnaHigh School,EKALAVYA Award winner, secured Bronze Medal in the National Cities Chess Championship in Kerala in June 2013, Silver Medal in the State Under-15 Chess Championship in April 2013

RICH SAVORY Recipes

By Triveni Suraj

Iron Rich--- Mixed Vegetable Soup

Ingredients--1 large brown onion, chopped

2 tsps --ground Turmeric

1 tsp-- ground coriander

2 tsps-- ground cumin

5 cups- chopped vegetables (pumpkin, potatoes, carrots,capsicum,celery

3cups-- reduced vegetable stock

2 cups-- water

250 gms--tomatoes, chopped

400 gms-- canned chickpeas

1/2 cup--parsley leaf, chopped

Method-- Heat oil in a large saucepan on medium, high heat. Add onions. Cook for 3 minutes. Add spices and chopped vegetables. Stir to soft.

Stir in stock, water, tomatoes and chickpeas. Bring to boil. Reduce heat to medium low. Simmer and keep for 40 minutes. Add tender vegetables (like beans, broccoli and green peas). Cook for 5 minutes. Stir in parsley. Season with pepper and serve hot.

Energy—1135 Kg
Fat—11.9 gms
Protein---9.5 gms
Dietary Fibre---9.5 gms

Good for Diabetics
Bajra Roti

Ingredients--1/2 cup--Bajra(black millet flour)

1/2 cup --whole wheat flour

1 cup-- grated red pumpkin

1 tsp-- ginger garlic paste

1 tsp-- lemon juice

2 tsp-- coriander, chopped

1 pinch-- asafoetida

salt to taste

Method-- Mix all ingredients together,except the oil and make a soft dough using enough water. Keep covered for 10-15 minutes

Divide the dough into equal portions and shape each into a round ball

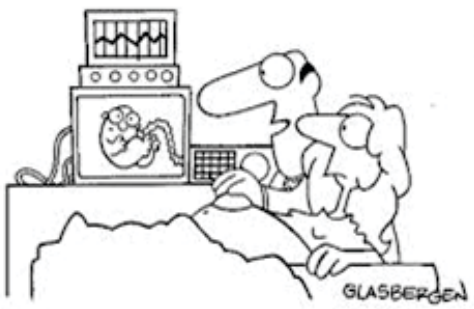
Roll out beach portion like a chapati

Cook on non-stick pan using a little oil

Serve hot with a cup of curds from skimmed milk

Energy—74 Kcal
CHO—12.9 gms
Fat—1.4 gms
Protein== 2.4 gms
Fibre—0.5 gm

JOKES



"Your baby is developing very nicely. Would you like to send him an e-mail?"

"ShradDhanjali"

May their souls rest in Peace

Dr.Nalini Bapat

Dr. Nalini Bapat was one of the leading Gynecologists in Indira Nagar . She passed away on 10th April 2013 from Massive Pulmonary Embolism in Singapore

Dr. V.N. Purandare

It is with a heavy heart that we inform you about the sad demise of **Dr. V.N. Purandare**, Past President of FOGSI and Editor Emeritus of JOGI at 9.30 pmon June 25th 2013. This was after prolonged ill health that he valiantly faced up to. A pioneer of gynaecological surgery in India he was a master surgeon, a great innovator and a popular teacher. He was always an individual respected for his clear thinking and opinions and his honesty and frankness. He will be greatly missed by all fogsians.

Dr. Leela Pai

Dr. Leela Pai
Passed away peacefully in her sleep in the early hours of 2nd October 2013

Wisdom for brains

Once, Krishna and Bhishma designed a test.

They called in Duryodhana early in the morning and asked him to go around the kingdom for the whole day and return when he found a 'good person' or by sunset, whichever was earlier.

A few minutes later they called in Yudhishthira and asked him to go around the entire kingdom for the whole day and return when he found 'an evil person' or by sunset, whichever was earlier.

In the evening, Duryodhan returned empty handed and said that he could not find a single good person in the entire kingdom.

Yudhishthira also returned empty handed and said that he could not find a single evil person in the entire kingdom.

- Dr.Parimala Devi

When the MIND is weak, situation is a Problem,

When the MIND is balanced, situation is a Challenge,

When the MIND is strong, situation becomes an Opportunity

The Problem with the World Is That the Intelligent People Are Full Of Doubts,

While The Stupid Ones Are Full Of Confidence.

~ Charles Bukowski

Quiz with a difference

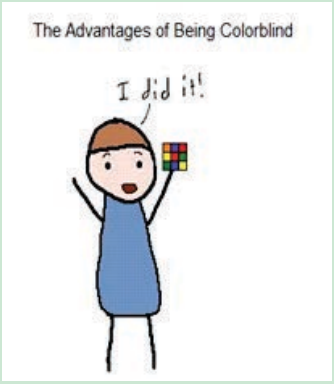
. Who designed the BSOG logo?
2. Who donated the President's Medallion?
3. Who started Gnanavarsha?
4. On which Gynecologist's name a stamp has been released?
5. Who was the youngest BSOG President to date?
6. Who had the first to GIFT Baby in South India?
7. Under whose presidentship BSOG got the Best Society Award?
8. Who was elected President twice?
9. Under whose president ship did BSOG get the coveted D K Tank Award?
10. Who is the PIED PIPER in BSOG?
11. Who designed the BSOG Quiz?

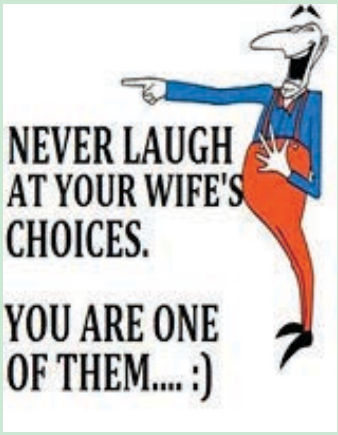
Answers

1. Dr Narayanan R
2. Dr Padmini Isaac
3. Dr Mohini Prasad
4. Dr Sita Bhatija
5. Dr Kamini Rao
6. Dr Sulochana Gunasheela
7. Dr Pushpa Srinivas
8 Dr P.R.Desai
9. Dr Sheela Mane
10. Dr Hema Divakar
11.Dr Jyothika Desai

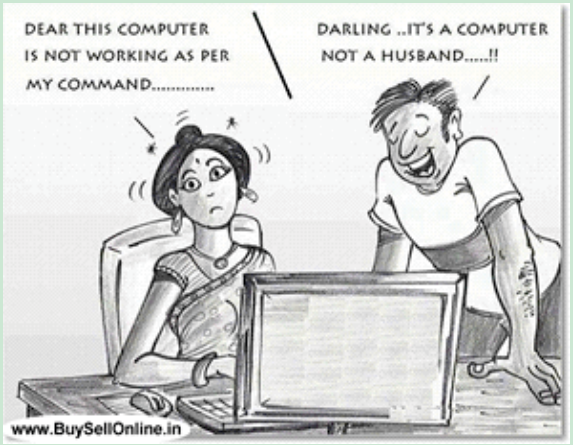
JOKES APART


THE DOCTOR WOULD LIKE A STOOL SAMPLE, A URINE SAMPLE, AND A SPERM SAMPLE.
WHAT DID SHE SAY?
THEY WANT YOUR UNDERWEAR.


The Advantages of Being Colorblind
I did it!


NEVER LAUGH AT YOUR WIFE'S CHOICES.
YOU ARE ONE OF THEM.... :)


Excuse me ! Do You have a book called, 'Husband–the master of Wife'??
Sir.. Comic department is on the 1st floor!


DEAR THIS COMPUTER IS NOT WORKING AS PER MY COMMAND.....
DARLING ..IT'S A COMPUTER NOT A HUSBAND.....!!
www.BuySellOnline.in


GO ON, BOB ! FETCH THE STICK !
YOU THREW IT , YOU FETCH IT !


I want you to whisper dirty things in my ear...
Kitchen, bathroom, livingroom...

SURROGACY – WOMB ON RENT

Dr Amit J.Upadhyay , Dr Kamini A.Rao

Infertility has been a curse in society since ages known. Generally women bear the burden of not being able to give birth to a family's heir. Amongst the various treatment options for infertility, surrogacy has also been mentioned in the history and is now a fast emerging advancement in the medical field of assisted reproduction.

Surrogacy is a means of helping women who are unable to bear children for a variety of reasons. The term 'surrogate mother' or 'surrogate' is used for the woman who carries pregnancy and delivers a baby for another woman.

Types of surrogacy:

'· **Natural surrogacy' or 'partial surrogacy'**

The intended host is inseminated with the semen of the husband of the 'genetic couple ' i.e. pregnancy is a product of husband semen and surrogate oocyte. Any resulting child is therefore genetically related to the host.

· **Gestational surrogacy,' 'full surrogacy,' or 'IVF surrogacy'**

Here the gametes of the 'genetic couple,' 'commissioning couple,' or 'intended parents' in a surrogacy arrangement are used to produce embryos that are subsequently transferred to another woman. The 'surrogate host' is genetically unrelated to any offspring that may be born.

Previously 'natural surrogacy' was the only means of helping certain barren women to have babies. When assisted conception techniques, such as in vitro fertilization (IVF) were introduced, embryos created entirely from the gametes of the 'commissioning couple' could be transferred to the 'surrogate host,' who therefore provided no genetic contribution to the resulting child. She bore the child and handed it over to the 'genetic parents.'

Surrogacy may be commercial or altruistic, depending upon whether the surrogate receives financial reward for her pregnancy.

'Gestational surrogacy' is now generally accepted in many countries as a treatment option for infertile women with certain clearly defined medical problems. The first baby born by gestational surrogacy was in the USA in 1985(2).

Surrogacy is now available as the treatment option for various indications like:

1. Women with congenital absent uterus
2. Hysterectomy done for malignancy, post partum haemorrhage, rupture uterus
3. Women with systemic diseases such as heart disease, renal problem which pose grave threat to the life of mother in case of pregnancy
4. Repeated failure of IVF treatment
5. Recurrent abortions
6. Risk of rupture uterus in cases of previous uterine surgery with scarred uterus or previous history of rupture
7. Dense intrauterine adhesions (not amenable for surgery)

Surrogacy should not be considered only for social or career reasons.

As per ICMR guidelines woman who want to act as a surrogate should fulfill the following criteria:

· A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple.

· In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.

· Where as in case of an unknown person, responsibility of finding a surrogate mother, through advertisement or otherwise, rests with the couple, or a semen bank. Only a registered ART bank can advertise for, procure or provide semen, oocyte donor or surrogate mother.

· A surrogate mother should be between 21 and 35 years of age, and should preferably have at least one child of her own.

· No woman can act as a surrogate more than thrice in her lifetime or for more than five successful live births in her life, including her own children. (1)

Role of ART clinics

· All ART clinics should maintain detailed records of the couple and surrogate mother.

· Any woman agreeing to act as a surrogate is medically tested for sexually transmitted and other communicable diseases.

· Both the couple or individual seeking surrogacy through the use of ART, and the surrogate mother, shall enter into a surrogacy agreement which shall be legally enforceable. In the event that the woman intending to be a surrogate is married, the consent of her spouse shall be required before she may act as such surrogate.

· A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy.

· A couple shall not have simultaneous transfer of embryos in the woman and in a surrogate.

· The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of individual / individuals who commissioned the surrogacy, as parents. (1)

Role of commissioning couple

· A couple cannot have the service of more than one surrogate at any given time.

· The commissioning parent(s) must ensure that the surrogate mother and the child she delivers are appropriately insured until the time the child is handed over and till the surrogate mother is free of any health complications.

· The persons who have availed of the services of a surrogate mother are legally bound to accept the custody of the child irrespective of any abnormality that the child may have.

· All expenses during the period of pregnancy and after delivery as per medical advice are borne by the couple. (1)

Role of surrogate host

· Any woman agreeing to act as a surrogate is duty-bound not to engage in any act that would harm the foetus during pregnancy and the child after birth.

· Surrogate mother relinquishes all parental rights over the child.(1)

Special considerations in Reproductive medical tourism (RT)

Each year, couples from abroad are attracted to India by so-called surrogacy agencies because cost of the whole procedure in India is as less as one third of what it is in United States and United Kingdom (10-20 lakhs).(4)

Surrogacy is banned in many countries, such as Germany, Japan, Sweden, parts of Australia, and Canada.

According to new visa rules issued by the Ministry of Home Affairs, single people and gay couples from outside India will no longer be able to seek a surrogate in India.

· Only couples who have been married for at least two years and are citizens of countries where surrogacy is legal will now be allowed to look for a woman in India to carry their child, in order to secure the rights of surrogates and of the babies.(3)

· A foreign couple not resident in India, seeking surrogacy in India appoint a local guardian(LG) who is legally responsible for taking care of the surrogate during and after the pregnancy, till the child is delivered.

· Proper documentation (a letter from either the embassy of the Country in India or from the foreign ministry of the Country) is essential, clearly and unambiguously stating that (a) the country permits surrogacy, and (b) the child born through surrogacy in India, will be permitted entry in the Country as a biological child of the commissioning couple.

· If the foreign party seeking surrogacy fails to take delivery of the child born, the local guardian is legally obliged to take delivery of the child.

· If a foreign couple seeks surrogacy in India, the child, even though born in India, shall not be an Indian citizen. (1)

Counseling

In-depth counseling of all parties engaged in surrogacy is of paramount importance and aims to prepare all parties contemplating this treatment of last resort to consider all the facts which will have an influence on the future lives of each of them. No one party is felt to be taking advantage of the other.

All issues should be discussed with both the genetic couple and the surrogate, including:

For the genetic couples:

· Review of all alternative treatment options

· Whether couple will take a known surrogate or an unknown surrogate

· The practical difficulty and cost of treatment by gestational surrogacy

· The medical and psychological risks of surrogacy

· Potential psychological risk to the child

· The chances of having a multiple pregnancy

· The possibility that a child may be born with a handicap

· The possibility that the host may wish to retain the child after birth

· The importance of obtaining legal advisor

For the host:

· The full implications of undergoing treatment by IVF surrogacy

· The possibility of multiple pregnancy

· The possibility of family and friends being against such treatment

· The need to abstain from unprotected sexual intercourse during and just before the treatment

· The medical risks associated with pregnancy and the chances of cesarean section

· Implications and feelings of guilt on both sides if the host should spontaneously abort a pregnancy

· The possibility that the host will feel a sense of bereavement when she gives the baby to the genetic couple

· The possibility that the child may be born with a handicap

Management of the 'Genetic mother'

The genetic mother takes certain blood tests like blood group, screening for communicable diseases e.g. HIV, HBsAg , HCV before starting treatment cycle. Assessment of ovarian function is carried out with hormonal levels (FSH, LH, estradiol and progesterone), and pelvic scan.

Management of the 'Surrogate host'

Once the host fitting into the above guidelines is identified, she is tested for HIV, HBsAg, HCV before embryo transfer. Embryo transfer to the surrogate host may either be carried out in a natural menstrual cycle or in a cycle with exogenous hormone treatment.

Advantages of having a surrogate house

For the Surrogate

· She is well taken care of with healthy diet, enough rest and proper medical treatment.

· The unborn baby is indirectly well taken care of.

· In cases of any medical emergency, the clinic is readily approachable.

· When the surrogates stay in a group, they have a lot of emotional, moral and psychological support.

· Sometimes they need to hide surrogacy from the society and extended family and so they can do this by staying in a surrogate house.

For The Couples

They can keep a track of the surrogate – her diet, health and other activities – hence they are less anxious.

Results

Live birth rates of between 37% and 43% per genetic or commissioning couple and 34% and 39% per surrogate host have

been reported, with a mean of two embryos transferred.(5,6) The incidence of pregnancy- induced hypertension and bleeding in third trimester is almost five times lower in surrogate hosts than in standard IVF patient controls.(7)

Complications in surrogacy programme

- The host may wish to keep the child.
- An abnormal child may be rejected by both the genetic and host parents.
- Certain religions forbid the practice of surrogacy e.g. Islam, Catholic Church.
- Compensation to surrogate is always a matter of debate. Financial pressures could lead to exploitation and commodification of the service. Regulation of surrogates varies widely from nation to nation and even within regions of individual countries [8-14]. Due to these financial and legal considerations, international surrogacy has emerged as an emerging industry, especially in developing nations [10].
- A child may, upon reaching the age of 18, ask for any information, excluding personal identification, relating to the donor or surrogate mother.

Personal identification of the genetic parent or parents or surrogate mother can be released only in cases of life threatening medical conditions which require physical testing or samples of the genetic parent or parents or surrogate mother, provided it is not released without the prior informed consent of the genetic parent or parents or surrogate mother.(1)

In spite of certain shortcomings, thousands of infertile couples have benefitted till date from surrogacy and will continue to be a viable treatment option in otherwise hopeless cases. Moreover, such treatment has encouraged reproductive tourism in India due to easy availability of surrogates and remarkably lower treatment cost. The mainstay of a successful surrogacy programme lies in thorough counseling of the surrogate and commissioning couple. The ultimate goal of the treatment at all times is safeguarding the interest of the resulting child.

FAQs on Blood Transfusion

Q. How much does the Hb increase after 1 unit of blood?

A. 1 unit of red cells will increase the Hb by approx. 1gm%

Q. What is informed consent for blood transfusion?

A. The patient should be informed about his/her need for blood and alternatives available, as well as risks involved in transfusion and non- transfusion.

Q. What are the risks involved in a blood transfusion?

A. The biggest risk in a blood transfusion is caused by clerical errors.

Estimated risks are as follows:

- Febrile non haemolytic transfusion reaction: 1:100
- Delayed haemolytic transfusion reaction: 1:4,000-9,000
- TRALI: 1:5,000-10,000
- ABO incompatibility: 1:12,000-77,000
- Anaphylaxis: 1:20,000-170,000
- HIV: 1:7,299,000
- Hepatitis B: 1:1,339,000

Q. What should one look for when visually checking the unit of blood prior to transfusion?

- Signs of damage or leakage
- Discolouration or turbidity
- Presence of clots or haemolysis

Q. Can blood be brought and stored in a hospital fridge?

A. NO. All red cells must be stored between 2-60C in a 24 hour monitored and alarmed fridge. It should not be stored in a fridge where other drugs, drinks or food are stored.

Q. What IV fluids should be avoided with packed cell transfusion?

A. No other intravenous fluid except 0.9% Sodium Chloride Injection I.P. should be administered with blood components.

Q. When should you use a blood warmer?

A. Blood warmers may be used for:

- Adults receiving an infusion of blood at rates greater than 50ml/kg/hr
- Infants undergoing exchange transfusions
- Patients with clinically significant cold agglutinins

Q. How soon after release from blood bank should the transfusion be started?

A. All blood components must be transfused as soon as they are received from the blood bank without warming them, ideally within 30 minutes. Once red cells have been removed from the fridge, their temperature starts to increase. As the temp increases, the risk of bacterial proliferation also increases.

Recommended transfusion times are:

1. Packed RBC: 2 hours, never beyond 4 hours.
2. FFP: 20-30 minutes after thawing at 37 C in a sterile water bath.
1. Cryoprecipitate and Platelet concentrates: 20-30 minutes

Q. How long after a blood transfusion should hemoglobin be checked?

A. After 24 hours.

Q. How soon after giving FFP should an INR be performed?

A. 6-12 hours after giving FFP.

Q. When should one check the platelet count after a platelet transfusion?

A. About 15-30mins after transfusion.

Q. What are the colour codes used on the labels to differentiate blood groups

A. O Blue A Yellow B Pink AB White

Dr Susheela Rani, Dr Arulmozhi Ramarajan

Awards Galore!!

Dr Rammurthy being felicitated by
Dr Jyothika Desai as an exemplary Teacher in the BSOG CME 2013

Dr John Ebnezar, who holds a Guinness World Record of writing 108 books in one year, being felicitated by JNMC Orthopaedic Department at KLE Society's Dr Prabhakar Kore Hospital in Belgaum on 22.7.13

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Our endeavor

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evolving Women's Health

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Gefer® forte inj

Each 5 ml contains Iron sucrose - 100 mg

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DHA 200 mg + Elemental calcium 500 mg + Elemental iron 60 mg

V-Candi™

Tioconazole Vaginal Gel 6.5%

Prolina® OG

29 Vital ingredients + Protein + Fat + Carbohydrate

DUBIX® - K

Tranexamic acid 500 mg + Mefenamic acid 325 mg + Vitamin K 5 mg Tablets

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Strides
ARCOLAB LIMITED

Strides House, Bilekahalli, Bannerghatta Road, Bangalore - 560 076, India. Tel: +91(80)67840000, Website : www.stridesarco.com