SIR GANGA RAM HOSPITAL
Trust of Generations

NARCHICON 2025

31st Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch

Organized by

Institute of Obstetrics & Gynaecology
Sir Ganga Ram Hospital, New Delhi

Date: **8th, 9th & 10th August 2025**
Venue: **Hotel - India Habitat Centre, Lodhi Road, New Delhi**

THEME

"PLAN PROMOTE PROPAGATE WOMEN'S HEALTH"

ABSTRACT & SOUVENIR

UPDATEKNOWLEDGEUPGRADESKILLSUPLIFTWOMEN'SHEALTH

NARCHI Delhi Secretariat
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Sir Ganga Ram Hospital, New Delhi
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FROM THE PRESIDENT'S PEN

Dr. (Prof.) Mala Srivastava
MBBS, DGO, DNB (Obs & Gynae), FICMCH, FICOG
President

NARCHI Delhi Chapter
Head of Gynae Oncology Unit
Professor GRIPMER
Senior Consultant, Endoscopic & Robotic Surgeon
Sir Ganga Ram Hospital,

New Delhi

Warm Greetings to Everyone!

On behalf of the organizing committee of 31st Annual conference of NARCHI Delhi Chapter to be held from 8th Aug to 10th Aug at India Habitat Centre. I extend a very warm welcome to all the distinguished faculty and delegates.

This conference is a unique clinical and scientific event that emphasizes on multidisciplinary collaboration. The theme of the conference is "Plan Promote Propagate Women's Health".

With this conference we are having seventeen workshops starting from "Theme: Navigating Fetal Anomalies – From Antenatal Diagnosis to Fetal Therapy", "Workshop for Asha Workers", "Empowering Frontline Care: Maternal health Nurses module", "Advance Oncology- Management of Toughest Cases and Recent Updates 2025", "POCT in Critical Care Obstetrics", "Hysteroscopy made easy: a hands-on workshop", "From Screening to Strategy: Preventing Gynecologic Cancers", "Optimizing Intrapartum Surveillance: Principles of physiological interpretation of CTG", "Menopause: Unlocking the potential of the second innings", "Patient Safety", "Promoting Fertility in Endometriosis for Practising Gynaecologist", "Genetic in Obs & Gynae", "Quality in Maternity Care", "Smith & Nephew", "Obstetric Anal Sphincter Injuries Workshop (OASIS)", "Adolescent Health & Infections in Perinatology", together with workshop on optimizing surgical outcomes with SNPWT.

The program is carefully tailored to address and upgrade obstetrics skills and surgical skills of endoscopy and robotics surgeries.

The conference will be a special event, where there will be discussion on the protocols for plethora of topics ranging from mother and child health, contraception, endoscopy, fertility issues, genetics and preventive oncology.

Each sessions is crafted for the thorough enrichment of our practicing Obstetrician and Gynaecologist and embellishment of the budding and the upcoming ones.

The programme starts with skits presented by young delegates on "GDM, Infertility, Breaking Bad News, Post Partum Care". The key note addresses is on Identification of High Risk foetus in a low risk mothers, Preventive Perinatology, Hepatitis E in pregnancy and Legal issues in medical practice: current perspective.

The delibrations are on "Epidemic of NCD 3 WS – when, where & which way to fight, Strong from start to silver, A gynaecologist guide to lifelong bone health, "Teen Time, Right Time… Why your clinic needs a dedicated Adolescent corner today" & The Precursor Puzzle : Biomarkers Predicting Endometrial Cancer- Risk Stratification beyond Histopathology.

The stalwarts are going to talk about "Anaemia in Adolescent Girls : A National Emergency", "Concealed PPH" & "Aneuploidy Screening".

The experts will enlighten us on "Foetal Growth in 3rd Trimester & Risk of Still Birth", "Prevention of VTE in Pregnancy : The silent crises" and "Chronic Pelvic Pain – What is Next"

We are really lucky to have the two important orations delivered by eminent leaders across India. First Oration is by Past FOGSI President Dr. S. Shantha Kumari. She will speak on "No to Violence Against Women : WHERE ARE WE ??" & Second Oration is by President Elect Dr. Bhaskar Pal. His topic is "COCP : Tailoring Therapy, Bursting Myths".

There are Panel discussions on "Medicolegal Issue in Obstetrics & Gynaecology", "Typical & Atypical Eclampsia – Case Base Discussion" and "Contraception in Different Scenarios".

There is a capsule of videos on laparoscopic surgeries delivered by eminent surgeons. They will show their videos on "Robotic Myomectomy", "Challenges in Endoscopic Surgery for Deep Infiltrating Endometriosis", "Total Laparoscopic Hysterectomy in Difficult Scenarios" & "Minimally Invasive Management of VVF".

One scientific hall is totally dedicated to post graduate activities like papers, posters

presentations, Quiz and Slogan competition on various burning topics relevant for day to day practise.

Exciting times are here again. This is an opportunity when we meet our teachers, friends, colleagues, exchange thoughts and share new ideas with our peers for the ultimate goal of better outcome of our patients. The esteemed experts are here to present their experiences in their respective fields in crisp and comprehensive manner.

I congratulate all the workshop conveners and co-conveners for nicely fabricating and planning the scientific agenda. There are modules for the ANM and Asha workers together with capsules for the Nurses.

The icing on the cake is our inaugural function with blessing of seniors. We take this opportunity to felicitate teachers and eminent personalities during the inauguration and appreciate our young turks for their contributions for this mega event. I am sure everyone will cherish the memories of this scientific agenda for a long time.

Thanks giving is a very sacred task of acknowledging and yet balancing the contribution of various personalities in this endeavor. It is also an equally difficult task where we must not forget any one and at the same, keeping the balance of importance of one personality over the other.

We have tried to maintain the legacy of Dr. S. K. Bhandari, Dr. B.G. Kotwani and Dr. Indrani Ganguli while planning the entire conference.

I feel privileged that Dr. Subrata Dawn, Dr. Veena Acharya, Dr. Manju Puri, Dr. S. N. Mukherjee bestowed the responsibility of holding this annual conference on us. It was their confidence that made this event possible.

I am also delighted to have the blessings of Dr. D. S. Rana, Chairman, Trust Society of Sir Ganga Ram Hospital. Dr. Ajay Swaroop, Chairman, Board of Management and Dr. Jayashree Sood, Vice Chairperson, Board of Management of Sir Ganga Ram Hospital as well as the blessings and good will of our eminent teachers like Dr. M. Kocchar and Dr. P. Chadha.

The organization of such an event can not be accomplished without an active involvement of many personalities - Dr. Kanwal Gujral, Dr. Abha Majumdar, Dr. Harsha Khullar who always guided us.

Dr. Geeta Mediratta, Dr. Chandra Mansukhani and Dr. Kanika Jain have been the real backbone of this conference. I am truly grateful to Dr. Debashis Dutta, Dr. Punita Bhardwaj, Dr. Sweta Gupta, Dr. Rahul D. Modi for their tremendous clinical as well as scientific support.

I am immensely grateful to the editorial team Dr. Mamta Dagar, Dr. Ruma Satwik and Dr. Sakshi Nayar for their efforts in keeping the bulletin in time with excellent scientific content and innovative ideas.

I have been very ably assisted by the very enthusiastic and optimistic treasurer Dr. Neeti Tiwari and Jt. Treasurer Dr. Renuka Brijwal. I am deeply indebted to Dr. Sharmistha Garg, Dr. Sunita Kumar, Dr. Ila Sharma, Dr. Huma Ali, Dr. Purvi Khandelwal and Dr. Bhawani Shekhar, Dr. Anusha Sharma, Dr. Saroj Rajan for their valuable contribution at various stages of preparation of this conference. I am also thankful to all my fellows, residents and post graduate students for their efforts of running around, giving buffer stability between patient care and organizational hurdles and being very courteous to offer their services with smile.

I am truly thankful for the support of my staff Mrs. Nikki Ghuman, Mrs. Shalu Matta, Ms. Asha Rani, Ms. Nikita & Mr. Rajinder Jain who had put in tremendous efforts in streamlining various spheres of activities during the conference preparation.

No event is possible without a generous support from all the sponsors who have contributed in various forms for the success of this conference.

There has been a great support from our team of event manager Mr. Vinod Kumar and his team. They have worked day and night for the success of this conference.

Last, but not the least is the unstinted and continuous support that I received from my husband Dr. Arvind Srivastava, my son Dr. Akshit Srivastava, my daughter Dr. Ankita Srivastava, my son in law Dr. Jitesh Manghwani and my grand daughter Mridha Manghwani. They agreed gladly to postpone the many social requirements of the family. They understood my absence even when I was at home for they know that "After the flight the bird must return to the nest".

We have tried to do the best of our ability to provide a good scientific programme and hospitality, however success of this conference would now depend upon the response from all of you.

We are here to offer our services with all humility, we would rather confess to be wrong if anywhere, than arguing when we were not.

Thanking you all for gracing the occasion, we hope that all your participation will prove to be academically as well as socially fruitful experience for years to come.

Long Live NARCHI Delhi Chapter!!

Dr. Mala Srivastava

President

NARCHI Delhi Chapter

FROM THE VICE PRESIDENT'S PEN

Dr. Chandra Mansukhani
MBBS, MS
Vice Chairperson of Institute
of Obstetrics & Gynaecology
Vice President of NARCHI
Delhi Chapter
Sir Ganga Ram Hospital ,
New Delhi

Dear Respected Seniors & Dear Friends

Warm Greetings to Everyone!

As we prepare for the upcoming conference, I want to emphasize the importance of our theme: "Plan Promote Propagate Women's Health." This theme is crucial for ensuring a safe, productive, and inclusive environment for all participants.

We, obstetricians are the custodian of women's health. We take care from womb to tomb. Therefore we have to plan strategies promote them and hence propagate them for the betterment of women's health. Among seventeen workshops, we shall try to promote and propagate focused learning and in depth discussion on topics related to womens health.

A special thanks to our distinguished guests and speakers, whose inspiring words and insightful perspectives set a perfect tone for the days ahead. Your contributions have ignited thought-provoking conversations and motivated us to continue our efforts towards enhancing reproductive and child healthcare.

Let's work together to make this conference a resounding success by embodying this theme in every aspect of our planning and execution. Your commitment is vital!

Best regards,

Dr. Chandra Mansukhani

Vice President

FROM THE SECRETARY'S DESK

Dr. Kanika Jain
DGO, DNB, FICMCH FICOG
Senior consultant Gynae Endoscopist
Gynae MAS unit
Sir Ganga Ram Hospital,
Secretary NARCHI Delhi
(2024-26)

Dear all NARCHI Delhi Members,

Greetings of the day !

It's my pleasure & honour , as secretary NARCHI Delhi, to write for this Souvenir. Our conference's theme is "Plan Promote Propagate Women's Health" which is so appropriate in today's day and age and the need of the hour.

The conference's agenda is a well balanced mix of Lectures, videos, demonstrations, key note address, drills and skits which will give you the clinical & scientific updates you need across all aspects of Gynaecology and Obstetrics to provide excellent health to all women.

It has been designed with a multitude of seventeen workshops to choose from, Quiz for PG students, poster and free paper competitions as well as slogan competition to participate and win prizes in.

Keynote presenters, orators, panelists, experts & specialists in their field from Pan India will share their insights, you will hear their success stories and get the latest updates on newer technology and medical devices. You will witness more events than ever before on various sub-specialties of Obstetrics & Gynaecology.

We, with the NARCHI secretariat at Sir Ganga Ram Hospital, are eagerly waiting to welcome you all to this academic extravaganza.

Let's leverage the upcoming conference events to synergize and promote excellence in women's health !!

As the saying goes:-

"Individually we are a drop, but together we are an ocean"

-Ryunosuke Satoro

Warm Regards,

Dr. Kanika Jain

Secretary

NARCHI Delhi Chapter(2024-26)

NATIONAL NARCHI PRESIDENT'S

Dr Manju Puri

National President NARCHI

Senior Professor
Department of Obstetrics
and Gynecology
SGT University Gurugram

It gives immense pleasure to extend my heartiest congratulations to the Institute of Obstetrics & Gynecology Sir Ganga Ram Hospital for organizing annual conference of NARCHI Delhi 2025. Team NARCHI Delhi has done a commendable work under the leadership of Dr Mala Srivastava President NARCHI Delhi. True to the theme of the conference Plan Promote Propagate Woman's Health, the organizing team has planned a comprehensive programme addressing various aspects of reproductive health. There are 17 dedicated workshops for obstetrician, nurses and frontline healthcare providers dedicated to topics spanning from the basic care to advances. There are workshops on Quality in maternal care and patient safety. These will be pivotal in promoting small group interactions and exchange of ideas, knowledge and experience. This academic event will stimulate the healthcare providers for delivering compassionate evidence based and ethical care, and strengthen their commitment to women's health.

May this conference spark new ideas, foster meaningful partnerships, and inspire all participants to strive for excellence in their service to women and society

Dr Manju Puri

National President NARCHI

Secretary General, NARCHI

Dr. S. Dawn
Secretary General,
NARCHI

It is a great pleasure for me to write a message for the 31st Annual Conference of NARCHI Delhi Branch to be held from 8th to 10th August 2025. My very best wishes for this conference to be a great success. The participants in the conference will enjoy a great scientific programme that

will address the relevant issues confronting women's health in India.

Dr Mala Srivastava with her able team will do their best for the successful outcome of the conference.

I also invite all the delegates to attend the NARCHI National Conference "NARCHICON 2025" at Jaipur from 19th to 21st September, 2025.

Dr S. Dawn

Secretary General, NARCHI

MESSAGE

Dr. S. N. Mukherjee
Retd. Senior consultant,
Gynecologist and
Obstetrician

I am delighted to learn that the Institute of Obstetrics & Gynaecolgoy, Sir Ganga Ram Hospital, is organizing the 31st Annual Conference of NARCHI Delhi Chapter on 9-10th August 2025 at India Habitat Centre, New Delhi.

Delhi Centre is very active and busy all around the year organizing several academic activities. The scientific program is very attractive and educative. It includes seminars, workshops, poster sessions, discussions and debates on important topics in the field of Obstetrics and Gynecology.

I understand that eminent speakers will deliver the prestigious Orations and esteemed teachers will address the delegates on current important topics. I am sure that the participants will enjoy and benefit greatly from the high standards of scientific deliberations.

I wish the Conference a grand success.

Dr. S. N. Mukherjee.

NARCHICON 2025

Programme Details

WORKSHOP 1

Department of Fetal Medicine, Sir Ganga Ram Hospital

Theme: Navigating Fetal Anomalies – From Antenatal Diagnosis to Fetal Therapy

Convener: Dr. Nandita Dimri

Co- Convener: Dr. Nidhish Sharma & Dr. Asmita Singh

Date: 04th Aug 2025

Time: 08:00 AM– 04:00 PM

Venue: Auditorium Hall A, Sir Ganga Ram Hospital

PROGRAMME

TIME	TOPIC	SPEAKER
08:00-08:45 am	**Registration**	
08:45-09:00 am	Welcome Address & Overview	Dr. Nandita Dimri
SESSION: I - Noninvasive Fetal Therapy:- The Inner Symphony – Heart, Thyroid & Adrenals		
Experts: **Dr. Raja Joshi, Dr. Neeraj Aggarwal, Dr. Setu Gupta**		
09:00 – 09:20 am	When Heart Rhythm goes "Awry" – What Next?	Dr. Mridul Agarwal
09:20 – 09:40 am	Faltering Fetal Thyroid Gland – To Treat on not to treat	Dr. S. Suresh
09:40 – 10:00 am	Congenital Adrenal Hyperplasia in Utero - The Unseen Challenge	Dr. Chanchal
SESSION: II – Minimally Invasive		
Experts: Dr. Geeta Mediratta, Dr. S. Suresh, Dr. Satish Saluja		
10:00 – 10:20 am	Role of Genetic Work up in the Rh negative Pregnancy	Dr. Ratna Puri
10:20 – 10:45 am	Fetal Therapy in Rh Isoimmunized Pregnancy – Success & limitations	Dr. Aparna Sharma
10:45 – 11:00 am	Potential of Fetal Hematopoietic Stem Cells in Fetal Therapy	Dr. Vandana Chaddha
11:00 – 11:15 am	**Audience Interaction (Session I & II)**	
11:15 – 11:30 am	**TEA BREAK**	
SESSION: III – Twin Trouble		
CHAIRPERSON: Dr. Neelam Kler, Dr. Kanwal Gujral		
11:30 – 12:30 pm	MCDA Gestation - From Complexity to Clarity – Resolving Diagnostic Dilemmas	Dr. S. Suresh
12:30 – 12:45 pm	Fetal Therapy in Complicated MCDA	

SESSION: IV - Fetal Thoracic Masses: Watchful Expectancy or Active Intervention		
CHAIRPERSON: Dr. Alpana Prasad, Dr. Satish Agarwal (Online)		
12:45 – 01:00 pm	Fetal Thoracic Masses - Role of Geneticist	Dr. Sunita Bijarnia
01:00 – 1:15 pm	Echogenic Lesions in Fetal Thorax – How to proceed?	Dr. Upma Saxena
1:15 – 1:30 pm	Congenital Diaphragmatic Hernia – Antenatal Factors Affecting Prognosis & Case Selection for Therapy	Dr. Sumitra Bachani
1:30 – 1:45 pm	Fetal Thoracic Lesion - Value addition by MRI	Dr. Seema Sud
1:45 – 2:00 pm	Our Latest Experience with Late Onset Congenital Diaphragmatic Hernia	Dr. Asmita Singh
2:00 – 2:15 pm	**Audience Interaction (Session III & IV)**	
2:15 – 3:00 pm	**LUNCH**	
SESSION: V - QUIZ		
Judges: Dr. Ashok Baijal, Dr. Nandita Dimri		
3:00 – 4:00 pm	**QUIZ** **Quiz Masters:** Dr. Nidhish Sharma, Dr. Asmita Singh, Dr. Preeti	
Closing Remarks		

WORKSHOP 2

NARCHI DELHI 2025

31st Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch

Theme: "Plan Promote Propagate Women's Health"

Workshop for ASHA Workers

Convener: Dr. Shivani Agarwal

Co- Convener: Dr. Anita Rajhoria

Dr. Seema Singhal

Date: 05- Aug- 2025

Time: 09:00 Am – 01:00 Pm

Venue: Sir Ganga Ram Hospital

Workshop Theme: Surakshit Matritva - Sanrakhit Parivar

PROGRAMME

TIME	TOPIC	SPEAKER	CHAIRPERSON
09:00-09:30 am	INTRODUCTION	Dr Shivani Agarwal & Dr Jyoti Sachdeva	
09:30-09:45 am	Anemia in Pregnant Women	Dr Anita Rajhoria	Dr Mrinalini Mani Dr Ritu Chowdhry
09:45-10:00 am	Newer Contraceptives in Basket of Nfpp	Dr Yamini Sarwal	
10:00-10:15 am	Birth Plan Facilitation (Avoiding Home Deliveries)	Dr Sumita Mehta	
10:15-10:30 am	Garbhini Parivar Sammelan	Ms. Parna	Dr Stuti Dr Supriya
10:30-10:45 am	Nutrition in Pregnancy	Prof. Neena Bhatia	
10:45-11:00 am	**TEA BREAK**		
Cervical and Breast Cancer Awareness			
11:00-11:05 am	INTRODUCTION	Dr Seema Singhal	
11:05-11:20 am	Garbhashay Griva Ka Cancer: An Overview	Dr Shruthi	Dr Anushree Mr Prashant Bharat
11:20-11:35 am	Garbhashay Griva Cancer: Kin Mahilaon Mein Khatra, Lakshan Ki Pehchan	Dr Muntaha	
11:35-11:50 am	Mahilaon Mein Is Samasya Ke Parinam	Dr Nilanchali Singh	
11:50-12:00 noon	Quiz 1	Dr Rajesh Kumari, Dr Shivani Agarwal	
12:00-12:15 pm	Tike (सुई, टीका) Se Roktham-Vacccine (Myths & Facts)	Dr Aarthi S Jayaraj	Dr Jyoti Meena Dr Vivek Maurya
12:15-12:30 pm	Screening Ke Tareeke	Dr Urvashi Miglani	
12:30-12:45 pm	Breast Cancer: Jaankari Hi Bachav Hai	Dr Deepa Gupta	
12:45-12:50 pm	Quiz 2	Dr Rajesh Kumari, Dr Shivani Agarwal	
12:50-01:00 pm	Vote of Thanks	Dr Shivani Agarwal, Dr Seema Singhal	

WORKSHOP 3

NARCHI DELHI 2025

31st Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch

Theme: "Plan Promote Propagate Women's Health"

Advance Oncology- Management of Toughest Cases and Recent Updates 2025

Convener: Dr. Aditya Sarin **Date:** 06- Aug- 2025

Time: 02:00 – 05:00 PM

Venue: Sir Ganga Ram Hospital

PROGRAMME

Time	Topic	Panelists
02:00-02:05 pm	Registration	
02:05-02:10 pm	Inauguration and Lamp Lighting	
Chairpersons: Dr Chintamani, Dr Rakesh Koul, Dr Mala Srivastava		
02:10-02:50 pm	Ca Breast **Moderator:** Dr Deepika Gupta	Dr Bimlesh Thakur Dr Deep Shankar Pruthi Dr Aditya Sarin
Chairpersons: Dr R Sekhon, Dr Seema Singhal,Dr Chandra Mansukhani		
02:50-03:30 pm	Ca Ovary **Moderator:** Dr Shyam Aggarwal	Dr Priya Bansal Dr Kanika Batra Dr Vaishali Palival Dr Anshuja Singla Dr Aditya Sarin
Chairpersons: Dr Rama Joshi, Dr Swasti, Dr Arvind Kumar		
03:30-04:10 pm	Ca Endometrium **Moderator:** Dr Shikha Halder	Dr Pallav Gupta Dr Shweta Tyagi Giri Dr Pakhee Agarwal Dr Arti Mehrotra Dr Sharda Patra
Chairpersons: Dr Archana Mishra, Dr Satender Kaur, Dr Geeta Mediratta, Dr Sunita Malik		
04:10-04:50 pm	Ca Cervix **Moderator:** Dr Jyoti Meena	Dr Divya Sehra Dr Nidhi Gupta (Hamdard) Dr Shruti Bhatia Dr Arpita Gupta Dr Arti Mehrotra
Chairpersons: Dr Vandana Arya, Dr Shikha Haldar, Dr. Sharmishtha Garg		
04:50-05:20 pm	Best of ASCO - ESGO 2025 **Moderator:** Dr Rahul Modi • Surgical Trials (Dr Saroj Rajan) • Medical Oncology Trials (Dr Arti Mehrotra) • Radiation Oncology Trials (Dr Arpita Gupta)	

WORKSHOP 4

Empowering Frontline Care: Maternal health Nurses module

Convener: Dr. Seema Prakash

Co-Convener: Dr. Rashmi
Dr. Neha Varun, Dr. Anita Rajauria
Co-Ordinator's: Dr. Srishti Prakash, Dr. Rashmi Shriya

Chief Guest: Dr. A.G Radhika, Dr. Rashmi Shriya

Venue: Sir Ganga Ram Hospital

Date: 06- Aug- 2025

Time: 01:30 – 05:00 PM

PROGRAMME

Time	Topic	Speaker/ Moderators	Chairperson's/Panelists/ Experts/Judges
MOC: Dr Rashmi Shreya			
1:00-1:30 pm	**Registration/Lunch**		
1:30-2:00 pm	Slogan (Topic will be given on Spot)	**Moderators:** Dr Chandana Dr Supriya Chaubey	**Judges:** Dr Deepika Loganey Dr Deepa Gupta Dr Bindu Ms Seema Mittal Ms Josephine
2:00-2:30 pm	Role Play/skit (Topic will be given on Spot) 5 min/Role Play 5 min discussion	**Moderators:** Dr Smiti Jain Dr Srishti Prakash Dr Haritha Mannem	**Judges:** Dr Mala Shrivastava Dr Tarini Taneja Dr Seema Prakash Dr Rachna Agarwal
2:30-3:00 pm	Welcome Address and Introduction followed by Inauguration & Lamp Lightening		
3:00-4:15 pm (15 min each)	Panel discussion 1. Antenatal Care	**Moderators:** Dr Neha Pruthi Dr Neha Varun	**Experts:** Dr Anita Rajorhia Dr Meenakshi Singh Dr Prachi Ranjhan Dr Garima Tyagi
	2. Postnatal Care	Dr Aastha Dr Aditi Ghai	Dr Rashmi Dr Somna Goyal Dr Srishti Prakash
	3. Breast feeding positions	Dr Divya Singhal Dr Rashmi Shreya	Dr Sunita Arora Dr Shama Batra Dr Renu Chawla Dr Vandana Gupta
	4. Emergency Obstetrics	Dr Haritha Mannem Dr Manpreet Saini	Dr Deepika Loganey Dr Sweena Arora Dr Vibha Bansal
	5. Contraception	Dr Supriya Chaubey Dr Smiti Jain	Dr Meenakshi Singh Dr Sujata Agarwal Dr Sanjita Behera
4:15d-4:45 pm	Valedictory		
4:45-5:00 pm	Vote of thanks: Dr Rashmi		

WORKSHOP 5

Hysteroscopy Made Easy: a Hands-on Workshop

Convener: Dr. Kanika Jain

Co- Convener: Dr. Swati Agrawal

Co-Ordinator: Dr. Aastha Aggarwal, Dr. Ila Sharma, Dr. Renuka Brijwal

Date: 07- Aug- 2025 (Thursday)

Time: 08:00 AM – 05:00 PM

Venue: Hall A & B, Auditorium, Sir Ganga Ram Hospital

PROGRAMME

TIME	TOPIC	SPEAKER
08:00-09:00 AM	Registration + Written Quiz	Breakfast
SESSION – I		**MOC:** Dr. Ila Sharma
EXPERTS: Dr. Abha Majumdar, Dr. Reva Tripathi, Dr. Y.M. Mala, Dr. Geeta Mediratta		
09:00-09:20 AM	Learning Hysteroscopy Assembly & Settings	Dr. Malvika Sabharwal
09:20-10:00 AM	Panel on "**Scope Smart: Practical Pearls & Pitfalls in Hysteroscopic Surgery"** **Moderators**: Dr. Indu Chawla & Dr. Sonia Naik **Panelists**: Dr. Debasis Dutta, Dr. Shivani Sabharwal, Dr. Madhu Goel, Dr. Ruma Satwik, Dr. Neema Singh, Dr. Alka Sinha	
10:00-10:30 AM	INAUGURATION & TEA	
SESSION – II		**MOC:** Dr. Ila Sharma
EXPERTS: Dr. Reena Yadav, Dr. Manju Puri, Dr. Harsha Khullar, Dr. Nidhi Khera		
10:30-10:45 AM	Hysteroscopic Myomectomy	Dr. Punita Bhardwaj
10:45-11:05 AM	Hysteroscopic Adhesiolysis	Dr. Milind Telang
11:05-11:15 AM	Discussion	
SESSION – III		**MOC:** Dr. Renuka Brijwal
EXPERTS: Dr. Mamta Dagar, Dr. Ratna Biswas, Dr. Ritu Sharma, Dr. Neeti Tiwari		
11:15-11:30 AM	Hysteroscopic Septal Resection	Dr. Farendra Bhardwaj
11:30-11:45 AM	Hysteroscopic Tubal Cannulation	Dr. Dinesh Kansal
11:45-11:55 AM	Discussion	
SESSION – IV		**MOC:** Dr. Renuka Brijwal
EXPERTS: Dr. Sonia Malik, Dr. S. S. Trivedi, Dr. Chandra Mansukhani, Dr. Sharmistha Garg		
12:00-12:10 PM	Hysteroscopic RPOCs removal	Dr. Swati Agrawal
12:10-12:30 PM	Hysteroscopic Isthmocele Repair	Dr. Ajay Aggarwal
12:30-12:50 PM	Complications of Hysteroscopy	Dr. Rahul Manchanda
12:50-01:00 PM	Discussion	
01:00-02:00 PM	LUNCH BREAK	
02:00-04:00 PM	**SESSION – V**	

Hands on workstation Coordinators: Dr. Kanika Jain, Dr. Indu Chawla, Dr. Swati Agrawal, Dr. Sonia Naik, Dr. Madhu Goel, Dr. Aastha Aggarwal		
Hands on Work Stations		**Workstation In-Charges**
Work Station - 1	Diagnostic Hysteroscopy – Assembly & Procedure	Dr. Renuka Brijwal Dr. Huma Ali
Work Station – 2	Operative Hysteroscopy – Assembly & Fluid Management	Dr. Neha Varun Dr. Pancham
Work Station - 3	Hysteroscopic Resection	Dr. Priyanka Dr. Aishwarya
Work Station - 4	Hysteroscopic Resection	Dr. Sakshi Miglani Dr. Bhawani Shekar
Work Station - 5	Hysteroscopic Morcellation	Dr. Ila Sharma Dr. Purvi Khandelwal
Work Station - 6	Hysteroscopic Morcellation	
04:00-04:40 PM	**SESSION – VI**	
EXPERTS: Dr. Shweta Mittal, Dr. Shalini Warman		
	Oral Quiz: Kahoot App	**Quiz Masters:** Dr. Aastha Aggarwal Dr. Ila Sharma Dr. Huma Ali

WORKSHOP 6

NARCHI DELHI 2025

31st Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch

Theme: "Plan Promote Propagate Women's Health"

Pre-Congress NARCHI Preventive Oncology Workshop

From Screening to Strategy: Preventing Gynecologic Cancers

Organising chairperson: Dr. Rachna Agarwal

Date: 07- Aug- 2025

Convener: Dr. Bindiya Gupta, Dr. Anshuja Singla

Time: 01:00 – 05:00 PM

Venue: Lecture Theatre 4: Fifth Floor UCMS and GTB Hospital, New Delhi

PROGRAMME

TIME	TOPIC	SPEAKER
1:00 - 1:30 pm	Registration and Lunch	
1:30 - 1:45 pm	Welcome Address	Dr Rachna Agarwal
	Inauguration and Lamp Lighting	
Session 1: Ovarian Cancer **Chairpersons:** Dr Kiran Guleria, Dr Seema Prakash, Dr Sandhya Jain, Dr Richa Sharma		**Expert:** Dr Rupinder Sekhon Dr Sumita Mehta
1:45 - 2:00 pm	Exploring early cancer detection strategies	Dr Seema Singhal
2:00 - 2:15 pm	Hereditary Breast and Ovarian Cancer: an Overview	Dr Shruthi Bhatia
2:15 - 2:30 pm	Risk Reduction in ovarian cancer: Video presentation	Dr Kanika Batra Modi
Session 2: Post-menopausal Bleeding Challenging case scenarios: Audience Q & A		
2:30 - 3:15 pm	**Experts:** Dr Amita Suneja, Dr Mala Srivastava, Dr Renu Tanwar, Dr Sharda Patra, Dr Archana Misra, Dr Swasti, Dr Shruti Bhatia, Dr Jyoti Meena	**Moderators:** Dr Satinder Kaur Dr Anshuja Singla
Session 3: Cancer cervix: Towards 90-70-90 **Chairpersons:** Dr Abha Sharma, Dr Saritha Shamsunder, Dr Rachna Agarwal, Dr Himsweta Srivastava		**Expert:** Dr Neerja Bhatla Dr Sweta Balani
3:15 - 3:30 pm	Colposcopy scoring systems for biopsy decisions	Dr Pakhee Agarwal
3:30 - 3:45 pm	Videos: Ablative procedures	Dr Aruna Nigam
3:45 - 4:00 pm	Videos: Excisional procedures	Dr Rashmi
4:00 - 4:30 pm	Case discussions: Audience study groups	**Facilitators:** Dr Rashmi Dr Sruthi Bhaskaran
4:30 - 4:40 pm	Role of LNGIUS in Endometrial pathology	Dr Priyanka Mathe
4:40 - 5:30 pm	**Hands on Session** 1. Normal Colposcopy 2. Thermal Ablation 3. LEEP 4. Newer Devices: Portable colposcopes 5. Hands on Hysteroscopy	Dr Alpana Singh Dr Balkesh Rathi Dr Richa Agarwal Dr Archana Chowdhary Dr Sruthi Bhaskaran

WORKSHOP 7

POCT in Critical Care Obstetrics

Convener: Dr. Jyotsna Suri, Dr. Rekha Bharti **Date:** 07- Aug- 2025

Co- Convener: Dr. Sheeba Marwah, Dr. Zeba Khanam **Time:** 09:00 am – 02:00 pm

Chief Guest- Dr. Sandeep Bansal

Guests of Honour- Dr. Geetika Khanna, Dr. Charu Bamba

Special Guest- Dr Pratima Mittal, Dr Achla Batra Dr. Mala Srivastava,

Advisor- Dr. Bindu Bajaj

Master of Ceremony- Dr. Panchampreet Kaur **Patron-** Dr. Anjali Dabral

Venue: Old Lecture Theatre, behind New OPD Block, VMMC and Safdarjung Hospital, Delhi

PROGRAMME

TIME	TOPIC	SPEAKER	CHAIRPERSONS
09:00 - 09:30 am	**Registration**		
09:30 - 10:00 am	**Inauguration and Welcome Address**		
Session 1: Coagulation in Crisis- ROTEM in Obstetric Hemorrhage			
10:00 - 10:20 am	Coagulation Cascade & Principles of Viscoelastic Testing	Dr Anjali Sharma (Pathology)	Dr Pratima Mittal Dr Mala Srivastava Dr Bindu Bajaj Dr Sarita Shamsunder
10:20 - 10:45 am	Interpretation of ROTEM and applications in PPH and DIC	Dr Zeba Khanam Dr Panchampreet Kaur	
10:45 - 11:00 am	**Audience Interaction**		
Session 2: Bridging Diagnostics and Emergency Response			
11:00 - 11:25 am	ABG: Interpretation & Clinical Use	Dr Jyotsna Suri	Dr Achla Batra Dr Anjali Dabral Dr Usha Kumari Rani Dr Harsha S Gaikwad
11:25 - 11:50 am	Rapid Ultrasound for Shock and Hypotension	Dr Nalini Bala Pandey	
11:50 am - 12:15 pm	Screening Echocardiography in Critically Ill Pregnant Patient	Dr Anunay Gupta (Cardiology)	
12:15 - 12:30 pm	DVT Screening	Dr Santvana Kohli (Anaesthesia)	
12:30 - 12:40 pm	**Audience Interaction**		
Session 3: Case Based Discussion: Near Miss Situations			
12:40 - 13:40 pm	Case 1: Preeclampsia with Pulmonary edema	**Panelists** Dr Upma Saxena Dr Sunita Malik Dr Sumitra Bachani Dr Anjila Aneja Dr Niharika Dhiman Dr Taru Gupta	**Moderators** Dr Rekha Bharti Dr Sheeba Marwah **Experts** Dr Jyotsna Suri Dr Ratna Biswas
	Case 2: AFLP		
	Case 3: Peripartum Cardiomyopathy		
13:40 - 14:00 pm	**Q & A and Vote of Thanks**		
14:00 - 14:30 pm	**Lunch**		

WORKSHOP 8

PATIENT SAFETY WORKSHOP

Convener: Dr. Poonam Joon
Co- Convener: Dr. Mala Srivastava
Venue: India Habitat Centre
Date: 08- Aug- 2025
Time: 09:00 am - 01:00 pm

PROGRAMME

TIME	TOPIC	SPEAKER
09:00-09:05 am	Welcome & Introduction	
Session I: Safe Patient Care Processes **Chairperson:** Dr Mala Srivastava, Dr Leena N Sreedhar, Dr Rinku Sen, Dr Sandhya Jain, Dr Kiran Guleria		
09:05-09:20 am	Infection Prevention & Control for Safe Motherhood	Dr Renu Gupta
09:20-09:35 am	Medication Safety in Obstetrics	Dr Sangeeta Sharma
09:35-09:50 am	Antimicrobial Stewardship in Obstetrics & Gynaecology	Dr Manju Puri
09:50-10:00 am	Discussion	
Session II: Clinical Risk Management **Chairperson:** Dr A.G. Radhika, Dr Taru Gupta, Dr Alka Jain, Dr Dipika Loganey		
10:00-10:15 am	Designing Safety Protocols in RMNCHA	Dr Vinita Gupta
10:15-10:30 am	Community Level Interventions in Women's Health and Safety	Dr Mrinalini Mani
10:30-10:45 am	Lifesaving Anaesthetic Skill for Emergency Obstetric Care (BLS)	Dr Devang Bharti
10:45-11:00 am	Discussion	
Session III: Safe Care Environment **Chairperson:** Dr Amita Suneja, Dr Manisha Arora, Dr Deepa Gupta, Dr Shakun Tyagi		
11:00 am -11:15 am	Quality Initiative in Patient Safety by Risk Management	Dr Poonam Joon
11:15 am -11:30 am	Near Miss- Lessons from Adverse Events for Safer Women's Health System	Dr Aparna Sharma
11:30 am -11:45 am	Managing Obstetrics Emergencies & Maternal Early Warning Systems	Dr Jyotsna Suri
11:45 am -12:00 pm	Discussion	
Session IV: Systems for Patient Safety **Chairperson:** Dr Bindu Bajaj, Dr Jyoti Sachdeva, Dr Puneeta Mahajan, Dr Dipti Nabh		
12:00 -12:15 pm	Sharing Patient experience	Dr Upasana Verma
12:15 -12:30 pm	Employees Health & Wellness for Quality and Safety Culture – Embracing Calm	Dr Vineet Banga
12:30 -12:45 pm	Medicolegal Aspect in Patient Safety	Dr Girish Tyagi
12:45-01:00 pm	Discussion	

WORKSHOP 9

GENETIC IN OBS & GYNAE WORKSHOP

Convener: Dr. Veronica Arora

Co- Convener: Dr. Neharika Malhotra

Chief Guest: Dr Ratna Dua Puri

Venue: India Habitat Centre

Date: 08- Aug- 2025 (Friday)

Time: 02:00 – 05:30 Pm

Guest of honor: Dr Rakhi Singh

PROGRAMME

TIME	TOPIC	SPEAKER
2:00 - 2:10 pm	Welcome I Inaugural Remark	
Session 1: **Chairperson:** Dr Vivek Kashyap, Dr Upma Saxena, Dr Rakhi Singh, Dr Mamta Phogat		
2:15 - 2:30	Ten Message, Geneticist to Obstetrician	Dr Neerja Gupta/ TBA
Session 2: Genomic Circuits: Cardiovascular and Renal Insights in Utero		
Chairpersons: Dr Neerja, Dr Suyesha, Dr Shehla Jamal, Dr Krishna Gopal		
2:35 - 2:50 pm	Learnings	Dr Seema thakur
2:55 - 3:30 pm CASE BASED PANEL	**Panel** **Moderator -** Dr Jayati, Dr Vibha	Dr Tina Verma Dr Bhavna Anand Dr Mridul Aggarwal Dr Kanav Anand Dr Seema Thakur
Session 3: From Limb to Liver: Genetic Disorders Shaping Fetal Morphology		
Chairpersons: Dr Vivek Kashyap, Dr Anita Rajhoria, Dr Shreyasi, Dr Anchal Sablok, Dr Mamta Phogat		
3:30 - 3:45 pm	Learnings	Dr Sunita Bjarmia-Mahay
3:45 - 4:15 pm CASE BASED PANEL	**Panel** **Moderator-** Dr Manisha, Dr Rhea	Dr Krishna Gopal Dr Chanchal Dr Shreyasi Dr Richa Dr Amit
Session 4 (20 min) **Expert-** Dr Anchal Sablok, Dr Pooja Gupta, Dr Shikha Mehta		
	LEARINGS FROM CLINICS 2-	Dr Chintan Chaudhary
	LEARINGS FROM CLINICS 1-	Dr Nupur Chawla
Session 5: Genes That Shape the Brain: CNS Disorders in the Womb		
Chairpersons: Dr Chanchal, Dr Rakhi, Dr Vertika, Dr Amreen		
4:30 - 4:45 pm	Learnings	Ratna Dua Puri
4:30 - 5:15 pm CASE BASED PANEL	Moderator- Dr Sumitra Bachini, Dr Bhawana Aggarwal	Dr Neha Gupta Dr Ratna Dua Puri Dr Alok Varshney Dr Pooja Agarwal Dr Salil Bhargava Dr Aman

WORKSHOP 10

Menopause: Unlocking the potential of the second innings

PRE-CONFERENCE

Organised By: Dept.of Obstetrics and Gynaecology, Deen Dayal Upadhyay Hospital

Organizing chairperson: Dr. Poonam Laul **Date:** 08- Aug- 2025 (Friday)

Conveners: Dr. Urvashi Miglani, Dr. Harvinder Kaur **Time:** 09:00 AM – 01:00 PM

Organising Secretary: Dr. Aishwarya Nandakumar, Dr. Alekhya

Venue: India Habitat Centre

PROGRAMME

TIME	TOPIC	SPEAKER
08:30-09:00 am	**REGISTRATION**	
09:00-09:15 am	Welcome Address & Introduction	
SESSION 1 **Chairpersons:** Dr Amita Suneja, Dr Y M Mala, Dr Renuka Malik, Dr Kiranjeet Kaur		
09:15-09:30 am	Repair, rebuild, reclaim: Bones in hormonal transition	Dr Niharika Dhiman
9:30-9:45 am	Fading muscles, rising risks: Confronting Sarcopenia in clinical practice	Dr Poonam Laul
9:45-10:00 am	MHT - When and How?	Dr Jyoti Bhaskar
10:00-10:30 am	**INAUGURATION**	
SESSION 2		
10:30-11:30 am	Case Based Panel Discussion on Menopause **Moderators:** Dr Urvashi Miglani, Dr Harvinder Kaur	**Panellists:** Dr Seema Singhal Dr Shalini Dr Meenakshi Ahuja Dr Anuradha
SESSION 3 **Chairpersons:** Dr Leena Sreedhar, Dr Poonam Laul, Dr Archana Pathak		
11:30-11:45 am	When Estrogen Fades: The Urogenital Fallout of Menopause	Dr Harsha
11:45-12:00 pm	Hot flashes, Cool minds - Emotional intelligence hacks for menopause	Ms Aadya
12:15-12:45 pm	**QUIZ**	
12:45 pm	**Vote of Thanks by Dr.Urvashi Miglani**	

WORKSHOP 11

Obstetric Anal Sphincter Injuries (OASIS) Pre- Conference WORKSHOP

Convener: Dr. Geeta Mediratta

Co- Convener: Dr. Sharmistha Garg, Dr. Huma Ali

Date: 08- Aug- 2025 (Friday)

Time: 01:00 – 05:00 PM

Venue: ASDC Sir Ganga Ram Hospital

PROGRAMME

TIME	TOPIC	SPEAKER
01:00-02:00 PM	**Lunch**	
Session I: Lecture		
Chairperson: - Dr. Achla Batra, Dr. Rajesh Kumari, Dr. K. Gujral, Dr. Chandra Mansukhani, Dr. Priti Dhamija		
02:00-02:15 PM	Anatomy of Anal Sphincter & Classification of OASIS	Dr. Geeta Mediratta
02:15-02:30 PM	Risk Factors for OASIS: Prediction and Prevention of OASIS	Dr. Sonal Bathla
02:30-02:45 PM	Surgical Principles of OASIS Repair	Dr. Karishma
02:45-03:00 PM	Discussion	
Session II: Hands on		
Chairperson: - Dr. Monica Gupta, Dr. Amita Jain, Dr. Uma Rani Swain, Dr. Mala Srivastava, Dr. Mamta Dagar		
03:00-03:30 PM	Video of Episiotomy Repair + Video of OASIS Repair	
03:30-04:30 PM	Hands on of OASIS 20 Table	
Session III: Lecture		
Chairperson:- Dr. J B Sharma, Dr. Ranjana Sharma, Dr. Harsha Khullar, Dr. Neeti Tiwari, Dr. Sakshi Nayar, Dr. Bhawani Shekhar		
04:30-04:40 PM	Planning delivery after previous OASIS Repair	Dr. Huma Ali
04:40-04:50 PM	Medicolegal aspect for OASIS	Dr. Sharmistha Garg
04:50-05:00 PM	Role of Endo-Anal Sonography | Anorectal manometry in OASIS	Dr. Shrihari Anikhindi

WORKSHOP 12

Promoting Fertility in Endometriosis for Practicing Gynecologist

Pre- Conference WORKSHOP

Convener: Dr. Shweta Mittal Gupta

Co- Convener: Dr. Neeti Tiwari

Co-Ordinator: Dr. Sakshi Nayar

MOC: Dr. Yukti Bhardwaj

Venue: India Habitat Centre

Date: 08- Aug- 2025 (Friday)

Time: 09:00 am – 01:00 pm

ROGRAMME

TIME	TOPIC	SPEAKER
09:00-09:05 AM	Welcome address	Dr Neeti Tiwari
09:05-09:10 AM	Introduction to the workshop	Dr Shweta Mittal Gupta
09:10-09:15 AM	Inauguration	
Session 1 Chairperson: Dr Kanika Jain, Dr Deepa Gupta, Dr Ashmita Jawa		
09:15-09:35 AM	How to improve integration between medical and surgical therapy in infertility with endometriosis	Dr Sweta Gupta
09:35-09:55 AM	Journey from Ovarian stimulation from IUI to IVF in endometriosis	Dr Abha Majumdar
09:55-10:05 AM	Discussion	
Session 2 Chairperson: Dr Abha Majumdar, Dr Anita Rajhoria, Dr Neeti Tiwari		
10:05-10:25 AM	The three musketeers against endometriosis Letrozole, Mifepristone and Elagolix	Dr Garima
10:25-10:45 AM	Insoluble dilemma in adenomyosis from diagnosis to management in infertility	Dr Ruma Satwik
10:45-10:55 AM	Discussion	
10:55 -11:55 AM	**Session 3 Panel discussion** "From theory to practice Case based scenarios in endometriosis with infertility" **Moderators:** Dr Neeti Tiwari, Dr Sakshi Nayar	**Panelist:** Dr Pikee Saxena Dr Renu Tanwar Dr Shalini Chawla Dr Shivani Sabharwal Dr Sabina Sanan Dr Bhawani Shekhar
Session 4 Chairperson: Dr Chandra Mansukhani, Dr Tarini Taneja, Dr Sunita Kumar		
11:55-12:15 PM	Egg freezing in endometriosis when should she rush?	Dr Shweta Mittal Gupta
12:15-12:35 PM	When should I worry about EAOC in my patient?	Dr Mala Srivastava
12:45 PM	Closing remarks with vote of thanks	

WORKSHOP 13

QUALITY IN MATERNITY CARE WORKSHOP

Convener: Dr. Sumita Mehta

Co- Convener: Dr. Anshul Rohatgi

Venue: India Habitat Centre

Date: 08- Aug- 2025 (Friday)

Time: 02:00 – 05:00 PM

PROGRAMME

TIME	TOPIC	SPEAKER
Welcome Address & Inauguration by Dr Mala Srivastava & Dr Sumita Mehta		
Session 1: Foundation of Quality in Maternal Health **Chairpersons:** Dr Jyoti Sachdeva, Dr Suman Lata Mendiratta, Dr Shakun Tyagi		
2:15 - 2:30pm	Introduction to Quality in Maternal Health	Dr Sumita Mehta
2:30 - 2:45pm	WHO QOC Framework Maternal and New Born Health	Dr Prabha Ranjan
Session 2: Antenatal to Postnatal Care **Chairpersons:** Dr Anuradha Khanna, Dr Sujata Das, Dr Aparna		
2:45 - 3:00 pm	FANC	Dr Anshul Rohatgi
3:00 - 3:15 pm	Safe Delivery Practices	Dr Neeta Sagar
3:15 - 3:30 pm	Postnatal Care and Postnatal Contraception	Dr Divya Chauhan
Session 3: Respectful Maternity Care (RMC) **Chairpersons:** Dr Poonam Sachdeva, Dr Shailja, Dr Leena Bhatnagar		
3:30 - 3:45pm	Principles and Practices of RMC	Dr. Mrinalini Mani
3:45 - 4:00pm	Skit on RMC	BJRM hospital
Session 4: Quality Improvement **Chairpersons:** Dr Seema Prakash, Dr CD Jassal, Dr Abhijeet Yadav		
4:00 - 4:15pm	Infection Prevention and Control in Maternal Settings	Dr. Nalini Mittal
4:15 - 4:30pm	Audits for Quality Assurance	Dr Bhanupriya
4:30 - 4:45pm	Patient Safety in Maternal Health	Dr. Anshuja Singla
4:45 - 5:00pm	Role Play	BJRM Hospital
Closing Ceremony Followed by High Tea		

WORKSHOP 14

Optimizing Intrapartum Surveillance: Principles of Physiological Interpretation of CTG

Convener: Dr. Aruna Nigam

Date: 08- Aug- 2025 (Friday)

Co- Convener: Dr. Sumedha Sharma

Time: 09:00 Am – 01:00 Pm

Organizing Committee: Dr Arifa Anwar Elahi, Dr Nidhi Gupta, Dr Supriya Chaubey, Dr Dina Aisha Khan, Dr Asma Bashir Khanday, Dr Pratibha Roy, Dr Paridhi Gupta, Dr Lubna Inam, Dr Kirti Verma

Venue: India Habitat Centre

PROGRAMME

TIME	TOPIC	SPEAKER	Chairpersons
09:00 - 09:05 am	Welcome & Introduction		
Session 1: Understanding the Basics			
09:05 - 09:45 am	Fetal Adaptation to Hypoxia: What CTG Tells Us	Dr Aruna Nigam	Dr Vinita Sarabhai Dr Richa Agarwal Dr Reva Tripathi
Session 2: Decoding the CTG: Machine & Strip			
09:45 - 10:00 am	CTG Machine	Dr Zeba Khanam	Dr Ritu Sharma Dr Shakun Tyagi Dr Mamta Dagar
10:00 - 10:15 am	CTG Strips: How to Read	Dr Nidhi Gupta	
10:15 - 10:25 am	Discussion		
10:25 - 10:45 am	Inauguration & Tea Break		
Session 3: Interpreting Danger signals			
10:45 - 11:15 am	Acute and Subacute Hypoxia: CTG Clues to Act Fast	Dr Chanchal Singh	Dr Ratna Biswas Dr Divya Pandey Dr Neeru Malik
Session 4: Guidelines: what is new			
11:15 - 11:45 am	International Expert consensus (2024)	Dr Sumedha Sharma	Dr Jayashree Sunder Dr Raka Guleria Dr Supriya Chaubey
Session 5: From Theory to Practice			
12:00–01:00 PM	CTG in Action: Practice & Special Cases (**Case** Discussion)	Dr Rinku Sen Gupta, Dr Arpita De, Dr Dina Aisha Khan, Dr Sumedha Sharma, Dr Aruna Nigam	

WORKSHOP 15

NARCHI DELHI 2025

31st Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch

Theme: "Plan Promote Propagate Women's Health"

ADOLESCENT HEALTH WORKSHOP

Convener: Dr. Latika Bhalla

Co- Convener: Dr. Chandra Mansukhani

Venue: Sir Ganga Ram Hospital

Date: 11- Aug- 2025

Time: 9:00 am to 1:00 pm

PROGRAMME

TIME	TOPIC	SPEAKER
09:00-09:30 am	**Registration**	
09:30-10:00 am	**Welcome Address & Inauguration**	
SESSION: I		
CHAIRPERSON: Dr. Geeta Mediratta, Dr. Sonia Rawat, Dr. Pankaj Garg		
10:00-10:20 am	Adolescent friendly health services	Dr. Sangeeta Yadav
10:20-11:00 am	**Panel Discussion**: Comprehensive Sexuality in Adolescent **Moderator:** Dr. Deepa Passi & Dr. Manjusha Goel **Expert:** Dr. Rajesh Mehta & Dr. K. Gujral **Panelists:** Dr. Sunita Manchanda, Dr. Neeta Kejriwal, Dr. Smita Gupta, Dr. Seema Gupta, Dr. Renu Raina	
11:00-11:30 am	**Tea Break**	
SESSION: II		
11:30-12:30 pm	**Panel Discussion**: Case based Approach to Adolescent Health Problems – HEADSS Project **Moderator:** Dr. Latika Bhalla **Expert:** Dr. Mala Srivastavas & Dr. Chandra Mansukhani **Panelists:** Dr. Anita Rajohria, Dr. Renuka Brijwal, Dr. Aradhna & Dr. Richa Prashar, Dr. Sharmistha Garg	
SESSION: III		
CHAIRPERSON: Dr. Harsha Khullar, Dr. Anup Thakur, Dr. Mamta Dagar		
12:30-12:50 pm	Teen Pregnancy & Problems	Dr. Sampath Kumari
CHAIRPERSON: Dr. V. K. Khanna, Dr. Praveen Suman, Dr. Suresh Gupta		
12:50-1:05 pm	Adolescent Parenting Skills	Dr. Ritu Gupta
1:00 pm	Vote of Thanks	Dr. Renuka Brijwal

MAIN CONFERENCE DAY 1

HALL - A (Gulmohar) – 9th AUGUST, 2025 (Saturday) - DAY I		
MOC Pre Lunch: Dr. Saroj Rajan/ Dr. Purvi Khandelwal		**MOC** Post Lunch: Dr. Ashmita Jawa
8:00 - 9:00 am	Quiz Theory	Dr. Sharmistha Garg, Dr. Renuka Brijwal & Dr. Purvi Khandelwal
SESSION I - Skit		
EXPERTS: Dr. Renu Tanwar, Dr. Manisha, Dr. Jyoti Meena, Dr. Vandana Gupta **Co-ordinator**: Dr. Kanika Jain		
Time	**Topic**	**Speaker**
9:00 – 9:10 am	GDM	Dr. Pikee Saxena
9:10 - 9:20 am	Infertility	Dr. Rupali Bassi
9:20 – 9:30 am	Breaking Bad News	Dr. Aparna Sharma
9:30 – 9:45 am	Post Partum Care	Dr. Garima Kapoor
SESSION II - KEY NOTES		
CHAIRPERSONS: Dr. Neera Agarwal, Dr. Chitra Raghunandan, Dr. Ratna Biswas, Dr. Raksha Arora		
09:45 -10:00 am	Identification of High risk foetus in a low risk mothers	Dr. Manju Puri
10:00-10:15am	Preventive Peritonatology	Dr. Milind Shah
10:15-10:30 am	Hepatitis E in pregnancy	Dr. Ashok Kumar
10:30-10:45 am	Legal issues in medical practice: current perspective	Dr. Neeti Tiwari
10:45-11:00 am	**TEA BREAK**	
SESSION III – LEELAWATI ORATION		
CHAIRPERSONS : Dr. S. N. Mukherjee, Dr. Abha Majumdar, Dr. Achla Batra, Dr. Geeta Mediratta, Dr. Kanika Jain		
11:00 -12:00 noon	**No to violence against women: WHERE ARE WE??**	Dr. S. Shantha Kumari
SESSION IV – PANEL DISCUSSION		
12:00 - 1:00 pm	**PANEL: MEDICOLEGAL ISSUE IN OBSTETRIC & GYNAECOLOGY** **Moderator**: Dr. M.C Patel **Experts**: Dr. S. S. Trivedi, Dr. Anjali Gera (Anaesthesia)	

	Panellists: Dr. Jyotsna, Dr. Himani Agarwal, Dr. Jaya Chawla, Dr. Vinita Gupta, Dr. Smriti Gupta, Dr. Anita Sabharwal	
1:00 -2:00 pm	**LUNCH BREAK**	
SESSION V – KEY NOTES		
CHAIRPERSONS: Dr. Jyoti Bhaskar, Dr. Anjila Aneja, Dr. Suman Mediratta, Dr. Renuka Malik		
2:00 – 2:15 pm	Epidemic of NCD 3 WS - when, where & which way to fight	Dr. Maninder Ahuja
2:15 – 2:30 pm	Strong from Start to Silver, A Gynaecologist guide to lifelong Bone health	Dr. Neelam Jain
2:30 – 2:45 pm	'Teen Time, Right Time .... Why your clinic needs a dedicated Adolescent corner today'	Dr. Taru Chaya
2:45 – 3:00 pm	The Precursor Puzzle : Biomarkers Predicting Endometrial Cancer – Risk Stratification beyond histopathology	Dr. Sharda Patra
SESSION VI – PANEL DISCUSSION		
3:00 -4:00 pm	**PANEL: TYPICAL & ATYPICAL ECLAMPSIA – CASE BASE DISCUSSION** **Moderator**: Dr. Sadhna Gupta **Experts:** Dr. Reva Tripathi **Panellists:** Dr. Indu Khatri, Dr. Himsweta Srivastava, Dr. Yukti Wadhwan, Dr. Divya Singhal, Dr. Neeru Thukral, Dr. Somna Goyal, Dr. Sheeba Marwah, Dr. Garima	
SESSION VII – QUIZ		
JUDGES:- Dr. Geeta Mediratta, Dr. A.G. Radhika		
4:00 -5:00 pm	**Quiz Final Round – HIGH RISK PREGNANCY** **Co-ordinator:** Dr. Sharmistha Garg Dr. Renuka Brijwal Dr. Purvi Khandelwal	
5:00 pm	**HIGH TEA**	

HALL - B (Magnolia) - 9th AUGUST, 2025 (Saturday) - DAY I		
8:00 - 11:00 am	Paper/Poster Presentation (Paper and poster will run throughout the day in hall B)	
SESSION III – LEELAWATI ORATION		
11:15 -12:00 noon	**Topic: No to violence against women: Where are we???**	Dr. S. Shantha Kumari
CHAIRPERSONS: Dr. Manju Arora, Dr. Shalini Agarwal		
12:00 – 12:20 pm	Optimising Surgical Outcomes in C-Section & Robotics with SNPWT **(Smith & Nephew)**	Dr. Anjila Aneja
12:20 – 12:40 pm		
1:00 -2:00 pm	**LUNCH BREAK**	
2:00 – 5:00 pm	Paper/Poster presentation	
5:00 pm	**HIGH TEA**	

MAIN CONFERENCE DAY 2

HALL - A (Gulmohar) – 10th AUGUST, 2025 (Sunday) - DAY II		
MOC Pre Lunch: Dr. Anusha Sharma/ Dr. Huma Ali		**MOC** Post Lunch: Dr. Renuka Brijwal
8:00 - 9:00 am	**Registration**	
SESSION I - PANEL DISCUSSION		
Time	**Topic**	**Speaker**
9:00 – 09:45 am	**PANEL: CONTRACEPTION IN DIFFERENT SCENARIOS** **Moderators**: Dr. Kavita Agarwal & Dr. Rashmi Malik **Experts:** Dr. Reena Yadav **Panellists:** Dr. Anita Rajouria, Dr. Kalpana Kumar, Dr. Amrita Jaipuriar, Dr. Reena Rani Punia, Dr. Nistha Jaiswal, Dr. Kalpana Gupta, Dr. Neha Sharma, Dr. Erum Sajid.	
SESSION II - KEY NOTES		
CHAIRPERSONS: Dr. Suneeta Mittal, Dr. N. B. Vaid, Dr. Deepti Goswami, Dr. Archana Dhawan		
9:45 -10:00 am	Anaemia in Adolescent Girls: A National Emergency	Dr. Sharda Jain
10:00 -10:15 am	Concealed PPH	Dr. Achla Batra
10:15 -10:30 am	Aneuploidy Screening	Dr. Reema Bhat
10:30 -11:00 am	**TEA BREAK**	
SESSION III – Dr. S. K. Das ORATION		
CHAIRPERSONS: Dr. Kamal Buckshee, Dr. Kanwal Gujral, Dr. Manju Puri, Dr. Harsha Khullar, Dr. Chandra Mansukhani		
11:00 -12:00 noon	**COCP: Tailoring Therapy, Bursting Myths**	Dr. Bhaskar Pal
SESSION IV – KEY NOTES		
CHAIRPERSONS: Dr. Ranjana Sharma, Dr. Manju Khemani, Dr. Meenakshi Ahuja, Dr. Abha Singh		
12:00 – 12:15 pm	Foetal growth in 3rd trimester & risk of Still birth	Dr. Tina Verma
12:15 – 12:30 pm	Prevention of VTE in pregnancy: The silent crises	Dr. Suviraj John

12:30 – 12:45 pm	Environment & Birth Defect	Dr Tarini Taneja
12:45 – 01:00 pm	Chronic Pelvic Pain – What is next?	Dr. Sunita Mallik
01:00 - 2:00 pm	**LUNCH BREAK**	
SESSION V – VIDEOS		
CHAIRPERSONS: Dr. Ranjana Sharma, Dr. Neena Singh, Dr. Garima Kachwaha		
02:00 – 02:15 pm	Robotic Myomectomy	Dr. Leena Malhotra
02:15 – 02:30 pm	Challenges in Endoscopic Surgery for Deep Infiltrating Endometriosis	Dr. Jyoti Mishra
02:30 – 02:45 pm	Total Laparoscopic Hysterectomy in Difficult Scenarios	Dr. Neema Sharma
02:45 – 03:00 pm	Minimally Invasive Management of VVF	Dr. Amita Jain
SESSION VI – PANEL DISCUSSION		
3:00 -4:00 pm	**PANEL: ADNEXAL MASSES FROM ADOLESCENT TO MENOPAUSE** **Moderator**: Dr. Mamta Dagar **Experts:** Dr. Vijay Zutshi **Co-Moderator**: Dr. Madhu Goel **Panellists:** Dr. Shalini Warman, Dr. Shikha Chadha, Dr. Ritu Rana**,** Dr.Sunila Jain, Dr. Arunima Agarwal, Dr. Alpana Agarwal, Dr. Deeksha Rashtogi, Dr. Anita Bhownani	
SESSION VII – SKIT		
Experts: Dr. Ashmita Mehla, Dr. Pallavi Pasricha, Dr. Vinita Sarabhai		
4:00 - 4:20 pm	Main Hoon Na – The Third Perspective	Dr. Jasmine Chawla
4:20 - 4:40 pm	Skit	Dr. Monika Gupta
SESSION VIII – SLOGAN		
JUDGES: Dr. Amrita Jaipuriar, Dr. PakheeAgarwal, Dr. Indu Chugh, Dr. Kanika Gupta		
4:40 – 5:00 pm	**SLOGANS – PREVENTIVE ONCOLOGY** **Co-ordinator:** Dr. Ashmita Jawa	
5:00 pm	**Valedictory**	

HALL - B (Magnolia) - 10th AUGUST, 2025 (Sunday) - DAY II		
8:00 -10:00 am	Paper/Poster Presentation (Paper and poster will run throughout the day in hall B)	
10:00 – 10:15 am	Vitamin D3: A Vital Nutrient for Women's Health at Every Key Life Stages **(Snofi)**	Dr. Mala Srivastava
SESSION III – Dr. S. K. Das ORATION		
11:00 -12:00 noon	**COCP: Tailoring Therapy, Bursting Myths**	Dr. Bhaskar Pal
CHAIRPERSONS: Dr. Sushma Dikshit, Dr. Poonam Mani		
12:00 - 12:20 pm	Overview of Robotic System & Safe Use of Energy Sources **(Medtronic)**	Medronix team
12:20 – 12:40 pm	Byzepta in PCOS/Decoding Indian PCOS Phenotype GLP-1 & UCP-: The new Therapeutic Targets **(EQOQ-Celegenex)**	Dr Mala Srivastava
12:40 – 1:00 pm	Leukomed Sorbact Dressing Sorbact Technology Proven for Prevention Of SSI **(Essity)**	Dr. Saroj Rajan
1:00 -2:00 pm	**LUNCH BREAK**	
2:00 – 5:00 pm	Paper/Poster presentation	
5:00 pm	**Valedictory**	

NARCHI 2025: Free Paper Presentation Schedule

Presentation Date	Time	Presentation Place	Presentation No.	Author Full Name	Abstract Title
09 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP01	Janvi Vashist	Diagnostic accuracy of hematological parameters for prediction of Gestational Diabetes Mellitus
09 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP02	Asmita Singh	Unmasking Congenital Diaphragmatic Hernia – From Diagnosis to Post Natal Surgical Management .
09 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP03	Himesh Chandra Choudhary	Comparison of Fasting Versus Fed State Oral Glucose Tolerance Test On Diagnosis on Gestational Diabetes Mellitus in Pregnant Women in Second Trimester
09 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP04	Chaiti Saha	Maternal and neonatal outcomes in preeclampsia with and without proteinuria
09 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP05	Maneesha Verma	Clinical and Biochemical Profiles in Adolescent PCOS: A Comparative Approach
09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP06	Srishti	Peripartum Stroke:Let's decode the Enigma
09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP07	Mamta Shou	Effect of early gestational body mass index (within 12 weeks) on maternal and neonatal outcomes in nulliparous women .
09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP08	Balla Vani	A novel technique of endometrial sampling using endocervical cytobrush for detection of endometrial pathology - a pilot study
09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP09	Chanchal	Serum Levels of Macrophage Colony Stimulating Factor (MCSF) as Diagnostic Marker for Cervical Pre-Cancer And Early Invasive Cancer
09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP10	Divya Rashmi	Evaluation of ovarian reserve with serum anti-mullerian hormone (AMH) levels post cystectomy in benign ovarian cysts: A prospective cohort study

09 August 2025	10:00-11:00 AM	Magnolia (Hall-B)	OP11	Shweta Singhal	Congenital Defects and Stillbirths: Bridging Prenatal Clues to Perinatal Loss
10 August 2025	08:00-09:00 AM	Magnolia (Hall-B)	OP12	Bani Gupta	Comparative evaluation between vaginoscopy and traditional hysteroscopy
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP13	Rishav Dubey	Expression of Estrogen and Progesterone Receptors and P53 in Histologic Subtypes of Endometrial Carcinoma and Their Association with Pathological Parameters: An Observational Study
10 August 2025	08:00-09:00 AM	Magnolia (Hall-B)	OP14	Maria Haroon	Feasibility and Acceptability of HPV DNA Self-Sampling Method for Cervical Cancer Screening in Pregnant Women for Detection of High Risk Human Papillomavirus Infection
10 August 2025	08:00-09:00 AM	Magnolia (Hall-B)	OP15	Rahul Amitabh	Decoding the S.FLT1/PLGF Ratio: A New Frontier in Placenta Accreta Spectrum Prediction
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP16	Parul Aggarwal	AI Detectives: Early Identification of Genetic Disorders Through Non-Invasive Prenatal Testing (NIPT)
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP17	Aparna Sharma	Correlation of serum calcium levels in labor with primary postpartum hemorrhage
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP18	Anjali	Role of transcutaneous electrical nerve stimulation in relieving labour pain
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP19	Smita Jugnu	Beyond the epidural: a novel integration of tens and massage in active labor in low-risk laboring women
10 August 2025	09:00-10:00 AM	Magnolia (Hall-B)	OP20	Angel Nandan	Depot Medroxyprogesterone Acetate (DMPA) is a widely used in jectable contraceptive but often causes abnormal uterine bleeding (AUB), leading to discontinuation.
10 August 2025	11:00-12:00 AM	Magnolia (Hall-B)	OP21	Geetanjali Singh	Title: Effectiveness of depot leuprolide on myoma volume in HMB due to leiomyoma

NARCHI 2025: E-Poster Presentation Schedule

Date	Time	Presentation Place	Poster	Author Full Name	Abstract Title
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 01	Shreya Mittal	OHVIRA syndrome: a rare cause of left-side pyocolpos in an adolescent girl
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 02	Vandana Meena	Rudimentary horn pregnancy
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 03	Shreya Mahajan	Mature Cystic Teratoma Ovary masquerading as Abdominal Malignancy : A Diagnostic Challenge
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 04	Mira Jasrai	A Rare Bilateral Ectopic Spectrum: Left Chronic Ectopic Pregnancy with Right Tubal Abortion
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 05	Vidushi Agarwal	Prenatal Detection of Cardiac Rhabdomyoma associated with Tuberous Sclerosis Complex in third trimester: A Case Report
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 06	Dasariyeshaswini	First Trimester Uterine Rupture: A Rare but Life-Threatening Event – Case Report
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 07	Aishwarya V Yajaman	Interstitial Lung Disease complicated as pneumothorax in pregnancy
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 08	N.Lakshmi Priya	Fundal Placenta Accreta-A rare presentation in a case of previous 2 LSCS with Intrauterine Feral Demise in Early Pregnancy
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 09	Monika Jain	Diagnostic Dilemma: When HELLP Mimics Dengue in Pregnancy
10 August 2025	09:00-10:00 AM	Exhibition Area (Lobby)	EP - 10	Priyanka Mitra	“Itp and hysterectomy- a post-partum tale”
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 11	Komal	Antenatal Diagnosis and Multidisciplinary Management of Left Congenital Diaphragmatic Hernia: A Case Report
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 12	Sonika Bansal	Cervical endometriosis: a rare form of genital endometriosis
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 13	Veena Sharma	An interesting case of abnormal uterine bleeding with aplastic anemia

10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 14	Veena Acharya	High risk pregnancy
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 15	Seejal Sirohi	Diagnostic Dilemma- A rare case of Cervical Polyp mimicking Uterine Prolapse
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 16	Anu Berwal	Exploring Vulval Fibroadenoma- A Rare Case
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 17	Kritika Dhingra	Management of Postmenopausal Labial Adhesions with Urethral Obstruction and Vaginal Stenosis: A Case Report
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 18	Neha	Rare case of postpartum peripheral wet gangrene
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 19	Ishani Vasudeva	Clinical Challenges in the Management of Chronic Myeloid Leukaemia During Pregnancy
10 August 2025	10:00-11:00 AM	Exhibition Area (Lobby)	EP - 20	Farha Naaz	Subacute uterine inversion
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 21	Ankita Singh	Case series on outcomes of pregnancy with different mullerian anomalies
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 22	Ritika Kumari	Hydatid cyst in pregnancy
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 23	Neeti Singhal	The atypical presentation of Ovarian Sertoli-Leydig cell tumor- a case report
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 24	Bani Gupta	Vaginohysteroscopy: A New Way of Evaluating the Uterine Cavity
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 25	Kareena Rai	A Rare Case of Tongue Hemangioma in a 33-Week Pregnant Woman: Multidisciplinary Management and Obstetric Considerations
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 26	Neetu Mandia	Idiopathic polyhydramnios & pregnancy outcome
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 27	Anusha Khare	Robert's uterus : a case report
10 August 2025	11:00-12:00 AM	Exhibition Area (Lobby)	EP - 28	Mamta Pandey	AFLP: The diagnostic and therapeutic enigma

Main Conference Abstracts

Dr. S. K. Das Oration

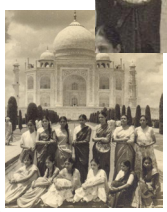
A Tribute to Dr. Subodh Das

Sharmila Pimple

Professor & Head Department of Preventive Oncology
Homi Bhabha National Institute Tata Memorial Centre Mumbai 400012, India

Dr. S. K. Das

A Shining Star born on 14th August 1937



Graduate KGMC Lucknow 1960
MD (Ob Gyn) SJH 1967

Visited England 1968 - 69

Worked at Grauesend & Northkent Hosp. Grauesend and Westhill Hospital, Dartford

Lecturer at Christian Medical College, Ludhiana (1969-71)

Joined CHS in Jan 1972 as Specialist and worked at Dhanbad for 6 years

A Dedicated Clinician from the young age

Keen Interest in academics, Member FOGSI since 1967

Hon. Secretary Dhanbad Society of FOGSI 1973

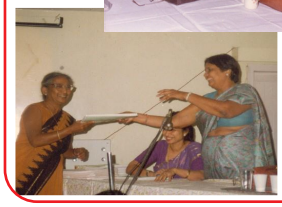
Transferred to Safdarjung Hospital in 1978
Started postgraduate teaching in 1981, designated Professor UCMS

Retired from SJH as HOD & Consultant in 1996

Attended Conferences & Training Programs

in USA, Russia, Sydney Rome, Hawaai

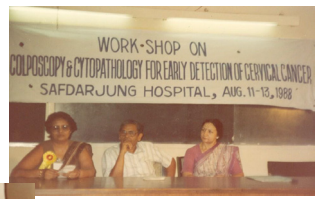
A True Leo and Born Leader
Marched on with Great zeal & Zest



Acclaimed Nationally

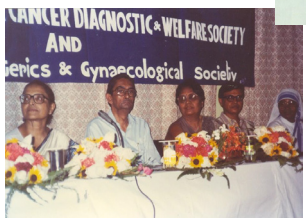
& Internationally

Inaugurated 1st Colposcopy Workshop at SJH in 1984



Still Holding 2-3 workshops every year

- **President IMA Delhi branch**
- **Chairperson of Oncology Committee FOGSI (1989-95)**



Authored An Atlas of Colposcopy (1995)

At an Exhibition for Cancer Awareness and Aid of Cancer Patients

Always Ready to Take Up any Challenge

Organizing Cervical Cancer Screening Camps

Founder President (1991-94)
Association of Gynecologic Oncology &

Patron, Indian College of Colposcopy & Cervical Pathologists

Untiring Efforts to start M.Ch. Gynae Oncogy

MCI has already recognized he course

Survived 2 'Near Miss Accidents' in 1992, 1994

Never Lost her Spirit and Enthusiasm

Moments of Relaxation

After retirement from Government Service at Rajiv Gandhi Cancer Research Institute

With
A Warm Friendly Smile
Like Bright Sunshine

Founder President
NARCHI (Delhi) 1976

PATRON NARCHI 2006

Dear Dr. Das

You are
a
Symbol
of
Strength and Simplicity
for
Us

Minimally Invasive Management of Vesicovaginal Fistula

Amita Jain

Senior Consultant Urogynaecologist, Institute of Urology & Robotic Surgery,
Medanta - The Medicity Hospital, Gurugram, Haryana

Introduction

Vesicovaginal fistula (VVF) is an abnormal communication between the bladder and the vagina. The cause of VVF differs in various parts of the world. The most common cause of iatrogenic VVF is injury to the bladder at the time of gynecologic surgery. It typically presents with symptoms of continuous urinary leakage from the vagina. This may be as early as 5–7 days after surgery or may be delayed weeks.

Apart from the well-known advantages of a less invasive surgical approach over traditional open repairs which include shorter hospital stay, less postoperative pain, early recovery and better cosmetic results; the minimally invasive approach provides improved visualization due to magnification and insufflation effects. This allows better visualisation of pelvic anatomy helping in more precise dissection and as a result, complicated urogynecological surgeries such as VVF repair becomes much easier to perform and desirable outcomes can be achieved with minimal morbidity, as it offered the best possibility to specifically treat the target anatomy with a reduced risk for involvement of the surrounding structures and a quick postoperative recovery [1]. Using the advance technological advantages of robotic technology (EndoWristTM instruments with increased degrees of freedom leading to improved dexterity and absence of fatigue, three-dimensional [3-D] vision with improved depth perception, motion scaling, tremor filtration, higher magnification, and the surgeon's ergonomic position in a longstanding and time-consuming operation), it is possible to perform VVF repair with easy solutions to overcome technical difficulties, particularly some of them frequently faced in complex fistula repair in form of narrow pelvic operating area, long and difficult suturing steps, and hypovascularized structures in long standing or recurrent cases [2]. Few challenges like additional cost, increased operating time and prolonged learning curve could also be surpassed by achieving expertise in this technique and increasing the number of surgeries.

References

1. Dutto L, O'Reilly B. Robotic repair of vesico-vaginal fistula with perisigmoid fat flap interposition: state of the art for a challenging case? Int Urogynecol J. 2013 Dec;24(12):2029-30. doi: 10.1007/s00192-013-2081-3.
2. Tsoi H, Elnasharty SF, Culha MG et al. Current evidence of robotic-assisted surgery use in functional reconstructive and neuro-urology. Ther Adv Urol. 2023 Dec 1;15:17562872231213727. doi: 10.1177/17562872231213727.

Anemia in Indian Adolescents: A National Emergency

Sharda Jain

Director, Lifecare Centreand IVF. Expert Ethical committee NMC. Secretary General DGF

The Crisis: Staggering Prevalence

- 60%** of adolescent girls (15–19 years) & **31.1%** of boys are anemic (NFHS-5).
- Severity**: 30% suffer moderate-to-severe anemia (Hb <10 g/dL).
- Rural-Urban Gap**: Rural girls show 12% higher anemia rates than urban peers.

Why "National Emergency"?

- Human Capital Loss : Anemia reduces cognitive capacity by 5–10 IQ points → impacts education & future productivity.
- Maternal Health Timebomb : 50% of future mothers enter pregnancy anemic → doubling maternal mortality risk & preterm birth.
- Economic Burden : Costs India **1.2% of GDP** annually (World Bank).

Root Causes

- Nutritional Poverty : 70% of girls consume <50% RDA of iron. Diets lack vitamin C (iron absorption) & protein.
- Teen Pregnancy : 7% of girls (15–19) begin childbearing → anemia accelerates.
- Menstrual Health Neglect : 50% lack access to hygienic absorbents → chronic blood loss.
- Parasitic Infections : 40% have soil-transmitted helminths (hookworm).
- Poor Compliance : <30% complete IFA therapy due to side effects & stigma.

Consequences Beyond Fatigue

- Physical : Stunted growth, reduced work capacity.
- Mental Health : 3× higher depression/anxiety risk.

  Dr. Sharda Jain Director, Lifecare Centre and IVF. Expert Ethical committee NMC. Secretary General DGF. Chairman - North India Gynaecologist Forum
- Reproductive : Delayed menarche, PCOD exacerbation.
- Vicious Cycle : Anemic teens → anemic mothers → LBW infants → intergenerational anemia.

Solutions: Beyond Iron Tablets

A. Policy Acceleration

- Mandatory IFA in PM-POSHAN : Integrate *double-fortified salt* (iron + iodine) & weekly IFA in school meals.
- Menstrual Equity : Scale UP's *"Kishori Suvidha"* (subsidized absorbents + health education).

Medical Interventions

- Screen Early : Hb testing at age 10 (school entry) & annual checks.
- Deworming : Biannual Albendazole (as per WHO) linked to IFA distribution.
- Treat, Not Supplement : Shift to *therapeutic iron doses* for moderate-severe cases (e.g., injectable iron in PHCs).

Community Action

- Anaemia Maitri Clubs : Peer-led groups for cooking iron-rich recipes (jaggery, millets, spinach).
- Father Engagement : Address male bias in household nutrition allocation.

Tech Innovation

- ANEMIA TRACKER App : ASHA-led mobile tools for compliance alerts & side-effect management.
- AI-Predictive Models : Identify high-risk clusters using sanitation, diet, and menstrual health data.

Kerala's Lessons for India

- School Health Revolution : 98% Hb screening coverage via school clinics + fortified noon meals.
- Adolescent Friendly Clinics (AFCs) : Confidential counseling + IFA at panchayat level.
- Local Food Sovereignty : Promotion of iron-rich crops (moringa, amaranth) in kitchen gardens.

Call to Action for Gynaecologists

- Advocate : Demand anemia as a political priority (state health missions).
- Screen Proactively : Test Hb in *every* adolescent OPD visit.

Prescribe Correctly :

- Moderate anemia: 100 mg elemental iron + 400 µg folic acid × 12 weeks.
- Severe: Parenteral iron sucrose (avoid blood transfusions unless Hb <4 g/dL).
- Educate : Teach girls about menstrual iron loss & dietary mitigation.

"Anemia is not a deficiency—it's systemic injustice. Fixing it is non-negotiable for Viksit Bharat 2047."

Key References

1. NFHS-5 (2019-21)
2. WHO Global Anaemia Report (2023)
3. Anemia Mukt Bharat Strategy (MoHFW)
4. Lancet Study on Indian Adolescent Health (2022)

"Teen Time, Right Time…Why your clinic needs a dedicated Adolescent corner"

Taru Chhaya

Director, Bansal Hospital, Shyam Nagar, Jaipur

Second stage cesarean section constitutes around 2.3 % of all cesarean sections in India[1]. Prevalence is around 5% in the United kingdom[2,3].

Adolescents, comprises individuals aged 10 to 19 years, represent a critical demographic often underserved in conventional healthcare settings. Establishing an Adolescent Corner within clinics aims to provide a dedicated, confidential, and youth-friendly environment addressing their special physical, emotional, and reproductive health needs.

These corners function as safe spaces for counseling, health education, screening, and basic clinical care, in alignment with national programs such as the Rashtriya Kishor Swasthya Karyakram (RKSK).

The success of an adolescent corner lies in its strategic setup, including a private location, trained and non-judgmental staff, and access to essential supplies such as sanitary products, IFA tablets, and contraceptives.

Crucial to its impact is community-based outreach, which involves engaging peer educators (Saathiyas), conducting school-based sessions, leveraging local health workers, and using social media to reach adolescents effectively.

Sustainable implementation requires robust monitoring and feedback mechanisms, such as service registers, client satisfaction surveys, and periodic reviews. These tools help assess utilization, identify service gaps, and guide continuous quality improvement.

Engaging adolescents, parents, and the local community fosters trust and accountability, ensuring that the services are adolescent-responsive and culturally sensitive.

To maintain long-term viability, adolescent corners must be integrated into the existing health system, supported through policy, local leadership, and funding mechanisms.

A well-managed adolescent corner not only improves individual health outcomes but also contributes to a healthier, more informed generation empowered to make safe and responsible choices.

The Precursor Puzzle: Biomarkers Predicting Endometrial Cancer – Risk Stratification Beyond Histopathology

Sharda Patra

Director Professor, Dept of Obstetrics &Gynaecology, Lady Hardinge Medical college &Associated Hospitals, New Delhi

Endometrial cancer (EC) develops along a continuum of molecular and histologic changes, with precursor lesions such as disordered proliferative endometrium and endometrial hyperplasia providing critical windows for intervention. Histopathology alone cannot fully predict the malignant potential of these lesions. Recent insights into molecular alterations have enhanced early detection and individualized risk assessment.Among the most consistently altered biomarkers are **PTEN** and **PAX2**, both of which are frequently lost in premalignant and early malignant endometrial lesions. PTEN loss activates the PI3K/AKT pathway, promoting unchecked proliferation, while PAX2 loss reflects loss of cellular differentiation. Their combined loss is now recognized as a biomarker signature of latent neoplastic transformation, even in non-atypical hyperplasia or proliferative endometrium [1,2].Importantly, such lesions may remain hormone-sensitive. **Progestin therapy**—particularly with levonorgestrel-releasing intrauterine systems—can restore glandular homeostasis, re-establish PTEN expression, and prevent progression in selected cases [3,4]. Biomarker-guided selection of patients for conservative management is now feasible. Molecular classifiers such as **ProMisE**, based on TCGA subgroups (POLE-mutant, MMR-deficient, p53-abnormal, NSMP), offer superior prognostic accuracy and therapeutic guidance [5]. Tools like **ENDORISK**, combining clinical, molecular, and imaging data, predict lymph node metastasis and survival with high reliability [6]. Serum markers like **HE4** also correlate with invasiveness and treatment response, although their clinical use remains adjunctive [7].These innovations collectively shift EC risk stratification from a purely morphologic approach to a **biologically informed, precision-based model** of care.

References

1. Naulet P, Puech F, Robin F, et al. PAX2 and PTEN loss in endometrial hyperplasia: a useful biomarker combination? Int J Gynecol Pathol. 2022;41(2):132–8.
2. Chen L, Han X, Meng L, et al. Dual loss of PAX2 and PTEN as a biomarker of early endometrial neoplasia: a meta-analysis. J Gynecol Oncol. 2023;34(1):e2.
3. Sanderson PA, Critchley HOD, Williams ARW, et al. Progestin therapy and regression of premalignant endometrium: mechanisms and molecular markers. Hum Reprod Update. 2021;27(3):493–509.
4. Raffone A, Travaglino A, Gencarelli A, et al. PTEN expression predicts response to progestin therapy in endometrial hyperplasia. Gynecol Oncol. 2022;165(3):603–9.
5. Kommoss S, McConechy MK, Kommoss F, et al. Clinical application of the ProMisE molecular classifier in endometrial carcinoma: results from a prospective study. Mod Pathol. 2020;33(1):118–26.
6. van den Bosch T, Mirkovic J, Mjahed R, et al. ENDORISK preoperative prediction model for endometrial cancer outcome: external validation. PLoS Med. 2020;17(5):e1003111.
7. Zhang Q, Lu Y, Shi Y, et al. Diagnostic and prognostic significance of HE4 in endometrial cancer: a systematic review and meta-analysis. Cancers (Basel). 2023;15(4):1012.

From start to silver -Bone Health'

Neelam Jain

Bone health is a critical yet often overlooked component of women's health across the life span. This presentation, "From Start to Silver: Bone Health," highlights the importance of building and maintaining optimal bone mass from adolescence through the reproductive years and beyond. Adolescence is a vital period for bone development, during which nearly 90% of peak bone mass is achieved. Proper nutrition, adequate calcium and vitamin D intake, and regular weight-bearing physical activity are essential during this phase to reduce the risk of future osteoporosis and fractures.

In women of reproductive age, hormonal fluctuations, pregnancy, lactation, and contraceptive choices all play significant roles in bone metabolism. The presentation discusses how conditions like amenorrhea, polycystic ovarian syndrome (PCOS), and use of certain hormonal contraceptives can negatively affect bone density. Attention is also given to the increased risk of bone loss during lactation and how timely nutritional interventions and physical activity can mitigate long-term consequences.

Public health strategies aimed at early intervention, lifestyle modification, and awareness programs are emphasized to prevent the silent progression of bone loss. The session also briefly introduces the importance of screening and risk assessment tools for identifying women at risk of low bone mineral density.

In conclusion, a life-course approach to bone health—starting from adolescence and extending into midlife—is imperative. Preventive strategies, early education, and proactive clinical practices are key to ensuring optimal skeletal health in women, ultimately reducing the burden of osteoporosis-related morbidity and healthcare costs in later life.

Challenges in Endoscopic surgery for Deep Infiltrating Endometriosis

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Deep infiltrating endometriosis (DIE) represents a severe form of endometriosis characterized by the infiltration of endometrial-like tissue more than 5 mm beneath the peritoneal surface, often involving critical structures such as the uterosacral ligaments, rectovaginal septum, bowel, ureters, and bladder. Surgical management remains the cornerstone for symptom relief, fertility restoration, and quality of life improvement, particularly when medical therapy fails. However, DIE surgery is presents significant challenges due to complex pelvic anatomy, dense fibrosis, and distorted tissue planes. Key difficulties include preoperative mapping of disease extent, preservation of vital structures like nerves and ureters, achieving complete excision while minimizing recurrence, and managing potential complications such as organ injury and postoperative dysfunction.

Endoscopic surgery whether done by laparoscopy or Robotic assistance, offers the benefits of quick recovery, less pain, precise tissue handling with magnified view. Multidisciplinary collaboration, advanced laparoscopic skills, and thorough preoperative planning with imaging modalities like MRI and transvaginal ultrasound are essential.

Despite advancements in minimally invasive techniques, the surgical management of DIE continues to demand a delicate balance between radicality and functional preservation, highlighting the need for individualized approach and long-term follow-up. Although fraught with multiple arguments against keyhole surgery, MIS is a well established route of choice for cases of deep infiltrating endometriosis.

Chronic Pelvic Pain, What next

Sunita Malik

Chronic pelvic pain (CPP) is defined as intermittent or constant pain in the lower abdomen or pelvis of a woman for at least six months, not occurring exclusively with menstruation or intercourse and not associated with pregnancy. It is severe enough to cause functional disability or necessitates medical care.

Accurate diagnosis and effective management from the first presentation can help reduce the disruption of a woman's life. The relationship between pain and pathology, such as endometriosis, adhesions, or venous congestion, is inconsistent, and treatment is associated with pain recurrence. Evaluation includes a thorough pain history, comprehensive questionnaires, and physical examination. Reproductive Tract Conditions like endometriosis, adhesions, pelvic congestion syndrome, subacute salpingo-oophoritis, and ovarian remnants and residual ovary syndrome are some of the reproductive tract causes of CPP.

Gastroenterological and Urologic conditions like inflammatory bowel syndrome (IBS) and interstitial cystitis/bladder pain syndrome (IC/PBS) can also cause CPP.

Neurologic and Musculoskeletal Causes like nerve entrapment and other neurologic and musculoskeletal issues can contribute to CPP.

Psychological factors such as depression and childhood physical abuse can increase pain vulnerability and promote the chronicity of pain.

Management: A multidisciplinary approach is recommended for managing CPP, including psychotherapy, physical therapy, cognitive-behavioral therapy, and medical treatment.

Surgical Interventions such as Laparoscopy and hysterectomy are considered in certain cases, but their effectiveness varies.

Concealed PPH :A Diagnostic Blind Spot

Achla Batra

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Postpartum hemorrhage (PPH) remains a leading global contributor to maternal morbidity and mortality. While overt uterine bleeding is readily identifiable and allows timely intervention, concealed PPH presents insidiously, often eluding early detection and complicating clinical management. This condition stems from injuries to paravaginal tissues, pelvic muscles, and vessels, allowing significant blood accumulation in hidden pelvic compartments such as the paravaginal space, ischiorectal fossa and retroperitonealy between the leaves of the broad ligament or the uterovesical space.

Clinically, patients may report sudden, severe abdominal, perineal, or rectal pain that is disproportionate and resistant to analgesia. Hemodynamic instability—manifested as hypotension, tachycardia, pallor, dizziness, and a notable hemoglobin drop despite minimal external bleeding—serves as a vital diagnostic cue. Ultrasound is the initial imaging modality but may fail to detect deep hematomas. Computed tomography (CT) with intravenous contrast offers improved visualization, while digital angiography provide detailed vascular and anatomical assessments, but may miss venous sources.

Management hinges on hemodynamic status and hematoma progression. Stable patients may benefit from close monitoring, analgesia, and antibiotics, with tamponade effect arresting hemorrhage. However, active bleeding necessitates surgical intervention or packing .Transcatheter arterial embolization (TAE) may be helpful in stable patients

The complexities of concealed PPH necessitate high clinical suspicion, thorough anatomical understanding, prompt imaging, and continuous patient monitoring to ensure timely diagnosis and management

Paper Abstracts

OP1

Diagnostic accuracy of hematological parameters for prediction of gestational diabetes mellitus

Janvi Vashist, Jyotsana Suri

Abstract: Gestational diabetes is characterized by a varying degree of glucose intolerance that manifests during pregnancy and is linked to heightened morbidity for both the foetus and the mother. Additionally, it is associated with potential long-term complications for both mothers and their offspring. This study was conducted at a tertiary care centre in North India with aim to use an innovative approach of using multiple routine biomarkers like: Hb, RBC count, Hct and HbA1c levels in antenatal women in 1st and 2nd trimester for early prediction of GDM at 24-28 weeks.

AIM : To study the predictive value of haematological parameters and glycosylated haemoglobin for Gestational Diabetes Mellitus.

Methodology: Around 580 pregnant women at less than 12 weeks POG were recuited in the study after taking informed consent . CBC and HbA1c were measured at 12 weeks and then repeated at 16-24 weeks which was followed by testing for GDM using DIPSI method at 24-28 weeks and then again at 32 weeks.

Observation and Results: The mean value of HbA1c, RBC count, Hb level and hematocrit were comparatively higher in patients who developed GDM compared to the normoglycemic patients.

Conclusion: Concurrent use of hematologoical parameters in first and early second trimester can be utilized as a tool to predict GDM.

OP2

Unmasking congenital diaphragmatic hernia – from diagnosis to post natal surgical management

Asmita Singh, Nandita Dimri Gupta, Dr Nidhish Sharma

Introduction: The incidence of congenital diaphragmatic hernia (CDH) ranges from 1.7 to 5.7 per 10,000 live births. Antenatal imaging helps in diagnosis, determining prognostic predictors and guiding regarding follow up of these fetuses with CDH. After birth, appropriate surgical repair in a tertiary care hospital can improve the neonatal outcome.

Aim: This study aims to present our experience in the diagnosis and post natal outcome of CDH cases over a span of 1 year.

Material and methods: This is a retrospective study of five consecutive patients who were diagnosed with CDH in fetal medicine unit , risk categorization included – position of liver - up or down, O/E LHR (observed by expected lung head ratio) and presence of other comorbidities , they subsequently underwent paediatric surgery in our hospital.

Results: In this series five fetuses had CDH on the left side . four out of them underwent post natal CDH repair without any peri-operative complications.

Discussion: In cases of non lethal fetal anomalies with significant morbidity , antenatal imaging and counselling is of utmost importance to reassure the apprehensive family.

Conclusion: Despite recent improvements in management, CDH remains a challenging condition, however with prompt diagnosis, meticulous prognostic stratification and timely post natal intervention and surgery , neonatal outcomes can be improved.

OP3

Comparison of fasting versus fed state oral glucose tolerance test on diagnosis on gestational diabetes mellitus in pregnant women in second trimester

Himesh Chandra Choudhary, Garima Kapoor

Introduction: Gestational Diabetes Mellitus (GDM) is glucose intolerance first recognized during pregnancy, posing significant maternal and neonatal risks, including future type II diabetes

AIM: Comparison of fasting versus fed state oral glucose tolerance test on diagnosis of GDM in pregnant women in second trimester.

Material and Methods: In this cross-sectional study conducted over 18 months at Safdarjung Hospital, New Delhi, 246 antenatal women aged 21–40 years and 12+0 to 27+6 weeks gestation were enrolled. Participants were categorized into fasting (≥8 hours since last meal) and fed (≤2 hours since last meal) groups. All underwent a 75g OGTT per DIPSI guidelines, with 2-hour post-glucose blood samples analyzed.

Results: Results showed no statistically significant difference in mean or median 2-hour glucose levels between fasting and fed groups. Likewise, there was no significant difference in the rates of GDM, overt diabetes, or impaired glucose tolerance between the groups.

Discussion: Multivariate regression analysis identified BMI as the only independent predictor of abnormal glucose tolerance; each 1 kg/m² BMI increase raised the odds of an abnormal OGTT result by 5%. Age, parity, and feeding state were not significant predictors.

Conclusion: The study concludes that fasting duration did not influence 2-hour glucose readings, while BMI significantly impacted GDM risk. Strengths included rigorous methodology and multivariate analysis, though limitations were recall bias due to self-reported fasting duration and a single-center design. Larger multicentric studies are recommended to validate these findings and optimize screening protocols.

OP4

Maternal and neonatal outcomes in preeclampsia with and without proteinuria

Chaiti Saha, Shikha Chadha

Introduction: Preeclampsia can be associated with significant maternal and neonatal morbidity and mortality. Although Most international societies have accepted that proteinuria is not mandatory for diagnosis of preeclampsia, it may be associated With poor maternal and perinatal morbidity and mortality.

AIM: To determine whether the presence of proteinuria correlates with worse outcomes.

Method: In this prospective observational study, 600 women with preeclampsia after 24 weeks of gestation were included, 300 in each group A & B that is preeclampsia with & without proteinuria respectively. All women were evaluated throughout pregnancy for any end organ involvement or utero placental insufficiency and treated as per hospital protocol. Pregnancy outcomes were studied and statistically analysed.

Result: Overall maternal complications were significantly higher in Group A (96.3% vs 70.3%, $p<0.0001$), with higher incidence of eclampsia ($p=0.012$), abruptio placenta ($p=0.002$), and HELLP syndrome. Renal, hepatic, and haematological dysfunctions are prevalent in Group B, posing serious management challenges. Group A had significantly more neonatal complications ($p<0.0001$).

Conclusion: This study affirms that proteinuria in preeclampsia correlates with worse neonatal outcomes and more classical maternal complications, but non-proteinuria cases are far from benign and posed diagnostic and management challenges.

OP5
Clinical and Biochemical Profiles in Adolescent PCOS: A Comparative Approach

Maneesha Verma, Shikha Chadha

Aim: The aim of this study was to evaluate and compare the clinical and biochemical characteristics of adolescents with polycystic ovary syndrome.

Introduction: The Pediatric Endocrine Society established diagnostic criteria for adolescent PCOS in 2015. However, limited Indian research applies these guidelines to assess clinical features compared to healthy peers. This study aimed to contrast clinical, biochemical, and ovarian morphology characteristics in adolescents with and without PCOS.

Materials and Methods: This forward-looking case–control study included 60 adolescent girls attending the gynecology outpatient department. Group A comprised 30 participants diagnosed with PCOS based on consensus criteria, while Group B included 30 adolescents without the condition. All underwent detailed clinical assessments, fasting hormonal analysis (serum TSH, prolactin, FSH, LH, and testosterone), metabolic evaluation (2-hour oral glucose tolerance test and lipid profile), and pelvic ultrasound during the follicular phase.

Results: In Group A, 40% were overweight and 36.7% obese, compared to 20% overweight and 20% obese in Group B. Average testosterone levels were significantly higher in the PCOS group, while gonadotropin levels showed no significant difference. Ovarian volume and follicle counts were markedly increased in adolescents with PCOS. Incorporating ultrasound findings into diagnosis would have reduced PCOS diagnoses by around 7%.

Conclusion: PCOS in adolescents notably affects body fat distribution and lipid metabolism, increasing the risk of long-term metabolic disorders. Early identification and regular screening, along with lifestyle interventions, are essential to mitigate these health risks.

OP6
Peripartum Stroke:Let's decode the Enigma

Srishti, Rekha Bharti, Panchamprret kaur, Anjali Dabral

Introduction: Stroke is more common in pregnant or recently pregnant women (30 per 100,000) than in nonpregnant women, with 10% occurring antepartum, 40% peripartum, and 50% postpartum. Pregnancy-related physiological and hemodynamic changes may lead to atypical presentations, complicating timely diagnosis. We present two peripartum stroke cases with unusual features, emphasizing the importance of early recognition and tailored care.

Case 1: A 25-year-old P2L2 woman on postnatal day 9 following a full-term normal vaginal delivery presented with generalized tonic-clonic seizures preceded by severe headache. Neuroimaging revealed a subarachnoid hemorrhage with atypical posterior reversible encephalopathy syndrome (PRES) features. Digital subtraction angiography suggested giant cell arteritis (GCA). She responded well to intravenous steroids, supporting GCA as the underlying cause.

Case 2: A 30-year-old G5P2L2A2 at 36+1 weeks gestation presented with aphasia, right facial palsy, and hemiparesis. MRI showed a left middle cerebral artery infarct. She underwent cesarean delivery for partial HELLP syndrome. Postoperatively, her Glasgow Coma Scale deteriorated. Non-contrast CT revealed a subacute infarct. She was managed conservatively with antiepileptics and made a full recovery by postoperative day 7.

Conclusion: These cases reflect how stroke can strike during both pregnancy and postpartum, often masked by common symptoms. Timely recognition and coordinated care are key to full recovery. A high index of suspicion is vital, as early intervention can save not just lives but futures for mothers and their families.

OP6

Effect of early gestational body mass index (within 12 weeks) on maternal and neonatal outcomes in nulliparous women

Mamta Shou, Urvashi Miglani

Introduction: Body Mass Index (BMI) in early pregnancy is a potential predictor of pregnancy-related complications. This study aims to evaluate the impact of early gestational BMI on maternal and neonatal outcomes among nulliparous women.

Methodology: A prospective observational study was conducted at Deendayal Upadhyay Hospital, Delhi, involving 530 nulliparous women. BMI was recorded within the first 12 weeks of gestation and classified using WHO criteria into underweight, normal, overweight, and obese categories. Maternal outcomes studied included mode of delivery and complications such as hypertensive disorders of pregnancy (HDP), gestational diabetes mellitus (GDM), anemia, preterm labor, and intrauterine growth restriction (IUGR). Neonatal outcomes included small for gestational age (SGA) and large for gestational age (LGA). Data were analyzed using chi-square tests and logistic regression.

Results: High BMI was significantly associated with increased incidence of HDP (p=0.002) and GDM (p=0.001). LGA babies (6.8%) were more common in overweight and obese mothers. Underweight women had a higher incidence of SGA babies (46%), anemia (p=0.001), and preterm delivery (12.6%). Women with normal BMI had the most favorable outcomes.

Conclusion: Early gestational BMI is a reliable predictor of maternal and neonatal outcomes. Early identification of abnormal BMI can help tailor antenatal care and reduce complications.

OP7

A novel technique of endometrial sampling using endocervical cytobrush for detection of endometrial pathology - a pilot study

Balla Vani, Amita Suneja

Introduction: Abnormal uterine bleeding(AUB) is a common gynecological concern that necessitates endometrial assessment to identify underlying endometrial pathologies. This study evaluated a novel, minimally invasive, and cost-effective tool using endocervical cytobrush with a protective sleeve(copper T inserter) using conventional cytology techniques for endometrial sampling.

Aim: To determine the accuracy and sampling satisfaction of endocervical cytobrush for endometrial cytology in the detection of endometrial pathology.

Methods: This observational, cross-sectional pilot study included 60 women presenting with AUB or postmenopausal bleeding. Endometrial samples were collected using an endocervical cytobrush with protective sleeve and analyzed using conventional cytology techniques . The cytological findings were then compared with histopathology from D&C. Sensitivity, specificity, and diagnostic accuracy were assessed to evaluate the effectiveness of cytological analysis in detecting endometrial pathology.

Ethical approval: (IECHR-2023-59-90)

Results: The sampling adequacy rate was 91.6%, with a sensitivity of 80% and specificity of 100% for detecting premalignant and malignant pathology, and overall diagnostic accuracy of 98.2%. The kappa agreement coefficient (0.86) demonstrated substantial concordance between cytology and histopathology.

Conclusions: The new sampling device using endocervical cytobrush with a protective sleeve is an innovative, cost-effective, easily available, and minimally invasive alternative to other cytobrushes, making it suitable for resource-limited settings.

OP8

Serum levels of macrophage colony stimulating factor (MCSF) as diagnostic marker for cervical pre-cancer and early invasive cancer

Chanchal, Bindiya Gupta

Abstract

Background & Objectives: Macrophage colony stimulating factor is one such promising biomarker that promotes macrophage colony formation and regulates the proliferation, migration and differentiation of macrophages. We therefore aim to evaluate the role of serum macrophage stimulating factor (MCSF) as a diagnostic marker for cervical pre-cancer and early invasive cancer.

Methods: This cross-sectional study included all sexually active women 25-65 years of age and screened for cancer cervix using Pap test and VIA, followed by colposcopy and HPV testing. Cervical tissue biopsy was taken in patients with swede score >4 and IFCPC major criteria. At the same sitting, 5ml of venous blood was taken for MCSF estimation, additionally 2ml each in plain and EDTA vial for CRP levels and DLC, TLC respectively. On biopsy confirmation three groups were made namely: Normal/chronic cervicitis (group-1), CIN1 (group-2), CIN 2/3/ invasive cervical carcinoma (group-3) to compare MCSF levels.

Results: M-CSF levels were elevated in CIN 2+ cases compared to CIN 1 and controls, but the difference was not statistically significant ($p = 0.189$). No significant correlation was found between M-CSF and HPV DNA positivity. A cutoff of 435 pg/ml for M-CSF showed high specificity (86.67%) and NPV (90%) for CIN 2/3 diagnosis, though without statistical significance, warranting larger studies. CRP levels were significantly higher in pre-invasive and early invasive cases, with a strong positive correlation between M-CSF and CRP, indicating M-CSF's possible role in inflammation.

Conclusion: Although M-CSF levels were elevated in higher-grade cervical lesions, the difference was not statistically significant, and no correlation was found with HPV DNA status. However, the high specificity and negative predictive value at the proposed M-CSF cutoff suggest its potential utility as a diagnostic aid, pending further validation in larger studies. The strong positive correlation between M-CSF and CRP levels indicates a possible role of M-CSF in the inflammatory processes associated with cervical carcinogenesis.

Key words: Macrophage colony stimulating factor (MCSF), C-reactive protein(CRP),Cervical intraepithelial neoplasia (CIN)

Introduction

Cervical cancer is the fourth most common cancer globally and the second in India, with over 600,000 new cases and 340,000 deaths worldwide annually, according to GLOBOCAN 2020. India alone accounts for approximately 124,000 cases and over 77,000 deaths1.

A hallmark of cervical cancer is its progression through well-defined precancerous stages, starting from low-grade to high-grade squamous intraepithelial lesions, eventually leading to squamous cell carcinoma—the most common type. Persistent high-risk HPV infection is the primary cause, with progression marked by cellular changes such as koilocytosis, dysplasia, and neoplasia2.

While several biomarkers like HPV E6/E7 mRNA, p16/ki-67, and DNA methylation have been studied for early detection3, they are not yet in widespread clinical use. Serum biomarkers offer advantages due to ease of collection and automation.

Existing markers such as SCC-Ag, CA-125, and CA 19-9 have shown limited utility. Emerging markers, including M-CSF, VEGF, microRNA, and DNA methylation, show promise. M-CSF, a hematopoietic growth factor, regulates macrophage activity and contributes to the tumor microenvironment by activating CSF1R.

In other cancers (breast, ovarian, prostate), elevated M-CSF is linked to tumor progression and poor prognosis. A meta-analysis suggests M-CSF has diagnostic potential in cervical cancer, with 70% sensitivity and 84% specificity4. However, its role in identifying precancerous stages remains underexplored and may aid in detecting transforming HPV infections poised to progress to invasive disease.

Objectives

Our primary objective was to estimate and determine the predictive ability of serum MCSF levels for pre-cancer and early invasive cervical cancer. Our secondary objectives were to correlate serum MCSF levels with high-risk HPV positivity, to study the correlation of serum MCSF levels with histology, stromal invasion, tumour differentiation in early invasive cervical cancer. and to correlate

neutrophil lymphocyte ratio and C-reactive protein (CRP) levels with serum MCSF levels.

Materials and Methods

It was a cross-sectional study conducted from May 2023 to November 2024 and we recruited screen positive patients till we got at least 30 cases of pre-cancer and early invasive cervical cancer. This study was undertaken in the Department of Obstetrics and Gynaecology, Department of Biochemistry and Department of pathology, University College of Medical Sciences and Guru Teg Bahadur Hospital, Dilshad Garden, Delhi after taking approval from the Institutional Ethics Committee-Human Research (IEC-HR) (Ethics approval number- IECHR- 2023-59-91). Written informed consent was taken from all recruited patients.

Sample size: Even on extensive search we could not find any article where the sensitivity levels of MCSF have been calculated in cervical precancer cases. So, we used the estimate of sensitivity for cervical cancer to calculate sample size so as to have a guiding number. From the previous study,at sensitivity of 70% and screen positive value of 7%, to estimate an absolute difference of 20% at alpha=5%, a sample of 290 cases were required. But due to time and financial constraints, we recruited screen positive patients till we got at least 30 cases of pre-cancer and early invasive cervical cancer.

INCLUSION CRITERIA

Women with positive cervical cancer screening test (Pap Smear, VIA) undergoing colposcopy and biopsy.

EXCLUSION CRITERIA

- Pregnant women.
- Women with immune-compromised status or HIV co-infection.
- Any other coexisting cancer.
- Previous history of treated CIN and carcinoma cervix

Methodology:

This cross-sectional study included all sexually active women 25-65 years of age and screened for cancer cervix using Pap test and VIA, followed by colposcopy and HPV testing. Cervical tissue biopsy was taken in patients with swede score >4 and IFCPC major criteria. At the same sitting ,5ml of venous blood was taken for MCSF estimation, additionally 2ml each in plain and EDTA vial for CRP levels and DLC, TLC respectively. On biopsy confirmation three groups were made namely: Normal/chronic cervicitis (group-1), CIN1 (group-2), CIN 2/3/ invasive cervical carcinoma (group-3) to compare MCSF levels.

Statistical analysis

The MCSF levels in all the groups were reported as mean +/-SD. Kruskal Wallis H test and One way ANOVA was employed to compare MCSF levels in different categories. Association between MCSF and HPV positivity were compared by Mann-Whitney U test which is the non-parametric equivalent of the t-test. Receiver operator characteristic (ROC) curves were constructed and area under the curve (AUC) was used to estimate the ability of MCSF to discriminate between the three groups. Best cut off values were determined using ROC curves and Sensitivity and specificity of MCSF in predicting precancer and cancer were calculated as percentage. $P< 0.05$ was taken as significant. SPSS-23.0 version was used to do the statistical analysis.

Observations and results

The study included women aged 25–70 years, with a mean age of 40.66 ± 8.95 years; most were aged 36–45 and belonged to the lower-middle socioeconomic class. Early marriage was common, with 86.67% married by 20 years, and a significant difference in age at marriage was noted among study groups (p=0.044). Most had first sexual intercourse between 16–20 years and first childbirth between 21–24 years, with no significant intergroup differences in childbirth age or parity. Median menarche age differed significantly (p=0.015), being lowest in the high-grade lesion group. Barrier contraception was the most used method (67.2%), predominantly in the chronic cervicitis group. Presenting symptoms were largely non-specific, and no symptom significantly differed between groups. VIA positivity increased with disease severity (p=0.002), and Pap smear results showed significant variation across groups (p=0.007), with more HSIL findings in higher-grade disease. Serum M-CSF levels were highest in Group 3, though differences were not statistically significant (p=0.189). ROC analysis for M-CSF yielded AUCs of 0.63 and 0.60 for CIN1 and CIN2/3/cancer, respectively, suggesting limited predictive accuracy. High-risk HPV positivity was

more prevalent in advanced lesions (83.3% in Group 3), yet M-CSF levels showed no significant association with HPV status (p=0.578). A significant positive correlation was found between CRP and M-CSF levels (p=0.046), and between CRP and N/L ratio (p=0.002), while N/L ratio had no significant link with M-CSF (p=0.815). Only CRP levels varied significantly among the groups (p=0.001).

Discussion

This study evaluated the diagnostic utility of serum Macrophage Colony-Stimulating Factor (M-CSF) as a biomarker for cervical precancer and early invasive cancer in 72 women categorized into three histopathological groups: benign (Group 1), CIN1 (Group 2), and CIN2/3 or invasive cancer (Group 3). M-CSF levels, correlated with histology, HPV status, CRP, and N/L ratio, were found to be higher in Group 3, though the difference was not statistically significant (p=0.189), likely due to small sample size. Most women were under 45 years and from lower-middle socioeconomic backgrounds, with early age at marriage and first intercourse—recognized risk factors for cervical cancer. VIA was more sensitive than Pap smear, which showed low positivity (42%) and a high rate of unsatisfactory results in high-grade lesions. HR-HPV positivity was significantly higher in advanced disease (83% in Group 3). ROC analysis yielded an AUC of 0.6, indicating limited standalone diagnostic value of M-CSF for CIN; however, its high specificity (86.67%) suggests potential as a confirmatory biomarker. A significant correlation between M-CSF and CRP (p=0.046) supports the link between chronic inflammation and cervical carcinogenesis. These findings align partially with previous studies but highlight the need for larger-scale research to validate M-CSF as a reliable biomarker, potentially in combination with other markers like VEGF or SCC-Ag, for early detection and risk stratification in cervical neoplasia.

Conclusion

The study highlights the potential role of M-CSF as an early diagnostic biomarker for cervical pre-cancer and cancer, with higher mean and median levels observed in CIN2+ cases compared to CIN1 and controls, although the difference was not statistically significant (p=0.189). No significant correlation was found between M-CSF levels and HPV DNA positivity. The optimal cut-off for diagnosing CIN2/3 was 435 pg/mL, demonstrating high specificity (86.67%) and negative predictive value (90%), but lacking statistical significance, warranting further validation in larger cohorts. Additionally, significantly elevated CRP levels in CIN2+ cases and a strong positive correlation between CRP and M-CSF levels suggest an inflammatory component in disease progression, implicating M-CSF in the underlying inflammatory milieu.

OP9

Evaluation of ovarian reserve with serum anti-mullerian hormone (AMH) levels post cystectomy in benign ovarian cysts: A prospective cohort study

Divya Rashmi, Anshuja Singla

Introduction: Ovarian cysts often go undiagnosed but they can lead to symptoms such as pelvic pain, dyspareunia, irregular cycles, and gastrointestinal or urinary issues. Complications like bleeding, torsion, and rupture may require treatment. Ovarian reserve is assessed using serum markers like anti-Müllerian hormone (AMH) which correlates with ovarian responsiveness.

Aim: To evaluate the ovarian reserve with serum AMH levels after cystectomy was done for benign ovarian cysts.

Methods: Fifty women of reproductive age group 15-45 years who required surgical management of benign ovarian cysts were recruited. We evaluated serum AMH, Day 2 serum FSH, and antral follicle count (AFC) preoperatively, as well as 1 and 3 months post-cystectomy, and also studied factors affecting serum AMH along with clinical outcomes such as menstrual pattern changes and symptoms of premature ovarian insufficiency.

Results: Serum AMH levels dropped by 51.8% one-month post-surgery, with a 35.3% recovery by three months, though levels remained below baseline. FSH decreased significantly by three months, while AFC declined at 1 and 3 months. AMH reduction occurred across cyst types, with recovery seen only in endometriomas. Younger age (<35), lower BMI (<25), smaller cysts (<10 cm), and unilateral cysts showed better AMH recovery. Bilateral cystectomy had a greater impact on ovarian reserve. Surgery type, duration, and cauterization affected AMH levels, but most factors showed no significant differences. 80% maintained regular cycles, with only 8% showing signs of premature ovarian failure.

Conclusions: This study highlights the significant, though partially reversible, effect of cystectomy for benign ovarian cysts on ovarian reserve. AMH and AFC were found to be more sensitive markers than FSH, showing marked declines immediately after surgery, with partial recovery by the third month. The findings emphasize the importance of preoperative counselling on fertility risks and preserving ovarian function. Further research is needed to understand ovarian recovery and improve surgical approaches.

OP10

Congenital Defects and Stillbirths: Bridging Prenatal Clues to Perinatal Loss

Shweta Singhal, Jyotsna Suri, Jasbir Kaur, Vandana Mehta, Deepthi Nair, Renuka Sharma

Background: Stillbirth remains a tragic event emotionally and medically majorly affecting south Asian countries like India. Among various contributing factors, congenital anomalies are increasingly recognized as a significant cause, yet their precise correlation and diagnosis with relation to stillbirth remains underexplored especially pertaining to our country.

Aim: To evaluate the frequency and types of congenital anomalies associated with stillbirth and establish a potential correlation between the two for improved prenatal diagnosis.

Methods: A cross sectional observational study was conducted on placenta and umbilical cord samples from stillbirth cases over a 6- month period. Gross and histopathological examination of placenta, umbilical cord was performed. Congenital anomalies was tabulated. Data was analysed statistically to assess correlations.

Results: We analysed 50 stillbirth cases in the period of 6 months, 10 exhibited one or more congenital anomalies including central nervous system malformations - anencephaly, hydrocephalus. A statistically significant correlation ($p < 0.05$) was observed between the presence of major anomalies and early third-trimester stillbirths. In 18% of cases, multiple anomalies coexisted, indicating possible syndromic associations.

Conclusion: Congenital anomalies contribute substantially to stillbirths and should be a routine focus of detailed prenatal test such as imaging. Early detection and genetic counselling may reduce the burden of recurrent losses and guide parental decision-making.

OP11
Comparative evaluation between vaginoscopy and traditional hysteroscopy

Bani Gupta, Vinita Sarbhai

Abstract:

Background: Hysteroscopy is the gold standard for diagnosing intrauterine pathologies. However, traditional office hysteroscopy, using a speculum and tenaculum, is often associated with patient discomfort and longer procedural times. Vaginohysteroscopy, a speculum-free approach using direct saline distension, offers a less invasive and more acceptable alternative.

Objective: To compare the success rate, pain levels, procedural time, complications, and patient satisfaction between vaginohysteroscopy and traditional hysteroscopy.

Methods: A randomized clinical trial was conducted in the Department of Obstetrics and Gynecology, Kasturba Hospital, Delhi, from July 2024 to July 2025. Forty-four women requiring diagnostic hysteroscopy were randomly assigned to two groups:

Group A (n = 22): Vaginohysteroscopy

Group B (n = 22): Traditional hysteroscopy

The primary outcome was the success rate, defined as complete visualization of the uterine cavity. Secondary outcomes included time to cavity entry, total procedure duration, pain assessment using a visual analogue scale, intraoperative complications, and patient satisfaction on a 5-point Likert scale. Data were analyzed using appropriate statistical tools with $p < 0.05$ considered significant.

Conclusion: According to our study, both techniques were comparable in terms of success rate, pain scores, and complication rates. While vaginohysteroscopy showed slightly better patient comfort and shorter procedure time, the overall difference was not statistically significant. These findings align with previous studies and suggest that both approaches remain viable options depending on patient and clinical considerations.

OP12
AFLP: The diagnostic and therapeutic enigma

Mamta Pandey, Jyotsna Suri, Zeba Khanam, Sumitra Bachani, Monika Gupta, Divya Pandey

Abstract: Acute fatty liver of pregnancy (AFLP) is a rare, yet fatal condition during pregnancy characterized by fatty infiltration of the liver parenchyma. Not only is it a diagnostic dilemma, but also a therapeutic challenge. We hereby present a series of 3 interesting cases of AFLP.

Case summary: The first case presented at 36+6 weeks of gestation with an initial Swansea score of 6. Blood products were arranged based on ROTEM test result and patient was taken for Cesarean section. Despite her prolonged period of stay , she was discharged alive with baby 3 weeks later .

The second patient presented on post partum day 2 of normal vaginal delivery with clinical diagnosis of Acute liver failure (Swansea Score 7) . Multimodal therapy was initiated as per hospital protocol with the difference of addition of N Acetyl Cystein (NAC) . A marked improvement in clinical and laboratory parameters were observed following NAC administration. She was discharged alive 4 weeks later with the baby

The third case presented on postoperative day one following a cesarean delivery with severe jaundice, leukocytosis, thrombocytopenia, ascites, and coagulopathy. She also had hypoglycemia and an initial Swansea score of 9. Serum transaminases were only mildly elevated. The cesarean was performed due to meconium-stained liquor and fetal distress. She had a history of high blood pressure during the antenatal period. Supportive management was initiated with broad-spectrum antibiotics, maintenance of euglycemia, transfusion of multiple units of cryoprecipitate and fresh frozen plasma, and ventilatory support. However, she succumbed a day later to multiorgan failure.

Conclusion: Acute fatty liver of pregnancy is a life-threatening obstetric condition characterized by abdominal pain, vomiting, coagulopathy, leukocytosis, hypoglycemia, ascites, and micro vesicular steatosis. Mortality among AFLP patient remains high. The management of such cases should involve multidisciplinary approach with inclusion of newer treatment like NAC.

OP13

Idiopathic polyhydramnios & pregnancy outcome

Neetu Mandia, Krishna Agarwal

Introduction: Polyhydramnios is defined as an excess of amniotic fluid surrounding the fetus. Polyhydramnios that is not a/w congenital anomalies of the CNS or GI tract, maternal diabetes, alloimmunization, fetal infection, placental tumor or multiple gestation is termed idiopathic.

Aim: To analyze outcomes of singleton pregnancies with idiopathic polyhydramnios

Case details: Three singleton idiopathic polyhydramnios pregnancies were followed till delivery and outcomes were assessed.

Case A: Patient X G5P2L2A2 with 33weeks+3days of POG (DVP=13cm) came with preterm premature rupture of membranes with meconium stained liquor and was taken for emergency lscs ivo msl grade2 in early labour. Baby had adverse outcome due to prematurity.

Case B: Patient Y G3P2L2 with 37weeks+1day of POG (DVP=10cm) with gestational hypertension was induced with dinoprostone gel followed by synto augmentation and was taken for emlscs ivo non-descent of head. Baby cried immediately after birth with apgar of 9/9/9 and birth weight of 3420gm, no need for NICU stay.

Case C: Patient Z Primigravida with 39weeks+3days POG (DVP=9cm) was kept for spontaneous progression of labour and delievered spontaneously with blood loss of around 1200cc. Baby cried immediately after birth with apgar of 9/9/9 and birth weight of 2690gm, no need for NICU stay.

Conclusion: Pregnancies complicated by idiopathic polyhydramnios are at increased rate of adverse outcome. Hence, idiopathic polyhydramnios should be treated as a high risk pregnancy requiring multidisciplinary approach.

OP14

Decoding the S.FLT1/PLGF Ratio: A New Frontier in Placenta Accreta Spectrum Prediction

Rahul Amitabh, Sarita Singh

Introduction: Placenta accreta spectrum(PAS) is associated with life-threatening hemorrhage, need for blood transfusions, ICU admission, mechanical ventilation, infection, prolonged hospitalization and maternal mortality of 1% to 7%.

AIM: To evaluate the correlation of soluble FMS like tyrosine kinase 1(S.FLT1) and placental growth factor(PLGF) ratio with placenta accreta spectrum (PAS).

OBJECTIVES

- To evaluate the correlation of S.FLT1 and PLGF ratio in PAS .
- To correlate the IHC expression of S.Flt1 and PLGF in placenta with their serum values.

MATERIAL & METHODS : The prospective Case control study was conducted in department of Obstetrics and Gynaecology, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi over a period of 18 months from March 2023-August 2024 after ethical clearance.40 cases and 20 controls were recruited.

INCLUSION CRITERIA:

For cases: women with singleton pregnancy>28weeks, antenatally diagnosed PAS on USG/MRI or intra op diagnosed PAS were included.

For controls: women with pregnancy>28 weeks and non adherent placenta undergoing cesarean section .

Exclusion Criteria: Woman with Preeclampsia, Gestational Diabetes Mellitus, Fetal growth retardation, Acute and chronic infections, twin or multiple pregnancy were excluded.

For cases the uterus with placenta was sent for histopathological analysis whereas for controls only placenta was sent. S.FLT1 and PLGF in blood was correlated to placental invasion on histopathology.

Result: The cutoff of S.FLT1/PLGF ratio ≤163.048, predicts PAS with a sensitivity of 62%, and a specificity of 95%. The area under the ROC curve (AUROC) for S.FLT1/PLGF ratio was 0.753 (95% CI: 0.631 - 0.874), thus demonstrating fair diagnostic performance. It was statistically significant (p = 0.002).

There was a significant correlation between serum values of PLGF with the tissue expression of PLGF on IHC. Patients with higher serum values of PLGF had higher IHC score for PLGF in tissue as well (p<0.001).

CONCLUSION: Our study suggests that S.FLT1 and PLGF ratio is a good predictor of PAS. PLGF can be recommended as a reliable tissue marker in PAS and also single best predictive biomarker for PAS.**Full**

OP15

AI Detectives: Early Identification of Genetic Disorders Through Non-Invasive Prenatal Testing (NIPT)

Parul Aggarwal, Nusarat Inamdar

Aim and Objectives: This study aims to explore how artificial intelligence (AI) enhances the accuracy and scope of non-invasive prenatal testing (NIPT) for early detection of genetic disorders, including Down syndrome, trisomy 18, trisomy 13, and rare mutations. The objectives are to examine AI's role in improving detection rates, reducing false outcomes, and expanding screening capabilities.

Study Question: Can AI-based models significantly improve the diagnostic accuracy and clinical applicability of NIPT for detecting common and rare genetic disorders in early pregnancy?

Materials and Methods: The review evaluates advanced AI algorithms applied to cell-free fetal DNA (cfDNA) from maternal blood collected at ~10 weeks gestation. Techniques such as convolutional neural networks (CNNs), support vector machines (SVMs), and ensemble models were analyzed. Key metrics included sensitivity, positive predictive value (PPV), and overall accuracy, compared to traditional statistical methods.

Results: AI-enhanced NIPT methods, such as aiD-NIPT, achieved over 99.4% accuracy for detecting trisomies 21, 18, and 13, with 99.07% sensitivity and 88.43% PPV. AI integration enabled robust analysis using fragment distance, distribution, and multimodal data.

Conclusion: AI-driven NIPT significantly improves early, accurate, and safe prenatal screening. Future expansion into single-gene and rare disorders, along with ethical and clinical considerations, will shape the next frontier of personalized prenatal care.

OP16

Correlation of serum calcium levels in labor with primary postpartum hemorrhage

Aparna Sharma, Poonam Laul

Introduction: Primary postpartum hemorrhage (PPH), defined as excessive bleeding within 24 hours of delivery, is a major global cause of maternal mortality and morbidity. Uterine atony is the most common cause of PPH. Effective uterine contractions depend on adequate intracellular calcium levels, and oxytocic drugs used to manage PPH function by increasing these levels. Research points towards a potential link between maternal serum calcium levels during labor and the risk of developing PPH.

AIM: To investigate the relationship between serum calcium levels in labor and the occurrence of primary PPH.

METHODS: This study included 320 primigravidae with term pregnancies and spontaneous onset of labor delivering vaginally. During active phase of labor, 5ml blood was collected for analysis. Patients were grouped based on serum calcium: Group A(<8.5 mg/dL;n=160) and Group B(>8.5 mg/dL;n=160). Active management of the third stage of labor was done according to WHO guidelines and patients were monitored for 24 hours to quantify total blood loss and assess PPH incidence.

Results: Group A had significantly higher mean blood loss(500.25±243.73 ml) compared to GroupB (394.13±109.68 ml). Also patients in Group A(26.5%) developed PPH compared to Group B(5%) ($p<0.05$). The mean serum calcium level was significantly lower in Group A(8.15±0.16 mg/dL) than in Group B(9.01±0.38 mg/dL).

Conclusion: findings suggest a strong correlation between lower serum calcium levels during labor and an increased risk of primary PPH. Monitoring serum calcium levels during labor could serve as a valuable tool for identifying women at higher risk of PPH, facilitating early intervention and improved maternal outcomes.

OP17

Role of transcutaneous electrical nerve stimulation in relieving labour pain

Anjali, Vinita sarbhai

Introduction: To relieve labour pain various pharmacological to non pharmacological methods are available with there own side effects. TENS is a non invasive technique for pain management that applies low-voltage voltage electrical currents to the skin using electrodes with very few side effects.

AIM: To study the role of transcutaneous electrical nerve stimulation in relieving the pain of parturition

Material and Methods: A study was carried out on 87 singleton pregnancy at POG 37-40 weeks, with 5 cm cervical dilation, cephalic presentation, spontaneous onset of labour with adequate uterine contractions. TENS application was done using Elle Obstetric TENS machine ® and monitored for relief in labour pains. Pain threshold assessed during venepuncture at enrolment. Subjects received routine perinatal care and labour monitoring done with labour care guide. Feto-maternal outcome was noted. Pain relief was compared using VAS 100 mm scale. Patient satisfaction was measured by Likert 5 point scale.

Results: After the intervention, 67.5% got excellent to good relief, 17.5% got average relief, 15% got no relief. There was no difference in the feto-maternal outcome.

Conclusion: TENS produces a significant decrease in pain during labour, therefore, it can be considered an alternative and useful method for labour analgesia.

OP18

Beyond the epidural: a novel integration of tens and massage in active labor in low-risk laboring women

Smita Jugnu, Ritu Sharma, Ruchi Verma, Bharti Bhandari

Introduction: Respectful maternity care (RMC) promotes a positive birth experience, by offering mothers various options for reducing labor pain. TENS is non-invasive option for mothers seeking nonpharmacological pain relief.

Research Question: Does addition of TENS therapy along with intrapartum massage produce better labor analgesia as compared to intrapartum massage alone?

Primary Objective: Compare efficacy of intrapartum massage with TENS therapy versus massage alone.

Methods: In a randomized controlled trial, we enrolled 100 low-risk women with cervical dilation of > 4 cm and VAS Score > 3 who were assigned either:

- Study group: received massage + TENS therapy
- Control group: received massage + Placebo

All received standard obstetrical care as per FOGSI guidelines. Pain severity after 30 min, 120 minutes of TENS therapy and within 4 hours post-vaginal delivery were assessed using a 100-mm visual analog scale (VAS). A change of 13 mm was considered significant reduction in labor pain.

Results: The mean VAS score in study group and control group were 6.3 (SD 0.8); 7.3 (SD 0.8) at 30 minutes and 5.2 (SD 0.8); 7.0 (SD 1.0) at 120 minutes respectively, with statistically significant difference ($p < 0.001$) among two groups.

The need for pharmacological analgesia was less in TENS group.

The two groups were statistically comparable with respect to obstetrical and neonatal outcomes. Patients assessed with pre-validated feedback questionnaire on Likert scale reported high satisfaction with TENS.

Conclusion: TENS is an alternative non-pharmacological method for labor analgesia associated with significant reduction in pain scores and high levels of maternal satisfaction.

OP19

Depot Medroxyprogesterone Acetate (DMPA) is a widely used in jectable contraceptive but often causes abnormal uterine bleeding (AUB), leading to discontinuation

Angel Nandan

Background: Depot Medroxyprogesterone Acetate (DMPA) is a widely used in jectable contraceptive but often causes abnormal uterine bleeding (AUB), leading to discontinuation.

Objective: To compare the effectiveness of oral Tranexamic Acid and oral oestrogen in managing AUB following DMPA use.

Methods: A randomized controlled trial involving 100 women with AUB after their first DMPA injection. Participants will receive either Tranexamic Acid (250 mg thrice daily) or oral oestrogen (1 mg thrice daily) for 7 days. Primary outcome is days to cessation of bleeding; secondary outcomes include side effects and bleeding patterns.

Conclusion: The study aims to evaluate a safer and more effective approach to manage DMPA-induced AUB, improving contraceptive continuation rates.

Poster Abstracts

PP1

OHVIRA syndrome: a rare cause of left-side pyocolpos in an adolescent girl

Shreya Mittal, Jyotsna Suri

Introduction: OHVIRA syndrome is a rare mullerian duct anomaly, characterised by didelphys uterus, obstructed hemivagina, and ipsilateral renal agenesis. It mainly presents in adolescent girls with cyclical lower abdominal pain during menstruation.

Aim: To study a rare cause of pyometra/ pyocolpos in a young female.

To discuss the clinical presentation, diagnostic difficulties and surgical management of the condition.

Methods: An 18-year-old unmarried female presented with a one-year history of lower abdominal pain, unresponsive to medical treatment and heaviness in lower abdomen. Her menstrual cycles were regular with normal flow. General physical and per abdominal examination were unremarkable.

Ultrasound findings suggestive of didelphys uterus with double cervix and double vagina, left-sided hematocolpos, and absent left kidney.

MRI revealed two widely spaced uterine horns with a deep fundal cleft and non-communicating endometrial cavities. Each horn opens into a separate cervix. Two distinct cervical and vaginal canals are visualised divided by a longitudinal septum with left vaginal canal distended by a large collection. Left kidney is not visualized.

Results: The patient underwent surgical resection of vaginal septum and pyocolpos drainage under anesthesia.

Intraoperative findings- vaginal septum was resected and pus drained. Edges were everted to prevent re-epithelialisation.

On postoperative follow-up, patient had normal menstrual cycles and significant symptom relief.

Pus sent for culture sensitivity had E.coli and antibiotic treatment advised accordingly.

Conclusion: OHVIRA syndrome is a triad of didelphys uterus, obstructed hemivagina and ipsilateral renal anomaly. It's early diagnosis and management can help prevent future complications such as infections and infertility.

PP2

Rudimentary Horn Pregnancy: A Rare Diagnostic and Management Challenge

Vandana Meena, Usha K Rani

Introduction: Rudimentary horn pregnancy is a rare Müllerian duct anomaly, representing 2–4% of ectopic pregnancies. It carries a significantly higher risk of maternal morbidity and mortality due to frequent delays or errors in diagnosis, particularly as pregnancy advances.

Aim: To present a rare late-gestation case of rudimentary horn pregnancy and highlight the associated diagnostic and management challenges.

Methods: A 24-year-old primigravida at 24 weeks and 2 days gestation presented with five months of amenorrhea, vaginal spotting, and absent fetal movements. Initial ultrasonography confirmed intrauterine fetal demise. After failed medical induction with misoprostol and mifepristone, repeat ultrasonography and MRI were performed, revealing a left-sided rudimentary horn pregnancy. The patient subsequently underwent emergency laparotomy for definitive management.

Results: Intraoperative findings confirmed a unicornuate uterus with a non-communicating left rudimentary horn measuring approximately 8×7 cm, containing the demised fetus. Surgical excision of the rudimentary horn along with left salpingectomy was performed. Postoperative recovery was uneventful, and the patient was discharged in stable condition.

Conclusions: Rudimentary horn pregnancies present significant diagnostic difficulties, particularly in advanced gestation where clinical signs are non-specific and ultrasonographic sensitivity declines. Early clinical suspicion, timely imaging, and surgical intervention are essential to prevent severe maternal complications. Laparotomy with excision remains the definitive management approach for such advanced cases.

PP3

Mature Cystic Teratoma Ovary masquerading as Abdominal Malignancy : A Diagnostic Challenge

Shreya Mahajan, Disha Rajput

Abstract: We present a case of a 23-year-old female with a lower abdominal midline mass and dull pain of one month duration. Tumour marker CA 19-9 was notably elevated, prompting suspicion of a gastrointestinal (GI) mass. However, further investigation including MRI revealed a midline mass, likely originating from the left adnexa, likely a dermoid teratoma. Given the clinical presentation, elevated markers, and imaging findings, the possibility of adnexal malignancy, GI malignancy or malignant transformation of a mature cystic teratoma had to be considered. The decision to proceed with surgical exploration was crucial to obtain a definitive diagnosis and avoid mismanagement of a potentially malignant condition. Histopathological confirmation of ovarian teratoma highlights the importance of considering ovarian pathology in differential diagnosis of young female presenting with midline abdominal mass even when GI involvement is suspected and tumour markers are elevated, while maintaining a high index of suspicion for malignancy.

PP4

A Rare Bilateral Ectopic Spectrum: Left Chronic Ectopic Pregnancy with Right Tubal Abortion

Mira Jasrai, Priyanka Suhag

Background/Introduction: Chronic ectopic pregnancy (CEP) is an uncommon and diagnostically challenging entity, often presenting with subtle symptoms and low or plateauing β-hCG levels. Simultaneous bilateral tubal involvement—particularly a chronic ectopic on one side and active tubal abortion on the contralateral side—is exceptionally rare and may be missed preoperatively.

Aim: To report a rare case of bilateral tubal ectopic pathology and emphasize the importance of thorough adnexal evaluation during laparoscopy in suspected ectopic pregnancies.

Method: A 26-year-old nulliparous woman presented with prolonged spotting and lower abdominal pain. Serum β-hCG levels were low and non-doubling. Transvaginal ultrasonography revealed a left adnexal mass suggestive of chronic ectopic pregnancy. Diagnostic laparoscopy was undertaken to confirm the diagnosis and manage the condition surgically.

Result: Intraoperatively, a left-sided tubo-ovarian mass consistent with chronic ectopic pregnancy was identified, along with incidental fimbrial bleeding from the right fallopian tube. A left salpingo-oophorectomy and right tubal milking were performed. Histopathology confirmed chronic ectopic pregnancy on the left and recent chorionic villi in the right tube, consistent with tubal abortion.

Conclusion: This rare case highlights the critical value of bilateral adnexal inspection during laparoscopy for ectopic pregnancy. Early surgical intervention not only confirms diagnosis but may detect otherwise missed concurrent pathology, reducing morbidity and preserving fertility.

PP5

Prenatal Detection of Cardiac Rhabdomyoma associated with Tuberous Sclerosis Complex in third trimester: A Case Report

Vidushi Agarwal, Upma Saxena

Introduction : Tuberous sclerosis complex (TSC) is a multisystem autosomal dominant genetic disorder that can present with variable prenatal findings which may evolve after second trimester Anomaly scans.

Aim: A 26 year-old, G2P1L1, on her ultrasonographic examination at 32+2 week was found to have multiple cardiac rhabdomyomas, pericardial effusion, polyhydramnios and abnormal echogenic tubers in brain parenchyma. Her biochemical aneuploidy screening and anomaly scan were unremarkable as was her family history.

Methods: Prenatal genetic diagnosis was offered after proper counselling. Amniocentesis followed by whole exome sequencing (WES) identified a pathogenic mutation in the TSC2 gene, confirming the diagnosis of Tuberous Sclerosis. The mother was started on oral sirolimus therapy.

Result: A cesarean delivery was performed at 37 weeks of gestation in view of previous LSCS with polyhydramnios. The baby had secondary apnea soon after birth and was placed on CPAP and shifted to intensive care unit. Postnatal evaluation of the neonate confirmed cardiac rhabdomyoma. The baby is under follow-up and is doing fine at present. Sanger sequencing performed in the couple revealed absence of the mutation.

Conclusion: This case underscores the importance of ongoing fetal surveillance despite a normal mid-trimester anomaly scan. Late-onset ultrasonographic findings may be the first clue to underlying genetic syndromes such as Tuberous Sclerosis. Serial imaging and genetic testing can guide timely interventions and parental counseling.

PP6

First Trimester Uterine Rupture: A Rare but Life-Threatening Event – Case Report

Dasari Yeshaswini, Jharna Behura, Kavita Gupta

Introduction: Uterine rupture is a rare but serious cause of obstetric hemorrhage, particularly in early pregnancy. First-trimester rupture is uncommon and is usually associated with uterine anomalies (bicornuate uterus). In some cases, the cause may remain unexplained.

Case Description: A 29-year-old woman, Gravida 2 Para 1 Live 1, with a history of previous Caesarean section, presented at 13 weeks and 5 days of gestation (by early scan) with complaints of abdominal pain. On examination, the patient appeared moderately pale, with blood pressure of 100/60 mm-Hg and pulse rate of 90 bpm. Per abdominal examination revealed diffuse tenderness, and the uterine size could not be assessed. On speculum examination, there was no vaginal bleeding. On per vaginal examination, the uterus size was not appreciable, and cervical motion tenderness was noted. Ultrasound showed a dead fetus of 13 weeks lying outside the uterus, an anterior placenta, and free fluid in the cul-de-sac, sub-hepatic, and left flank regions—suggestive of uterine rupture/scar dehiscence.

Emergency laparotomy revealed approximately 800 cc of hemoperitoneum. A complete fundal rupture was seen, with fetus and placenta in the abdominal cavity. The previous lower segment Caesarean scar was intact. Bilateral tubes and ovaries were normal. Bilateral tubal ligation was performed.

Conclusion: Although extremely rare, fundal rupture in early pregnancy can lead to life-threatening complications. Early suspicion and prompt surgical management are crucial for a favourable outcome.

PP7

Interstitial Lung Disease complicated as pneumothorax in pregnancy

Aishwarya V Yajaman, Deepti Goswami, Poonam Kashyap, Kajal Prasad

Abstract: Interstitial Lung Disease is characterized by diffuse inflammation and fibrosis of lung interstitium. It poses high risk for pneumothorax (12-20%) with a mortality of 60%.

A 29year old G2P1L1 at 32 weeks of gestation presented to emergency room with sudden onset breathlessness and bluish discoloration of hands and legs. History and documents revealed that she was a known case of Interstitial Lung disease (Nonspecific Interstitial Pneumonia) since three years and was on oral corticosteroids and oxygen therapy and by history patient was non-compliant. The disease got exacerbated once at 28 weeks of gestation which was conservatively managed. Interestingly enough, her previous pregnancy was uneventful. Patient presented with a poor general condition (E1V2M1), gasping and generalized cyanosis, pulse rate of 150 bpm, BP 110/60 mmHg, Respiratory rate of 40 cpm, SpO2- 50% on room air and 92% with NRBM with decreased bilateral air entry. Fetal heart rate 110 bpm, irregular. Patient was immediately intubated and intercostal chest tube was inserted. Patient was taken up for cesarean section as a resuscitative measure. Unfortunately baby had a still birth due to prolonged hypoxia. Later patient received ICU care, triple inotropes, broad-spectrum antibiotics and IV corticosteroids.

This case illustrates how lung diseases can get complicated during pregnancy and proves to be fatal. Although there are fewer than 100 reported cases of pneumothorax in pregnancy, it potentially increases morbidity and mortality. This calls for a need in serious research in the prospect of risk stratification during pregnancy which could probably reduce maternal and fetal mortality.

PP8

Fundal Placenta Accreta-A rare presentation in a case of previous 2 LSCS with Intrauterine Feral Demise in Early Pregnancy

N. Lakshmi Priya, Jharna Behura, Poonam Bagga

Introduction: Fundal Placenta Accreta is a rare and challenging condition characterized by abnormal placental adherence to the myometrium typically in the upper segment.

Case Description: A 30 year old gravida 4, para 2, abortion 1 with a history of previous two caesarean and one D&C presented at 19weeks 1day of gestation for a routine ultrasound, which showed intrauterine fetal demise and abnormal, increased vascularity of the placenta at the fundus. However, other features of placenta accreta were not observed. She was planned for medical termination by mifepristone and misoprostol after which she expelled the fetus but the placenta was retained. The lower segment placenta was removed as much as possible, but the patient had profuse vaginal bleeding and severe hypotension for which laparotomy was performed after stabilizing vitals. Intraoperative findings revealed fundal placenta accreta.Emergency subtotal hysterectomy was performed due to uncontrolled haemorrhage.The patient required multiple blood transfusions and was stabilized postoperatively.

Conclusion: Diagnosing fundal placenta accreta is challenging due to its atypical location. Although grayscale ultrasound is a first-line tool, its sensitivity is limited for fundal locations due to difficulty in visualizing the upper uterine segment. Management often requires radical interventions like caesarean hysterectomy, especially in cases involving extensive invasion or life-threatening haemorrhage. This case underscores the importance of clinical suspicion and prompt surgical management in atypical presentations.

PP9

Diagnostic Dilemma: When HELLP Mimics Dengue in Pregnancy

Monika Jain

Introduction: Distinguishing between HELLP syndrome and dengue fever during pregnancy can ben a clinical challenge. Both conditions can present with low platelet counts and elevated liver enzymes, yet their management pathways differ, one often requiring urgent delivery, the other best managed with supportive care.

Case-Report: We present the case of a 26 year old woman, 32 weeks pregnant, who came to us with a recent fever, profound fatigue, and concerning lab results. Her platelet count was dangerously low, and liver enzymes were elevated. Initially, all signs pointed to partial HELLP syndrome, a serious pregnancy complication known to masquerade in many ways. She was closely monitored, transfused with platelets, and given corticosteroids to help mature the baby's lungs in preparation for a possible early delivery.

But then, the picture shifted. New symptoms like joint pains and recurrent fever prompted further testing. When her dengue NS1 antigen returned positive, the diagnosis changed. Instead of an obstetric emergency, we were now managing a viral infection in pregnancy. She was treated conservatively with fluids and monitoring, and her condition improved.

Tragically, despite medical efforts, the baby was stillborn following a preterm labor. The mother, however, stabilized and was discharged in good health after few days.

Conclusion: This case highlights how overlapping symptoms can pose as a diagnostic dilemma. In regions where dengue is common, it must remain high on the differential especially in pregnancy to avoid unnecessary interventions and ensure both maternal safety and fetal considerations.

PP10

ITP and hysterectomy- a post-partum tale

Priyanka Mitra, Upma Saxena

Introduction: ITP is the most common cause of thrombocytopenia in pregnancy. The incidence is 1-2 every 10,000 pregnancies. It is caused by IgG antibodies directed against platelet glycoproteins. The management in pregnancy includes a multidisciplinary approach involving obstetrician, hematologist, and anesthetist.

Case Report: We report the case of a 27 yr P2L1 who presented to us on post-natal day 20 of pre-term vaginal delivery with IUD, known case of ITP on steroids with severe anemia, sepsis, hypothyroidism with secondary PPH. An ultrasound was done which revealed the presence of vascular RPOC's. Dilatation and evacuation were performed which resulted in a blood loss of 500 ml and was managed with uterotonics and Bakri balloon tamponade. Patient was shifted to ICU on inotropes and received Injection romiplostim after hematology consultation. Even after transfusion of multiple blood products, her platelet count was 20,000 per mcltr.

On post D and E Day 10, patient again had increased bleeding p/v for which uterotonics was given and Bakri balloon tamponade reinserted. A CT abdomen was performed which revealed a collection in the endometrial cavity and a collection communicating with uterine cavity through defect extending into paracervical space. An emergency laparotomy was performed which revealed the presence of a foul-smelling hematoma in the right broad ligament which was followed by hysterectomy.

Conclusion: ITP is a complex heterogenous disorder with an uncertain etiology. Timely treatment can reduce both maternal and fetal complications.

PP11

Antenatal Diagnosis and Multidisciplinary Management of Left Congenital Diaphragmatic Hernia: A Case Report

Komal, Shreya Singh, Upma saxena

Introduction: Congenital Diaphragmatic Hernia (CDH) is a severe fetal anomaly with variable prognosis depending on severity, associated findings, timing of diagnosis, and access to multidisciplinary care.

Aim : A 26-year-old woman, G3P1L1A1, referred to fetal medicine following her level 2 ultrasound, which revealed a left-sided congenital diaphragmatic hernia with right mediastinal shift. Biochemical aneuploidy screening was not done. There were no significant soft markers or other structural anomalies noted.

Methods : The patient presented to fetal medicine OPD at our centre where detailed ultrasonographic evaluation was done which confirmed the findings of left sided CDH. Her o/eLHR (observed/expected lung head ratio) was 48.37% with no features of hydrops. Fetal echocardiography was normal. After proper genetic counselling and explaining prognosis, prenatal genetic testing via amniocentesis followed by QF-PCR was done which was normal.

Result : The fetus was followed by four weekly ultrasound till delivery. A female baby of 3 kg delivered at 38 weeks via normal vaginal delivery. The baby did not cried at birth and required resuscitation, including intubation and one cycle of CPR. The baby was shifted to icu and underwent surgical repair on day 1 of life after confirmation of diagnosis. Postoperatively, the baby developed a left pneumothorax, managed with ICD insertion, and required inotropic support. The baby discharged on day 28 after stabilization. Baby is under follow up and doing well till 4 months of age.

Conclusion : Antenatal diagnosis and coordinated perinatal management with multidisciplinary approach improve prognosis, enhance survival and reduce complications in affected neonates.

PP12

Cervical endometriosis: a rare form of genital endometriosis

Sonika Bansal, Reeta

Introduction: Endometriosis of the cervix is a rare form of genital endometriosis. Cases of the localization of hemorrhagic cystic lesions assuming a dark blue or chocolate brown appearance on the vaginal part of the cervix are quite rare.

Case Report: 33 years old, P2L2, came to gynae OPD with complaints of irregular menses, dysmenorrhea and dyspareunia. On per vaginal examination, posterior cervical lip was bulky, bulging and tender on palpation. On TVS, a cystic lesion abutting the ovary in the cervical canal visualized having 'ground glass appearance'. Needle aspiration followed by incision drainage was done at the point of maximum bulge, dark reddish-brown thick fluid was drained which was sent for cytology. Cervical biopsy from the margin of the lesion were taken and sent for histopathology. Cytology of the fluid revealed the presence of endometrial cells and hemosiderin-laden macrophages. Histopathology of cervical tissue revealed endometrial glands and stroma within the cervical tissue.

Discussion: Although most cases of cervical endometriosis are asymptomatic, some may present with abnormal vaginal bleeding or variable cervical appearance, making preoperative diagnosis challenging. Expectant management is appropriate for asymptomatic patients with small lesions, while symptomatic cases often require local excision.

Conclusions: Endometriosis of the cervix is a rare condition that presents with variable clinical manifestations, making it difficult to diagnose and posing a significant challenge in clinical practice.

PP13

An interesting case of abnormal uterine bleeding with aplastic anemia

Veena Sharma, Bhagyashree, Zeba khanam, Jyotsna Suri, Sumitra bachani, Monika Gupta, Divya Pandey

Background: Abnormal uterine bleeding is a frequent gynaecologic complaint secondary to structural or non-structural causes, or both. We discuss an interesting case of abnormal uterine bleeding in a newly diagnosed aplastic anemia .

Case summary: A 21-year-old nullipara presented to the emergency department with pancytopenia and heavy menstrual bleed for two months. She had an ultrasound report of a large space occupying lesion in the uterine myometrium suggestive of a leiomyoma. On further imaging, discrete punctate infiltrative foci were also noted in the bony pelvis. A diagnosis of aplastic anaemia was made on a subsequent bone marrow biopsy. She was put on GnRH injection, eltrombopeg, antithymocyte globulin and danazol. She is currently under our follow-up.

Conclusion: Aplastic anemia may present as pancytopenia and AUB in young reproductive aged females. Timely diagnosis and therapy are essential for positive outcomes.

PP14

High risk pregnancy

Veena Acharya, Neelam Jain

Abstract: High-risk pregnancy refers to a condition in which the mother, fetus, or both are at increased risk of complications during pregnancy, childbirth, or after delivery. This classification can result from pre-existing maternal health conditions, complications that arise during pregnancy, or lifestyle and environmental factors. Common risk factors include maternal age (under 17 or over 35), hypertension, diabetes, obesity, multiple gestation (twins or more), previous pregnancy complications, and infections. Additionally, socioeconomic status and access to prenatal care play crucial roles in outcomes.

Early identification and continuous monitoring are critical in managing high-risk pregnancies. Advances in prenatal diagnostics, including ultrasonography, genetic screening, and non-invasive prenatal testing (NIPT), allow for better prediction and management of potential complications. Interdisciplinary care, involving obstetricians, maternal-fetal medicine specialists, nutritionists, and mental health professionals, is often required to optimize outcomes for both mother and baby.

Management strategies focus on minimizing risk through personalized care plans, regular monitoring, lifestyle modifications, and, when necessary, medical or surgical interventions. Patient education and psychological support are equally vital, as high-risk pregnancies can impose significant emotional and psychological stress.

In conclusion, while high-risk pregnancy poses challenges, timely diagnosis, multidisciplinary management, and patient-centered care significantly improve maternal and fetal outcomes. Continued research and improved access to quality maternal healthcare services are essential in reducing complications and ensuring healthier pregnancies for women worldwide.'

PP15

Seejal Sirohi, K Usha Rani

Diagnostic Dilemma- A rare case of Cervical Polyp mimicking Uterine Prolapse

Abstract: 35 year old woman, P2 L2 with ?Procidentia ?prolapsed uterine fibroid ?chronic uterine inversion came with complaint of a mass coming out of vagina for 4 years which became nonreducible for 1 day and spotting for 4 days.

Patient noticed a mass coming out of vagina for 4 years with a constant pingpong ball size which aggravated on standing, coughing and straining and could be reduced manually by fingers.. She had spotting for 4 days following which a large mass suddenly came out of vagina which was irreducible. On P/V examination, firm mass 12*10cm with long stalk attached, healed ulcers on surface,Uterus not separately palpated, bilateral fornices free. Clinical Presentation Mimicked Procidentia/ Uvprolapse. Grossly, cut section of the polyp showed whorled appearance and few pressure necrotic areas. The decision to vaginally remove the mass taken. Vaginal polypectomy done as during per op: 15* 10cm fibroidal polyp coming out of posterior lip of cervix found. Pedicle cauterized and polyp sent for HPE.

PP16

Exploring Vulval Fibroadenoma- A Rare Case

Anu Berwal, Komali Kancharla

AIM: To report a case of vulval fibroadenoma

Introduction: Vulval fibroadenoma is an uncommon, benign tumor with debatable origin, either from ectopic breast tissue or mammary-like anogenital glands.

Material Methods: A 33-year-old P2L2 presented with a painless vulval mass for last 4 years, gradually increasing in size. On examination, 5×4×3 cm pedunculated mass seen hanging from right labia majora. It was smooth, firm, non-tender and not fixed to underlying structures. Ultrasonography suggested heterogenous lesion with mild vascularity. Excisional biopsy of mass was done.

Results: On cut section, a homogenous, pink-tanned soft tissue mass with slit-like areas seen. Microscopy showed glandular and stromal hyperplasia. Glands composed of cuboidal cells supported by myoepithelial cells. The stroma contained spindle cells arranged in fascicles with peri-canalicular growth pattern. Diagnosis of vulval fibroadenoma was made, probably arising from specialized anogenital glands.

Discussion: The overall incidence of EBT is 2%-6% in females with axilla being most common and vulva being second most common site. Often presenting after puberty, it tends to enlarge in response to hormonal changes. Clinically, vulval fibroadenomas are similar to breast fibroadenomas, both in presentation and histopathological features. Diagnosis is typically made through fine needle aspiration cytology or core needle biopsy. Treatment involves surgical excision with clear margins to minimize risk of recurrence. In cases where malignancy is suspected, immunohistochemical studies for hormone receptors may provide further diagnostic and prognostic insight.

Conclusion: This report aims to create awareness about this rare condition and need for inclusion of peripheral tissues during excision to understand histogenesis.

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PP17

Management of Postmenopausal Labial Adhesions with Urethral Obstruction and Vaginal Stenosis: A Case Report

Kritika Dhingra, Nilima G, Dr Ranjana Sharma

Background: Labial adhesions and vaginal stenosis are distressing conditions in postmenopausal women, though uncommon, often resulting from estrogen deficiency. They can lead to significant urogenital symptoms, including urinary obstruction and dyspareunia.

Case Description: A postmenopausal woman (P3L3), aged 51 presented with complaints of thin urinary stream and the sensation of obstruction during micturition for 4–5 months. Along with superficial dyspareunia, leading to sexual abstinence. History included similar symptoms managed with topical estrogen therapies. Local examination under anaesthesia revealed 50% labial fusion, an almost obliterated urethral opening with adhesions, and a blind-ending vaginal canal admitting only 1 cm of a finger.

Management and Outcome: The patient underwent Foley's catheter insertion under spinal anaesthesia. A midline perineal incision was made to access and recreate the vaginal canal, achieving ~8 cm in depth. Dense adhesions were released, manual vaginal dilatation was done and a thick vaginal ring at 2–3 cm from the hymen was incised at 5 and 7 o'clock positions. Fenton's procedure was done. Haemostasis was secured, and a vaginal pack was placed. Postoperative recovery was uneventful. The patient was discharged with topical estrogen therapy, antibiotics, analgesics, and advice on the use of vaginal dilators and resumption of sexual activity.

Conclusion: This case underscores the need for heightened clinical awareness of labial adhesions and vaginal stenosis in postmenopausal women presenting with urogenital symptoms. Comprehensive surgical management, supported by postoperative topical estrogen therapy and education on vaginal dilator use, can effectively restore anatomical integrity and improve quality of life.

PP18

Rare case of postpartum peripheral wet gangrene

Neha, Sumitra Bachani, Jyotsana Suri, Monika Gupta, Zeba Khanam

Background: Septic shock can be associated in less than 0.5% cases with rapidly progressive vascular collapse and disseminated Intavascular coagulation.Its associated with over 50% mortality in such cases. This condition is known as purpura fulminans which calls for rapid multidisciplinary care.

Case Summary: A 26 year old postpartum women was referred in view of Bilateral upper limb and lower limb gangrene. She had undergone a full term vaginal delivery at a PHC and had been discharged uneventfully. By postpartum day 5, she developed high grade fever with breathlessness and progressive bluish discoloration of all 4 limbs.

On examination: Wet gangrene in all 4 limbs extending till proximal interphelengeal joint, all peripheral pulses palpable.on pelvic examination cervix unhealthy with lips coated with thick infected yellowish colour discharge, doppler of bilateral upper and lower limb was normal, USG revealed RPOC of 5.6 x 3.5 cm. Her initial management included broad spectrum antibiotics, anticoagulant and evacuation of RPOC. Despite this her general condition deteriorated with persistent high grade fever and she underwent sub total hysterectomy per op 500 ml serosanginous ascitis fluid drained with pus flakes, on cut section uterus had 250 cc of organised POCS with clots. She received multiple blood products post operatively. Her TLC count was 21000 and her ANA, APLA profile were negative, pus culture was positive for Ecoli, antibiotics were modified accordingly. Diagnosis of purpura fulminans was made.

However, her post operative period was complicated by episodes of sudden desaturation and metabolic encephalopathy requiring invasive ventilation and ICU care.She gradually improved with wound care, physiotherapy, and anticoagulation therapy. She was discharged on oral anticoagulants with continued wound care and limb support.

Conclusion: This case highlights the importance of early detection and aggressive management of puerperal sepsis to prevent sepsis associated purpura fulminans and its devastating complications. Timely surgical intervention, multidisciplinary care and vigilant supportive management are crucial for patient recovery.

PP19

Clinical Challenges in the Management of Chronic Myeloid Leukaemia During Pregnancy

Ishani Vasudeva, Monika Gupta, Zeba Khanam, Jyotsana Suri, Sumitra Bachani, Divya Pandey

Background: Chronic Myeloid Leukaemia (CML) is a myeloproliferative neoplasm accounting for approximately 10% of all pregnancy-related leukaemias. Although rare during pregnancy, it portends poor fetomaternal prognosis. We discuss the therapeutic dilemma in the management of a case of CML in pregnancy.

Case Summary: A 25-year-old primigravida presented to the outpatient department (OPD) with an incidental finding of leucocytosis (108,880 cells/μL), basophilia, eosinophilia, thrombocytosis and moderate anaemia at three months of amenorrhea. She tested positive for the BCR-ABL1 gene mutation and was diagnosed with CML. She was started on hydroxyurea fearing teratogenicity with tyrosine kinase inhibitors (TKIs), however, imatinib was started at around 29 weeks secondary to unrelenting leucocytosis and massive splenomegaly. Two weeks after starting imatinib therapy, she presented to the emergency department with breathlessness, hypoxemia, and preterm premature rupture of membranes. Echocardiography revealed pericardial effusion and a hypokinetic heart with a severely reduced ejection fraction. She delivered via caesarean section and required prolonged mechanical ventilation, during which she developed leukopenia, sepsis and succumbed three weeks later.

Conclusion: Although TKIs have revolutionized the management of CML, their use during pregnancy is limited by their teratogenicity and potential for serious side effects. One such side effect is heart failure and pericardial effusion, which may be masked by pregnancy-related cardiorespiratory changes. Hence, pregnant patients with CML require close follow-up and multidisciplinary care during therapy to ensure successful outcomes

PP20

Subacute uterine inversion

Farha Naaz, Divya Pandey, Jyotsna Suri, Sumitra Bachani, Monika Gupta, Zeba Khanamgupta

Background: Subacute uterine inversion occurs after 24 hours but within 4 weeks after delivery. The incidence of uterine inversion ranges from 1 in 3,500 to 1 in 20,000 and can lead to adverse maternal outcomes if not identified and managed promptly.

Case Summary: A 30-year-old female, P2L2, presented with complaints of bleeding per vagina on postoperative day 1 following an emergency laparotomy due to failed manual repositioning of the uterus, which was attempted on postnatal day 7 in view of subacute uterine inversion. On examination, the uterus was felt in the vagina, cervical lips were not palpable, and bleeding per vagina was present. On ultrasonography, features suggestive of uterine inversion were observed. Under antibiotic cover, a relaparotomy with abdominal hysterectomy and bilateral salpingectomy was performed under general anesthesia in view of failed manual repositioning. Per operative findings revealed a completely atonic uterus and bilateral edematous fallopian tubes. The patient recovered well and was discharged in stable condition.

Conclusion: This case highlights the dangers of unsupervised home deliveries and the need for skilled birth attendance and early recognition of postpartum complications. Uterine inversion is a rare but life-threatening condition with 15% morbidity and mortality.

PP21

Case series on outcomes of pregnancy with different mullerian anomalies

Ankita Singh, Vinita Sarbhai

Introduction: Müllerian anomalies are congenital malformations of the female reproductive tract resulting from abnormal development, fusion, or resorption of the Müllerian ducts. Though rare, these anomalies can significantly affect fertility and pregnancy outcomes.

Case Description: This series presents five cases of pregnancy complicated by different types of Müllerian anomalies:

- **Case 1:** A 24-year-old primigravida with breech presentation and PPROM at 33+4 weeks underwent emergency LSCS, revealing a didelphys uterus.
- **Case 2:** A 21-year-old G2P1L1 with a known didelphys uterus delivered vaginally at 35+6 weeks. Vaginal septum and two cervices were identified on p/v.
- **Case 3:** A 22-year-old G2A1 at 31+4 weeks had non-progressing labor; LSCS confirmed a unicornuate uterus.
- **Case 4:** A 26-year-old woman with infertility was diagnosed with a partial uterine septum on HSG. She conceived following hysteroscopic septoplasty and ovulation induction, delivering vaginally at term.
- **Case 5:** A 25-year-old G3A2 presented with threatened abortion at 12 weeks. Ultrasound diagnosed a bicornuate uterus. She underwent LSCS at 35+4 weeks for a precious pregnancy.

Discussion and Conclusion: All patients experienced pregnancy complications such as malpresentation, preterm labor, or infertility. Surgical interventions, including LSCS and septoplasty, along with individualized antenatal care, were pivotal in achieving favorable outcomes. Early diagnosis and a multidisciplinary, patient-specific approach are essential in managing pregnancies complicated by Müllerian anomalies to optimize maternal and fetal prognosis.

PP22

Hydatid CYST in Pregnancy

Ritika Kumari, Divya Pandey

Introduction: Hydatid disease, or echinococcosis, is a zoonotic parasitic infection caused by Echinococcus granulosus, most commonly affecting the liver and lungs. It is endemic in regions with widespread sheep and cattle rearing. The occurrence of hydatid disease during pregnancy is rare, with an estimated incidence of 1 in 20,000 to 30,000 pregnancies. However, when it does occur, it poses significant maternal and fetal risks due to potential cyst rupture, anaphylaxis, compression effects, and challenges in imaging and treatment during gestation.

Aim: To present a rare case of hydatid cyst in pregnancy, and to discuss diagnostic challenges, management options, and maternal-fetal outcomes through a review of available literature.

Case Summary:

A primi 37+ 6 week(b/d) presented with right upper quadrant pain. Imaging with ultrasonography revealed a hepatic hydatid cyst. A multidisciplinary approach was employed involving obstetrics, general surgery. The patient was managed conservatively with albendazole and regular fetal monitoring.

Results: The patient delivered FTNVD, baby girl of 2.4 kg on 10 july with no complications.

PP23

The atypical presentation of Ovarian Sertoli-Leydig cell tumor- a case report

Neeti Singhal, Arifa Anwar, Asma Bashir Khanday

Abstract: Sex cord stromal tumours are the most rare form of ovarian tumors with incidence of less than 5 %. Mixed sex-cord stromal tumor or Sertoli-Leydig cell tumors are rarest among these accounting for less than 0.5 % of all ovarian tumors according to WHO classification.75% patients present with abdominal mass and have symptoms of virilisation depending on the quantity of androgen production.We report the case report of a young woman with Sertoli-Leydig cell tumor along with the challenges in management observed.

Case: An 18 year old unmarried female presented to us with complaint of generalised abdominal pain with amenorrhea for last 2-3 months.Patient had history of prior hormonal treatment based on provisional diagnosis of ovulatory dysfunction.Her physical therapy examination revealed symptoms of virilisation like clitromegaly,hirsuitism,voice change but no palpable mass. Usg and MRI revealed 5 cm adnexal mass suggesting endometriotic or haemorrhagic cyst.Blood investigations showed elevated testosterone and inhibin levels and low FSH levels.RMI score and IOTA adnex model showed low risk of malignancy .Despite low risk of malignancy on RMI and IOTA , patient was planned for surgical exploration and complete removal of adnexal mass due to the constellation of clinical features which were suggestive of sex cord stromal tumor. Histopathological features confirmed the diagnosis of Sertoli-Leydig cell tumor.

Conclusion: This case underscores the importance of considering rare ovarian tumors in young women presenting with atypical features even when initial risk assessments for epithelial cancers are low.

PP24

Vaginohysteroscopy: A New Way of Evaluating the Uterine Cavity

Bani Gupta, Vinita Sarbhai

Background: Traditional hysteroscopy often causes discomfort due to the use of cervical instruments. Vaginohysteroscopy is a less invasive technique that avoids speculums and tenaculums by directly introducing the hysteroscope through the vaginal introitus under saline distension. This approach may improve patient comfort while maintaining diagnostic accuracy.

Objective: To evaluate the efficacy, success rate, pain, complications, patient satisfaction, and diagnostic utility of vaginohysteroscopy in an outpatient setting.

Methods: This prospective observational study was conducted at Kasturba Hospital, Delhi, involving 26 women who underwent vaginohysteroscopy using a 2.9 mm rigid hysteroscope under sedation. Normal saline served as the distension medium. The procedure was performed without a speculum or tenaculum. The hysteroscope was introduced under direct vision through the vaginal introitus and cervix into the uterine cavity.

Primary outcomes included successful uterine entry and complete visualization. Secondary outcomes were procedural time, pain (assessed using a visual analogue scale), complications, and patient satisfaction (assessed via a 5-point Likert scale).

Results: Complete visualization of the uterine cavity was achieved in 96.2% of patients. The average pain score was 4.8 during the procedure and 4.48 after 30 minutes. No intraoperative complications were reported. The procedure was brief and well tolerated, with high levels of patient satisfaction.

Conclusion: Vaginohysteroscopy is a safe, efficient, and well-tolerated technique for uterine evaluation. Its high success rate and favorable patient experience make it a valuable alternative to conventional hysteroscopy in outpatient care.

PP25

A Rare Case of Tongue Hemangioma in a 33-Week Pregnant Woman: Multidisciplinary Management and Obstetric Considerations

Kareena Rai

Abstract: Hemangiomas are benign vascular tumors predominantly occurring in the head and neck region, but their manifestation on the tongue during pregnancy is extremely rare. We present a unique case of a 25-year-old gravida 2, para 1 woman at 33 weeks of gestation who reported with spontaneous intermittent bleeding from the lateral border of her tongue, associated with blood-tinged sputum. The diagnosis was clinically suspected as a hemangioma, further confirmed by angiography due to inability to perform MRI owing to heavy bleeding.

Angiographic evaluation revealed diffuse vascular blush with hypertrophied branches of the external carotid artery. Under a multidisciplinary team approach involving obstetricians, radiologists, and anesthesiologists, super-selective embolization of the feeding vessels was successfully performed under general anesthesia, ensuring fetal safety through abdominal shielding. The procedure resulted in significant reduction in vascularity, with no compromise to major vessels. The patient tolerated the procedure well, required brief ICU observation, and was discharged hemodynamically stable with no further bleeding.

This case underscores the importance of early recognition and timely intervention in rare vascular lesions during pregnancy, where hormonal and hemodynamic changes may exacerbate growth and bleeding risk. It also highlights the effectiveness of minimally invasive procedures like embolization in managing high-risk oral vascular lesions antenatally. A planned postpartum contrast-enhanced MRI and sclerotherapy were advised for comprehensive follow-up.

The rarity of such presentations necessitates increased awareness among obstetricians and gynecologists to ensure safe maternal and fetal outcomes in similar complex scenarios.

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