NARCHICON 2024

30th 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: **03rd - 06th October 2024**
Venue: **Hotel The Lalit, New Delhi**

THEME

"BE AWARE-ADOPT-ADHERE TO THE PROTOCOLS"

ABSTRACT & SOUVENIR

UPDATEKNOWLEDGEUPGRADESKILLSUPLIFTWOMEN'SHEALTH

NARCHI Delhi Secretariat
Institute of Obstetrics and Gynaecology
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 30th Annual conference of NARCHI Delhi Chapter to be held from 4th Oct to 6th Oct at The Hotel Lalit. 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 **"Be Aware-Adopt-Adhere to the Protocols"**. This 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 program is carefully tailored to address and upgrade obstetrics skills and surgical skills of endoscopy and robotics surgeries.

The programme caters to the current topics of 3 P's of Obstetrics, key note addresses on Adolescent Health, Syphilis and Cholestasis of pregnancy together with Epidemiological profile of cancer in women and Role of PRP in Endometrial Re-Juvenation. The deliberations are on Triaging in Obstetrics, Sexual health of women, Saving Ovarian and Journey of IVF in India.

The stalwarts are going to talk about "Eclampsia, Anaemia and Cervical cancer Mukt Bharat". The experts will enlighten us on Sepsis in Obstetrics, Surgical Site infection. Artificial intelligence in Reproductive health and identifying complication in twin pregnancies.

We are really lucky to have the three important orations delivered by eminent leaders across India. There are Panel discussions on Adolescent Health, Case based discussion on Loop holes in MTP - Act". The reverse panel is on Medicolegal issues in Obstetrics. There are video sessions on Episiotomy, Repair of 3rd and 4th degree tears, "Instrumental Deliveries forceps and Vaccum and Patwardhan's Technique/ Breech extraction.

One scientific hall is totally dedicated to post graduate activities like papers, posters presentations, Quiz and Slogan competition together with drills, skit and role play of 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. The icing on the cake are eleven focused workshops which includes workshops on "Mastering Myomectomy Video workshop", "Obstetrics Skill Workshop", "Video Workshop On Urogynaecology", "Critical Care In Obstetrics", "Transforming Health Care Through Passion and Innovation", "Fine Tuning Ovarian Stimulation For Practicing Gynaecologist", "CTG: Intrapartum Fetal Monitoring", "Comprehensive Obstetrics Skills- Nurses Module", "Stillbirths: Decoding The Enigma", "Genetics", "Family Planning Services: Expanding Choices, Ensuring Rights", "Preventive Oncology", and together with skits, role play and drills. This will involve surgical medical as well as social aspects of various challenges faced by women during antenatal period and postnatal period pertinent to the present world.

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 short culture program. 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 and Dr. Indrani Ganguli while planning the entire conference.

I feel privileged that Dr. Subrata Dawn, Dr. Veena Acharya, Dr. Achla Batra 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. B. G. Kotwani, 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 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 and 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, Ms. Asha Rani and Ms. Nikita, Mr. Harsh Malik. 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: **"Be Aware-Adopt-Adhere to Protocols"**. This theme is crucial for ensuring a safe, productive, and inclusive environment for all participants.

Being aware of the protocols we have in place helps us navigate challenges effectively. Adopting these practices means integrating them into our daily practices and adhering to them ensures we maintain the highest standards throughout the event.

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 **"Be Aware-Adopt-Adhere to Protocols"** 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, skits & role plays 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 12 workshops to choose from, Quiz for PG students, poster & free paper competitions 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-specialities of Obstetrics, Gynaecology & Paediatrics.

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 Achla Batra

National President NARCHI 2022-24

Governing council member FOGSI ICOG (elect)

Chairperson IHCP division Still Birth society India

Member FOGSI project on reducing caesarean births

President NARCHI Delhi 2019-21

Professor OS Gyn VMMC & Safdarjung Hospital (experience 40 years)

It gives me great pleasure to write this message for NARCHICON 2024 Delhi which is being organised by Sir Gangaram Hospital under the able leadership of Dr Mala Srivastava along with her enthusiastic team of Chandra Mansukhani ,Geeta Mendiratta and Kanika Jain on 4, 5and 6 th October 2024 at hotel Lalit.

Motto of NARCHI is to provide quality services in reproductive and child health so as to decrease morbidity and mortality in women and children. The theme of this conference **"Be Aware-Adopt- Adhere to protocol"** is in true spirit of NARCHI

This theme is very appropriate in today's scenario of evidence-based medicine. The protocol-based management minimises risk of omission and is important for safety of patients as well as doctors.

The scientific programme has been meticulously planned and there is lot of emphasis on personalized training according to interest of participants through preconference workshops in many fields

I am sure everyone is going to enjoy and benefit from this scientific bonanza with high standard of scientific deliberations

My best wishes to the organizing team for great success of conference

Dr Achla Batra

National President NARCHI

MESSAGE

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

I am delighted to learn that the Institute of Obstetrics & Gynaecology, Sir Ganga Ram Hospital, New Delhi, is organising the Annual Conference of NARCHI, Delhi Chapter, on 5-6th October 2024.

The main goals of NARCHI are related to quality MCH services, Population Stabilization, training of Doctors and Nurses, Community Awareness/Education programs. The Institute is busy all around the year in conducting CME, Seminars and training activities related to NARCHI objectives.

The organisers have prepared an attractive scientific program. 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.

Wish the Conference a grand success.

Dr. S. N. Mukherjee.

NARCHICON 2024

Programme Details

WORKSHOP 1

NARCHI DELHI 2024

SANT PARMANAND HOSPITAL

30th Annual Conference of National Association for Reproductive & Child Health of India

Theme: "Be Aware-Adopt-adhere to the protocols"

VIDEO WORKSHOP ON UROGYNAECOLOGY

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

Date: 3rd October 2024
Time: 08:00 - 04:00 PM

Venue: Auditorium, Sant Parmanand Hospital, Civil Lines, Delhi

Convener : Dr. Sonal Bathla
Co-Convener : Dr. Uma Rani Swain

Chief Guest : Dr. Sharda Jain

Guest of Honour: Dr. Ashok Kumar, Dr. Nirmala Agarwal

	REGISTRATION	
	WELCOME ADDRESS AND INTRODUCTION	**MOC: Dr. Anju Bala**

Time	TOPIC	Speaker	Chairpersons
Session 1- Ascending Beyond : The Art & Science of Non Descent Vaginal Hysterectomy			
9:00 - 9:20 am	The Art of Vaginal Surgery: An Anatomical Approach	Dr. Monika Gupta	Dr. Sharda Jain, Dr. N B Vaid, Dr. Indu Chawla, Dr. Neha Mishra, Dr. Shalu Jain, Dr. Mohini Agarwal
9:20 - 9:40 am	Non Descent Vaginal Hysterectomy: Surgical Dilemmas	Dr. Sonal Bathla	
9:40 - 10:30 am	Panel: NDVH unveiled: Expert Perspectives & Practices	Dr. Sweta Balani Dr. Priti Arora Dhamija	Dr. Rajeshree Jain, Dr. A.G Radhika, Dr. Reena Yadav, Dr. Rashmi Malik, Dr. Rinku Sen Gupta, Dr. Anshuja Singla
10:30 - 11:00 am	**INAUGURATION AND TEA BREAK**		
Session II- A Comprehensive Session : Understanding the Management of Utero-Vaginal Prolapse			
11:00 - 11:20am	Tissue Triumph: Advocating Prolapse Treatment through Native tissue Repair	Dr. Uma Rani Swain	Dr. Manju Khemani, Dr. Shakuntala Kumar, Dr. Jayshree Sunder, Dr. Arbinder Dang, Dr. Vandana Agrawal, Dr. Payal Agarwal
11:20 - 11:40am	Reinforcing the Vault: Insights into Sacrospinous Colpopexy	Dr. R. K Purohit	
11:40 - 12:00noon	Advanced Techniques in High Uterosacral Suspension for better Surgical Outcome & Patient Care	Dr. Hara Prasad Pattanaik	
12:00 - 12:50pm	Panel Discussion : Evidence Based Management of Prolapse of Different Compartments of Vagina	Dr. Sandhya Jain Dr. Swati Agrawal	Dr. Ranjana Sharma, Dr. Manju Puri, Dr. Achla Batra, Dr. Pawan Bhasin, Dr. Poonam Sachdeva.
1:00 - 2:00 pm	**Lunch**		
Session III-Confidence Regained:Conquering Bladder Incontinence withModern Solutions			
2:00 - 2:20 pm	Applied Anatomy for SUI & Role of Autologous Sling	Dr. Karishma Thariani	Dr Chitra Setya, Dr Jyoti Chugh, Dr Abha Sharma, Dr Uma Vadynathan, Dr Sonia Madaan Dr Anju Bala
2:20 - 2:40 pm	Burch Colposuspension	Dr. Alka Sinha	
2:40 - 3:00 pm	Physiology & Medical Management of Urge Urinary Incontinence	Dr. Nikhil Khattar	
3:00 - 3:50 pm	Panel : Transforming Lives with Innovative Incontinence Solutions	Dr. Amita Jain Dr. Manasi Deoghare	Dr. J B Sharma, Dr. Geeta Mediratta, Dr. Shrihari Anikhindi Dr. Rajesh Kumari, Dr. Jaya Chawla
3:50 - 4:00 pm	**Vote of Thanks**		

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WORKSHOP 2

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

MASTERING MYOMECTOMY VIDEO WORKSHOP

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

Date: 3rd October 2024
Time: 09:00 - 05:00 pm

Venue: Hall 'A' Auditorium, Sir Ganga Ram Hospital

Convener
Dr. Punita Bhardwaj

Chief Guest
Dr. Jaya Shree Sood

Guest of Honour
Dr. A.K. Bhalla

Co-Convener
Dr. Renuka Brijwal,

Co-Convener
Dr. Jhanvi

09:00-09:15 AM	REGISTRATION		
—	WELCOME ADDRESS AND INAUGURATION		
Time	**Topic**	**Speaker**	**Chairperson**
9:30 – 10:00 am	Port Placements in Laparoscopic Myomectomy	Dr. Shivani Sabharwal	Dr. K. Gujral Dr. Sanjivni Khanna Dr. Geeta Mediratta
10:00 - 10:30 am	Incision and Enucleation in Laparoscopic Myomectomy	Dr. Debasis Dutta	
10:30 - 11:00 am	Tissue retrieval & Laparoscopic Myomectomy	Dr. Alka Sinha	
11:00 – 11:30 am	Hemostasis in Endoscopic Myomectomy	Dr. Dinesh Kansal	Dr. Harsha Khullar Dr. Sandeep Talwar Dr. Tripti Sharan
11:30 - 12:00 noon	Uterine Reconstruction and Laparoscopic Myomectomy	Dr. Punita Bhardwaj	
12:00 -12:30 pm	**TEA BREAK**		
12:30 – 01:30 pm	Complications & Pit falls in Laparoscopic Myomectomy **Moderator:** Dr. Punita Bhardwaj **Discussants:** Dr. Alka Sinha, Dr. Anupama Sethi, Dr. Dinesh Kansal , Dr. Jyoti Mishra, Dr. Meenakshi Goyal, Dr. Neema Sharma, Dr. Sanjeevni Khanna, Dr. Shivani Sabharwal, Dr. Usha Kumar		Dr. Renu Mishra Dr. Pikee Saxena Dr. Renu Tanwar
01:30 - 02:00 pm	**LUNCH**		
02:00 – 02:30 pm	Hysteroscopic Morcellation	Dr. Anupama Sethi	Dr. K. K. Roy Dr. Indu Chawla Dr. Anjila Aneja
02:30 – 03:00 pm	Hysteroscopic Myomectomy	Dr. Neema Sharma	
03:00 – 03:30 pm	Complications in Operative Hysteroscopy	Dr. Meenakshi Goyal	
03:30 – 04:00 pm	Laparoscopy v/s Robotic myomectomy	Dr. Jyoti Mishra	Dr. Neena Singh Dr. Mala Shrivastava Dr. Chandra Mansukhani
04:00 – 04:30 pm	Robotic and Multiple myomectomy	Dr. Usha Kumar	
Vote of Thanks			

Hands on Endotrainer for all registered delegates 9:00 to 6:00 pm

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WORKSHOP 3

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

OBSTETRICS SKILL WORKSHOP

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

Date: 3rd October 2024
Time: 08:00 - 04:00 PM

Venue: Hamdard Institute of Medical Sciences and Research, Jamia Hamdard, New Delhi

08:30 - 09:00 AM	REGISTRATION	
—	WELCOME ADDRESS AND INTRODUCTION	
Time	**TOPIC**	**Speaker**
Session 1 - Chairpersons: Dr. Vinita Sarabhai, Dr. Ritu Sharma		
9:05 - 9:15 AM	Breech vaginal delivery	Dr. Dina Aisha Khan
9:15 - 9:25 AM	Shoulder Dystocia	Dr. Supriya Chaubey
9:25 - 9:35 AM	Instrumental vaginal delivery	Dr. Shilpi Nain
9:35 - 9:45 AM	Balloon Tamponade	Dr. Nidhi Gupta
9:45 - 10:00 AM	**TEA**	
Time	**TOPIC**	**Speaker**
Session 2 - Chairpersons: Dr. Bindu Yadav, Dr. Reva Tripathi		
10:00 - 10:10 AM	Approach in case of adhesions	Dr. Neha Varun
10:10 - 10:20 AM	Second stage Cesarean section	Dr. Sumedha Sharma
10:20 - 10:30 AM	Delivering baby in malpresentations and use of forceps and vacuum in cesarean	Dr. Arpita De
10:30 - 10:40 AM	Hemostatic sutures	Dr. Arifa Anwar
10:40 - 10:50 AM	Stepwise devascularization & Int iliac Ligation	Dr. Aruna Nigam
10:50 - 1:00 PM	**HANDS ON SESSION:** 2nd stage (Patwardhan), Shoulder dystocia, Instrumental vag deliy, Baby delivery with Malpresentations in CS & instruments in CS, Hemostatic sutures, SWD & int iliac artery ligation, Balloon Tamponade.	
1:00 - 1:45 PM	**LUNCH**	
Time	**TOPIC**	**Speaker**
Session 3 - Chairpersons : Dr. Sunita Malik, Dr. Raka Guleria		
1:45 -2:00 PM	LSCS- Normal Technique	Dr. Jayshree Sunder
2:00 - 2:15 PM	Bladder Repair	Dr. Yasir
2:15 - 2:30 PM	Peripartum Hysterectomy	Dr. Aruna Nigam
2:30 - 2:45 PM	Complete Perineal Tear Repair	Dr. Mohini Agarwal
2:45 - 4:15 PM	**HANDS ON SESSION :** Cesarean suturing, Bladder suturing, Complete perineal repair (on Tissues)	
4:15 - 4:45 PM	**VOTE OF THANKS AND TEA**	

Organizing Chairperson
Prof Aruna Nigam

Organizing Secretary
Dr. Nidhi Gupta

Treasurer
Dr. Asma Khanday

Organizing Committee

Dr. Arifa Anwar Elahi
Dr. Pratibha Roy
Dr. Sumedha Sharma
Dr. Garima Maan
Dr. Dina Ayesha Khan
Dr. Neha Rathore
Dr. Supriya Chaubey
Dr. Lubna Inam

Senior Residents

Dr. Neeti singhal
Dr. Shazia anjum
Dr. Ambreen Fatima

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WORKSHOP 4

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India

Theme: "Be Aware-Adopt-adhere to the protocols"

GENETICS

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

Date: 4th October 2024
Time: 02:00 - 05:00 pm

Venue: Hotel The Lalit, Connaught Place, New Delhi

Chief guest
Dr. Dipika Dekha

Convener
Dr. Veronica Arora

----	REGISTRATION		
01:00 PM	WELCOME ADDRESS BY THE CHIEF GUEST AND SECRETARY SIAMG		
(10min)	**Pre workshop questionnaire**		
Time	**TOPIC**	**Speaker**	**Chairpersons**
2:00 - 2:25	Markers and their meaning	Dr. Seema Thakur	Dr. Sangeeta Gupta Dr. Ramnik Sabharwal Dr. Vidhi Hathi
2:25 - 2:50	Chromosomal microarray demystified. Indications and Interpretation	Dr. Sunita Bijarnia Mahay	Dr. Leena Sridhar Dr. Alok Varshney Dr. Anubhuti Rana
2:50 - 3:15	Exome Elaborated- Indications and Interpretation	Dr. Ratna Puri	Dr. Vandana Chadha Dr. Neerja Gupta Dr. Upma Saxena
3:15 - 3:40	Prenatal genetic testing beyond exome and microarray	Dr. Madhulika Kabra	Dr. Vatsala Dadwal Dr. Dipika Deka Dr. Jyoti Bali
3:45 - 5:00	**Hands on training for genetic report interpretation**		
Time	**Topic**	**Group 1**	**Group 2**
	Case based hands on training for ordering and interpretation of tests	Dr. Sangeeta Khatter Dr. Sameer Bhatia	Dr. Swasti Pal Dr. Mayank Nilay
10 min	**Post Workshop Questionnare**		
Quiz on genetic test interpretation			

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WORKSHOP 5

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

FP SERVICES: EXPANDING SERVICES, ENSURING RIGHTS

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

Date: 4th October 2024
Time: 02:00 - 05:00 pm

Venue: Hotel The Lalit, Connaught Place, New Delhi

Convener
Dr. Sumita Mehta

Co-Convener
Dr. Anshul Rohtagi

	REGISTRATION		
02:00 - 02:15 pm	**WELCOME ADDRESS**		
Time	**Topic**	**Speaker**	**Chairperson**
	SESSION - I		
02:15 - 02:30 pm	MTP Act- Connecting the Dots	Dr. Amita Agarwal	Dr. Nalini Bala Pandey Dr. Richa Sharma Dr. CD Jassal Dr. Poonam Sachdeva
02:30 - 2:45 pm	Second Trimester Abortion- Protocols and Techniques	Dr. Anshul Rohtagi	
	SESSION - 2		
2:45 - 3:00 pm	Postabortion Contraception : Challenges & Stitching the Gap	Dr. Rashmi Gera	Dr. Harsha Khullar Dr. Suman Lata Mendiratta Dr. Rachna Sharma Dr. Arifa Anwar
3:00 - 3:15 pm	Breaking Barriers-Immediate Postpartum LARC	Dr. Kanika Chopra	
	SESSION - 3		
3:15 - 3:30 pm	Manual Vacuum Aspiration : Regaining Confidence	Dr. Sumita Mehta	Dr. Ashok Kumar Dr. Sudha Gupta Dr. Anita Rajorhia
3:30 - 3:45 pm	Subdermal Implant: New Kid on the Block	Dr. Anshuja Singla	
	SESSION - 4		
3:45 - 4:15 pm	Role Play- Contraception Conundrum	**Experts :** Dr. Renu Manchanda Dr. Jyoti Sachdeva Dr. Vinita Gupta Dr. Neeta Sagar	
4:15 - 5:00 pm	**"Hands-on Workshop" on MVA and subdermal Implants**	**Trainers :** Dr. Shailja R Sinha Dr. Sumita Mehta Dr. Anshuja Singla Dr. Neha Varun	

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WORKSHOP 6

NARCHI DELHI 2024

Royal College of Obstetricians & Gynaecologists

30th Annual Conference of National Association for Reproductive & Child Health of India

Theme: "Be Aware-Adopt-adhere to the protocols"

PRE CONFERENCE WORKSHOP

CTG:INTRAPARTUM FETAL MONITORING

Organized by:

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

&

"IRC RCOG India North"

Date: 4th October 2024
Time: 9:00am-1:00pm

Venue: Hotel The Lalit, Connaught Place, New Delhi

Convener : Dr. Mamta Dagar
Co-Convener : Dr. Purvi Khandelwal

MOC : Dr. Purvi Khandelwal & Dr. Huma Ali

08:30-09:00 AM	REGISTRATION
09:00-09:15 AM	WELCOME ADDRESS AND INTRODUCTION (Dr. Mamta Dagar)
	Chairpersons : Dr. Kanwal Gujral, Dr. Geeta Mediratta, Dr. Mamta Dagar, Dr. Neeti Tiwari

Time	Session 01	Speaker
09:15-09:30 AM	• Pathophysiology Behind CTG (5 min Q/ A & Discussion)	Dr. Jharna Behura
09:30-09:50 AM	• CTG Interpretation (5 min Q/ A & Discussion)	Dr. Poonam Tara
09:55-10:10 AM	• Pathological CTG - when to Intervene (5 minutes Q/A & Discussion)	Dr. Jayasree Sundar
10:15-10:30 AM	• Optimal Fetal Surveillance in Labour (5 min Q/ A & Discussion with)	Dr. Mamta Mishra
10:45-01:00 PM	**Breakout session-CTGs with 5 case scenarios ,15 min each session :** Dr. Jayasree Sundar, Dr. Jharna Behura, Dr. Poonam Tara, Dr. Shelly Arora, Dr. Mamta Mishra, Dr. Muntaha Khan, Dr. Huma Ali, Dr. Purvi Khandelwal, Dr. Puja Jain	

FACULTIES

Dr. Kanwal Gujral
Dr. Neeti Tiwari
Dr. Jayasree Sundar
Dr. Jharna Behura
Dr. Geeta Mediratta
Dr. Huma Ali
Dr. Poonam Tara
Dr. Shelly Arora
Dr. Mamta Dagar
Dr. Purvi Khandelwal
Dr. Mamta Mishra
Dr. Muntaha Khan
Dr. Puja Jain

SUMMARY

This workshop is designed for professionals involved in intrapartum care. It provides a comprehensive overview of CTG interpretation and management strategies to improve fetal outcomes during labor. The combination of lectures and breakout sessions ensures practical, hands-on experience with real case scenarios.

WHY YOU MUST ATTEND

- Understanding the pathophysiology of fetal hypoxia and its manifestation on CTG
- Correct Interpretation of CTG
- Interpret CTG abnormalities that might suggest hypoxia
- Improve your decision making in Intrapartum management & avoid Intrapartum hypoxia

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WORKSHOP 7

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

CRITICAL CARE IN OBSTETRICS

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

Date: 4th October 2024
Time: 08:30 - 04:30 PM

Venue: Old LT opp OPD Building , VMMC and Safdarjung Hospital, New Delhi

MOC: Dr. Himal and Dr. Sakshi

CONVENER : DR. JYOTSNA SURI
CO-CONVENER : DR. REKHA BHARTI

Time	TOPIC	Speaker	Chairpersons
08:30 - 09:00 AM	REGISTRATION AND PRELIMINARY QUIZ		
09:00 - 09:05 AM	WELCOME ADDRESS AND INTRODUCTION		DR. BINDU BAJAJ
09:05 - 10:00 AM	**Session 1- Cross Talk : Evaluation of Critically Ill Pregnant Women**		
09:05 - 09:30 AM	Why critically ill pregnant women are a challenge?	Dr. Sheeba Marwah, Dr. Binita Jaiswal	Dr. Anjali Dabral, Dr. Bindu Bajaj, Dr. Usha Rani, Dr. Sunita Yadav
09:30 - 9:55 AM	Early warning scores Why & When?	Dr. Ratna Biswas, Dr. Anjila Aneja	
09:55 - 10:00 AM	Audience Interaction		
10:00 - 11:00 AM	**Session II- Point of Care Tests in Critically Ill Pregnant Women**		
10:00 - 10:25 AM	RUSH Protocol	Dr. Nalini Bala Pandey	Dr. Achla Batra, Dr. Mala Srivastava, Dr. Jyoti Sachdeva, Dr. Upma Saxena
10:25 - 10:50 AM	ABG	Dr. Jyotsna Suri	
10:50 - 11:00 AM	Audience Interaction		
11:00 - 11:30 AM	INAUGURATION		
11:30 - 11:50 AM	Tea Break		
11:50 - 12:50 AM	**Session III- Panel Discussion**	**Moderators: Dr. Rekha Bharti, Dr. Zeba Khanam**	**Expert: Dr. Jyotsna Suri**
	Eclampsia with HELLP, PE & AKI,	Dr. Sumitra Bachani, Dr. Meenakshi, Dr. Rajesh Kumar, Dr. Rajesh Kumari (SJH)	
	AFE, Maternal Collapse with DIC	Dr. Taru Gupta, Dr. Prasoon Gupta, Dr. Leena N Sreedhar	
12:50 - 01:30 AM	**Session IV- Sepsis in Obstetrics**		
12:50 - 01:05 PM	SSC bundle approach	Dr. Niharika Dhiman	Dr. Sudha Salhan, Dr Anita Kumar, Dr. Reeta, Dr. Kavita Agarwal
01:05 - 01:20 PM	Antibiotics in Sepsis	Dr. Rekha Bharti	
01:20 - 01:30 PM	Audience Interaction		
01:30 - 02:00 PM	Lunch		
02:00 - 02:30 PM	**Session V- Quiz Masters:** Dr. Sheeba Marwah, Dr. Zeba Khanam **Quiz Judges:** Dr. Harsha S. Gaikwad, Dr. Rajesh Kumari (AIIMS)		
02:30 - 04:30 PM	**Session VI- Workshop Five Workshop Stations: 20 minutes each**		
Stations I	Ventilator Setting	Dr. Harish Sachdeva & Team Anaesthesia	
Stations II	CPR	Dr. Sheeba Marwah, Dr. Zeba Khanam, Dr. Sakshi Nischal	
Stations III	Airway Management	Dr. D. S. Meena & Team Anaesthesia, Dr. Aprajita Gupta	
Stations IV	Oxygen & NIV	Dr. Rohit Kumar, & Team Respiratory Medicine, Dr. Akanksha Mohanty	
Stations V	Vasopressors	Dr. Rekha Bharti, Dr. Monika Gupta, Dr. Himal Singla	
04:30 PM	**Quiz Result**		

Advisors
DR. BINDU BAJAJ
DR. ANJALI DABRAL

Organising Secretary
DR. SHEEBA MARWAH

Jt. Organising Secretary
DR. ZEBA KHANAM

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WORKSHOP 8

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

TRANSFORMING HEALTHCARE THROUGH PASSION AND INNOVATION

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

Date: 4th October 2024
Time: 08:00 - 11:00 AM

Venue: Hotel The Lalit, Connaught Place, New Delhi

Chief Guest : Dr. Manoj Gupta

Convener : Dr. Sushma Sinha **Co-Convener : Dr. Divya Chauhan**

07:45 AM	REGISTRATION	
Time	**TOPIC**	**Speaker**
	Stations	
8:00 am – 9:00 am	MCP card orientation	Dr. Divya Chauhan
	Hand Hygiene	Neelam Chauhan
	tools to identify high risk women	Seema Prakash
	Breastfeeding -each one teach one	Komal Chauhan
Time	**TOPIC**	**Speaker**
	Lectures	
9:00 am – 9:15 am	**WELCOME ADDRESS AND INTRODUCTION BREAKFAST**	
9:15 am – 9:30 am	**LAMP LIGHTNING**	
9:30 am – 9:45 am	Comprehensive Antenatal and Postnatal care	Dr Anjali Dosajh
9:45 am – 10:00am	Identify High Risk pregnancy	Dr Seema Prakash
10:00 am - 10:15am	Anaemia in Pregnancy and recommended diet for pregnant and lactating women	Dr Sushma Sinha
10:15 am to 10.45am	Role of Asha and ANM for Safe delivery	Dr Divya Chauhan
10:45 am - 11:00 am	Kilkari	Parna Chakroboty

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WORKSHOP 9

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
(NARCHI)-Delhi Branch and (IFS) Indian Fertility Society
Theme: "Be Aware-Adopt-adhere to the protocols"

FINE-TUNING OVARIAN STIMULATION FOR PRACTISING GYNECOLOGISTS

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

Date: 4th October 2024
Time: 09:00 - 01:00 PM

Venue: Hotel The Lalit, Connaught Place, New Delhi

Convener : Dr.Shweta Mittal Gupta
Co-Convener : Dr.Neeti Tiwari

Coordinator: Dr.Sakshi Nayar

08:45 AM	REGISTRATION	
9:00am – 9:05am	Welcome address by convener	
9:05 am - 9:10 am	Address by chief guests	
Time	**TOPIC**	**Speaker**
Session 1 - Chairpersons: Dr. Sharmistha Garg, Dr. Tejashri Shrotri, Dr. Shikha Gurnani		
9:10 am - 9:30 am	Revisiting Oral ovulogens	Dr.Ruma Satwik
9:30 am - 9:50 am	How to use gonadotropins safely for ovarian stimulation in IUI?	Dr.Surveen Ghumman
9:50 am -10:10 am	When and how to trigger?	Dr Puneet Rana Arora
Time	**TOPIC**	**Speaker**
Session 2 - Dr. Sheetal Sachdeva, Dr. Shivani Sabharwal, Dr. Ankita Sethi		
10:10am - 10:30am	How do I improve my Success rate in IUI ?	Dr.Abha Majumdar
10:30am - 10:45am	How to set up level 1 ART clinic?	Dr.Rashmi Sharma
10:45am -11:00am	Antioxidants in infertility (sponsored by Celagenics)	Dr. Sakshi Nayar
11.00am -11.15 am	**Tea Break**	
Time	**Session 3 - Panel Discussion**	
11:15 am – 12:15 pm	Moderator: Endocrinopathies affecting Ovarian stimulation: Practical approach	
	Moderators: Dr.Shweta Mittal Gupta, Dr.Neeti Tiwari	
	Panelists : Dr. Pikee Saxena, Dr. Setu Gupta (Endocrinologist), Dr. Jyoti Bali, Dr. Sunita Arora, Dr. Renu Tanwar, Dr. Nisha Bhatnagar , Dr. Bhawani Shekhar, Dr. Manisha Navani	
Time	**Session 4**	
12:15 PM – 1:00 PM	**Reverse panel :** Difficult situations in ovarian stimulation	
12:15- 12:25	Case 1: Stagnant follicle with clomiphene citrate Presenter : Dr. Renu Singh ; Experts: Dr. Shalini Chawla Khanna, Dr. Parul Garg	
12:25-12:35	Case 2: Multiple follicles with thin ET with letrozole stimulation Presenter : Dr. Snigdha ; Experts : Dr. Aanchal Agarwal , Dr. Ankita Sethi	
12:35- 12:45	Case 3: Unilateral small endometrioma with infertility Presenter: Dr. Tanu Sharma ; Experts: Dr. Tejashri Shrotri, Dr. Keya Kalra	
12:45 - 12:55	Case 4: Mild Male factor infertility Presenter : Dr. Nisha Yadav; Experts : Dr. Sweta Gupta, Dr. Shikha Jain	
1:00 pm	**Lunch**	

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WORKSHOP 10

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

STILL BIRTHS: DECODING THE ENIGMA

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

Date: 4th October 2024
Time: 02:00 - 05:00 pm

Venue: Hotel The Lalit, Connaught Place, New Delhi

Convener
Dr. Nidhi Khera

Co-Convener
Dr. Kumar Ankur

Co - Convener
Dr. Chanchal

	REGISTRATION
02:00 - 02:05 pm	WELCOME ADDRESS

Time	Topic	Speaker
PREVENTIVE OF STILL BIRTH		
Chairpersons : Dr. Kanwal Gujral, Dr. A.G. Radhika, Dr. Vatsla Dadhwal, Dr. Alok Bhandari		
02:05 - 02:20 pm	Is Stillbirth preventable ?	Dr. Tamkeen Khan
02:25 - 02:40 pm	Intrapartum Prevention of Stillbirth	Dr. Rinku Sen Gupta
02:45 - 03:00 pm	Role of Neonatologist in preventing Stillbirth	Dr. Avneet Kaur
THE UNTHINKABLE HAS HAPPENED .... what next?		
Chairpersons : Dr. Asmita Rathore, Dr. Dipika Deka, Dr. Preety Aggarwal, Dr. Shilpa Ghosh		
03:05 - 03:25 pm	Evaluation of Stillbirth Fetus & Placenta	Dr. Ratna Puri
03:30 - 04:30 pm	**Panel Discussion : Case Scenarios : What went wrong ?**	
	Moderators : Dr. Chanchal, Dr. Nidhi Khera **Experts** : Dr. Reva Tripathi, Dr. Dipika Deka **Panelists :-** Dr. Jayasree Sundar, Dr. Poonam Tara, Dr. Manisha, Dr. Nandita Dimri, Dr. Seema Thakur, Dr. Kumar Ankur	
Chairpersons : Dr. Tamkeen Khan, Dr. Kiran Arora, Dr. Krishna Aggarwal, Dr. Richa Aggarwal		
04:30 - 05:00 pm	Role Play - Breaking News of Still birth	Dr. Kamna Datta & Team
Vote of Thanks		

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WORKSHOP 11

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

PREVENTIVE ONCOLOGY WORKSHOP

"Organized by Institute of Obstetrics & Gynaecology, Deen Dayal Upadhyaya Hospital, New Delhi"

Date: 4th October 2024
Time : 11:30 - 05:00pm

Venue: Hotel The Lalit, Connaught Place, New Delhi

Chief Guest : Dr. Mala Shrivastava
Guest of Honour : Dr. Pushpa Singh

Organising Chairperson : Dr. Poonam Laul
Convener: Dr. Urvashi Miglani, Dr. Harvinder Kaur
Organizing Secretary: Dr. Ritu Goyal, Dr Richa, Dr. Aishwarya

11:30-11:40 PM	REGISTRATION	
	WELCOME ADDRESS AND INTRODUCTION	
Time	**TOPIC**	**Speaker**
SESSION 1 – Chairpersons: Dr. Sunita Seth, Dr. Sunita Malik, Dr. Sunita Lamba , Dr. Shanti		
11:40-11:50AM	Changing perspectives of Cervical Screening with HPV Tests	Dr. Shalini Aggarwal
11:50-12:00O Clock	The enigmatic HPV tests: Which one to choose	Dr. Rashmi Yadav
12:00-12:10PM	Endometrial and Vulval Cancer Screening: What can be done	Dr. Swasti
12:10-12:20PM	Preventive Strategies for Ovarian Cancer	Dr. Monisha Gupta
Time	**TOPIC**	**Speaker**
SESSION 2 – Chairpersons: Dr. Y. M. Mala, Dr. Suman Lata , Dr. Shashi Raheja		
12:20-12:30PM	HPV vaccination: Recent Updates	Dr. Poonam Laul
12:30-12:40PM	Tissue Basis of Colposcopy and Scoring Systems	Dr. Niharika Dhiman
12:40-12:50PM	Colposcopy Equipment : What's new	Dr. Shweta Balani
12:50-01:00PM	Management of CIN : The underlying principles	Dr. Shruti Bhatia
01:00-02:00PM	**LUNCH**	
Time	**SESSION 3**	
02:00-03:00PM	**Panel Discussion** **Experts :-** Dr. Amita Naithani, Dr. Shweta Giri **Panellists :-** Dr. Ritu Goyal, Dr. Kamna Datta, Dr. Kanika Batra Modi, Dr. Monika Madaan	**Moderators :-** Dr. Urvashi Miglani Dr. Harvinder Kaur
Time	**TOPIC**	**Speaker**
SESSION 4 – Video Sessions Chairpersons: Dr. Vijay Zutshi, Dr. Indu Chawla, Dr. Veena Acharya, Dr. Reena Yadav		
03:00-03:10PM	Lletz	Dr. Shruti Bhatia
03:10-03:20PM	Thermoablation	Dr. Urvashi Miglani
03:20-03:30PM	Conisation	Dr. Aruna Nigam
03:30-03:40PM	Vulvoscopy	Dr. Archana
03:40-04:30PM	**Brain teasers : Dr. Ritu Goyal, Dr. Richa Madaan and Dr. Aishwarya Nandakumar**	
04:30-05:00PM	**Hands on Session**	

COURSE HIGHLIGHTS

- SKILL ENHANCING HANDS-ON SESSIONS
- CRISP PRECISE DELIBERATIONS ON BASICS
- CASE BASED PANEL DISCUSSION WITH IMPORTANT TAKE HOME MESSAGES
- ENGAGE IN KNOWLEDGE SHARING BY EXPERTS OF THE FIELD
- ENLIGHTENING VIDEO SESSIONS ON PROCEDURES, HIGHLIGHTING TIPS AND TRICKS
- ENGAGING QUIZ FOR INQUISITIVE MINDS

WHO SHOULD ATTEND

- GYNAECOLOGISTS
- POST GRADUATES IN OBSTETRICS AND GYNAECOLOGY,
- TRAINEES IN GYNAE ONCOLOGY

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WORKSHOP 12

NARCHI DELHI 2024

30th Annual Conference of National Association for Reproductive & Child Health of India
Theme: "Be Aware-Adopt-adhere to the protocols"

"COMPREHENSIVE OBSTETRIC SKILLS" NURSES MODULE

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

Date: 4th October 2024
Time: 08:00 - 11:00 am

Venue: Hotel The Lalit, Connaught Place, New Delhi

Convener : Dr. Seema Prakash
Special Guest : Dr. Mala Shrivastava, Mrs. Upasana Arora
Guest of Honour : Dr. Ashwani Dalmia, Dr. Archana Verma, Dr. Tarini Taneja, Dr. Kanika Gupta
Special Invitee : Dr. (Col) Pranjali Dhume, Dr. Pratiksha Gupta, Mrs Shalini Mittal
Co-Convenor : Dr. Srishti Prakash, Dr. Neha Varun
Chief Coordinators : Dr. Anita Rajorhia, Dr. Bhanupriya
MOC : Dr. Bhanupriya, Dr. Rashmi Shreya

Time	TOPIC	Speaker	Chairperson's/ Panelists/ Experts
7:30 - 8:00 am	**Registration**		
8:00 - 8:15 am	**Welcome Address and Introduction**	Dr. Seema Prakash	Dr. Neha Varun Dr. Srishti Prakash
8:15 - 9:15 am	**Skits :** 5 min/skits 15 min discussion **Topics :** 1. Obstetric hemorrhage emergency management 2. Lactation counselling in women 3. Breaking Bad News 4. Patient Identification 5. Respectful Maternity Care	**Moderators:** Dr. Neha Varun Dr. Srishti Prakash Dr. Smiti Jain Dr. Haritha Mannem Ms. Anjali Sharma Ms. Josephine Ms. Manita Ms. Promila	**Judges:** Dr. Kanika Gupta Dr. (Col) Pranjali Dhume Dr. Tarini Taneja Dr. Sunita Arora Dr. Shivani Gaur Dr. Pratiksha Gupta Dr. Shama Batra Dr. Vandana Gupta
9:15 - 9:30 am	**Slogan**	**Moderators:** Dr. Neha Pruthi Dr. Tanvi Ms. Promila Ms. Seema Mittal	**Judges** Dr. Sujata Agarwal Dr. Rashi Agrawal Dr. Mamta Tyagi Dr. Ritu Arya Dr. Manpreet Saini
9:30 - 9:45 am	**Posters 1**	**Moderators:** Dr. Chandana Shekhar Dr. Aditi Ghai Ms. Neelima	**Judges:** Dr. Vandana Gupta Dr. Vineeta Gupta Dr. Vibha Bansal
	Posters 2	**Moderators:** Dr. Shuchita Sharma Dr. Supriya Chaubey Ms. Seema Mittal	**Judges:** Dr. Haritha Mannem Dr. Deepa Gupta Ms. Shalini Mittal Dr. Neelam Gupta
9:45 - 10:00 am	**INAUGURATION & LAMP LIGHTING**		
	Panel discussion	**Moderators:**	**Judges:**
10:00-10:15 am	**1. Antenatal Care**	Dr. Neha Pruthi Dr. Vineeta Gupta Dr. Neha Varun	Dr. Pratiksha Gupta Dr. Rashi Agrawal Dr. Mamta Tyagi Ms. Urvashi Chaglani
10:15-10.30 am	**2. Postnatal Care & Contraception**	Dr. Aditi Ghai Dr. Manpreet Saini Dr. Bhanupriya	Dr. Kanika Gupta Dr. Tarini Taneja Dr. Sunita Arora Dr. Shuchita Sharma Ms. Latha
10.30-10.45 am	**3. Emergency Obstetrics**	Dr. Rashmi Shriya Dr. Aastha Srivastav Dr Srishti Prakash	Dr. Sushma Sinha Dr. Anita Rajorhia Dr. Ritu Arya Ms. Josephine
10:45-11:00 am	Valedictory function/Vote of thanks		

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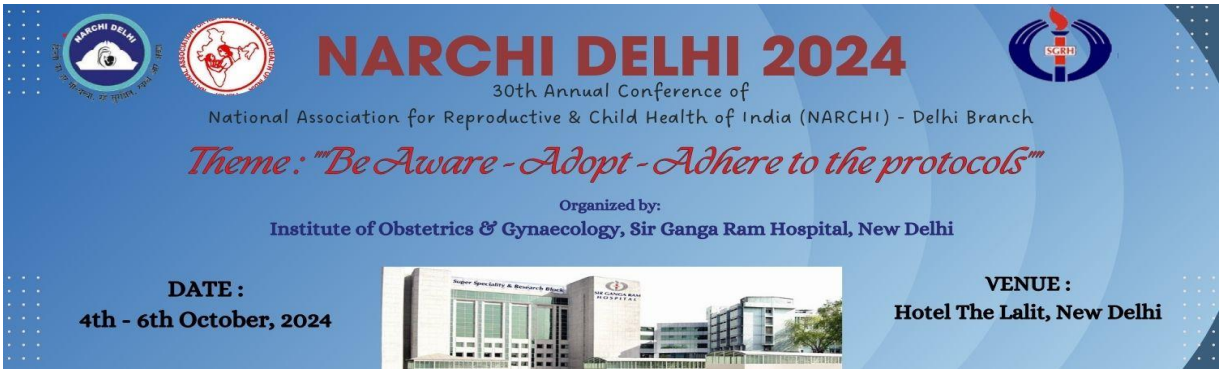
MAIN CONFERENCE DAY 1



HALL A - 5TH OCTOBER, 2024 (Saturday) - DAY I

MOC : Dr. Ila Sharma (9:00-1:30 pm) & Dr. Purvi Khandelwal (2:30 – 5:00 pm)

8:00 - 9:00 am	**Scientific Free Paper /Poster Presentation**	
	SESSION I 3 P'S of Obstetrics	
CHAIRPERSONS : Dr. Indu Chugh, Dr. Neelam Jain, Dr. Vinita Singh, Dr. Sunita Arora		
TIME	**TOPIC**	**SPEAKER**
09:00 - 09:15 am	Evidence based strategies for preterm birth reduction in singleton pregnancies	Dr. Kanwal Gujral
09:15 - 09:30 am	Prediction of Pre-Eclampsia : What's new ?	Dr. Sangeeta Gupta
09:30 - 09:45 am	Indian Innovation in Management of PPH	Dr. Ashmita Rathore
09:45 - 10:00 am	Discussions	
	SESSION II - Reverse Panel ON MEDICO - LEGAL ISSUES IN OBSTETRICS	
10:00 - 11:00 am	**MODERATOR :** Dr. Geetendra Sharma **EXPERTS :** Dr. Anjali Gera, Dr. Neeti Tiwari Mr. Ankur Rai **PANELISTS :** Dr. Geeta Mediratta, Dr. Supriya Jaiswal, Dr. Anita Rajoria, Dr. Yukti Wadhwan, Dr. Kiran Chandna, Dr. Reena Yadav, Dr. Taru Gupta	
11:00 - 11:30 am	**TEA BREAK**	
	SESSION III DR. S.K. DAS ORATION	
CHAIRPERSONS : Dr. Kamal Buckshee, Dr. Sushma Chawla, Dr. Achla Batra, Dr. Geeta Mediratta		
11:30 - 12:15 pm	**Topic :**The emerging challenge of the transitions in women's cancers: The need for an Integrated Reproductive Health Systems Approach	**Orator :** Dr. Sharmila Pimple
	SESSION – IV : KEY NOTES	
CHAIRPERSONS : Dr. Sudha Prasad, Dr. Neerja Goyal, Dr. Deepa Masand, Dr. Sanjivini Khanna, Dr. Jyoti Bali		
12:15 – 12:30 pm	1. Clinico-epidemiological Profile of Cancer among women in India	Dr. Amey Oak
12:30 – 12:45 pm	2. Syphilis in Pregnancy	Dr. Deepika Deka
12:45 – 01:00 pm	3. Adolescent Health	Dr. Veena Acharya
01:00 – 01:15 pm	4. Cholestasis of Pregnancy	Dr. Ashok Kumar
01:15 – 01:30 pm	5. Role of PRP in Endometrial Rejuvenation	Dr. Tarini Taneja
01:30 - 02:30 pm	**LUNCH BREAK**	
	SESSION V - PANEL DISCUSSION - CASE BASED DISCUSSION ON LOOP HOLES IN MTP - ACT	
02:30 - 03:30 pm	**MODERATOR :** Dr. Richa Sharma **CO- MODERATOR :** Dr. Anuradha Panda **EXPERTS :** Dr. Manju Verma, Dr. Renu Patel	**PANELISTS :** Dr. Kavita Bhatti, Dr. Anita Sabharwal, Dr. Anurag Vashist, Dr. Smriti Gupta, Dr. Shikha Chadha, Dr. Divya Singhal, Dr. Tripti Saran, Dr. Meenakshi Rohilla
	SESSION VI - KEY NOTES	
CHAIRPERSONS : Dr. Leena Shridhar, Dr. Neeru Kiran Banerjee, Dr.Bindu Bajaj, Dr. Priyanka Suhag		
03:30 - 04:00 pm	1. Legal issues in Medical practice: Current practices	Dr. Girish Tyagi
04:00 - 04:15 pm	2. Triaging in Obstetrics	Dr. Archana Verma
04:15 – 04:30 pm	3. Genital Penetration Pain Disorder	Dr. Ragini Agarwal

SESSION VII		
CHAIRPERSONS : Dr. Chandra Mansukhani, Dr. Mala Srivastava		
04:30 - 04:45 pm	Next Gen Surgical Excellence : Mizzo Flex Single Access Surgical Robotic System in Action	Dr. Ritika Srivastav
04:45 - 05:00 pm		
05:00 - 05:30 pm	**TEA BREAK**	
06:00 pm onwards	**INAUGURATION FOLLOWED BY CULTURAL PROGRAM & DINNER**	

HALL B - 5TH OCTOBER, 2024 (Saturday) - DAY I

MOC : Dr. Sakshi Nayar (8:00-1:30 pm) & Dr. Renuka Brijwal (2:30 – 5:00 pm)

SESSION I		
TIME	**TOPIC**	**SPEAKERS**
08:00 - 10:00 am	Scientific Free Paper /Poster Presentation	
10:00 -10:45 am	Quiz Theory Elimination Round	
EXPERT : Dr. Ruma Satwik		
10:45 - 11:00 am	Contraceptive Failure – Skit	Dr. Harvinder Kaur
11:00 - 11:30 am	**TEA BREAK**	
SESSION II		
EXPERT : Dr. Abha Singh		
11:30 - 01:30 pm	Respectful Maternity Care	Dr. Manju Puri & Dr. Aparna K.Sharma
01:30 - 02:30 pm	**LUNCH BREAK**	
SESSION III		
EXPERTS : Dr. Ritu Mittal Arya, Dr. Aparna Sharma		
02:30 - 03:00 pm	Shoulder Dystocia – Drill	Dr. Juhi Bharti
CHAIRPERSONS : Dr. Madanjeet Paschricha, Dr. Rashmi Malik		
03:00 - 03:15 pm	Hugo Medtronics Presentation	Mr. Gautam Palani
03:15 - 03:30 pm	Melodies of Comfort: Enhancing Labour Experience with Music Therapy	Dr. Bhavneet Bharti
SESSION IV		
Expert : Dr. Manju Khemani, Dr. Manju Puri		
03:30 - 04:00 pm	PPH - Drill	Dr. Shashilata Kabra
04:00 - 04:30 pm	Eclampsia – Drill	Dr. Ratna Biswas
04:30 - 05:00 pm	Breaking The Bad News – Role Play	Dr. Aruna Nigam

MAIN CONFERENCE DAY 2

HALL A - 6TH OCTOBER, 2024 (Sunday) - DAY II

MOC : *Dr. Ila Sharma (9:00-1:30 pm) & Dr. Huma Ali (2:30 – 5:00 pm)*

8:00 - 9:00 am	Scientific Free Paper /Poster Presentation	
SESSION I - PANEL DISCUSSION - ADOLESCENT HEALTH		
TIME	**TOPIC**	**SPEAKER**
09:00 - 09:45 am	**Moderators :** Dr. Sadhana Gupta & Dr. Latika Bhalla **Experts :** Dr. Ranjana Sharma & Dr. Seema Sharma **Panelists :** Dr. Anjila Aneja, Dr. Meena Samant, Dr. Vandana Gupta, Dr. Indu Bala Khartri, Dr. Namrta Bhardwaj, Dr. Shobhane Hema, Dr. Sadhna Jaiswal, Dr. Deepa Passi, Dr. Sunita Manchanda	
SESSION II - KEY NOTES		
CHAIRPERSONS : Dr. Reva Tripathi, Dr. Y.M. Mala, Dr. Meenakshi Ahuja, Dr. Deepa Gupta,		
09:45 - 10:00 am	1. Eclampsia Mukt Bharat - Easy Approach	Dr. Gorakh Mandrupkar
10:00 – 10:15 am	2. Anaemia Mukt Bharat by 2047	Dr. Sharda Jain
10:15 – 10:30 am	3. Cervical Cancer Mukt Bharat	Dr. Priya Ganesh Kumar
10:30 – 10:45 am	4. Surgical Site Infection	Dr. Achla Batra
10:45 - 11:15 am	**TEA BREAK**	
SESSION III – LEELAWATI ORATION		
CHAIRPERSONS : Dr.S.N.Mukherjee, Dr.S.Dawn, Dr. Neera Agarwal, Dr. Malvika Sabharwal, Dr. Neelam Bala Baid, Dr. M. Srivastava		
11:15 - 12 noon	Salute to Motherhood	Dr. P.C. Mahapatra
SESSION IV - CONFERENCE ORATION		
CHAIRPERSONS : Dr. V.L. Bhargava, Dr. Sunita Mittal, Dr. Shobha Sagar Trivedi, Dr. K.K. Roy, Dr. Chandra Mansukhani		
12:00- 12:45 pm	Challenging The Challenges	Dr. Manju Puri
SESSION V		
CHAIRPERSONS : Dr. Sonia Malik, Dr. Shakti Bhan Khanna, Dr. Sudha Salhan		
12:45 - 01:05 pm	Journey of IVF in India	Dr. Abha Majumdar
01:05 - 01:25 pm	Saving Ovaries	Dr. Alka Kriplani
01:25 - 01:30 pm	Discussion	
01:30 - 02:30 pm	**LUNCH BREAK**	
SESSION VI - KEY NOTES		
CHAIRPERSONS : Dr. Swaraj Batra, Dr. Kiran Agarwal, Dr. Vatsla Dadhwal, Dr. Monica Rana		
02:30 - 02:45 pm	Sepsis in Obstetrics	Dr. Harsha Khullar
02:45 – 3:00 pm	Improving Program Implementation : National Family Planning & Maternal Health Programs	Dr. Jyoti Sachdeva
03:00 – 03:15 pm	Identifying Complications in Twin Pregnancy	Dr. Anita Kaul
03:15 – 03:30 pm	Artificial Intelligence in Reproductive Health	Dr. Jaya Chaturvedi

SESSION VII - VEDIO SESSION - LABOUR ROOM PROCEDURES		
CHAIRPERSONS : Dr. Poonam Sachdeva, Dr. Manisha Navani, Dr. Krishna Agarwal, Dr. Veena Vidyasagar,		
03:30 - 03:40 pm	Episiotomy	Dr. Neha Varun
03:40 – 3:50 pm	Repair of 3rd & 4th Degree Tears	Dr. Bhanu Priya
03:50 - 04:00 pm	Instrumental Delivery Forceps	Dr. Kavita Agarwal
04:00 - 04:10 pm	Vacuum Delivery	Dr. Pallavi Gupta
04:10 - 04:20 pm	Patwardhan's Technique / Breech Extraction	Dr. Ratna Bishwas
04:30 - 05:15 pm	Final Quiz Round	
05:15 pm	Valedictory Session	

HALL B - 6TH OCTOBER, 2024 (Sunday) - DAY II

MOC : *Dr. Bhawani Shekhar (8:00-1:30 pm) & Dr. Anusha Sharma(2:30 – 5:00 pm)*

SESSION I		
TIME	**TOPIC**	**SPEAKERS**
08:00 - 10:00 am	Scientific Free Paper /Poster Presentation	
10:00 -11:00 am	Neonatology Resuscitation - Drill	Dr. Pankaj Garg
11:00 - 11:30 am	**TEA BREAK**	
SESSION II		
CHAIRPERSONS : Dr. Mamta Dagar, Dr. Ashmita Mehla		
11:30 - 12:00 noon	Breaking The Bad News	Dr. Sonal Bathla
12:00 – 12:30 pm	Violence Against Women - Skit	Dr. Monika Gupta
SESSION III		
CHAIRPERSONS: Dr. Kanika Jain, Dr. Vidhi Chaudhary		
12:30 – 12:45 pm	Menopause - Role Play	Dr. Sujata Agarwal
12:45- 01:10 am	Doctor ki Maut (Moot Court)	Dr. Jasmine Chawla
01:10 – 01:30 pm	Menstrual Hygiene - Role Play	Dr. Nidhi Khera
01:30 - 02:30 pm	**LUNCH BREAK**	
SESSION IV		
CHAIRPERSONS : Dr. Neeti Tiwari Dr. Sharmistha Garg		
02:30 - 03:00 pm	Counselling for LSCS - Role Play	Dr. Meenaskhi
03:00 - 03:30 pm	Pre Eclampsia - Drill	Dr. Upma Saxena
03:30 - 04:00 pm	Antenatal Care Counselling	Dr Seema Prakash
JUDGES : Dr. K. Gujral, Dr. Harsha Khullar, Dr. Anita Rajoria		
04:00 - 04:30 pm	Slogan Completion	

Paper Presentation Schedule

No.	Title	Name	Abstract Title	Date	Hall Name	Time
FP1	Dr.	Zeba Afreen	Emotional response and mental health of women undergoing second-trimester Medical Termination of Pregnancy for fetal anomalies.	5/10/2024	A	8:00-9:00
FP2	Dr.	Vandana Meena	Prediction of pre-eclampsia using quadruple test in first trimester	5/10/2024	A	8:00-9:00
FP3	Dr.	Geethanjali Gonimadatala	Prediction of Preterm Birth Using Quadruple Test in Second Trimester	5/10/2024	A	8:00-9:00
FP4	Dr.	Nishtha Singh	Comparison of Modified Shock Index with Shock Index in Predicting Maternal Outcomes in Primary Postpartum Hemorrhage.	5/10/2024	A	8:00-9:00
FP5	Dr.	Tamana	Obstetric Admissions to the Intensive care unit of a Tertiary Care Hospital	5/10/2024	A	8:00-9:00
FP6	Dr.	Shivam Yadav	Placenta Accreta Spectrum: Tragedy in Chaos, Triumph in Preparation	5/10/2024	A	8:00-9:00
FP7	Dr.	Gamana Sri	Neutrophil to Lymphocyte ratio in prediction of severe eclampsia	5/10/2024	B	8:00-9:00
FP8	Dr.	Shreya Sharma	Evaluation of renal resistive index as an ultrasonic marker of acute kidney injury in pregnancy associated sepsis	5/10/2024	B	8:00-9:00
FP9	Dr.	Avya Sinha	Serum magnesium and calcium in second trimester of pregnancy for prediction of pregnancy induced hypertension	5/10/2024	B	8:00-9:00
FP10	Dr.	Aparna Baranwal	Role of Systemic immune inflammatory index (SIII) as predictor for Gestational diabetes mellitus and fetomaternal outcome: A cross-sectional analysis	5/10/2024	B	8:00-9:00
FP11	Dr.	Salimun Nisa	Fetomaternal outcome in preeclampsia / eclampsia women with posterior reversible encephalopathy syndrome	5/10/2024	B	8:00-9:00
FP12	Dr.	Harsha Jodwal	High normal blood pressure and development of hypertensive disorders of pregnancy	5/10/2024	B	8:00-9:00

FP13	Dr.	Prashanth S Uppin	Prediction of Preeclampsia in high risk pregnancies by using sFlt/PlGF ratio	5/10/2024	B	9:00-10:00
FP14	Dr.	Himakshi Boro	Antiphospholipid syndrome in preeclampsia with severe features and fetal growth restriction.	5/10/2024	B	9:00-10:00
FP15	Dr.	Priya Lal	Assiciation of Serum Leptin Levels with Induction of Labour	5/10/2024	B	9:00-10:00
FP16	Dr.	Manisha Navani	To Assess the role of Myoinositol and Metformin on clinical,metabolic and hormonal profile of patients with PCOS	5/10/2024	B	9:00-10:00
FP17	Dr.	Sneh Tanwar	To study the effectiveness of surgical bundle in reducing Surgical Site Infection following caesarean deliveries.	5/10/2024	B	9:00-10:00
FP18	Dr.	Aishwarya Arikatla	Effect of change in the position of parturient in second stage of labour on the mode of delivery	5/10/2024	B	9:00-10:00
FP19	Dr.	Shalini Parashar	Effect of oral misoprostol for cervical ripening in term pre-mature rupture of membrane	6/10/2024	A	8:00-9:00
FP20	Dr.	Akanksha gupta	Fetal biometric parameters and ultrasonographic markers in gestational diabetes mellitus	6/10/2024	A	8:00-9:00
FP21	Dr.	Suman Kumari	Role of Sham Feeding in Postoperative Recovery of Gastrointestinal Motility in Low-Risk Caesarean Section.	6/10/2024	A	8:00-9:00
FP22	Dr.	Sowmiya K	Comparison of Single foley catheter with Double foley catheter in cervical ripening of nulliparous women	6/10/2024	A	8:00-9:00
FP23	Dr.	Sanjeevani Nanda	Evaluation of patient satisfaction with conservative management of pelvic organ prolapse	6/10/2024	A	8:00-9:00
FP24	Dr.	Gandi Revathi Sai Prasanna	Comparison of clinical and ultrasound fetal weight estimation in predicting actual birth weight	6/10/2024	A	8:00-9:00
FP25	Dr.	PRAGYA SAINI	“Ease the Pain: How Birth Companion Transform Labor Comfort!”	6/10/2024	B	8:00-9:00

FP26	Dr.	Lashyatha Muppavarapu	Evaluation of cesarean section rates by using Robson ten group classification system in newly tertiary established hospital in northern India	6/10/2024	B	8:00-9:00
FP27	Dr.	Dhruthi. S	Evaluation of labour care guide for labour management in low risk pregnancy	6/10/2024	B	8:00-9:00
FP28	Dr.	Anushka Gupta	Exploring Hysteroscopy's Diagnostic Accuracy for Chronic Endometritis in Infertile Women: Precision Assessment	6/10/2024	B	8:00-9:00
FP29	Dr.	Smriti Thakur	Role of second trimester ultrasound ion prediction of placenta accreta spectrum syndrome	6/10/2024	B	8:00-9:00
FP30	Dr.	Manisha Jhirwal	In Time Communication About Critically Ill Obstetric Patients to Labour Room Team Saves Life: A Quality Improvement Study	6/10/2024	B	8:00-9:00
FP31	Ms.	Preethy Dinesan	A cross-sectional study to evaluate the satisfaction of low-risk pregnant women regarding Midwife-led antenatal care in a tertiary care facility in India	6/10/2024	B	9:00-10:00
FP32	Dr.	Manisha Navani	A comparative study to find efficacy of 2.5mg versus 5 mg dose of Letrozole for ovulation induction in patients with PCOS. Letrozole	6/10/2024	B	9:00-10:00
FP33	Dr.	Tanya Grover	Does CTG chorioamniotis really exist?	6/10/2024	B	9:00-10:00
FP34	Dr.	Vishwani Khurana	Glycemic Variability and Time-in-Range: Novel Metrics for Assessing Pregnancy Risk in T2DM.	6/10/2024	B	9:00-10:00
FP35	Dr.	Niharika Sharma	Role of heat stable intravenous carbetocin vs intravenous oxytocin in active management of third stage of labour after vaginal birth: A prospective study	6/10/2024	B	9:00-10:00
FP36	Dr.	Jyoti khatri Gupta	varied presentation and management of puerperal sepsis	6/10/2024	B	9:00-10:00
FP37	Dr.	Preeti Saxena	Diagnostic role of vaginal wash fluid lactate and prolactin levels in patients with preterm premature rupture of membranes	6/10/2024	B	9:00-10:00

E Poster Presentation Schedule

No.	Name	Abstract Title	Date	Time
Screen 1				
EP1	Bhagyashree	Prenatal diagnosis and management of cardiac rhabdomyoma	5/10/2024	8:00-9:00
EP2	Kanchan Basnet	Congenital lung malformation- a rare entity	5/10/2024	8:00-9:00
EP3	Nisha Chopra	Insights and outcomes : two rare cases of fetal sacrococcygeal teratoma	5/10/2024	8:00-9:00
EP4	Nivedita Shankar	Intrauterine transfusion revolutionizing the management of fetal anemia	5/10/2024	8:00-9:00
EP5	Riyal Ranasaria	"Unveiling the mystery: vanishing twin vs. Chorionic cyst – a diagnostic conundrum	5/10/2024	8:00-9:00
EP6	Arpita Mitra	Successfully managed pregnancy in patients with pulmonary artery hypertension	5/10/2024	8:00-9:00
EP7	Ayushi	Twin pregnancy with hydatidform mole co-existing with live pregnancy	5/10/2024	8:00-9:00
EP8	Damini Rathee	Peripartum cardiomyopathy	5/10/2024	8:00-9:00
Screen 2				
EP9	Dr. Sheetal Pushkar	Spontaneous hemoperitoneum in pregnancy	5/10/2024	8:00-9:00
EP10	Janvi Vashist	Endocrine turbulence : the maternal and fetal challenges of overt primary hypothyroidism in pregnancy: a case report.	5/10/2024	8:00-9:00
EP11	Priti Tanwar	Chronic endometritis and dystrophic calcification presenting as secondary infertility	5/10/2024	8:00-9:00
EP12	Priyanka Das	A tale of metallic valve in pregnancy-navigating prosthetic mitral valve thrombectomy	5/10/2024	8:00-9:00
EP13	Sai Priya	Challenging presentation of tuberculosis in puerperium	5/10/2024	8:00-9:00
EP14	Sakshi Malhotra	Peripartum cardiomyopathy(ppcm): an intriguing challenge	5/10/2024	8:00-9:00
EP15	Sukriti Gaur	Caesarean scar ectopic pregnancy	5/10/2024	8:00-9:00
EP16	Puja Singh	Peripartum cardiomyopathy: circumvention of a formidable challenge	5/10/2024	8:00-9:00
Screen 1				
EP17	Sakshi Bajaj	Navigating challenges of metallic valve : a tale of arrhythmia complicating restenosis	5/10/2024	9:00-10:00
EP18	Akanksha Dalal	A rare case of mid-trimester uterine rupture triggered by a fall: challenges in diagnosis and management	5/10/2024	9:00-10:00
EP19	Ambika Agarwal	Rare presentation of accessory and cavitated uterine mass (acum) with right ovarian cyst: a case report	5/10/2024	9:00-10:00

EP20	Anmol Shivhare	Traumatic urethro vaginal fistula	5/10/2024	9:00-10:00
EP21	Anusha Khare	Ohvira syndrome- a rare case report	5/10/2024	9:00-10:00
EP22	Archita Chawla	Case report: cervical net- a rare presentation of cervical fibroid	5/10/2024	9:00-10:00
EP23	Dr Sandhya Verma	From hemetometra to normal menses	5/10/2024	9:00-10:00
EP24	Dr Srishti	Multidisciplinary management of a pregnant woman with left mandibular osteoclastoma	5/10/2024	9:00-10:00
Screen 2				
EP25	Dr Tamana	Neurotoxic snake bite with respiratory failure in a pregnant female : a case report	5/10/2024	9:00-10:00
EP26	Dr.sonam Singh	Abdominal ectopic	5/10/2024	9:00-10:00
EP27	Gopini Meghana	Umbilical endometriosis	5/10/2024	9:00-10:00
EP28	K P Apoorva	Horseshoe flap neovaginoplasty in primary vaginal atresia: an operative insight!	5/10/2024	9:00-10:00
EP29	Komal Dahiya	Ruptured rudimentary horn pregnancy	5/10/2024	9:00-10:00
EP30	Liya P J	Cervical ectopic pregnancy	5/10/2024	9:00-10:00
EP31	Shiny Anuhya	Anterior vaginal wall endometrioma – masquerading as gartner's cyst	5/10/2024	9:00-10:00
EP32	Rashi Varshney	Harlequin ichthyosis: a rare genetic skin disease	5/10/2024	9:00-10:00
Screen 1				
EP33	Prachi Lochab	Medical management of rare interstitial ectopic pregnancy	6/10/2024	8:00-9:00
EP34	Kriti Ranga	Heat stroke as rare cause of stillbirth	6/10/2024	8:00-9:00
EP35	Anuja Chopra	Pregnancies resulting from in-vitro conception: the menace for modern-era obstetricians	6/10/2024	8:00-9:00
EP36	Aakriti Aggarwal	A rare case of ovarian fibroma misdiagnosed as leiomyoma	6/10/2024	8:00-9:00
EP37	Anusha Sharma	Unicentric castleman disease: a case report	6/10/2024	8:00-9:00
EP38	Rishab Dubey	Placental site trophoblastic tumour - a rare case report	6/10/2024	8:00-9:00
EP39	Spurti Javalgi	Treatment of recurrent hpv- dependent vulvar intraepithelial neoplasia (vin) : a case report	6/10/2024	8:00-9:00
EP40	Nikhil Ritolia	Spontaneous rupture of a mature ovarian cystic teratoma: a rare case report	6/10/2024	8:00-9:00
Screen 2				
EP41	Payal Hooda	Colorectal cancer with enterocutaneous fistula in pregnancy: a case report	6/10/2024	8:00-9:00
EP42	Mandakini Mogare	Case report of ruptured corpus luteum cyst-managed conservatively	6/10/2024	8:00-9:00
EP43	Mokshita Malhotra	Case report of tubal molar gestation: a rare occurence	6/10/2024	8:00-9:00

Main Conference Abstracts

Dr. S. K. Das Oration

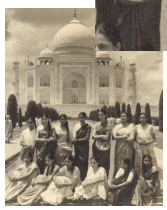
A Tribute to Dr. Subodh Das

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

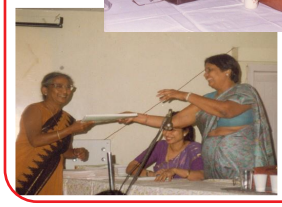
Transferred to Safdarjung Hospital in 1978
Started postgraduate teaching in 1981, designated Professor UCMS

Retired from SJH as HOD & Consultant in 1996

Attended Conferences & Training Programs

in USA, Russia, Sydney Rome, Hawaai

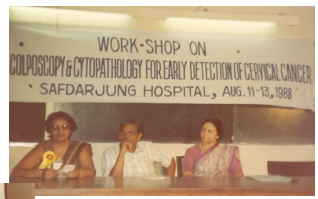
A True Leo and Born Leader
Marched on with Great zeal & Zest



Acclaimed Nationally

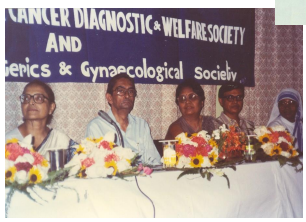
& Internationally

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 &

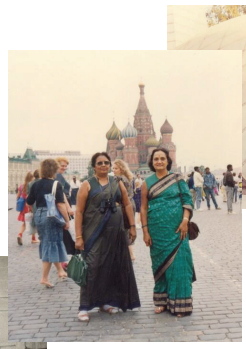
Patron, Indian College of Colposcopy & Cervical Pathologists

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

Third and fourth-degree perineal tear

Bhanupriya

Professor, Department of Obstetrics & Gynaecology, UCMS & GTB hospital

Perineal trauma after vaginal birth is common, with approximately 9 of 10 women being affected. The incidence of obstetrical anal sphincter injury (OASI) is approximately 3%, with a significantly higher rate in primiparous than in multiparous women (6% vs 2%). To standardize care, the Sultan classification is recommended for grading the severity of perineal trauma (Table 1)

Table 1: The Sultan classification of perineal trauma

Type of tear	Definition
First-degree	Injury to perineal skin and/or vaginal mucosa.
Second -degree	Injury to perineum involving perineal muscles but not involving the anal sphincter.
Third -degree*	Injury to perineum involving the anal sphincter complex **Grade 3a tear:** Less than 50% of external anal sphincter (EAS) thickness torn. **Grade 3b tear:** More than 50% of EAS thickness torn. **Grade 3c tear:** Both EAS and internal anal sphincter (IAS) torn.
Fourth-degree	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa**

*Advisable to upgrade the tear stage, in case of doubt in third degree tear

** If the tear involves the rectal mucosa with an intact anal sphincter complex (button hole tear), it is not a fourth-degree tear and needs separate mention.

Risk Factors

Strategies to reduce perineal trauma should focus on the identification of modifiable risk factors and actions aimed at mitigating them. Identified modifiable risk factors associated with second-degree perineal trauma include operative vaginal birth and maternal birth positions with increased sacrum flexibility (such as lithotomy, supine and sitting as opposed to squatting, kneeling, and lateral). Non-modifiable risk factors include increased maternal age, post-term birth, increased fetal birthweight, perineal edema, and a prolonged second stage of labor.

Assessment of OASI

- Examine systematically to assess the severity of damage. This should include an assessment of the perineum, lower vagina and rectal examination to exclude any damage to the anal sphincter complex (external and internal anal sphincters and rectal mucosa).
- A second opinion must be obtained from an experienced clinician if the practitioner is inexperienced at assessing perineal damage or unsure of the degree of trauma sustained.
- If the trauma is complex, may need regional / general anaesthetic.

Surgical technique

Third- and fourth-degree tear repair

Principles of repair

- Suture as soon as possible following delivery to reduce bleeding and risk of infection.

- Informed consent, adequate lighting and expertise, repair under anaesthesia
- Do not take figure of eight sutures (hemostatic causes tissue ischemia)
- Anorectal mucosa: continuous / interrupted 3-0 vicryl knot tied in the anal canal
- Internal anal sphincter: repaired separately with interrupted or mattress sutures (either monofilament 3-0 PDS or 2-0 vicryl without any attempt to overlap it.
- External anal sphincter: Repaired either by an end to end or overlapping method. For partial thickness tears an end to end technique should be used.

Post operative management

- Broad spectrum antibiotics to reduce the risk of postoperative infections and wound dehiscence
- Laxatives is recommended to reduce the risk of wound dehiscence. Avoid stool bulking agents
- Physiotherapy following repair of OASIS could be beneficial
- Review at a convenient time (usually 6–12 weeks postpartum)

Future deliveries

- Women who are clinically asymptomatic can be allowed vaginal delivery by an expert.
- Episiotomy should be only performed if indicated. No role of prophylactic episiotomy.
- All women who have sustained OASIS in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should be counseled regarding the option of elective cesarean birth.

Vacuum delivery

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Assisted vaginal birth or operative vaginal birth refers to a birth in which a clinician uses vacuum or forceps to aid in delivery of the baby. Incidence of operative vaginal delivery ranges from 3-15% and has been declining over time.

Operative vaginal delivery may be required in the second stage of labor in the event of non-reassuring fetal status or to cut down the second stage of labor in women with medical conditions where Valsalva is to be avoided or poor maternal bearing down. In properly selected patients, forceps/ vacuum is faster and safer than a caesarean section and hence, training in operative vaginal delivery is an essential part of obstetric practice. Metal vacuum cup, silicone vacuum cup and hand held Kiwi Omnicup are commonly used for vacuum delivery.

Steps of vacuum delivery:

- Confirm pre requisites: term baby in cephalic presentation with head <1/5 palpable on abdominal examination (preferably head not palpable), fully dilated cervix with ruptured membranes, head at or below +2 station with caput and moulding <2+ and adequate pelvis. Operation theatre (OT) backup should be available. (Application of vacuum at station higher than +2 should only be done by an experienced operator.)
- Explain the procedure to the mother, obtain verbal consent. (Written consent if trial being done in OT)
- Should be done by/in presence of an operator who is skilled in operative delivery as well as managing any complications that may arise from it.
- Ensure adequate analgesia
- Empty bladder
- Check all equipment: attach the vacuum to suction machine, check pressure by putting cup on gloved hand
- Apply the cup over the flexion point (center of the cup should be 3 cm anterior to the posterior fontanelle)
- Check that no maternal tissue is trapped between the fetal head and vacuum cup.
- Create suction upto 600 mmHg
- Non dominant hand is placed in the vagina such that thumb is on the cup and 1-2 fingers are on the fetal head,
- Dominant hand applies traction on the instrument handle along with uterine contractions, perpendicular to the cup along the pelvic axis
- At crowning, assess need for episiotomy
- Turn off suction and remove the cup following delivery of the head.
- Deliver the baby (hand over to an experienced pediatrician), cord clamp, active management of third stage of labor
- Inspect cervix and vagina for tears and for OASI (obstetric anal sphincter injury) and repair if any
- Repair episiotomy
- Single dose of prophylactic intravenous antibiotic to be administered in cases of operative vaginal delivery
- Document the findings
- Explain post- delivery care to the woman

Discontinue if the vacuum pops off twice, or if there is no descent with moderate traction. Complications of vacuum include need for episiotomy (50-60%), Vulvovaginal tears (10%), OASI (1-4%), PPH (10-40%) and Urinary or bowel incontinence.

Fetal complications include cephalhaematoma (1–12%), Facial or scalp lacerations (10%.), Retinal haemorrhage (17–38%), jaundice or hyperbilirubinaemia (5–15%), subgaleal haemorrhage (3 to 6 in 1000), Intracranial haemorrhage (5 to 15 in 10,000) and fetal death (very rare)

Genito-pelvic Pain/Penetration Disorder (GPPPD)

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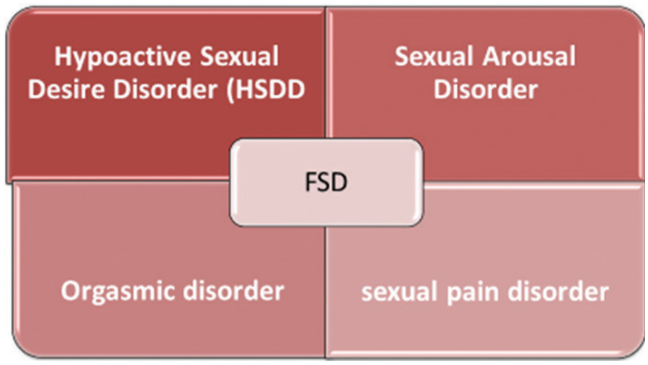
Female sexual Dysfunction

Female sexual dysfunction (FSD) is a continuum of psychosexual disorders centered on sexual desire with interrelated problems of arousal, orgasm, and sexual pain that impairs quality of life for many women.



FSD can afflict women of any age, and its expression changes with the endocrinology of advancing years. Impact is often subtle.

FSD may express as seemingly unrelated emotional disturbances that degrade quality of life in family relationships, in the workplace, or both.

For some, it is a minor short-term problem. For others it is debilitating

Genito pelvic pain/penetration disorder (GPPPD)

There's a new diagnostic name on the street for pelvic pain, and it's a long one. Genito pelvic pain/penetration disorder (GPPPD) is a combination of painful sex (dyspareunia) and involuntary vaginal muscle spasms (vaginismus).

Used to describe persistent or recurrent difficulties when it comes to sexual dysfunction, it's diagnosed by extreme pain or ongoing discomfort, usually while trying to have sex. It causes emotional distress and a (totally understandable!) loss of interest in sex and reduced sexual desire.

Genito-pelvic pain/penetration disorder involves difficulties with attempted or completed vaginal penetration during sexual intercourse, including involuntary contraction of the pelvic floor muscles when vaginal entry is attempted or completed (levator ani syndrome, or vaginismus), pain (dyspareunia) that is localized to the vestibule (provoked vestibulodynia) or at other vulvovaginal or pelvic locations, and fear or anxiety about penetration attempts.

Women with genito-pelvic pain/penetration disorder commonly have impaired arousal, orgasm, or both.

Type

1. Vaginismus or Levator ani syndrome

2. Vulvodynia

Treatment of these disorders need psycological attention and along with that a range of medical treatments,

Use of Botox in levator ani syndrome and use of CO2 laser treatment in case of vulvodynia is quite promising.

Patwardhan technique and reverse breech extraction for delivery of impacted fetal head at cesarean section

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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].

Cesarean performed in second stage is associated with significantly higher rate of maternal and fetal complications. Maternal complications includes but is not limited to atonic postpartum hemorrhage , uterine incision extension(12.5%), postoperative fever(18.8%) and wound infection(4.8%)[4] . Common perinatal complications are meconium stained amniotic fluid (34.2%), increased nursery admission (15.3%) ,neonatal hyperbilirubinemia (9.7%) and perinatal mortality (1.3%)[4]. Injury to the fetal skull though rare can have devasting effects including intracranial hemorrhage and perinatal mortality .

Systematic reviews have observed the "pull" method, including reverse breech extraction and the Patwardhan method may be safer than vaginal "push method" The analysis of pooled data has shown an increased risk of uterine incision extensions (OR, 3.44; 95% CI, 2.62-4.52; P .0001), need for blood transfusion (OR, 2.42; 95% CI, 1.07-5.48; P=.03), and infections (OR, 4.25; 95% CI, 1.65e10.96; P=.003 with push method [5,6,7]. The stretching of the thinned out lower segment gives way to extension of incision downwards towards the bladder which might be injured and lateral towards the broad ligament with concomitant avulsion or tearing of uterine arteries and veins leading to traumatic PPH. The torn end of uterine artery often retracts under the hematoma making to difficulty to ensure hemostasis necessitating additional procedures such as the ligation of anterior division of internal iliac artery.

Vertical extension may involve the descending cervical arteries and vaginal venous plexuses causing profuse hemorrhage.

Delivery of the head which is low down and wedged in the pelvis requires considerable skill and experience to deliver without any complications. The best technique for delivery is a matter of debate. However various techniques have been described with advantages and disadvantage of each .

1. Shoulder first or the Patwardhan technique
2. Foot first or reverse breech extraction .
3. Head first or the traditional push technique

Shoulder first : Patwardhan Technique

This technique was originally described by Dr Patwardhan in 1957 . There is a long learning curve due to the complexity of maneuvers. The risk of injury looms large in unexperienced hands and with hastily performed procedures. On the other hand , once mastered delivery can be achieved with less difficulty and with minimal complications

A liberal uterine incision is indispensable as a preliminary step to ease the performance of further maneuvers . A small inadequate incision length is more likely to lead to extensions. A higher incision at the level of fetal shoulder is preferred, this does not incur a risk of involving the upper uterine segment as a second stage cesarean has a very well formed lower segment . A "c" shaped slightly deep curvilinear incision will provide extra length to the uterine incision as compared to the shallow curvilinear incision performed for a normal cesarean, but care must be taken that the ends of the incision does not extend into the upper segment. There is potential for future scar dehiscence originating at the extended ends which encroach the upper segment.

The technique of delivery varies according to the position of the back. If back is anterior one shoulder usually presents at the incision site. The anterior arm is brough out by insinuating the fingers of the

operator through the axilla and hooking out the arm after which gentle traction is applied to the arm to pull it on the same side which draws the posterior shoulder anteriorly towards the hysterotomy site and the fingers are gently hooked through the axilla of the baby to deliver the second arm[9].

Now both hands of the obstetrician are hooked through the axilla on each side of the baby so as to bring the fingers anteriorly over the fetal thorax and the thumb lies over the shoulder blade. Gentle traction is given downwards to flex the baby's back and bring it down and out through the incision aided by fundal pressure by assistant. This is followed by delivery of the buttocks and legs . The baby is lifted up to extract the fetal head which is the last to come out[9].

Modified Patwardhan technique for back-posterior.

In back posterior, once the incision is made one of the shoulder and arm may come out of the incision , this need not be reposited back, instead the leg of the same side as the arm is brought out next followed by contralateral leg. After the delivery of these three limbs, the baby is held bilaterally on the lower part of the fetal trunk which is reversed and deliver by a flexion movement, followed by the delivery of the arm that was not previously released and the fetal head[8].

Reverse breech method for back-posterior

A simpler way of delivery of fetus with deeply impacted head and back posterior is by reverse breech extraction. Operator's hand is insinuated upwards towards the fundus to grasp any foot, identified by the heel. Once this is established the foot is brought down by gentle traction . Further traction on the lowered feet brings the other buttock and the foot into view which is grasped and further on the delivery is like in breech extraction , that is delivery of shoulders followed by head.

Head First : Push Technique

This traditional method has been in practice in many countries , is easy to perform and does not require much training. Here an assistant dis-impacts the fetal head vaginally by grasping the head with the hand with the fingers spread out, head is flexed and lifted up toward the uterine incision. Once this is established the operator delivers the head through the uterine incision.

The Cochrane review 2016[6] compared the outcomes between push method, reverse breech extraction . Four randomized trials involving 357 women were included. The primary outcome of birth trauma was reported by three trials and there was no difference between reverse breech extraction and head push for this rare outcome.

Secondary outcomes including endometritis , extension of uterine incision, mean blood loss and neonatal intensive care unit admission were less with reverse breech extraction.

No differences were observed between groups for many of the other secondary outcomes reported : blood loss > 500 mL; blood transfusion; wound infection; mean hospital stay; average Apgar score. The duration of surgery was significantly shorter for reverse breech extraction, which may correspond with ease of delivery .

Conclusion

Reverse breech technique including Patwardhan technique is associated with faster delivery and lower risk of uterine incision extension thus making it an acceptable method for delivery of impacted fetal head by those who are trained to do so.

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Artificial Intelligence in Obstetrics & Gynecology

Jaya Chaturvedi

Artificial intelligence, which has been applied as an innovative technology in multiple fields of healthcare, analyzes large amounts of data to assist in disease prediction, prevention, and diagnosis, as well as in patient monitoring. In obstetrics, artificial intelligence has been actively applied and integrated into our daily medical practice.

AI applications using deep learning have extended beyond computed tomography, magnetic resonance imaging (MRI), ultrasonography (US), and pathology slides to include diagnoses or determinations of disease severity. Using AI methods in medical care could facilitate individual pregnancy management and improve public health, especially in low- and middle-income countries.

In recent years, there has been a renewed interest in the use of AI in obstetrics and gynaecology, driven by the availability of large amounts of data. One of the primary areas in which AI and ML are being used in obstetrics and gynaecology is in the analysis of imaging data, such as ultrasound and magnetic resonance imaging. AI algorithms can be trained to automatically identify and classify different structures in the images, such as the placenta or fetal organs, with high accuracy. Another area of focus is the use of AI to predict preterm birth. Researchers have used ML algorithms to analyse data from electronic health records and identify patterns that are associated with preterm birth. By analysing large datasets of patient information and outcomes, AI algorithms can identify patterns and risk factors that may not be apparent to human analysts. This can help to improve the prediction of obstetric outcomes and guide clinical decision making.

In recent years, AI has also been applied in obstetrics and gynaecology for real-time monitoring of high-risk pregnancies and identifying fetal distress.

AI and ML are also being used to develop new tools for the management of gynaecological conditions, such as endometriosis and fibroids. These tools can be used to predict the progression of the disease and guide treatment decisions. One example of the use of AI in benign gynaecology is the development of computer-aided diagnostic systems for endometriosis. These systems use ML algorithms to analyse images of the pelvic region and identify the presence of endometrial tissue, which can be a sign of endometriosis.

Another area where AI and ML are being applied is in the management of fibroids. ML algorithms are being used to analyse imaging data and predict the growth and behaviour of fibroids, which can aid in the development of personalised treatment plans.

In the field of oncology, AI is being used to improve the accuracy and speed of cancer diagnosis. AI algorithms can analyse images of tissue samples to identify the presence of cancer cells and predict the likelihood of a positive outcome following treatment. AI algorithms can be trained to analyse images from pelvic scans and identify signs of ovarian cancer with high accuracy.

In addition to these specific applications, AI and Machine Learning (ML) are also being used to improve the efficiency and organisation of care in obstetrics and gynaecology. For example, by analysing large amounts of clinical data, AI algorithms can be used to identify patients at high risk of complications, prioritise them for care and ensure that they receive the appropriate level of care in a timely manner.

AI and ML have the potential to revolutionise the field of fertility and *in vitro* fertilisation (IVF). By using data from large patient populations, AI and ML algorithms can help identify patterns and predict outcomes that would be difficult for human experts to discern. This can lead to improvements in diagnosis, treatment planning, and overall success rates for patients undergoing IVF.

AI and ML are rapidly evolving fields that have the potential to revolutionise the field of surgery. These

technologies can be used to assist surgeons in a variety of ways, from pre-operative planning to real-time guidance during procedures. One of the key areas where AI and ML are being applied in surgery is in image analysis. For example, algorithms can be used to automatically segment and identify structures in medical images, such as tumours or blood vessels. This can help surgeons plan procedures more accurately and reduce the risk of complications.

Overall, AI has the potential to improve the diagnosis and management of obstetrics and gynaecology conditions, and many studies have shown that AI systems can perform at least as well as human experts in several areas. However, it is important to note that AI and ML are still in the early stages of development in obstetrics and gynaecology and more research is needed to fully understand their potential benefits and limitations.

Evidence based strategies for Spontaneous Preterm Birth reduction in singleton pregnancies

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Preterm birth complicates 7-11 % of pregnancies, out of which 30-35% follow preterm premature rupture of membranes (PPROM), 20-25% are medically indicated. In approximately 40-50% labour starts with intact membranes, it is in this group some risk reduction strategies would work. Out of all the risk factors previous spontaneous preterm birth (sPTB), PPROM, previous mid trimester abortion have the strongest association. Overall 90% of births before 34 weeks and 80% before 37 weeks occur in women with no history of prior preterm birth (PTB) including nulliparas. Hence, there is a need for an efficient clinical predictor which can be applied universally to all pregnant women - Transvaginal ultrasonic cervical length (TVUCL). Cervical length below 10th percentile of that gestational age is defined as a short cervix. At 18-24 weeks of gestational age the 10th percentile is < 26 mm, therefore a CL ≤ 25 mm is defined as short cervix. At a CL ≤ 25mm at 24 weeks there is 5 fold increase in PTB.

Recommendations of TVUCL screening

- All pregnant women between 16-24 weeks of pregnancy regardless of previous obstetric history- NICE, SMFM, SOGC, ISUOG.
- ACOG- Previous history of PTB – serial screening two weekly starting from 16 to 24 weeks.
- No history of PTB- once at mid trimester scan.

Various risk reduction strategies are :-

- Progesterone (natural or micronized vaginal progesterone 100-200 mg vaginal suppository or tablet, vaginal gel 90 mg of micronized progesterone, oral progesterone and 17 hydroxy progestrone (17 OHP). Limited data exists on the role of oral progesterone. 17 OHP has been withdrawn from US market because of safety concerns.
- Cerclage
- Arabin pessary
- Other strategies

Evidence based recommendation for reduction sPTB of preterm birth are as follows :-

- Singleton pregnancy CL ≤ 25mm , no previous PTB- Vaginal progesterone
- Singleton pregnancy, previous PTB, normal cervical length (> 25mm) - No treatment. Serial CL monitoring is recommended.
- Singleton pregnancy, previous PTB, CL ≤ 25mm, cerclage vs progesterone. Cerclage preferred over progesterone. At a CL ≤ 20mm, cerclage is a definite indication.
- Consider Cerclage if history indicated /physical examination indicated.
- Evidence does not favor arabin pessary for sPTB reduction.
- Other risk reduction strategies at preconception period include optimization of BMI and maternal medical conditions, quitting addictions, optimal spacing between two pregnancies.

Single embryo transfer for in vitro fertilization, fetal reduction in multiples, aspirin prophylaxis for women at high risk of preeclampsia, treatment of asymptomatic bacteriuria, periodontal diseases and sexually transmitted diseases, tocolysis for Preterm Labour and reducing stress are some of the post conceptional strategies.

Improving Program implementation in Delhi- National Family Planning and Maternal Health Programs

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State Program Officer (Maternal Health & Family Planning Programs), DFW

Maternal health and Family Planning are essential components of public health, playing a crucial role in improving the well-being of individuals, families, and communities. As we work towards reducing maternal and newborn mortality in Delhi, enhancing the implementation of Family Planning (FP) and Maternal Health (MH) programs is key to achieving improved health outcomes. Despite our best efforts, several barriers hinder the success of FP and MH programs, such as health-seeking behaviours and suboptimal service delivery. However, addressing capacity building, community engagement, setting health goals, and adopting impactful practices can significantly improve program implementation.

1. Ensuring Quality of Services

High-quality services form the foundation of successful health programs. Adherence to standards set by MOHFW, DFW, FOGSI, and other bodies is essential. Infection prevention, bio-medical waste (BMW) management, and patient satisfaction are critical components of quality assurance. Regular feedback mechanisms, such as patient exit interviews, should be incorporated to assess services across family planning interventions like Comprehensive Abortion Care(CAC) , antenatal (ANC), postnatal care(PNC), and sterilization services. Respectful care, informed choice, confidentiality, and follow-up must also be prioritized to reduce grievances and improve patient trust.

The Family Planning Indemnity Scheme mandates institutional mechanisms for quality assurance, especially for sterilization services, and should be implemented rigorously across public and private facilities. Regular problem identification and the use of quality improvement cycles, such as POCQI, are essential to continuous service enhancement.

2. Strengthening Capacity Building

A skilled healthcare workforce is essential for delivering effective services. Initiatives like Dakshata training, focusing on labour room protocols, and Emergency Obstetric Care (EmOC) training for nurse-midwives have contributed significantly to reducing maternal morbidity and mortality. Virtual platforms, such as the Safe Delivery App and Mobile Academy, provide cost-effective digital training solutions. Skill-based trainings, including NSV, PPIUCD, and Implants, should be widely adopted in both public and private sectors.

3. Improving Supply Chain Management

A reliable supply chain is vital to ensure the continuous availability of contraceptives, maternal health drugs, and equipment. Logistics Management Information Systems (LMIS-FP) play a key role in preventing stockouts and minimizing wastage.

4. Data-Driven Decision Making

Effective monitoring, supportive supervision, and documentation are essential for continuous improvement. Auditing tools, such as LaQshy and Manyata, help in maintaining labour room standards. E-learning apps, dashboards, and e-prescription tools simplify program management and help in monitoring key performance indicators (KPIs) through real-time data. The MCP card audit is a useful strategy for tracking antenatal care, while the government's health information systems, such as HMIS and ePMSMA, help in data-driven decision-making. Regular review meetings, data-driven decisions, and self-assessments are critical for addressing service gaps and improving program implementation.

5. Strengthening Community Engagement and Behaviour Change Communication

Community engagement is crucial for overcoming cultural barriers and misconceptions surrounding contraceptives. Initiatives like Saas Bahu Sammelans , Garbini Parivar Sammelans, and UNHD should be regularly organized to foster greater acceptance of FP and MH services. Involving community leaders can further promote the adoption of health practices.

6. Leveraging Technology

Technology has streamlined the implementation of family planning and maternal health programs. Tools like e-learning apps, dashboards, auto-analysis apps, and e-prescriptions simplify program processes. Regular dissemination of IEC materials and advisories ensures consistent program engagement. IVR platforms and helplines, such as the 1800-555 line for family planning and Kilkari for maternal health, provide real-time support and information. These innovations improve service delivery and empower individuals by making healthcare more accessible.

7. Partnerships and Coordination

Finally, partnerships with NGOs, private sector, National and International organizations such as FOGSI , NARCHI , WHO are essential for scaling up the effectiveness of these programs. A coordinated approach between sectors, including nutrition and immunization services, creates a holistic health system that benefits the entire community.

Conclusion

Improving the Family Planning and Maternal Health programs requires a holistic approach that encompasses quality enhancement, capacity building, community involvement, and technological innovations. With evidence-based interventions and a commitment to quality care, Delhi can significantly improve health outcomes for mothers and children, contributing to the overall development of the state.

Maternal Sepsis – "Golden Hour"

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Obstetric sepsis or Maternal Sepsis is a challenge.

According to WHO worldwide around 830 women die every day from pregnancy or childbirth related complications.

Maternal sepsis is the third leading cause of maternal death globally i.e. 11% of all maternal deaths. So effective prevention, early identification and early management can reduce the mortality.

Sepsis is not a specific illness, but a non-linear complex syndrome, which has a still uncertain pathobiology. The new definition of sepsis is a life threatening condition, defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or post-partum period. So the definition shifts from inflammatory response to life threatening organ dysfunction.

Due to physiological changes during pregnancy and impaired immune system to accept foreign protein from fetoplacental unit pregnant women are at more than 50% risk. Various scores are assigned. The initial SOFA Score should be zero in individuals without disease. Of the SOFA criteriae, those most affected by pregnancy are creatinine and MAP.

Various common sources of infection in sepsis are the obstetrical and non-obstetrical and various organs / system damage can be caused by sepsis. Early management of sepsis is just like managing a MI patient where the first hour i.e. the golden hour is very important. Similarly sepsis is a medical emergency. This one hour bundle includes measure lactate level, if >2 mmol/litre, repeat in 2-4 hour. All blood culture should be taken prior to starting the broad spectrum antibiotics. Begin rapid administration of 30ml/kg crystalloids for hypotension or if lactate > 4 mmol/litre. Lastly give vasopressin, if patient is hypotensive during or after fluid resuscitation to maintain MAP ≥ 65mmHg, in first hour itself.

In pregnancy, the fluid therapy may be overly aggressive as colloid oncotic pressure is lower and risk of pulmonary edema is higher. Only about 50% hypotensive septic patients are fluid responders, but those who are not may develop pulmonary or cerebral edema. So one should be careful and non-invasive test by ultrasound has been used to identify fluid responsiveness by measuring diameter of IVC with respiration.

In hypotensive patients who are not fluid responsive, vaspression should be utilized to increase BP. Non-adrenaline is the first line target. Second line vasopressor is vasopressin followed by adrenaline. Glucocorticoid can be used in patient in septic shock that is unresponsive to adequate fluid resuscitation and vasopressin administration.

Surgical intervention in cases where septic focus is identified.

Early recognition and initial management in first hour of presentation or recognition can help in decreasing mortality.

Paper Abstracts

FP1

Emotional response and mental health of women undergoing second-trimester Medical Termination of Pregnancy for fetal anomalies

Zeba Afreen, Vatsla Dadhwal, Sujata Satapathy, Vidushi Kulshrestha, Richa Vatsa, Anubhuti Rana, Aparna Sharma, Juhi Bharti

Introduction: The decision to undergo second-trimester termination of pregnancy (TOP) for fetal anomalies involves complex medical, ethical, and emotional challenges. Women in this situation often face significant emotional distress, intensified by the later stage of pregnancy and maternal-fetal attachment.

AIM: To study the emotional response, mental health, and post-traumatic stress in women undergoing second-trimester MTP for fetal anomalies.

Method: This prospective observational study, conducted at the Department of Obstetrics and Gynaecology, AIIMS from July 2022 to December 2023, assessed the emotional responses and mental health of 120 women who underwent medical termination of pregnancy for fetal anomalies between 14-24 weeks POG. Four questionnaires were administered before MTP and one month post-MTP: Impact of Event Scale-Revised (IES-R), Kessler Psychological Distress Scale (K-10), Hospital Anxiety and Depression Scale (HADS), and Perinatal Grief Scale (PGS).

Results: Assessments showed a significant decrease in scores over one month: post-traumatic stress (25.9 ± 14.88 to 10.45 ± 8.43), psychological distress (21.72 ± 6.87 to 13.50 ± 4.05), anxiety (8.91 ± 4.53 to 4.27 ± 3.38), depression (7.80 ± 4.39 to 3.98 ± 3.57), and perinatal grief (80.18 ± 14.0 to 67.69 ± 5.63) ($p < 0.001$).

Conclusion: This study reveals the significant psychological impact of terminating a pregnancy due to fetal anomalies on women. It emphasizes the emotional hardships experienced during and after the procedure, noting initial distress followed by differing levels of recovery over a one-month period.

FP2

Prediction of pre-eclampsia using quadruple test in first trimester

Vandana Meena, Upma Saxena

Objective: This study aims to evaluate the effectiveness of first-trimester quadruple test in predicting pre-eclampsia and other fetomaternal outcomes.

Methods: A prospective observational study was conducted at Safdarjung Hospital, New Delhi, over 18 months. Pregnant women with singleton pregnancies between 11-13 weeks +6 days of gestation were recruited. Serum levels of AFP, fβ-hCG, PAPP-A, and PlGF were measured using DELFIA technology and outcomes were monitored until delivery, focusing on the development of pre-eclampsia and other fetomaternal outcomes.

Results: The study population had a mean age of 26.66 years, with a BMI range from 13.5 to 54.54 kg/m². Nearly half of the participants (48.7%) were first-time mothers, and 72.7% had no history of abortion. The mean arterial pressure (MAP) averaged 87.18 mmHg, showing variations linked to age, BMI, and gravidity. Among the biochemical markers, PlGF (MoM) emerged as the most effective predictor of adverse outcomes, including pre-eclampsia, with an AUROC of 0.765. While AFP and hCGb demonstrated variable performance, PlGF consistently performed well across different diagnostic criteria. The majority of deliveries occurred at 38.35 weeks, with 60.3% resulting in normal deliveries and 39.7% in cesarean sections. Additionally, NICU stays and fetal growth restriction (FGR) were observed in 17.2% and 8.1% of cases, respectively.

Conclusion: The first-trimester quadruple test, particularly PlGF (MoM), provides effective early prediction of pre-eclampsia and other adverse fetomaternal outcomes, making it a valuable tool for early risk assessment in pregnancy. This test is particularly useful in low resource settings offering a practical approach to early detection and management.

FP3

Prediction of Preterm Birth Using Quadruple Test in Second Trimester

Geethanjali Gonimadatala, Upma Saxena

Objective: This study aims to assess the effectiveness of the quadruple test, which includes alpha-fetoprotein (AFP), free beta-human chorionic gonadotropin (fβhCG), unconjugated estriol (uE3), and inhibin A, in predicting preterm birth and other feto-maternal outcomes.

Methods: We conducted a prospective observational study at Safdarjung Hospital, New Delhi, involving 200 pregnant women with singleton pregnancies between 15 and 20+6 weeks of gestation. Serum levels of AFP, fβhCG, uE3, and inhibin A were measured. Participants were monitored until delivery, and feto-maternal outcomes were recorded.

Results: The mean age of participants was 26.0 ± 4.05 years, with a mean BMI of 25.80 ± 6.73 kg/m². Average biochemical marker levels were: beta HCG (14.27 ± 13.20), AFP (48.95 ± 49.92), uE3 (6.21 ± 3.29), and Inhibin A (330.00 ± 148.76). Delivery outcomes included 65.0% full-term normal vaginal deliveries, 19.0% preterm vaginal deliveries, 12.5% FT- LSCS and 3.5% PT-LSCS. Significant associations were found between fetal maturity and AFP and Inhibin A levels. Inhibin A demonstrated the highest diagnostic performance (AUROC 0.719), while beta HCG and uE3 showed limited utility (AUROC 0.513 and 0.537, respectively). AFP exhibited moderate diagnostic performance (AUROC 0.64) with high sensitivity but low specificity.

Conclusion: The quadruple test, particularly Inhibin A, shows promise as a predictor for preterm birth, with AFP also providing moderate diagnostic utility. While individual biomarkers varied in effectiveness, combining them improved predictive accuracy. Integrating multiple biomarkers may enhance the prediction of preterm birth and related outcomes, suggesting a need for further research to refine these predictive models.

FP4

Comparison of Modified Shock Index with Shock Index in Predicting Maternal Outcomes in Primary Postpartum Hemorrhage

Nishtha Singh, Upma Saxena

Introduction: Postpartum hemorrhage (PPH), is a major cause of maternal morbidity and mortality. The Shock Index (SI), defined as the ratio of HR to SBP & and the Modified Shock Index (MSI), defined as the ratio of HR to mean arterial pressure (MAP) are tools to assess hemodynamic status.

Objective: To evaluate and compare the efficacy of the MSI with SI in predicting adverse maternal outcomes in primary PPH

Methods: A prospective observational study enrolled 80 women with primary PPH fulfilling the criteria. Data collected included HR, SBP, and DBP, from which MAP, SI, and MSI were calculated and outcomes were recorded.

Results: The mean age of women was 25.26 years, Majority(35.0%) were 2nd gravida with mean gestation of 38.13 weeks. Atonic PPH was observed in 92.5% with the majority(71.2%) having mild PPH. Medical management was effective in 46.2% while balloon tamponad and c-hysterectomy needed for 12.5 & 2.5% respectively. The SI at maximal blood loss with a cutoff of 0.964 had sensitivity, specificity, PPV & NPV of 100%, 77.3%, 48.3%, and 100% respectively. The modified shock index at maximal blood loss with a cutoff of 1.473 had a sensitivity, specificity, PPV & NPV of 100%, 84.8%, 58.3% & 100%, respectively.. The diagnostic accuracy of MSI versus SI was 87.5% versus 81.2% .

Conclusion: This study suggested that MSI was comparable to SI for predicting adverse maternal outcomes in primary PPH. However, MSI had better diagnostic accuracy at maximal blood loss guiding more effective management strategies leading to improved maternal survival.

FP5

Obstetric Admissions to the Intensive care unit of a Tertiary Care Hospital

Tamana, Swarn

Introduction: Analysis of obstetrical admissions to the intensive care unit provides a great opportunity to assess the factors responsible for maternal mortality.

Aims and Objectives: To evaluate the clinical characterstics and outcomes of obstetric admissions to the Intensive care unit in a tertiary care hospital.

Materials and Methods: This was a Prospective observational study which included pregnant and puerperal women (until the 42nd day of postpartum) who were admitted to ICU over a period of 1 year. The clinical and laboratory parameter, including risk factors and outcomes were recorded.

Results: During the study period 18250 deliveries were observed out of which 138 were admitted to our ICU, representing 0.75% of hospital deliveries. Most patients were in age group of 20-30 (74.6%) with 72.47% being multigravida. Most common cause of ICU admission was obstetric haemorrhage (36.2%) followed by hypertensive disorders of pregnancy (29.7%). Only 31.1% patients admitted were on regular antenatal visit. Maternal mortality was seen in 12 patients (8.6%) with septicemia being the most common cause. Women in late trimester, unbooked, multiparous, history of previous Caesarean section are at increased risk obstetrical ICU admissions.

Conclusion: The most common precipitants of obstetrical ICU admissions were obstetric haemorrhage and hypertensive disorders of pregnancy, both of which can be managed well if the patient has regular antenatal visits and investigations. Proper management of obstetrical ICU admissions is a shifting focus from maternal mortality to improved maternal health care.

FP6

Placenta Accreta Spectrum: Tragedy in Chaos, Triumph in Preparation

Shivam Yadav, Divya Pandey, Jyotsna Suri, Sumitra Bachani, Monika Gupta, Zeba Khanam

Placenta accreta spectrum (PAS), previously known as morbidly adherent placenta, is becoming more common due to increasing rates of caesarean sections. A comprehensive sonographic evaluation of all high-risk cases during the 18-22 weeks scan can aid in early diagnosis and appropriate preparation. If missed during antenatal surveillance, it can result in severe outcomes for both the mother and the baby. Through this e-poster, we discuss different cases of PAS where patients received either elective or emergent management based on their initial presentation.

FP7

Neutrophil to Lymphocyte ratio in prediction of severe eclampsia

Gamana Sri, Aishwarya

Introduction: Hypertensive disorders of pregnancy have shown to increase maternal morbidity and mortality. Pregnancy is a controlled inflammatory state.Excessive systemic inflammatory response is basis of clinical manifestation of Pre-eclampsia. Neutrophil to lymphocyte ratio (NLR) is one of markers of systemic inflammation. Many studies have shown relationship between NLR and prediction,classification of severity of Pre-eclamps ia.

Aim: To study role of Neutrophil to Lymphocyte Ratio in prediction of pre-eclampsia with severe features.

Methods: This prospective observational study was conducted in department of obstetrics and gynecology of Safdarjung hospital, New Delhi, India over a period of 18 months.One hundred and twenty Singleton pre-eclampsia pregnant women between 20-36 weeks of gestation were recruited. Routine Antenatal investigations including NLR were done. We followed,managed throughout pregnancy, labor and 1 week after delivery as per standard guidelines for prediction of severe pre-eclampsia and to compare NLR levels at Preeclampsia with organ dysfunction,fetal outcomes.Twenty one out of 120 patients developed severe pre-eclampsia, again Neutrophil to Lymphocyte ratio was calculated.

Results: The NLR value of 3.42 have shown strong predictive value for Severe pre eclampsia from non severe Preeclampsia withAUC of 0.87, sensitivity 90.50%, specificity of 74.70% with p-value <0.0001. With severity of pre-eclampsia,mean NLR levels increases pvalue <0.0001. No association found between NLR at time of enrollment (I.e., Non severe Preeclampsia) with abnormal s.bilirubin,

AST, ALP, Prothrombin time levels. NLR values with a cutoff of 3.41 predicted NICU Admissions with AUC of 0.694, sensitivity 77.80%, specificity 67% not statistically significant p-value =0.054

Conclusion: Measurement of Neutrophil to Lymphocyte ratio increases probability for predicting development of Severe Pre-eclampsia.

FP8

Evaluation of renal resistive index as an ultrasonic marker of acute kidney injury in pregnancy associated sepsis

Shreya Sharma, Bhanu Priya

Introduction: Acute Kidney Injury (AKI) in Pregnancy associated sepsis (PAS) leads to significant morbidity and mortality, hence needs prompt diagnosis. Current diagnostic criteria of rising serum creatinine or decreased urine output are late phenomenon in AKI. Intra renal vasoconstriction is one of the earliest changes of AKI depicted by Renal Resistive Index (RRI) using Doppler ultrasound.

Aim: To evaluate Renal Resistive Index as an ultrasonic marker of Acute Kidney Injury in Pregnancy Associated Sepsis.

Methods: All pregnant, post-abortal and postpartum women presenting with signs and symptoms of suspected maternal sepsis were included. Detailed history, examination and investigations were done for risk assessment. RRI was measured within 24 hrs of admission. AKI was defined as per the KDIGO criteria as AKI stage 1, 2, 3. Any progression in AKI stages and maternal outcomes were followed-up till discharge. Institutional ethical clearance was taken.

Results: We studied 112 subjects. The mean RRI in AKI subjects (n=42) was 0.68 ± 0.07 and in Non-AKI (n=70) was 0.61 ± 0.07. Among AKI subjects RRI values were 0.66 in AKI 1, 0.682 in AKI 2 and 0.71 in AKI stage 3. A cut off value of >0.6875 and >0.711 of mean RRI was calculated as the significant predictor of AKI and AKI 2/3 (AUC of 0.834 and 0.711; sensitivity 76%, specificity 88%).

Conclusion: RRI within 24 hrs of admission is a non-invasive, point of care marker of early prediction of AKI with fair diagnostic accuracy that predicts severity and progression of AKI in PAS women.

FP9

Serum magnesium and calcium in second trimester of pregnancy for prediction of pregnancy induced hypertension

Avya Sinha, Jyotsna Suri, Zeba Khanam, Sumitra Bachani, Divya Pandey, Monika Gupta

Introduction: Pregnancy-induced hypertension (PIH), a major contributor to global maternal morbidity and mortality, is a disorder marked by elevated blood pressure with or without end-organ damage. It is a condition unique to pregnancy that stems from abnormal uteroplacental development, and possibly, altered mineral homeostasis.

Objective: To determine whether estimating serum calcium (Ca2+) and magnesium (Mg2+) levels in the late-second trimester can predict PIH later in pregnancy.

Material and methods: In this prospective cohort study, 225 normotensive gravid women underwent total serum Ca2+ and Mg2+ estimations between 20 and 28 weeks of gestation and at delivery. They were followed up until 48-hours after delivery for the development of PIH (preeclampsia, gestational hypertension, eclampsia).

Results: A total of 52 (23.11%) women developed PIH, of which 14 (6.22%) women had preeclampsia. Although mean (SD) (mg/dl) serum Mg2+ (1.92(0.25) vs. 1.92(0.21); p=0.669) and Ca2+ (8.79(0.38) vs. 8.78(0.38); p=0.696) levels decreased between the second trimester and delivery, levels remained consistently higher in women with PIH. The ROC-AUC of serum Mg2+ for predicting PIH and preeclampsia at 20-28 weeks of gestation was 0.577 (95%CI:0.509, 0.642); p=0.09) and 0.647 (95%CI:0.581, 0.709; p=0.041), respectively; for serum Ca2+, the values were 0.544 (95%CI:0.476,0.61; p=0.359) and 0.558 (95%CI:0.491, 0.62; p=0.46), respectively. At a serum Mg2+(mg/dl) cut-off value of >1.9, the sensitivity of predicting preeclampsia was 92.96%, with a NPV value of 98.3%.

Conclusion: Total serum Ca2+ and Mg2+ levels decrease from the second to third trimesters of pregnancy. A total serum Mg2+ level of >1.9 mg/dl at 20-28 weeks of gestation is a relatively inexpensive screening tool that can fairly predict preeclampsia later in pregnancy.

FP10

Role of Systemic immune inflammatory index (SIII) as predictor for Gestational diabetes mellitus and fetomaternal outcome: A cross-sectional analysis

Aparna Baranwal, Banashree Nath

Introduction: Pregnancy is a diabetogenic state with altered inflammatory profile in which there is hyperinsulinemia along with insulin resistance in an effort to provide nutrition to the foetus. This inflammation can serve as marker of development of Gestational diabetes mellitus (GDM). The systemic immune inflammatory index (SIII) had been used in the prognosis of cancer and its role in the prediction of GDM is being investigated now. SIII is calculated as (neutrophils × platelets/ lymphocytes) and expressed as 10*9 cells/L.

Aim: To study the role of SIII in prediction of the development of GDM and compare the fetomaternal outcome in women with and without GDM.

Method: Eighty patients with GDM and eighty patients with low risk pregnancy were recruited and records were collected from C-DAC's Hospital Management Information System.Their SIII values in 1st and 3rd trimesters were calculated and comparison done.

Results: Demographphic profile analysis revealed no significant difference between the two groups. SII values revealed significant difference in first trimester and third trimester (P<0.05) in both the groups. There was significant difference between birthweight of babies in GDM and non-GDM groups(P=<0.001). The birthweight varied significantly (P=0.021) even in GDM patients whose blood sugar was controlled with diet alone and drugs (OHA or insulin).

Conclusion: SIII can serve as a useful marker for prediction of development of GDM. Women who needed either OHA or insulin for control of blood sugar had higher chances of delivering babies with higher birthweight.

FP11

Fetomaternal outcome in preeclampsia / eclampsia women with posterior reversible encephalopathy syndrome

Salimun Nisa, Upma Saxena

Introduction : Posterior reversible encephalopathy syndrome (PRES) is a typical neuroradiological syndrome with an incidence of 0.01% and characterized by neurological symptoms such as headache, visual impairment, focal neurological deficit, seizure (most commonly GTCS), altered mental status. It can be diagnosed by CT scan and MRI. PRES is seen to be associated with adverse fetomaternal outcomes.

Aim : To study fetomaternal outcomes in women with PRES in preeclampsia /eclampsia with neurological symptoms and frequency of women diagnosed with PRES in preeclampsia/eclampsia with neurological symptoms.

Method : This was a prospective observational cohort study conducted on 64 singleton pregnant women more than 20 weeks of gestation with preeclampsia/eclampsia with neurological symptoms in the Department of Obstetrics and Gynaecology, VMMC and Safdarjung hospital, New Delhi. Study duration was 18 months.

Results and Conclusion : Adverse fetomaternal outcomes i.e. HDU/ICU stay, need for intubation, abruption, postpartum hemorrhage, caesarean section rate, FGR, prematurity, RDS, MSL and low 1 and 5 minute APGAR score were significantly higher (p value <0.05) in women with PRES. PRES was observed more in women with antepartum eclampsia, primigravida and younger age group and frequency of PRES in the women having preeclampsia/eclampsia with neurological symptoms was found to be 62.5%. According to this study NCCT head can be effectively used as primary radiological modality for making diagnosis of PRES where MRI is not be available.

FP12

High normal blood pressure and development of hypertensive disorders of pregnancy

Harsha Jodwal, Harsha S Gaikwad

Introduction: A latest review of literature focused on correlation of new onset high normal blood pressure and development of hypertensive disorder of pregnancy.

Aim: To estimate the occurrence of hypertensive disorders of pregnancy in pregnant women with high normal blood pressure and to study the feto-maternal outcomes.

Method: A Prospective Cohort study conducted

on 150 women with persistent high normal blood pressure (130-139/ 80-89) from >20 weeks of gestation attending the routine antenatal clinic. These women were followed up till delivery. The characteristics of women with high normal blood pressure range who developed hypertensive disorders of pregnancy as Gestational hypertension, Pre-eclampsia, or Eclampsia were studied and analysed. All women were managed as per institutional protocol. The maternal and neonatal outcomes were recorded.

Results: A total of 150 women were recruited in the study, the mean age of the study population was 25.65 ± 3.32 years and the mean POG at development of HDP was 31.17 weeks. In this study, 31 (20.7%) of the participants had developed gestational hypertension, 15 (10.0%) of the participants had developed preeclampsia, 4 (2.7%) of the participants had developed HELLP syndrome. There was a strong positive correlation between high normal blood pressure and development of gestational hypertension and preeclampsia and this correlation was statistically significant (p = <0.001).

Conclusion: Hypertensive disorders of pregnancy affected 50 (33.3%) women, 31 (20.7%) had gestational hypertension, 15 (10%) had preeclampsia and 4 (2.7%) had HELLP syndrome. Antepartum hemorrhage and intrauterine demise were also found in these women.

FP13
Prediction of Preeclampsia in high risk pregnancies by using sFlt/PlGF ratio
Prashanth S Uppin, Anjali Dabral

Objectives: To determine sFlt/PlGF ratio cutoff for predicting preeclampsia in high- risk women attending antenatal clinics and to compare the new cutoff with the previously established sFlt/PlGF ratio cutoff of 38 for predicting preeclampsia in these women.

Material & Methods: This prospective observational double-blind cohort study was conducted from August 2022 to January 2024 on 120 pregnant women at high risk of development of preeclampsia due to the presence of chronic hypertension, gestational hypertension, or FOGSI GESTOSIS score ≥3. Women with preeclampsia were excluded. The main outcome measure was the development of preeclampsia.

Results: The sFlT/PlGF ratio cutoff for the development of preeclampsia at 1 week and 4 weeks with AUC 0.79 and 0.87, respectively, was 25. The sensitivity, specificity, PPV, and NPV of sFlT/PlGF ratio cutoff of 25 for the development of PE within 1 week and four weeks was 100.0%, 56.6%, 23.3%, 100.0%, (p<0.001) and 100.0%, 66.7%, 50.0% & 100.0%, (p<0.001), respectively, Table 3. On applying the sFlT/PlGF ratio cutoff of 38 for prediction of PE at 1 week and 4 weeks, the sensitivity, specificity, PPV, and NPV were 64.3%, 67.0%, 20.5%, and 93.4% (p=0.023) and 63.3%, 72.2%, 43.2%, 85.5% (p=0.023), respectively. The sFlT/PlGF ratio cutoff of 25 for the development of preeclampsia at 1 week and 4 weeks had 100% NPV compared to 93.4% and 85.5%, respectively, for the sFlT/PlGF ratio cutoff of 38.

Conclusion: sFlt/PlGF ratio cutoff of 25 can be used for predicting preeclampsia in Indian women with better accuracy than cutoff of 38.

FP14
Antiphospholipid syndrome in preeclampsia with severe features and fetal growth restriction
Himakshi Boro

Introduction: Antiphospholipid syndrome (APS) is a systemic autoimmune disorder that is characterized by the presence of antiphospholipid antibodies (aPL), which are associated with an increased risk of thrombosis and adverse pregnancy outcomes. This study is proposed to find the relation between antiphospholipid syndrome, and preeclampsia with severe features and FGR due to placental insufficiency.

Aim: To determine the proportion of antiphospholipid syndrome in women with preeclampsia and fetal growth restriction due to placental insufficiency.

Methods: A prospective, case-control study of 50 women who delivered at <36 weeks ± 6 days due to preeclampsia with severe features or fetal growth restriction was compared with 50 matched controls. Cases and controls were tested for aPL. The positive subjects for any of the three parameters were retested after 12 weeks. Positive aPL was defined as positivity for lupus anticoagulant (LAC), or anti-cardiolipin (aCL) IgG or IgM, or anti-β2-glycoprotein I (aβ2GPI) IgG or IgM.

Results: Two cases (4%) with aPL positivity in two consecutive samples, 12 weeks apart were diagnosed with APS. None of the controls were tested positive for APS. Of all the parameters, only LAC positivity was seen amongst the cases. aPL positivity in patients with preeclampsia and FGR sub-group was 8.3% and 3.3% respectively.

Conclusion: So far, it is recommended to test for aPL antibodies in inter-pregnancy interval. The validity of testing when the patient is pregnant also needs to be evaluated. More studies are required to be done with strict compliance with clinical and laboratory criteria for APS.

FP15

Assiciation of Serum Leptin Levels with Induction of Labour

Priya Lal

Induction of labour (IOL) is a common practice in obstetrics, expected to rise over time. It poses challenges, especially in nulliparous women, with a significant failure rate leading to emergency operative deliveries. High-risk pregnancies further increase the risk of induction failure. Leptin, a key regulator of energy balance, has been implicated in various physiological processes, including myometrial contractility, suggesting its involvement in labor dysfunction and induction outcomes. Obesity, a known risk factor for induction failure, is associated with elevated leptin levels and numerous complications during pregnancy and delivery, including an increased risk of Cesarean section. In this study, serum leptin levels were estimated in pregnant females undergoing induction of labour at term and to determine the association between plasma leptin levels and the outcome of induction of labour.

Elevated serum leptin levels were significantly associated with failed induction, with levels >2.5 ng/mL, predicting failure of induction. Furthermore, leptin levels were higher in participants with conditions like hypertension, PROM, diabetes, and fetal growth restriction.

The study contributes valuable clinical evidence regarding the association between maternal serum leptin levels and induction failure. Using serum leptin as a predictive marker aids in clinical decision-making and resource optimization, especially in settings with limited resources.

FP16

To Assess the role of Myoinositol and Metformin on clinical,metabolic and hormonal profile of patients with PCOS

Manisha Navani

Introduction & Methods: The aim of the study is to assess the Role of Myoinositol & Metformin on clinical,

hormonal & metabolic profile of patients in Poly cystic Ovarian Syndrome. The women started with the intake of

Myoinositol at a dosage of 2000 mg and 500 mg metformin used for a period of 01 Year. The primary outcome of the

study was to determine the restoration of normal menstrual cycles, improvement in acne, reduction in hirsutism, weight
loss & fertility.

Results: We found maximum cases in 25-29.9 i.e. 51%. BMI - The chi-square statistic is 0.0003. The p-value is

.047363. The result is significant at $p < .05$. Mean fasting blood glucose - 93.44±8.27. Mean Ultrasound Pelvis -

16.92±4.48 & Mean TSH - 2.73±2.66

Conclusion: In the present study, both Metformin and MI were equally effective in improving the clinical, metabolic,

and hormonal profile in PCOS patients. BMI was significantly reduced by both the metformin and MI after 12 weeks

of treatment. According to the available evidence on this molecule derived from inositol, MYO should be considered

an effective and safe treatment for obese and non-obese women with PCOS with insulin resistance and

hyperinsulinemia, administered with the aim of improving oocyte quality and maturation and the reproductive

prognosis in patients. Treatment with metformin (MET) ameliorated the insulin sensitivity and decreased the

androgens levels, but the limitations to MET use are its gastrointestinal side effects.

Keywords: Assess, Myoinositol, BMI, Metformin, Menstrual cycle & Poly cystic Ovarian Syndrome

FP17

To study the effectiveness of surgical bundle in reducing Surgical Site Infection following caesarean deliveries

Sneh Tanwar

Introduction: Surgical site infection is the most common complication following caesarean section and results in higher maternal morbidity and mortality. Surgical site infections are also a major cause of prolonged hospital stay and comprise a large burden to healthcare system. Thus, there is an urgent need to identify ways to reduce wound complications.

Aim: To study the effectiveness of surgical bundle in reducing Surgical Site Infection following caesarean deliveries.

Methods: A prospective cohort study was conducted in the Department of Obstetrics and Gynaecology in Deen Dayal Upadhyay Hospital, Delhi from April 2021 to June 2022 and included 620 women undergoing emergency caesarean section.

A surgical bundle comprising of:

(i) pre-operative antibiotic prophylaxis- Inj Ceftriaxone 1gm i.v after skin sensitivity testing at the time of skin incision.

(ii) Preoperative vaginal cleaning with betadine 5% after Foleys catheterisation and before abdominal scrubbing.

(iii) Chlorhexidine - alcohol solution (2.5% chlorhexidine + 70% ethanol) for skin preparation, was tried to be implemented in emergency caesarean deliveries.

Patients were divided into two groups on the basis of surgical bundle adherence and implementation. Group 1(n=310; surgical bundle not used) and Group 2 (n=310; surgical bundle used). Patients were followed for 30 days postoperative period for surgical site infection.

Results: There was a significant decrease in number of surgical site infections in the group where the surgical bundle was used (all three measures applied). Rates of SSI in surgical bundle not used vs used were 41/310 (13.2%) vs 19/310 (6.1%) respectively with p-value <0.001.

Conclusion: As there is more than 50% reduction in rates of surgical site infection it is concluded that use of a combination of evidence based surgical measures significantly reduce surgical site infection in caesarean deliveries.

[Informed consent was taken from all the subjects. Approval from scientific review committee and Institutional Ethics Committee -Deen Dayal Upadhyay Hospital were taken prior to study (IEC-DDUH/upn20/2021-03-16/20/v1;16/03/2021)]

FP18

Effect of change in the position of parturient in second stage of labour on the mode of delivery

Aishwarya Arikatla, Suman

Introduction : Rising institutional deliveries have lead to increasing caesarean section rates in India. Of the various interventions proposed by WHO to reduce caesarean section rates one of them was to adopt alternate positions in second stage of labour.

Aim : To determine the effect of labour positions in second stage of labour on mode of delivery.

Methods: This prospective observational study was conducted in the department of obstetrics and gynaecology of Safdarjung hospital, New Delhi, India over a period of eighteen months . Two hundred and ten women in second stage of labour were counselled and educated about various labour positions .We followed patients who adopted supine, kneeling and squatting positions in second stage of labour and divided them into three groups according to the choice they made The groups were followed for effect on mode of delivery, Foetal distress,second stage duration, post partum heamorrhage and perineal tears.

Results: Age and literacy of the patient, gestational age, parity, booking status, need for augmentation were comparable in the three groups. When upright positions (squatting and kneeling together) were compared with supine position there was a significant increase in normal vaginal delivery rate p value-0.039, decrease in duration of second stage of labour p<0.001, increase in second degree perineal tears p<0.005. There were also fewer fetal heart deccelerations p<0.001 and no difference in amount of blood loss p<0.196 or rate of NICU admissions.

Conclusion: Delivery in upright position increases the probability of vaginal delivery

FP19

Effect of oral misoprostol for cervical ripening in term pre-mature rupture of membrane

Shalini Parashar, Krishna Agarwal

Introduction: Labor induction is beneficial for term PROM patients as it lowers infection

risks without raising caesarean rates. Prostaglandins, which ripen the cervix and stimulate

contractions, are commonly used for this purpose.

Aim: To study effect of oral misoprostol for cervical ripening in term pre-mature rupture of

membrane in terms of oxytocin requirement.

Methods: Conducted at the Department of Obstetrics & Gynecology at Maulana Azad Medical College and associated Lok Nayak Hospital from September 2022 to February 2024, this open label randomized controlled trial included 164 participants. Participants were randomly assigned to either the oral misoprostol group or the intracervical PGE2 group, with 82 women in each. All participants were pregnant women with term PROM, selected based on specific inclusion and exclusion criteria.

Results: The study found that oral misoprostol led to a reduced need for oxytocin compared to intracervical PGE2, with a lower maximum dose and shorter administration time. The interval from induction to vaginal delivery was also shorter with oral misoprostol. No significant differences were observed in Bishop score changes or hyperstimulation rates between the two groups. However, failed induction and subsequent caesarean sections were more common in the PGE2 group. Neonatal outcomes were similar across both groups.

Conclusion: Oral misoprostol is an effective alternative to intracervical PGE2 for labor induction in term PROM, notably reducing the need for oxytocin and resulting in a shorter time from induction to delivery. It offers comparable efficacy and safety to PGE2 in improving the bishop score.

FP20

Fetal biometric parameters and ultrasonographic markers in gestational diabetes mellitus

Akanksha gupta

Introduction: Diabetes, including gestational diabetes mellitus (GDM), poses significant public health challenges, with GDM affecting 5-25% of pregnancies worldwide. In India, about 4 million women are affected. GDM can lead to complications like macrosomia, preterm delivery, and increased future diabetes risk. Effective screening and treatment can reduce adverse outcomes. Recent studies suggest ultrasound markers and fetal biometric parameters might aid in early GDM diagnosis and management, improving screening timing and outcomes.

Aim: Comparison of mid trimester fetal Biometric parameters and ultrasonographic markers in gestational diabetes mellitus (GDM) pregnancy with non GDM pregnancy

Method: In this case-control study, 70 pregnant women underwent ultrasonographic evaluation between 24 and 28 weeks of gestation: 35 with gestational diabetes mellitus (GDM) and 35 without. Both groups were assessed with an obstetric ultrasound scan, measuring fetal biometry (biparietal diameter, head circumference, abdominal circumference, femur length), adipose subcutaneous tissue thickness, cardiac width, cardiac circumference, intraventricular septum thickness, amniotic fluid volume, placental thickness, placental grading, and umbilical cord diameter.

Result: Seventy patients were included, with 35 having GDM. Significant differences were observed in head circumference (p=0.033), abdominal circumference (p=0.002), femur length (p=0.004), and other markers like ASCT, cardiac width (p=0.001), cardiac circumference (p=0.001), and IVS (p=0.001), all higher in GDM pregnancies. The mean amniotic fluid index was 156.37±3.8 mm for GDM cases versus 153.37±2.16 mm for controls (p=0.017), and the mean placental thickness was 40.01±2.79 mm in cases compared to 38.41±3.01 mm in controls (p=0.002).

Conclusion: Early ultrasound evaluation can aid in the timely detection and management of GDM-related complications.

FP21

Role of Sham Feeding in Postoperative Recovery of Gastrointestinal Motility in Low-Risk Caesarean Section

Suman Kumari, Arikatla Sai Aiswarya

Introduction: Caesarean section is the commonest obstetric surgery worldwide. In India caesarean section rates are as high as 47.4% in private sector and 14.3% in public health facilities, burdening the hospital infrastructure. This study was done to evaluate the role of sham feeding for early postoperative recovery of gastrointestinal motility in low-risk caesarean section and its effect on hospital stay.

Aim: To find the effect of sham feeding in postoperative recovery of gastrointestinal motility in low-risk caesarean section.

Method: This was a prospective observational study conducted in VMMC and Safdarjung hospital, on 280 postoperative caesarean section patients, which were subdivided into two groups, Group I included patients in whom chewing gum was given within 2 hours of caesarean section and repeated two hourly, Group II included patients who were managed as per hospital protocol.

Result: In group I the mean time of appearance of first bowel sound was 7.92 hours which was significantly reduced compared to 14.14 hours in group II. In group I mean time for passage of first flatus, stool and hospital stay were also significantly reduced as compared to group II. The time for appearance of bowel sound and passage of first flatus and stool were reduced significantly when gum was chewed two hourly as in our study as compared with studies where it was chewed eight hourly.

Conclusion: Chewing gum in the post-operative period is a safe and low-cost intervention to improve patient well-being and early discharge.

FP22

Comparison of Single foley catheter with Double foley catheter in cervical ripening of nulliparous women

Sowmiya K, Sangeeta Gupta

Introduction: Induction of labour is in practice since 18th century. Several methods are available for ripening of the cervix. Ripening efficacy of a balloon catheter is as good as pharmacological methods. This study compares single foley catheter with indigenous double foley catheter in cervical ripening in nulliparous women.

Aims: To compare the efficacy of Single foley catheter versus Double foley catheter in cervical ripening in nulliparous women.

Methods: Prospective randomised study was conducted from February 2023 to February 2024 at a tertiary care centre at New Delhi. 200 nulliparous women planned for induction of labour with unfavourable cervix with singleton viable pregnancies were randomly allotted into 2 groups. Group 1 induced with single foley device inflated with 50cc saline. Group 2 induced with indigenously made Double foley catheter with 50cc saline in both balloons.

Results: There was significant improvement in Bishop score post device expulsion in SFC group (3.85±1.6) versus DFC group (3.12±1.49) p=0.001.76% of DFC group had successful cervical ripening as compared to 67% in SFC group. (p=0.046). Device insertion to delivery interval was significantly more in the DFC group than SFC group (p=0.019). LSCS due to failed induction was comparable in both groups (p=0.355).

Conclusion: We have observed that there is better cervical ripening, greater duration of device retention and greater duration of device insertion to delivery interval in the DFC group as compared to SFC group. However, overall rate of LSCS, LSCS due to failed induction, maternal adverse events and neonatal outcome were comparable between both the groups.

FP23

Evaluation of patient satisfaction with conservative management of pelvic organ prolapse

Sanjeevani Nanda, Monika Gupta

Introduction: There are both conservative and surgical approaches for the management of pelvic organ prolapse (POP).

Aim: To evaluate patient satisfaction with use of pessary as compared to pelvic floor muscle training (PFMT) for conservative management of POP

Methods: In this prospective cohort study, after baseline symptom bother evaluation, women with symptomatic POP opting for pessary or PFMT were recruited (30 participants each). At the end of 3 months, participants were evaluated for willingness to continue the chosen option.

Results: Overall, 68.3% of the participants were

willing to continue the ongoing conservative approach with no significant difference between the pessary and PFMT groups (p = 0.165). The change in symptom bother scores over 3 months was significantly greater in those who were willing to continue pessary treatment. Baseline PFDI score was significantly greater in participants not willing to continue PFMT. A higher grade of prolapse at presentation was not predictive of willingness of the patient to continue the treatment. Reasons for dissatisfaction included the treatment being cumbersome, non-achievement of desired symptomatic relief, the development of vaginal discharge or pain / discomfort / erosion (in case of the pessary group) and multiple follow-ups. Pessary use, despite significantly greater symptomatic and anatomical improvement, had a significantly greater proportion of participants opting for prolapse surgery at the end of the study interval.

Conclusion: Patient satisfaction was comparable between the pessary and PFMT groups for the management of POP. Key factors contributing to favorable outcome were symptomatic improvement and the absence of side effects. Pessary group had side effects of vaginal discharge, pain, discomfort and erosions leading reduced patient satisfaction.

FP24
Comparison of clinical and ultrasound fetal weight estimation in predicting actual birth weight

Gandi Revathi Sai Prasanna, Upma Saxena

Introduction : Fetal weight estimation is one of the most important factor in deciding the management of patient, mode of delivery, newborn outcome and its survival. The effective fetal weight is an important parameter to predict birth outcome when calculated few days before delivery. Fetal weight at the either ends of the spectrum are associated with higher risk of fetal-maternal complications. Fetal weight estimation is mainly of two types: clinical and ultrasound. In countries where ultrasound is not easily accessible, clinical method is relied on. Inaccurate estimation leads to greater harm ,hence this study was undertaken.

Aim: To compare fetal weight estimation by clinical and ultrasound method with actual birth weight.

Method : This was a Prospective Observational cohort study on 200 Term pregnant women admitted in ward or labour room and expected to deliver within 72 hr in department of Obstetrics and Gynaecology, VMMC and Safdarjung hospital, New Delhi. Study duration was 18 months.

Results and conclusions: The mean (SD) of Clinical, USG estimated and actual fetal weights were 2790.95 (429.48) and 2736.86 (429.37) and 2622.90 (423.74), respectively. The sensitivity, specificity, PPV and NPV of clinical fetal weight estimation are 81.8%, 94.5%, 84.9% and 93.2% in producing results as of ultrasound with a diagnostic accuracy of 91%.There was a statistically significant agreement between the clinical and USG estimated fetal weights with actual fetal weight, showing that both clinical Fetal weight and USG estimated fetal weight were effective in predicting actual fetal weight after birth.

FP25
Ease the Pain: How Birth Companion Transform Labor Comfort!

Pragya Saini

A Non-Randomized Interventional study was conducted in the Department of Obstetrics and Gynecology at Maulana Azad Medical College and Lok Nayak Hospital, New Delhi which enrolled 150 singleton, nulliparous women intending to deliver at LNH, after obtaining informed consent. Participants were categorized into two distinct groups: the Birth Companion group, comprising women accompanied by a birth companion during active labor, and the Control group, consisting of women without birth companion. Pain perception during labor was measured through the Visual Analog Scale (VAS) score, alongside the assessment of the need for pharmacological analgesia. Anxiety levels were measured using VAS scores immediately after delivery. The outcomes yielded a statistically significant reduction in pain scores, decreased requirements for pharmacological analgesia, lower anxiety scores, shortened labor durations, and decreased necessity for labor augmentation with synthetic oxytocin among women with birth companion in comparison to those without birth companion.

The study highlights a significant connection between birth companion and women's perception of labor pain, their need for pain relief and their satisfaction levels after delivery. This study underscores the critical need to increase awareness among both patients and healthcare professionals

about the essential support and comfort that birth companions offer during labor.

FP26
Evaluation of cesarean section rates by using Robson ten group classification system in newly tertiary established hospital in northern India

Lashyatha Muppavarapu, Banashree Nath

Introduction: Cesarean section (CS) rates have recently been rising increasingly for patient and clinician related factors.World health organisation has proposed Robson ten group classification to assess cesarean rates at all levels globally.New health care set up has innumerable challenges in process of its rise to a capacity of institution for delivering comprehensive health care services. Impact of this process on obstetric services including mode of delivery has not been investigated.

Aim: This study aims to analyse cesarean rates using Robson classification at new tertiary setup in Northern India.

Methods: This is facility based cross sectional study in newly started tertiary teaching hospital. Data collected from medical records of all women who delivered from inception to July 2024 and are categorized using Robson ten group classification into 10 groups.Overall CS rate was calculated and contribution of each group to overall CS rate was calculated.

Results: A total of 715 women delivered during the period of 23 months out of which 530 (74 %) women delivered by caesarean section. Analysis of cesarean rates using Robson classification revealed R5 group to have highest contribution 166 (23 %) followed by R2 group 153 (21%), R1 group 99 (13.8 %) and R10 42 (5.86 %).

Conclusion: Labour monitoring and emergency services including cesarean deliveries are to be optimized in respect to availability of manpower and logistics particularly in new institution.Vaginal delivery after cesarean section and those who are induced for labor need special attention for ensuring safe delivery in these patients who need intense labour monitoring.

FP27
Evaluation of labour care guide for labour management in low risk pregnancy

Dhruthi. S, Shakun Tyagi

Introduction: An estimated 287,000 maternal deaths, 1.9 million stillbirths, 2.4 million neonatal fatalities, occur each year, with low-and middle-income countries (LMICs) accounting for the majority of these cases. Up to 45% of these deaths occur during labour, delivery, and the first 24 hours postpartum, and they are generally avoidable with timely interventions. Improving the quality of care around the time of birth has been found to be the most impactful strategy. The WHO Labour Care Guide (LCG), a "next generation" partograph, was created in December 2020 and recommends that the LCG to be used as a standard part of clinical care worldwide to enhance the quality of intrapartum care, decrease the use of unnecessary interventions, and better assist women throughout birth. Nevertheless, no such approach has been examined in a randomized study because the LCG is an entirely novel tool. Thus, in order to evaluate the impact of implementing LCG into practice and take an initiative to encourage its use in labour rooms, we carried out this study trial.

Aims

1) To evaluate the use of Labour Care Guide, as compared to modified WHO Partogram, on Cesarean Section rate amongst Low-risk women in active labour.
2) Evaluate the effect of implementing the Labour Care Guide strategy on women's, fetal and neonatal health and process of care outcomes

Method: Non-randomised interventional study.

Results & Conclusions: The WHO LCG is a complex-looking yet simple and feasible labour-monitoring tool for the reducing primary cesarean delivery rate without increasing fetomaternal complications & emphasizing respectful maternity care.

FP28
Exploring Hysteroscopy's Diagnostic Accuracy for Chronic Endometritis in Infertile Women: Precision Assessment

Anushka Gupta, Renu Tanwar

The study aimed to evaluate the diagnostic accuracy of hysteroscopy in detecting chronic endometritis (CE) in infertile women, using CD138

immunohistochemistry (IHC) as the gold standard. Conducted at Maulana Azad Medical and Lok Nayak Hospital, New Delhi, over 18 months, the non-randomized cross-sectional study involved 153 infertile women. Patients with acute pelvic inflammatory disease or active tuberculosis were excluded. Hysteroscopy was performed between days 7 and 10 of the menstrual cycle under paracervical block, assessing for CE indicators like focal or diffuse hyperemia, micropolyps, strawberry aspect, and stromal edema. Following hysteroscopy, an endometrial biopsy was obtained for CD138 IHC staining, with CE defined by the presence of one or more plasma cells per ten high power fields.

The study found hysteroscopic findings indicative of CE in 47.1% of participants, while CD138 IHC was positive in 48.4% of cases. The sensitivity, specificity, positive predictive value, negative predictive value, and diagnostic accuracy of hysteroscopy for CE were 83.78%, 87.34%, 86.11%, 85.19%, and 86.62%, respectively. These results show a statistically significant correlation between hysteroscopic findings and CD138 IHC expression for CE.

The study concludes that hysteroscopy is an effective diagnostic tool for CE, offering accuracy comparable to CD138 IHC. It provides a non-invasive alternative to endometrial biopsy, preserving endometrial integrity, and potentially improving diagnostic accuracy in clinical settings.

FP29

Role of second trimester ultrasound ion prediction of placenta accreta spectrum syndrome

Smriti Thakur, Sangeeta Gupta

Introduction: The term placenta accreta spectrum syndrome refers to the abnormal placentation disorder characterized by the abnormally adherent placenta. This study focuses on the prediction of placenta accreta syndrome in antenatal women via ultrasonography in second trimester.

Aim: To study the accuracy of a second trimester ultrasound-based PAS staging system in predicting the Placenta Accreta Spectrum Disorder (as defined by FIGO classification system).

Material Tnd Methods: Prospective observational study was conducted on 70 pregnant women in their second trimester attending the Antenatal Care Outpatient Department at LNH in high-risk population. Ultrasound findings determined the PAS stage. A follow-up scan conducted at 34-36 weeks of gestation. Diagnostic accuracy of ultrasound in prediction of PAS on second trimester ultrasound was calculated and correlation was drawn between the USG-PAS staging system and FIGO classification system.

Results: Out of the 70 patients in our study, a total of 22 patients underwent hysterectomy. Considering histopathological examination as the final diagnosis of placenta accreta syndrome, the sensitivity, specificity, PPV, NPN as 100%, 83.3%, 71.4% and 100% respectively. Overall diagnostic accuracy of USG in assessing PAS disorder was 88.6%

Conclusion: Second trimester ultrasound was found to be a very useful tool in prediction of placenta accreta spectrum disorder when done in high-risk population. The results were statistically significant and the diagnostic accuracy of second trimester ultrasound in diagnosing high risk cases predisposed to PAS was 88.6%. Absence of USG features does not rule out of the possibility of PAS. Further work needs to be done.

FP30

In Time Communication About Critically Ill Obstetric Patients to Labour Room Team Saves Life: A Quality Improvement Study

Manisha Jhirwal, Pratibha Singh, Mahaveer Rodha

Introduction: The labor room team should be informed in time about pregnant women who are critically ill so that better fetal and maternal outcomes can be achieved. The lack of communication between the emergency team and the labour room team may result in adverse obstetrical outcomes. It has been observed that the patient often waits for a long time to be informed of the situation to the labor room team. The study aimed to improve communication between emergency and labor room team about the critical pregnant patients within one hour of presentation from baseline of 60% to 100%.

Methods: A quality improvement study has been conducted in health care institute. The study included all the critically ill pregnant and post-natal patients requiring ICU care reporting in emergency department. It was conducted as Plan Do Study Act

(PDSA) cycle in three phases for the period of 16 weeks with FISHBONE tool analysis.

Results: The baseline assessment showed that only 6 out of 10 patients (60%) critically ill patients were informed by emergency team to labour room team within one hour of arrival in emergency department. We conducted a PDSA cycle 3 times and achieved the target of 100% in 3rd PDSA cycle.

Conclusions: This study shows that effective team work leads to improved feto-maternal outcomes in critically ill patients. A significant reduction in maternal morbidity and mortality can be achieved by triaging the patient to effective and structured care and timely informing the patient to the concerned department.

FP31
A cross-sectional study to evaluate the satisfaction of low-risk pregnant women regarding Midwife-led antenatal care in a tertiary care facility in India

Preethy Dinesan

Background: The WHO suggests that introducing a comprehensive midwifery care package could prevent 83% of maternal deaths, stillbirths, and neonatal deaths. Subsequently, Government of India recognizes Midwifery care is one of the many initiatives to improve quality care in a respectful and dignified manner. The antenatal care is the primary barometer to ensure maternal and fetal health. Utilization of antenatal care services depends on many factors including the satisfaction of care provided.

Objective: The study aimed to evaluate the satisfaction levels of low-risk pregnant women regarding the antenatal care provided by Nurse-Midwives.

Method: After ensuring the items' content validity, we developed a questionnaire by exploratory factor analysis which contains 18 items under four factors. The data was collected through this interviewer-administered structured questionnaire. This descriptive cross-sectional study included 60 low-risk multi-gravid women selected through purposive sampling at the antenatal OPD of a tertiary care facility in India, who have been facilitated by Nurse-Midwives for their antenatal care. The collected data was coded in an Excel sheet and analyzed using SPSS IBM version 23.

Results: Respectful Maternity Care received an average score of 27.87 out of a possible 30 (92.89%), indicating high satisfaction. Comfort and Safety received an average score of 15.68 out of 20 (78.42%), suggesting a moderate level of satisfaction. Antenatal Education was highly rated with an average score of 18.77 out of 20 (93.83%), indicating strong satisfaction with educational components. Privacy & Preparation for Motherhood scored 18.20 out of 20 (91.00%), Combining all these factors, Overall satisfaction yielded an average score of 80.52 out of 90 (89.46%). No participants were dissatisfied in any aspect of antenatal care led by midwives, indicating a generally high level of satisfaction with the comprehensive antenatal care experience provided by Nurse - midwives.

Discussion: The study findings are identical with 'the projected effect of scaling up midwifery' the Lancet Series on Midwifery (2014), the State of the World's Midwifery Report (2014), which revealed that women received midwife led care were more satisfied.

Conclusion: Midwife led care aims to provide pregnant women with respectful individualized, person-centered care at every contact, with the implementation of effective clinical practices and the provision of relevant and timely information which makes antenatal care more satisfied.

FP32
A comparative study to find efficacy of 2.5mg versus 5 mg dose of Letrozole for ovulation induction in patients with PCOS. Letrozole

Manisha Navani

Background: Polycystic Ovarian Syndrome PCOS accounts for over 75% of anovulatory infertility. Letrozole is an effective alternative to clomiphene citrate as a first line drug for ovulation induction in women with PCOS. Letrozole has a definitive role in anovulatory women who have not responded to the clomiphene citrate therapy.

Aim: The objective of this study is to compare the safety and efficacy of two doses of Letrozole 2.5 mg and 5 mg as ovulation induction drug in infertile women with PCOS.

Materials and methods: This was a comparative observational study. After fulfilling the selection criteria, total 90 females of PCOS were enrolled and randomly divided into two equal groups. One is treated with Letrozole 2.5mg and other is 5mg,

starting from the 2nd day of menses for 5 days.

Socio-demographic parameters, duration of infertility, ovulation rate, number of matured follicles, endometrial thickness, primary and secondary outcome were measured.

Results: There is no statistical significant difference found between Letrozole 2.5mg and Letrozole 5mg group in terms of socio-demographic and clinical characteristics (P>0.05). The ovulation rate was slightly higher in Letrozole 2.5mg group (96%) as compared to Letrozole 5mg group (92%), but not statistically significant (p>0.05). There was no significant difference in number of days to achieve follicular maturity and mean endometrial thickness at hCG administration between both groups (p>0.05). The common side effects of Letrozole therapy were nausea, dizziness and ovarian cyst formation

Conclusion: This study has shown that both the doses 2.5 mg and 5 mg Letrozole have equal effectiveness for ovulation induction and it recommends the use of 2.5 mg letrozole dose for initiation of ovulation induction in PCOS.

FP33
Does CTG chorioamniotis really exist?

Tanya Grover, Sumedha Sharma, Aruna Nigam

Chorioamnionitis is the inflammation of chorion and/or amnion. Subclinical/histologic chorioamnionitis which is more common than clinical chorioamnionitis, is asymptomatic and defined by inflammation/neutrophilic infilteration of the chorion, amnion, and placenta or umbilical cord without any clinical signs/symptoms. In prior studies, 'CTG CHORIOAMIONITIS' was diagnosed either based on a persistent rise in the baseline for the given gestation or on a persistent increase in the baseline fetal heart rate during labor >10% without preceding CTG signs of hypoxia and in the absence of frank clinical chorioamnionitis. In our study, we assess the cardiotocographic changes along with maternal and neonatal outcomes in patients with histopathologically confirmed chorioamnionitis. 43 patients had subclinical chorioamnionitis of which only 51.1% patients had CTG abnormality whereas 48.9% patients without subclinical chorioamnionitis also had CTG abnormalities We here conclude that, CTG features like 10% increase in baseline, decreased variability , sinusoidal or saltatory pattern are not significantly associated with subclinical chorioamnionitis and can result in unnecessary interventions and increased cesarean section rates. It's essential to balance the use of CTG with clinical judgment and other diagnostic tools to avoid unnecessary interventions while ensuring the safety of both mother and fetus.

Keywords: CTG, chorioamnionitis

FP34
Glycemic Variability and Time-in-Range: Novel Metrics for Assessing Pregnancy Risk in T2DM

Vishwani Khurana, Aruna Nigam, Arpita De

Introduction: Type 2 diabetes mellitus during pregnancy poses significant health risks to both mother and child. Effective glycemic control is crucial to minimize these risks, yet research comparing glycemic profiles between pregnant women with T2DM on pharmacotherapy and healthy pregnant women is limited. This study aims to address this gap by utilizing FGM to analyze ambulatory glycemic profiles and glycemic variability in these populations.

Methods: We conducted a cross-sectional observational study involving 60 pregnant women (40 with T2DM and 20 healthy controls) in North India at POG 24 to 36 weeks. Participants wore FGM devices to collect continuous glucose data. We analyzed and compared various glycemic parameters along with feto-maternal outcomes among the two groups.

Observation: Glucose profile of 720 days was analyzed with 69,120 data points, of which 46,080 glucose values of pregnant T2DM women were compared with 23,040 glucose values of healthy pregnant women.

T2DM group showed 23.75% higher mean glucose levels compared to controls. Maximum glucose values in T2DM group ranged from 48 to 250 mg/dl vs. 50 to 138 mg/dl in controls. All measures of glycemic variability (MAGE 52.85 mg/dl Vs. 35.72 mg/dl; SD 22.84 mg/dl Vs. 14.00 mg/dl) were significantly higher in the T2DM group compared with the control group. MAGE >55 mg/dl was associated with poor fetal outcomes (LGA, neonatal hypoglycemia, stillbirth). Our study found that T2DM group had an invariably higher glucose levels which led to a higher time spent above the euglycemic range. (TIR 83.24% vs 67.71%, TBR 11.47% vs 32.03%, TAR 5.29% vs 0.26%). LGA subgroup showed a higher TAR (15.2%) compared to normal outcomes.

Discussion: Our study demonstrated that pregnant women with T2DM experience significantly higher glycemic variability and poorer outcomes compared to healthy pregnant women. The use of FGM provided valuable insights into 24-hour glycemic control, capturing transient glucose excursions that may be missed by traditional self-monitoring of blood glucose (SMBG).

The association between higher MAGE values (>55 mg/dl) and poor fetal outcomes highlights the importance of managing glycemic variability, not just average glucose levels. The analysis of TIR, TAR, and TBR provides an essential tool for monitoring and managing glucose values and outcomes in T2DM pregnancies.

Keywords: continuous glucose monitoring, glycemic parameters, glycemic control, diabetes in pregnancy, glycaemic variabilty.

FP35
Role of heat stable intravenous carbetocin vs intravenous oxytocin in active management of third stage of labour after vaginal birth: A prospective study

Niharika Sharma, Arifa Anwar Elahi, Nidhi Gupta

Background : Post Partum Hemorrhage (PPH) is a leading cause of maternal mortality .Every year about 14 million women around the world suffer from postpartum hemorrhage. Active management of third stage of labour (AMTSL) decreases the incidence of PPH. One of the important component of AMTSL is injection of uterotonics.

Method: It is a randomised prospective study in which 310 pregnant women were enrolled in group A and B and received carbetocin and oxytocin respectively. To 1st group intravenous injection of 100 mcg carbetocin slowly over 1 minute and to other group, 10 U oxytocin intravenously slowly over 1 minute was administered post-vaginal delivery. Amount of blood loss, requirement of additional drugs or uterotonics and other maternal outcomes were studied for.

Results: Both the groups studied were comparable in terms of basic demographic details. Mean blood loss in oxytocin group was much higher with p value of 0.001. Requirement of additional uterotonics between group A and B was almost in the ratio of 1:2.3 (p value=0.02). In primigravida patients, ≥500 ml blood loss was 1.8% vs 5.36% and in multigravida patients, it was 1% vs 2.02% in carbetocin vs oxytocin group. In terms of additional drug usage, in primigravida patients, it was 7.27% vs 17.86% (p-value 0.09) and in multigravida patients, it was 3% vs 9.09% (p-value 0.07) in carbetocin vs oxytocin group.

Conclusion: It can be concluded that carbetocin is not inferior to oxytocin and may be a preferable alternative for reducing blood loss during active management of the third stage of labor but more studies are needed.

Keywords: Carbetocin; Oxytocin; Postpartum hemorrhage; Uterotonics agent; Vaginal delivery

FP36
Varied presentation and management of puerperal sepsis

Jyoti khatri Gupta

Introduction: Pyoperitoneum as consequence of puerperal sepsis is characterized by accumulation of pus within the peritoneal cavity. Timely and effective surgical management is crucial to mitigate associated high maternal morbidity and mortality.

Aim: To elucidate clinical presentation, diagnostic challenges and interventions in the management of pyoperitoneum in postpartum women to enhance understanding of best practices and management strategies in similar clinical scenarios.

Methodology: Records of patients with confirmed pyoperitoneum through imaging/clinical evaluation who underwent surgical intervention in department of obstetrics and gynaecology at LHMC & SSKH between 1 July 2024 and 31 august 2024 were retrospectively reviewed.

Patient Selection:Inclusion criteria comprised of patients diagnosed with puerperal sepsis with pyoperitoneum through imaging studies/clinical evaluation. Excluded patients with non-surgical management.

Included variables: Demographic variables, centre for ANC care and delivery, comordities, clinical presentation i.e., symptoms, illness duration, examination/diagnostic findings, surgical interventions (type of surgery, adjunctive procedures, intraoperative findings) and postoperative period were analysed. Data Analysis: Descriptive statistics.

Results: In majority of cases requiring surgical intervention there was uterine scar dehiscence secondary to infection.

Conclusion: In cases of paralytic ileus and surgical site infection following cesarean section, not improving with medical management or those with pelvic abscess, high degree of suspicion of uterine scar dehiscence should be kept in mind as one of the possibilities.

FP37
Diagnostic role of vaginal wash fluid lactate and prolactin levels in patients with preterm premature rupture of membranes

Preeti Saxena

Introduction: Preterm PROM (pPROM) refers to the rupture of membranes before 37 weeks of gestation, the incidence 25%. Lactate concentration in amniotic fluid is 7-9 mmol/L, which are four to six times higher than those in maternal or fetal blood, while prolactin is ten times more concentrated in amniotic fluid than in maternal blood. The diagnosis of pPROM can remain elusive in many cases, especially with doubtful leaking per vaginum, so we planned this study to investigate the potential of these two biomarkers in the diagnosis of pPROM.

Aim: To evaluate the lactate and prolactin levels in vaginal wash fluid for the diagnosis of preterm premature rupture of membranes (pPROM).

Methods: This was an observational study with 50 cases and equal number of uncomplicated, age and gestational age matched controls. Cases were defined as women between 28-36 weeks gestation with leaking per vaginum and amniotic fluid pooling on per speculum examination. The sample of vaginal wash fluid was obtained, aliquoted in 1.5 microlitres and stored at -20 degree celsius until further use. Vaginal fluid lactate and prolactin levels were measured by using commercially available ELISA kits following manufacturers protocol. A prior approval was obtained from Institutional Ethics Committtee for Human Research (IECHR-2022-55-99).

Results: The demographic profile of cases and controls were well matched. The vaginal wash fluid lactate levels in cases and controls were significantly different (3609.8 ± 410.58 µg/L v/s 1430.42 ± 205.58 µg/L, respectively; with a p value of <0.001). Receiver operating characteristic (ROC) curve analysis was applied in both the groups to assess the diagnostic performance of Lactate (µg/L) in pPROM. The area under the curve was 100% at cut-off value level of 2277.8 µg/L. The mean value of vaginal fluid prolactin levels in cases was 250.59 ± 25.59 ng/L while it was 119.29 ± 14.78 ng/L in the control group with a p value of <0.001. In the ROC analysis, for an AUC of 100%, the cut off value obtained for vaginal fluid prolactin level for the diagnosis of pPROM was 172 ng/L.

Conclusion: Vaginal fluid lactate and prolactin levels can be used as a noninvasive, reliable and sensitive test for the diagnosis of pPROM, especially in the cases with the diagnostic dilemma. We recommend a cut off value of 172.050 ng/l for prolactin and 2277.800 for lactate levels, above which pPROM is confirmed.

Poster Abstracts

EP1

Prenatal diagnosis and management of cardiac rhabdomyoma

Bhagyashree, Noopur Chawla, Sumitra Bachani, Jyotsna suri, Monika Gupta, Divya Pandey, Zeba Khanam

Introduction: Cardiac rhabdomyoma is the most common primary cardiac tumour accounting for approximately 60% of these tumours in fetuses. It may be associated with tuberous sclerosis in 50% to 79% of cases. It often leads to favourable pregnancy outcomes however they lead to complications such as arrhythmias, valve dysfunction, outflow tract obstruction, heart failure, and stillbirth.

Aim: To emphasize the importance of prenatal diagnosis and multidisciplinary management.

Results:

Case 1: A 22-year-old primigravida was diagnosed at 36 weeks gestation with a fetal intracardiac mass measuring 45.1×27.4×22.0 mm, arising from the interventricular septum. The patient went into spontaneous labour at term and delivered a healthy neonate. Postnatal follow-up with 2D echo showed no signs of heart failure

Case 2: A 33-year-old antenatal woman presented at 22 weeks of gestation with a fetal intracardiac mass measuring 7.0x9.3 mm originating from the interventricular septum. Cardiac function was normal. Fetal therapy with mTOR inhibitor sirolimus was started at 31 weeks due to the increasing size of the mass. pregnancy followed till delivery and a healthy neonate was delivered at term. Postnatal evaluation was done heart failure features were not seen.

Conclusion: Fetal cardiac rhabdomyomas are rare tumors and they often regress after birth. Early prenatal detection is essential for guiding management, assessing fetal well-being, and postnatal care. In these cases, management can range from expectant to therapeutic intervention to monitoring.

EP2

Congenital lung malformation- a rare entity

Kanchan Basnet, Ana Fatima, Sumitra Bachani, Sarita Singh

Introduction: Congenital lung malformations are, heterogeneous group of rare disorders that include, Congenital pulmonary airways malformations, bronchopulmonary sequestration, and congenital lobar emphysema.

CPAM is a rare pulmonary developmental hamartamatous abnormality comprised of adenomatoid proliferation of bronchioles that form cysts at the expense of normal alveoli. They have a normal communication with the trachea bronchial tree, vascular supply & venous drainage to pulmonary circulation and lined by respiratory epithelium. They are of five types amongst them Type1 (MACROCYSTIC>10 mm)is most common type with good prognosis.

Pathogenesis: Pulmonary insult during development of bronchial tree results in overproduction of terminal bronchiolar structures without alveolar differentiation.

25yr Primigravida @ 25wksPog came with level II USG showing a CPAM of size 1*1 cm in left upper lung. USG follow up every 15 days and CVR was calculated(CVR is CPAM volume ratio – which is a prognostication marker-> value <1.6 is favorable prognosis) ,was offered antenatal steroid. She had a preterm LSCS i/v/o breech in labor. In post natal follow up at 3rd and 6th month by CECT and CXR her cyst size increased, hence is planned for cyst excision.

Conclusion: Prenatal diagnosis and post natal observation by CXR and CECT provides good long term outcome as genetic association with CPAM is were rare.

EP3

Insights and outcomes : two rare cases of fetal sacrococcygeal teratoma

Nisha Chopra, Noopur Chawla Pruthi, Kalpana Pandey, Sumitra Bachani, Jyotsna Suri, Monika Gupta, Divya Pandey, Zeba Khanam

Introduction: Sacrococcygeal teratoma (SCT) is a benign Germ Cell Tumour in fetus with an incidence of 1 in 35,000-40,000 live births with female sex predominance.

We hereby report two interesting and rare cases of SCT.

Case 1: A 25-year G2A1 presented at 28+3 weeks with breathlessness. Her ultrasound revealed large heterogenous soft tissue mass in fetus arising from tip of coccyx with both internal and external components measuring upto 14.7 x 10 x 9.5 cm

causing pressure effects, hydroureteronephrosis with renal parenchyma thinning , fetal ascites, edema and polyhydramnios with fetal demise. Labour was induced ,delivered stillborn girl weighing 2.3kg, and histopathology reported immature grade 2 teratoma with no malignant components.

Case 2: A 24-year G3P1L1A1 at 37 weeks presented in labour and delivered baby boy of 2.55 kg with sacral mass of 12x10 cm with features s/o Sacrococcygeal teratoma. She has only one recent antenatal scan which had missed the tumour mass. Despite planned surgical resection, the neonate died on day 10 from cardiovascular complications.

Both cases, unfortunately, didn't have an antenatal diagnosis at appropriate gestation. An SCT with large size can present as hydrops and high-output cardiac failure as in first case, where in-utero interventions like radiofrequency ablation or interstitial laser can be done till 28 weeks gestation as per current published literature . Postnatal resection has variable outcomes, offering survival in 33% of cases but with significant risks.

Conclusion:

Sacrococcygeal teratoma can have favourable outcome if diagnosed early with multidisciplinary approach in-utero treatment and postnatal surgical correction.

EP4
Intrauterine transfusion revolutionizing the management of fetal anemia

Nivedita Shankar, Harsha Shailesh Gaikwad

Introduction: Maternal Rhesus isoimmunization occurs when a pregnant woman develops an immunological response to a paternally derived red blood cell antigen. The antibodies may cross the placenta, and can cause hemolysis and may lead to fetal anemia, hydrops fetalis, and even fetal death. The advent of direct ultrasound guided intrauterine transfusion has proved to be a miracle in saving fetuses from this grave problem .

Clinical details: A 35 yrs G3P1L1A1 at 24+3 wks POG presented to fetal medicine in Rh isoimmunised state with ICT titre of 1:32 and MCA PSV 1.77 MoM. Patient had not received anti-D after her first delivery. Four cycles of successful IUT done by intrahepatic route because of posterior location of placenta. 1st cycle 25wks, 2nd at 27 wks, 3rd cycle at 31 wks, 4th cycle at 34 wks . A healthy girl child delivered at 35 wks POG by c-section with birth weight of 2kg, without any need for exchange transfusion or blood transfusion later in neonatal period.

Discussion: Each Rh isoimmunized pregnancy should be offered ICT titer and antibody typing when it is above the critical titer of that particular lab, the patient should be monitored with MCA PSV and sign of hydrops after 16 weeks. If MCA PSV is not raising above 1.5 MoM, monitoring should be continued with MCA PSV and delivery should be advised at 36 to 37 weeks. When MCA PSV has become more than 1.5 MoM, then comes in the role of intrauterine transfusions . IVIG can be given to postpone intra uterine transfusion at a later gestation.

Conclusion: Intrauterine transfusion is a safe and effective procedure to treat RBC-alloimmunization and prevent preterm birth and optimize neonatal management of alloimmune anemia.

EP5
Unveiling the mystery: vanishing twin vs. Chorionic cyst – a diagnostic conundrum

Riyal Ranasaria, Reeta Bansiwal

Background:A vanishing twin refers to the early loss and reabsorption of one twin in a multiple pregnancy, often discovered through follow-up ultrasounds where a previously seen gestational sac or fetal structure is no longer visible. In contrast, a chorionic cyst is a fluid-filled sac located within the chorion, the outer membrane of the placenta, typically found incidentally on routine scans.

Case Summary : A case of a G3P2L1 pregnant woman presented with an umbilical cyst on her Level 2 scan at 21 weeks of gestation. Initial assessments revealed a cystic structure measuring 2.9 x 2.2 cm near the umbilical cord insertion with septations. At 35 weeks, the patient reported decreased fetal movements and vaginal spotting. Ultrasound showed a small for gestational age (SGA) fetus and a subchorionic placental hematoma. Subsequent specialist evaluation identified an intertwin membrane, suggesting a vanishing twin scenario. The dilemma between vanishing twin and chorionic cyst was solved by MRI and histopathology of placenta post delivery.

While both conditions can present as cystic structures in the placental area, their clinical

implications, management, and outcomes differ significantly. Accurate differentiation between these two conditions is crucial for appropriate prenatal monitoring and management, impacting both maternal and fetal care.

EP6

Successfully managed pregnancy in patients with Pulmonary Artery Hypertension

Arpita Mitra, Garima Kapoor

ABSTRACT

Introduction: Pulmonary artery hypertension (PAH) is defined as an increase in mean pulmonary arterial pressure ≥25 mmHg at rest as assessed by right heart catheterisation. In pregnancy, PAH is associated with a significantly high morbidity and mortality rate. Pregnancy is contraindicated in severe PAH (modified WHO risk class 4). In light of the above context, we present two cases where pregnancy was successfully managed in patients with severe PAH.

Case1: A 25-year-old G2P1L1 K/C/O RHD with severe MS and severe PAH, previous LSCS with H/O PTMC presented in ANC OPD at 10 weeks POG. She belonged to NYHA class 3. She was advised MTP, but was willing to continue pregnancy. A multidisciplinary cardio-obstetric team was formed for management. She underwent elective cesarean section under general anaesthesia at 37 weeks delivered a healthy girl child weighing 2.32 kg.

Case2: A 35-year-old G3P1L1A1 K/C/O RHD with severe MS, moderate TR, and severe PAH, previous LSCS was referred to SJH at 25 weeks POG. She belonged to NYHA class 2. She was managed by a cardio-obstetric multidisciplinary team. She underwent elective LSCS with B/L tubal-ligation at 38 weeks under epidural anaesthesia, delivered a healthy male child weighing 2.45 kgs.

Intraoperative and postoperative period was uneventful in both cases.

Discussion: PAH in pregnancy is a high-risk medical condition. It is crucial to educate patients and encourage the use of safe contraceptive methods. Delivery planning should involve a multidisciplinary team approach. The post-partum period is particularly critical and should be closely monitored.

EP7

Dadc twin pregnancy with h.Mole with co-existing live fetus with hyperthyrodism in serodiscordant couple

Ayushi

Introduction: A case of DCDA twin pregnancy, POG 13 week with IUI conceived pregnancy, presented with complaints of spotting per vaginum since 3-4 days.

Aim: To study the correlation of molar pregnancy with hyperthyroidism.

To study the serial beta Hcg levels post suction and evacuation and look for further reoccurrence.

To study role of 5% lugols iodine in H.mole induced hyperthyroidism.

Termination of pregnancy to prevent poor obstetrics outcome in near future.

To study the karyotpe of the of the products evacuated out in suction evacuation.

To study the histopathology report of the products evacuated out in suction evacuation.

Methods : Patient evaluation from endocrinology point of view, serial beta HCG levels.

Serial S.TSH levels to see the response of suction evacuation and 5% lugols idone.

Serial ultrasound pelvic examination.

Fetal MRI imaging conducted before suction and evacuation.

Suction evacuation as a method of termination of pregnancy under sedation.

Karyotpying and histopathological evaluation from the department of pathology.

Results: Histopahtlogical examination confirms the diagnosis of hydatidiform mole as complete molar pregnancy.

Post suction evacuation Hyperthyroidism signs and symptoms resolved over weeks.

MRI pelvis reveals twin pregnancy with one live fetus and other completeH.mole.

Karyotype suggestive of complete molar pregnancy.

EP8

PERIPARTUM CARDIOMYOPATHY

Damini Rathee, Yashika Kotla

Introduction: Peri partum cardiomyopathy is a new onset heart failure between the last month of pregnancy and 5 months post delivery with no

determinable cause. It's diagnosis of exclusion. The prevalence of postpartum cardiomyopathy in India is 0.75 per 1000 live births. We are presenting a case of postpartum cardiomyopathy on account of its rarity and difficulty in early diagnosis.

Case Description A 34 years old female, booked ANC of our hospital, short statured, G2A1 @ 40 weeks(b/d)/ 40+1 week(b/T1) presented with pain-abdomen. Antenatal period was uneventful. She was hemodynamically stable and on further examination was diagnosed with cephalo-pelvic disproportion in labor. Therefore, she was taken up for emergency c-section where intra operatively rise of BP was noted with no other significant findings. On Post-operative day 1, patient complained of shortness of breath. On examination patient had tachycardia, elevated JVP and bilateral pulmonary crepitations, for which CXR , ECG, NTproBNP and cardiac enzymes sent. CXR suggestive of pulmonary edema. NTproBNP was raised. ECG showed significant changes with raised cardiac enzymes. Patient landed into arrhythmia with echo showing reduced left ventricular ejection fraction. On postoperative day 6, she was diagnosed with Postpartum cardiomyopathy. Patient was managed in ICU with standard heart failure therapy.

Conclusion Peripartum cardiomyopathy, though rare, can affect women before or after delivery and can be challenging to diagnose without a high index of suspicion. Early diagnosis is crucial to prevent progression into complications like thromboembolic events. This case underscores the importance of thorough diagnostic evaluation for Peripartum cardiomyopathy.

EP9
Spontaneous Hemoperitoneum in Pregnancy

Sheetal Pushkar, Anuradha Singh, Kiran Aggarwal, Shivangni Sinha

Background : Spontaneous hemoperitoneum in pregnancy (SHiP) is a rare but life-threatening condition with an estimated incidence rate of 0.04 per 1000 births characterized by the accumulation of blood in the peritoneal cavity without trauma or obvious cause in pregnancy and up to 42 days postpartum that lead to significant maternal and perinatal complications. SHiP mostly occurs in the third trimester of pregnancy with an incidence of 27% in the second trimester.

Case : We present a case of a 40 year old multigravida female at 30 weeks of gestation who presented with acute abdominal pain. Urgent imaging revealed a small amount of free fluid in perihepatic and perisplenic space with blood clots highly suggestive of hemoperitoneum. An emergency laparotomy was performed which confirmed the diagnosis and approximately 1-1.5 liters of hemoperitoneum with 1 liter of blood clot from the pouch of douglas were evacuated. Cesarean section was performed at the same time placenta was delivered with intact membranes, there was atonic pph which was not medically managed. In view of doubt of rent in the lower uterine segment with increased vascularity over the post surface , atonic pph and general condition of the patient Total Abdominal Hysterectomy was done. Total blood loss was 3.5 liters. Both mother and baby recovered without further complications.

Conclusion : This case highlights the importance of early recognition and prompt surgical intervention in SHiP to prevent maternal and fetal morbidity and mortality. Given its rarity and non-specific presentation, SHiP remains a diagnostic challenge and requires a high index of suspicion in pregnant women with acute abdomen and hemodynamic instability.

EP10
Endocrine Turbulence : The Maternal and Fetal Challenges of Overt Primary Hypothyroidism in Pregnancy: A Case Report

Janvi Vashist, Noopur Chawla Pruthi, Zeba Khanam, Jyotsana Suri, Sumitra Bachani, Divya Pandey, Monika Gupta

Introduction: The prevalence of overt hypothyroidism during pregnancy is 0.3-0.5 %. It is associated with significant maternal and fetal complications, especially when associated with high serum anti-TPO levels. We hereby discuss an interesting and rare presentation of overt primary hypothyroidism during pregnancy.

Aim: To present the myriads of presentations and complications with their management in a patient with overt primary hypothyroidism during pregnancy, managed in a tertiary care center.

Results: A 28-year-old gravid female presented to the Emergency department with complaints of shortness of breath and hypertension at 24 weeks POG. On evaluation, her TSH was 539 µIU/mL, T4 was low and anti-TPO was 1300. On 2D-ECHO, she had pericardial effusion and her USG pelvis

showed bilateral theca Lutein cysts, the cause of which was attributed to hypothyroidism. She was managed conservatively inpatient till 30 weeks of gestation when she developed severe uncontrolled hypertension and was taken up for Emergency LSCS. The post-op period was uneventful. She continued to follow up in the Cardiology and Endocrinology departments and was discharged with the baby on Post op day 28. She was asked to follow up with a monthly thyroid function test. Thyroid hormone levels returned to normal values and her pericardial effusion resolved by 3 months post-delivery. A multidisciplinary team including an endocrinologist, cardiologist, intensivists, and neonatologist played an important role in maternal and fetal stabilization.

Conclusion: Hypothyroidism during pregnancy is seen commonly and can be associated with grave maternal and cardiovascular complications if left untreated. Hence, a timely and accurate diagnosis and a multidisciplinary team approach is needed for the successful management of these patients.

EP11

Chronic Endometritis and Dystrophic Calcification Presenting as Secondary Infertility

Priti Tanwar, Rekha Bharti

Introduction – Endometrial calcifications can be found in women undergoing evaluation for abnormal uterine bleeding and infertility. Women with history of previous abortion may have retained bones seen on ultrasound as hyperechoic areas in endometrium.

Case: A 27yr old P1L1A1 with history of AUB ,secondary infertility presented in OPD with endometrial biopsy report of chronic endometritis with dystrophic calcification.Biopsy done as evaluation of secondary infertility. She had history of missed abortion 2 years back followed by evacuation. Ultrasonography reported irregular bright linear shadow in upper uterine cavity 30x6.8x10mm, suggestive of endometrial calcification. Hysteroscopy revealed bones in endometrial cavity could not be removed by hysteroscopic grasper. Cervical dilatation done,and fragments of fetal bones were removed. Repeat ultrasound revealed hyperechoic lesion in endometrial cavity. Repeat hysteroscopy showed transversely placed long bones with multiple fragments of flat bones. Hysteroscopic removal was unsuccessful, hence, dilatation of cervix with removal of fetal bones was done with ovum forceps with difficulty as long bones were placed transversely.Patient was discharged and called for follow up after one week.

Discussion – Prolonged retention of intrauterine bone is a rare complication of abortion and cause of infertility by acting like an intrauterine device. Endometrial biopsy for secondary infertility done and diagnosed as chronic endometritis before hysteroscopy diagnosis was made. Early hysteroscopy can prevent considerable emotional, mental, social distress to the woman and family.

EP12

A Tale of Metallic Valve in Pregnancy- Navigating prosthetic mitral valve thrombectomy

Priyanka Das, Jyoti Meena, Deepali Garg, Vatsla Dadhwal

Introduction: Pregnancy with prosthetic valve is increasing nowadays as the health care services are improving and more women with Rheumatic heart diseases are being treated with prosthetic valves. Prosthetic valve thrombosis is dreaded complication with maternal mortality of 1.47% and fetal mortality of 16-33% during pregnancy.

CASE: We report a case of 22 years primigravida at 30 weeks of gestation with NYHA 4, post mitral valve (MV) replacement with thrombus formation in acute heart failure, abstained from systemic anticoagulation for 9 months. The dilemma was whether to operate immediately or start medical management and wait for 48 hours for ACS completion for fetal lung maturity. After 6 hours of systemic anticoagulation and a single dose of ACS, there was a sudden deterioration of the patient condition, after intubation an emergency caesarean section followed prosthetic MV thrombectomy. This delay in surgery did not affect maternal outcome but affected fetal outcome adversely.

CONCLUSION: Mechanical valve thrombosis is a dreaded complication. Failure to comply with proper anticoagulation frequently resulted in prosthetic valve thrombosis and hence prompt surgical management is the best way for optimal maternal and fetal outcome.

EP13
Challenging presentation of Tuberculosis in Puerperium

Sai Priya, Monika Sahoo, Rajesh Kumari, Deepali Garg, Neha Varun, Jyoti Meena, Neeta Singh, Vatsla Dadhwal

Introduction: India contributes to nearly 21% of the global burden of TB among pregnant women and the estimated prevalence of TB stands at 2.3 per 1000 pregnant women, which translates to about 44,500 patients annually. Here we report a case of unusual presentation of TB in puerperium with maternal collapse.

Case details: A 26 year old woman presented in gasping state on post-partum day-16 of preterm vaginal delivery, was revived after 3 cycles of CPR and intubated. The most likely differential was shock of cardiogenic cause. Within 3 days, she had high grade fever and pancytopenia managed on lines of possible septic shock and AKI. CXR was suggestive of miliary mottling, CECT suggestive of bilateral diffuse lung opacities suggestive of ARDS but bronchoalveolar lavage was negative for TB. In view of pancytopenia and unremitting fever, bone marrow biopsy was done and it showed multiple granulomas suggestive of bone tuberculosis . ATT was started and within 2 days fever subsided, general condition of the patient improved and she was discharged in stable condition after 2 weeks.

Discussion: A progressive disseminated hematogenous form of TB is uncommon and needs to be considered in the possible causes of acute febrile conditions during pregnancy and puerperium with initiation of treatment based on clinical suspicion to prevent morbidity and mortality.

Conclusion: This case emphasizes the prevalence of TB in every possible scenario including maternal collapse and role of multidisciplinary team for clinching the diagnosis and appropriate management.

EP14
Peripartum Cardiomyopathy (PPCM): An Intriguing Challenge

Sakshi Malhotra, Sangita N. Ajmani

Introduction: PPCM is a dilated cardiomyopathy defined as systolic heart failure in the last month of pregnancy or within 5 months of delivery.

Can be life-threatening, characterized by significant LV dysfunction and heart failure.

Case: A 23 year old G2P1L1 at 38 weeks POG came to our LR with complaints of LPV since 2 days. FHS NL by steth and NST. USG confirmed IUD. Patient was induced with Misoprostol, did not progress. Had to be taken up for Em LSCS in view of chorioamnionitis.

IUD baby delivered. Post op Hb:7g/dl. Auscultation: B/L AE+, HR:90/min, S1S2+ .

1 unit PCV transfused on POD2 of LSCS.

Patient developed dyspnea and tachypnea on POD5.

Examination and Management: On Auscultation: HR: 125/min, irregular rhythm, S3 gallop. Chest: Bilateral basal fine crepitations. Vesicular breath sounds ↓. RR:30/min. SpO2: 92% on RA. Lower limb oedema + Supplemental O2 via nasal canula and furosemide given. X-ray PA:Cardiomegaly.

Provisional diagnosis: Heart failure

Patient improved with Diuretics and O2 and was discharged in stable condition with advice to follow up in Cardiology department.

2D ECHO done at LNJP hospital revealed PPCM, mild MR, LVSD and EF:40-45%.

Discussion: Symptoms of PPCM include fatigue, edema and dyspnea which are similar to normal peripartum states and pregnancy. Therefore, diagnosis is often delayed and the disorder is under recognized with devastating consequences.

Conclusion: PPCM is a relatively uncommon condition and a positive short-term prognosis is likely if the LV size returns to normal after pregnancy.

EP15
Caesarean Scar Ectopic Pregnancy: Lurking Threat (A Rare Case Report)

Sukriti Gaur, Sumedha Harne, Shefali Gupta

Introduction: Caesarean scar ectopic pregnancy is a rare type of ectopic pregnancy. It is the implanatation of gestational sac at the site of a previous uterine scar (most commonly- caesarean section scar). It can lead to significant morbidity and mortality if not managed timely.

Aim: A rare case of caesarean scar ectopic to improve the outcome by early diagnosis and treatment

Discussion: A 32yrs old P2L2 at 12 wks of

gestation presented at emergency department of Jaipur Golden Hospital, Rohini, New Delhi. On ultrasonography, a heterogenous mass with foci of calcification along the anterior lower uterine segment at scar site of approximately 71x43x37 mm was reported, suggestive of Type III scar ectopic pregnancy (ET- 6.7mm)

Methods

1. Expectant management-rarely done
2. medical management-systemic methotrexate
3. local injection and embolisation
4. surgical methods
   a) dilatation and surgical evacuation
   b) hysteroscopic resection
   c) open / laparoscopic/vaginal excision and resuturing
   d) combined laparoscopic and hysteroscopic procedure
   e) hysterectomy

Result: Patient was managed by surgical intervention and 7x5 cm ectopic was opened and removed.

Conclusion: Caesarean scar pregnancy can be associated with major hemorrhage and followed by hysterectomy.Adequate counselling and availability of surgical expertise and blood transfusion should be a part of comprehensive treatment plan.

EP16
Peripartum cardiomyopathy: circumvention of a formidable challenge

Puja Singh, Monika Sahoo, Rajesh Kumari, Neha Varun, Deepali Garg, Jyoti Meena, Neeta Singh, Vatsla Dadhwal

Introduction: Peripartum cardiomyopathy (PPCM) is a potentially dangerous idiopathic cardiomyopathy that causes heart failure during final weeks of gestation or within months after childbirth. **Case details:** A 36 years old G2A1 at 30 weeks of period of gestation (POG) with complaint of breathlessness and generalised anasarca since 4-5 days (NYHA III) with Gestational Diabetes Mellitus (GDM) on Oral Hypoglycaemic agents. She was hemodynamically stable but echocardiography reported Ejection Fraction (EF) 10-15%, global Left Ventricle (LV) hypokinesia, dilated LV, moderate Mitral Regurgitation (MR) moderate Tricuspid Regurgitation (TR). Electrocardiography and Xrays chest were normal. With help of cardiology team diagnosis of severe PPCM was made. She was managed in Intensive Care Unit (ICU). The presentation was very unusual and management was challenging because of extreme prematurity, very low EF and severe LV dysfunction. Multidisciplinary team efforts helped us to take patient till 35 weeks of POG with careful maternal and fetal monitoring in Cardiac Care Unit (CCU) and she underwent Caesarean section at 35 weeks of POG. Patient was discharged in stable condition on post operative day 6 and baby was discharged after 15 days of Neonatal Intensive Care Unit (NICU) stay. **Discussion:** There is higher likelihood of caesarean delivery, severe maternal cardiovascular events, rehospitalisation and higher mortality. While there is vast number of LVEF recovery noted in such patients. Conclusion: PPCM is a rare pregnancy related disorder so high index of suspicion is recommended with multidisciplinary team approach because they are diagnosed when they have severe symptoms.

EP17
Navigating Challenges of Metallic valve : A tale of arrhythmia complicating restenosis

Sakshi Bajaj, Monika Sahoo, Jyoti Meena, Rajesh Kumari, Deepali Garg, Neha Varun, Neeta Singh, Vatsla Dadhwal

Introduction : Aortic stenosis is one of fixed output lesions, but it is relatively uncommon in women of childbearing age, associated with an increased risk of maternal cardiovascular events, obstetric morbidity, death and fetal complications including miscarriage, growth restriction, stillbirth, preterm birth and iatrogenic prematurity **Case :** A 24 years old primigravida at 28 weeks post aortic valve replacement 5 years back presented with worsening dyspnea and dizziness with severe restenosis of mechanical valve. The dilemma here was a decision between redo aortic valve replacement and conservative approach with intense monitoring in view of extreme fetal prematurity. The patient was managed with multidisciplinary team efforts for 2 weeks when she received anticoagulants, beta blockers, diuretics and steroid cover for fetal lung maturity. She had a sudden episode of ventricular tachycardia at 30 weeks, immediately intervened by the team of obstetrics, cardiothoracic surgery, cardiac anaesthesia and neonatology, medically resuscitated, intubated and

immediately shifted to OT followed by caesarean section and a re do AVR the following day. **Discussion :** The leading maternal complication in patients with severe AS who are already symptomatic before pregnancy is heart failure. An in depth assessment by all teams with preparedness for all eventualities helps in improved perinatal outcomes. **Conclusion :** This case of a near miss gives insight into the successful management of a critical case of severe aortic stenosis with a thorough team approach.

EP18

A Rare Case of Mid-Trimester Uterine Rupture Triggered by a Fall: Challenges in Diagnosis and Management

Akanksha Dalal, Ashoo Gupta

Introduction: Uterine rupture typically occurs in the third trimester or during labor but can exceptionally happen in the second trimester due to trauma. This case study presents a 31-year-old woman who suffered a uterine rupture at 17 weeks of gestation following a fall.

Patient History:

Age- 31 years

Previous Obstetric History: Caesarean section

Current Pregnancy History: No pre-existing uterine abnormalities or complications

Incident- Fall in the washroom, landing on the abdomen

- Symptoms: Dull abdominal pain

Clinical Presentation:

Vital Signs:

- BP: 100/60 mmHg (hypotensive)
- HR: 110 bpm (tachycardic)
- Pale skin

Physical Examination:

- Abdomen: Distended and tender

Diagnostic Workup:

Ultrasound: Free fluid in the abdomen; regular fetal heartbeat

Management:

- Surgical Intervention: Emergency laparotomy
- Findings:
- Anterior uterine wall rupture
- Fetus and placenta partially expelled
- Approach:

Rupture repaired without hysterectomy

Outcome:

Maternal:

- Blood transfusions needed
- Counselling on future pregnancy risks provided

Fetal:

- Fetus did not survive

Discussion: This case highlights the extreme rarity of uterine rupture in the second trimester due to trauma. The previous caesarean section likely contributed to uterine weakness. Immediate surgical intervention was essential to stabilize the patient.

Conclusion: Traumatic uterine rupture in the second trimester is rare but should be considered in cases of abdominal trauma, especially with a history of uterine surgery. Timely diagnosis and management are critical for improving outcomes. Patient education on trauma risks during pregnancy is vital.

EP19

Rare Presentation of Accessory and Cavitated Uterine Mass (ACUM) with Right Ovarian Cyst: A Case Report

Ambika Agarwal, Harsha Gaikwad, Bindu Bajaj

Introduction: ACUM is a rare uterine anomaly that presents with severe dysmenorrhea in young women. This condition is characterized by a non-communicating accessory uterine cavity, often confused with other pelvic pathologies.

Aim: To report a rare case of ACUM associated with right ovarian cyst in a young female and to discuss its clinical presentation, diagnostic challenges, and management.

Method: A 19-year-old unmarried female presented with a two-year history of dysmenorrhea. Radiological investigations, including USG and MRI, revealed a focal, round, cavitated lesion within the myometrium (3.7 x 5.3 x 4.7 cm) adjacent to the left uterine wall, not communicating with endometrial cavity, suspected as ACUM, along with a right ovarian teratoma (3.5 x 3.6 cm). Surgical excision of the ACUM and ovarian cyst was performed.

Result: Intraoperatively, a left-sided ACUM was identified and excised. Histopathology confirmed a cystic cavity with adenomyosis. The right ovarian cyst was identified as a corpus luteum hemorrhagicum. The patient's symptoms improved postoperatively.

Conclusion: ACUMs are an underdiagnosed cause of refractory dysmenorrhea; further research is needed on prevalence, long-term effects on fertility, and treatment options.

EP20
Traumatic urethrovaginal fistula

Anmol Shivhare, Sumitra Bachani

Introduction: The most common cause of urethrovaginal fistula is obstructed labor, other causes include Iatrogenic ,traumatic ,post radiation .Here we discuss a rare case of urethrovaginal fistula caused by insertion of pen and its management with multi-disciplinary team approach leading to better outcome..

Background: 43 yrs old P2L2 with came to GRR with history of foreign body insertion in vagina , on inspection vulva and perineum normal, on per vaginal examination tip of the pen felt in lower one-third of anterior vaginal wall. USG suggestive of elongated tubular structure in vagina traversing the urinary bladder till the dome of the bladder, tenting the dome of bladder wall, No free fluid in the abdomen. CT cystography suggestive of linear foreign body extending from vagina into urinary bladder with no spillage of dye from urinary bladder into the abdominal cavity. Patient planned for cystoscopy with robotic laparoscopic omental patch repair of bladder if needed. In urology OT on table on examination the pointed end of the pen was 3cm out from the anterior vaginal wall, the pen was slowly removed. Intraoperatively defect was traversing through anterior vaginal wall and opening posterior urethra. On cystoscopy, no defect seen in posterior urinary bladder and the dome of urinary bladder was intact. Urethra-vaginal defect was closed using Martius repair. Silicone catheter kept in-situ for 21 days, urine culture followed. Catheter was subsequently removed, bladder function normal.

Conclusion: In this rare case of FB we want to highlight the importance of multidisciplinary team management approach including radiodiagnosis, urology ,general surgery and gynaecology played a pivotal role in better outcome of patient.

EP21
OHVIRA SYNDROME – A rare case report

Anusha Khare, Geeta Chadha

INTRODUCTION

- OHVIRA syndrome'Obstructed HemiVagina and Ipsilateral Renal Anomaly', also known as Herlyn–Werner–Wunderlich syndrome, is a rare congenital anomaly of the Müllerian and Wolffian duct systems. It is characterized by the triad of uterus didelphys with an obstructed hemivagina and ipsilateral kidney agenesis or kidney dysplasia.
- Patient usually presents with OHVIRA 1-2 years after menarche.

Case Report

- A 12 years old girl came with complaints of scanty flow during menses.
- She was investigated thoroughly, diagnosis of OHVIRA syndrome was made.
- Vaginoscopic (hysteroscopic) incision of tranverse vaginal septum resulting in an outflow of old menstrual blood.

Discussion

Patients typically present after menarche with abdominal pain, dysmenorrhea, or urogenital malformations. The diagnosis is confirmed by an ultrasound or magnetic resonance imaging. Golden standard is magnetic resonance imaging (MRI) . Treatment consists of drainage of the hydrocolpos/hematocolpos; in some cases, further surgery is indicated.

Conclusion

The septum removal procedure should be performed with appropriate care to prevent excessive bleeding, damage to the bladder, rectum and cervix. If the patient was not treated properly it may result with retrograde tubal reflux, endometriosis and infertility problems in future.

EP22
Case report: Cervical NET- a rare presentation of cervical fibroid

Archita Chawla, Anjali Dabral

Neuroendocrine tumours are relatively rare comprising ~ 2% of all malignancies. Its prevalence is roughly<200,000 in united states making it an

orphan disease. Neuroendocrine tumours of cervix is a rare variant with poor prognosis and high mortality. Cervical NEC comprises 0.9-1.5% out of which small cell NEC is most common.

My patient was a 34 years old,P1L1 presented in OPD with complain of dribbling of urine ,Heavy menstrual bleeding with passage of clots , foul smelling discharge not responding to antibiotics. Per speculum cervix appear grossly healthy. Usg suggested Large heterogenous mass of 6.4*9.7*11.8CM irregular shaped mass in the cervical region posteriorly. On MRI ,Large well defined rounded lobulated exophytic mass of size 8.8*9.2*7cm arising from right lateral aspect of cervix with extension up to lateral pelvic wall and anterior abdominal wall.pateint was planned for myomectomy. Intraoperatively, Uterus was adherent to anterior abdominal wall from below the fundus till anterior wall of cervix Bladder was adherent to lower part of uterus .cervical degenerated mass extending up to the right side broad ligament. omentum was adhered to posterior wall of uterus. B/l internal iliac arteries ligated i/v/o difficult hemostasis . Histopathological report of the mass tumour size 7X5X3 cm showed small cell carcinoma grade 3 , stromal invasion was present, parametrium, margins were invovled both circumferential and ectocervical involvement was present.

Patient was then given various cycles of cisplatin and etoposide.Pateint was advised to follow up with PET-CT.

EP23
From Hematometra to Normal Menses

Sandhya Verma, Zeba Khanam

Introduction: Vaginal atresia is a condition in which a part or whole vagina fails to canalise. It is seen in one out of every 5000 live birth. We, hereby discuss the presentation & management of a challenging case of vaginal atresia.

Background: A 15 y old patient with primary amenorrhea presented to the gynaecology out-patient department with complain of lower abdominal pain and pyuria for one year. She had an ultrasound suggestive of hematocolpos and Rt hydroureteronephrosis And a renal DTPA scan demonstrating minimally functioning kidneys. On examination a dimple was seen at the point of introitus , a mass of 14*16 cm was tipped per rectally, no bulge was felt on the anterior and distal portion of rectum. An MRI at the hospital demonstrated a hematometra and atretic cervix and vagina. She was taken for elective laparotomy, a horse shoe vulval flap vaginoplasty was done through and abdomino-perineal approach. About 500cc of chocolate colour fluid was drained was drained. A vaginal mould with a ,long distal draining 18 French foleys catheter tip placed in-situ. The tip of mould catheter was placed at the level of uterine fundus to prevent the stenosis of the genital tract. The mould catheter was replaced on POD 7. On post-op day 48 she developed intermittent watery discharge from the neo-vagina. The draining fluid was high in creatinine compared to serum creatinine and hence diagnosis of iatrogenic rt ureterogenic fistula was made. Right nephrectomy was done on later date. On follow up patient had regular menses and normal bladder functioning.

Conclusion: Vaginal atresia is a rare mullerian anomaly which may be embryologically associated with renal anomaly. Management of such cases should be done at tertiary care centre with a multi-disciplinary approach.

EP24
Multidisciplinary Management of a Pregnant Woman with Left Mandibular Osteoclastoma

Srishti, Versha Dhama, Rekha Bharti, Anjali Dabral

Introduction: Osteoclastoma, or Giant Cell Tumor of Bone, is a benign yet locally aggressive tumor, usually found in long bones. Its occurrence in the mandible is rare, and even more so during pregnancy. Osteoclastoma typically affects individuals between 20 to 40 years, often coinciding with reproductive years.

Case: A 30-year-old, G3P2L2 woman at 32+2 weeks of gestation presented with a left mandibular tumor. Admitted to the obstetrics ward, her antenatal workup followed standard protocols. A multidisciplinary team, including obstetricians, maxillofacial surgeons, and pathologists, managed the case. Imaging was selected to minimize fetal exposure, with CT used to assess the tumor. Histopathology was performed. The patient and fetus were closely monitored for tumor growth and complications. She delivered at 33+4 weeks

gestation and underwent further treatment by the oncosurgery team. Follow-up care continues in the maxillofacial surgery department.

Discussion: This case underscores the need for individualized, multidisciplinary care in managing rare tumors during pregnancy. Osteoclastoma in pregnancy requires careful monitoring, often delaying intervention until after delivery unless maternal health is compromised. It highlights the importance of balancing surgical and oncological interventions against fetal risk.

Conclusion: This case serves as a reminder of the delicate balance required in these scenarios and the importance of collaborative decision-making in optimizing outcomes for both mother and baby.

EP25
Neurotoxic snake bite with respiratory failure in a pregnant female : A case report
Tamana, Swarn

Introduction: Snake-bites are rarely seen during pregnancy as pregnant patients are mostly home bound.Maternal and fetal losses have been reported in venomous snake bite. We hereby report a case of a neurotoxic snake-bite in a pregnant patient with positive outcome as a result of early intervention.

Case Report : A 30 year old multigravidae patient with 37 weeks peroid of gestation presented to labour room with history of snake bite. Post snake bite she started with history of double vision and dropping of eyelids and difficulty in swallowing of saliva and later progressed in 5 hours to difficulty in breathing and subsequently developed altered mental state . On presentation her GCS was 12/15, hemodynamically stable, FHR 140, SPO2 90%. Diagnosis of Neurotoxic snake bite with impending respiratory failure was made and patient was immediately intubated. Antisnake venom was started immediately and injection Neostigmine and injection atropine was given. Patient was taken for immediate C section and a healthy baby was delivered. Mother was extubated after 34 hours and both mother and baby were discharged in a healthy state.

Conclusion: Early decision making and interventions in neurotoxic snake bite in pregnant female are of paramount importance to save the lives of both mother and foetus. Any delay in polyvalent antivenom and intubation can turn out to be detrimental and lead to worse outcomes.

EP26
ABDOMINAL ECTOPIC
SONAM SINGH

We report a case of 22 years old female presented to emergency department with h/o amenorrhea x 2.5 Months.Last menstural period was 8/1/24 and period of gestation 8 weeks.Patient came to the emergency department with chief complain of on and off pain in abdomen since 15 days .Patient was reffered from a private hospital i/v/o failed diagnostic laparoscopy,uterine perforation,bowel and bladder injury.An emergency bedside ultrasound was done which was showing s/o ectopic single live pregnancy an gestational age 8 weeks by crl in right adenexa with g sac seen adjacent to right ovary.Afterwards mri abdomen and pelvis was done which was s/o cystic structure m/a 2.4 X 1.8 Cm in right adenexa.Right ovary not seen.Gestational sac with internal echoes with fetal pole seen .Crl 13.8 Mm.Gestational age with internal echoes with fetal pole seen.Crl 13.8 Mm.G age 7+3 weeks. Ca seen fhs 193 bpm.

Abdominal (Peritoneal) ectopic pregnancy ,defined as ectopic pregnancy occurring within the peritoneal cavity outside genital organs (uterus,tubes,ovaries) represents a very rare form of ectopic pregnancy. ruptured tubal ectopic pregnancies account for the majority of abdominal pregnancies.Abdominal pregnancy has a maternal mortality rate between 0.5 and 18% and a perinatal mortality rate between 40 and 95%.

EP27
Umbilical Endometriosis
Gopini Meghana, Rekha Bharti

Introduction: Endometriosis refers to the presence of functional endometrial tissue outside the normal uterine cavity. Although rare, umbilical endometriosis is the commonest type of cutaneous endometriosis, comprising 0.4-4% of extragenital lesions, and around 0.5–1% of all cases of endometriosis. It can occur spontaneously(primary) and after surgical procedures (secondary)

Case: A 35-year-old, P1L1, with previous caesarean delivery done 10 years back, presented with complain of infertility, cyclical bleeding from

umbilicus during menstruation associated with pain for 2 years. On local examination, umbilicus was inverted without palpable mass or bleeding. Examination during menstruation revealed bleeding from umbilicus. Ultrasound showed well-defined hypoechoic collection of size 1.5x2cm in subcutaneous planes with hyperdense content showing communication to skin surface through umbilicus. MRI showed a well-defined 4.1 x2cm lesion at the level of umbilicus extending from skin surface to Linea alba in midline in subcutaneous plane likely endometriotic deposit, and right hematosalpinx. Wide local excision with right salpingo-opherectomy and adhesiolysis with umbilical reconstruction was done. Post operative period was uneventful. Histopathology showed features of endometriosis.

Discussion: Umbilical endometriosis is a rare condition, 70% cases are of primary type and 35% have coexisting pelvic endometriosis. Cyclic pain, bleeding, local swelling are commonest symptoms. Most have associated infertility. History and examination, especially during menstruation can establish diagnosis in most cases. Imaging is used to find out extent of lesion and plan line of management. Wide local excision is the primary treatment of choice. However, medical therapy can be used for symptomatic relief and to reduce the size of lesion. The risk of malignancy and recurrence after wide local excision is rare.

EP28
Horseshoe Flap Neovaginoplasty in primary vaginal atresia: an operative insight!

K P Apoorva, Himal Singla

Introduction: The incidence of MRKH syndrome is 1 in 4500 female births. In about 10% of patients a functioning uterus and cervix, and an upper vaginal segment are present. Type I (isolated) MRKH is less frequent than MURCS association. MURCS is associated upper urinary tract malformations are found in about 40% of cases with MRKH syndrome.

Case Report: A 15-year-old girl came to OPD with complaints of primary amenorrhea and cyclical pain abdomen for 1 year. On examination vitals were stable, secondary sexual characters were normal (Tanner stage 4). Per abdomen examination: soft, non tender, no organomegaly. Local examination of genital region: labia majora and labia minora, urethral opening normal, vaginal dimple seen. Per rectal examination: uterus palpable. Clinically diagnosed as complete vaginal atresia. On routine investigation patient was diagnosed as hepatitis B positive with high DNA titres and started on treatment with tab. Tenofovir alafenamide. Usg pelvis and KUB s/o uterus anteverted enlarged in size and moderate fluid collection seen – hematometra and cervix ballooned out with no vagina seen. MRI pelvis and KUB s/o hematometra and severe hydronephrosis with parenchymal thinning in right kidney and tortious right ureter with ectopic opening? Into vagina. Left kidney and ureter were normal. DTPA scan s/o poorly functional right kidney.

Results: Patient underwent laparotomy with neovaginoplasty with horseshoe shaped labia minora flap and mould inserted. On post op day 7 mould was changed, and flap was healthy. Serial vaginal dilatation was done.

Conclusion: The clinical management of vaginal agenesis must be multidisciplinary and specifically adjusted to maximize sexual comfort. The horseshoe flap vaginoplasty implies this to be an effective procedure for vaginal agenesis, but proper mould use after surgery and serial vaginal dilatation is still critical.

EP29
RUPTURED RUDIMENTARY HORN PREGNANCY

Komal Dahiya, Devender Kaur

Introduction: A ruptured rudimentary horn pregnancy is a life threatening obstetrical emergency where the diagnosis is usually delayed or missed.

Rudimentary horn is developmental anomaly of foetus. Unicornuate uterus is classified as type 2 Mullerian anomaly. Our patient is classified under U4a (unicornuate uterus with communicating horn)

Aim: To report a patient with bHCG levels 87000 mui/ML who presented with ruptured ectopic pregnancy and hemoperitoneum.

Method

Case report

Result: A 27yr old G3P1L1A1 presented to our hospital at 14 weeks and was stable with moderate anaemia.

She did Usg on 25/07/24, which shows G sac in right adenexa adjacent to right ovary seen separately

from, visualised left uterine cavity showing live foetus of CRL- 4.26cm corresponding to 11 weeks ? Uterus like parenchyma around it ?? Further investigate to rule out bicornuate/ didelphus uterus.

She however without any further investigation to confirm the diagnosis and any consultation remained at home, and finally visited to hospital on 2/8/24.

She was admitted to hospital, was getting prepared for OT, with in this time frame, she developed symptoms like dizziness, acute pain in abdomen. On examination she became cold, calm, had tachycardia with BP recording of 86/42. On P/A abdomen was distended with tenderness, uterine size not palpable due to guarding. On P/V examination cervical motion tenderness present, no bleeding p/v.

She was shifted to OT asap, emergency laparotomy was done. Per operatively hemoperitoneum of 500ml was there, foetus along with placenta was lying in abdominal cavity. Rt side rudimentary horn which was ruptured was removed along with ipsilateral fallopian tube. Patient was shifted on stable vitals, and recovered well after that.

Conclusion: There is a need for an increased awareness of ectopic pregnancy and its dangerous complications, specially in developing countries where the possibility of detection before rupture is less likely. When such cases are presented, it also creates positive influence on patients, and it sensitises them to have frequent visits, and and to seek medical care timely.

Despite advances in USG and other diagnostic modalities, such cases of rudimentary horn pregnancy are delayed in diagnosis, specially can be missed in hand of inexperienced hands.

High index of clinical suspicion is needed to reduce mortality and morbidity.

EP30
CERVICAL ECTOPIC PREGNANCY

Liya P J, Bindu Bajaj, Pooja

Introduction: Cervical pregnancy is a rare form of ectopic pregnancy. In this the trophoblast invades the endocervix and pregnancy develops in the fibrous cervical wall. It can be presented with painless vaginal bleeding.

Case Details: 28 year old G2P1L1 with history of previous 1 LSCS at 8 weeks gestation present with spotting per vaginum. She had history of MTP pill intake 3 weeks back. Her USG was suggestive of cervical pregnancy. An USG guided suction evacuation was performed, and the patient was planned for methotrexate treatment based on serial beta hCG levels. Beta hCG levels were monitored weekly until they dropped below 5 mIU/mL. subsequent USG showed resolved cervical pregnancy.

Discussion: This patient presented with cervical pregnancy. Patient was managed by surgical method followed by serial beta hCG monitoring because pregnancy was viable. Management options include use of methotrexate, chemoembolization, suction evacuation or hysterectomy. Intraoperative bleeding can be controlled by preoperative UAE, by intracervical vasopressin injection or by a cerclage placed at the internal cervical os to compress feeding vessels.

Conclusion: Cervical pregnancy is a rare condition. There is no management proved superior, thus early diagnosis can help avoid complications and requirement of aggressive management.

EP31
Anterior Vaginal wall Endometrioma – Masquerading as Gartner's Cyst

Shiny Anuhya, Deepali Garg, Sonam Yadav, Monika Sahoo, Neha Varun, Rajesh Kumari, Vatsla Dadhwal, Neeta Singh

Introduction: Endometriosis affects 10% reproductive aged women. It occurs when endometrial glands and stroma deposit outside the uterine cavity, typically found in pelvis i.e., ovaries, pouch of Douglas, broad ligaments, uterosacral ligaments and bowel. Less than 1 % of endometriosis presents as vaginal endometrioma.

Case report: 42 year old woman P3L3, with all previous vaginal deliveries came with complaints of swelling in the vagina which gradually increased over 2-3 years associated with cyclical vaginal discomfort and dyspareunia. On examination, 3 * 2 cm vaginal wall cyst, which was fluctuant and non-tender noted over anterior vaginal wall, 1 cm distal to urethra. Cystoscopy done to exclude urethral diverticulum due to close proximity of the cyst to urethra. Cyst excision done and thick chocolate coloured, heterogeneous fluid drained.

Histopathological examination revealed cyst wall lined by columnar cells, lympho-mononuclear inflammation.

Discussion: Endometriosis at episiotomy scar will present as a painful cyst and with cyclical discomfort. Usually, an ultrasonography will suffice but MRI is preferred when urethral communication is suspected. Medical management includes hormone therapy like OCPS to reduce local estrogen production, thereby decreasing tissue growth and inflammation at endometriotic implants. This helps to alleviate dysmenorrhea and pelvic discomfort in endometriosis.

Conclusion: Differential diagnosis of vaginal wall cyst includes Gartner's duct cysts, urethral diverticulum, Bartholin's cyst and rarely endometrioma

Surgical excision of the entire cyst wall with wide margins is preferred in vaginal endometrioma over medical management because of its risk of malignant changes and to prevent recurrence

EP32
Harlequin ichthyosis: a rare genetic skin disease

Rashi Varshney

Abstract: Harlequin ichthyosis(HI) is a rare and fatal genetic disease of newborns transmitted as autosomal recessive. The disease is associated with high infant mortality shortly after birth. The pathognomic feature of the disease is the presence of thick keratinized scales and deep fissures all over the body. These affect the shape of the eyes, nose, mouth, and ears causing typical dysmorphic faces. There is also restricted movement of the chest leading to breathing difficulties The newborn suffers from severe neonatal complications due to premature birth, respiratory distress, increased susceptibility to infections, and dehydration. Diagnosis is based on the typical appearance at birth and confirmed by genetic testing. We report a first case in our hospital of a 21-year-old primigravida who delivered a preterm baby with Harlequin ichthyosis. The baby required NICU admission due to respiratory distress for supportive care. The only positive history was that the parents had a consanguineous marriage with no family history of similar conditions. This mandates genetic counseling of the ABCA12 gene in parents and prenatal genetic testing in future pregnancies.

Keywords: Harlequin ichthyosis, autosomal recessive, genetic disease, ABCA12 gene

Background: Harlequin ichthyosis is a rare and severe form of congenital genetic skin disorder. Incidence is approximately 1 in 300,000 births transmitted as an autosomal recessive disorder. It is caused by mutations in the lipid transporter adenosine triphosphate binding cassette A12(ABCA12)gene. The disease has a 25% chance of recurrence in subsequent pregnancy. Early pretem birth ,family history and consanginous marriages are the risk factors. This disease is characterized by thick, armor-like scales all over the body, underdevelopment of the nose and ears, sparse hair, hypoplastic digits, short limbs, a complete absence of eyebrows, eyelashes, and ectropion. As the skin barrier is severally compromised, these newborn suffer from excessive water loss and electrolyte abnormalities leading to temperature dysregulation, dehydration and increase risk of infections. They usually have a poor prognosis with high perinatal morbidity and mortality. Most infants die within a few days of life despite advanced support. Prenatal diagnosis of harlequin ichthyosis is possible by good ultrasound examination for typical morphological abnormalities, either chorionic villus sampling or amniotic fluid sample for ABCA 12 mutation testing. Management of such cases requires a multidisciplinary approach from the onset. We report a case of a woman who delivered a fetus with Harlequin ichthyosis diagnosed postnatally.

Case Report : A 21-year Primigravida was admitted at 34 weeks of gestation with preterm prelabour rupture of membranes. She was an unbooked case with no prior regular antenatal visits. Her past medical history was unremarkable. The parents had a history of consanguineous marriage but no family history of any inherited disorder. She missed her level II ultrasound and any prenatal screening tests .. No remarkable abnormality was noted in the last ultrasound examination done at 28 weeks of gestation.Patient was kept on conservative management with steroid cover with betamethasone and antibiotics. . A repeat ultrasound was performed during the stay which showed evidence of fetal growth restriction with severe oligohydramnios with The patient went into spontaneous preterm labor and delivered a girl baby at 35 weeks of gestational age. The weight of the baby was 1660 gm with a APGAR score of 5 at 1 min and 7 at 5 min.The baby had all the features

of Harlequin icthyosis.

The baby was covered with thick, waxy, plate-like scales with deep erythematous fissures all over the body, there was facial distortion with severe eclabium, ectropion, and underdeveloped ears. The limbs were in a semi-flexed position. The infant had restricted respiratory movements. The baby was immediately taken to NICU for further care. The baby was put on supportive treatment with intravenous fluids and broad-spectrum antibiotics. Parents were counseled about the prognosis and need for genetic testing for confirmation of diagnosis which they declined due to financial issues.The parents also refused any treatment for the newborn and got their newborn discharged on request on day 2 of life. They were also counseled regarding need for parental testing for ABC12 A gene mutation and prenatal genetic testing in future pregnancies.

Discussion: Harlequin ichthyosis is a rare and most severe and fatal form of autosomal recessive congenital ichthyosis. It manifests as severely keratinized skin, widespread fissures with harlequin facies, and severe life-threatening complications in newborns. About 90-95% of HI are associated with pathogenic mutation inABCA12 gene located on chromosome 2q33-q35. This gene codes for a protein necessary for transporting lipids out of the cells in the outermost layer of skin Prenatal diagnosis requires high suspicion where there is a positive family history, consanguinity between the parents, and the presence of skin disorder in offspring. Likewise in our case, there was a history of consanguineous marriage. The skin lesions can also be diagnosed by ultrasound as early as the second trimester. Three-dimensional ultrasound can show the typical fetal facies (fish-like mouth, eversion of eyelids, flat nose, and dysplastic ears). Limb abnormalities like curved toes hypoplastic fingers and clenched fists are also visible on ultrasound. These abnormalities become more pronounced as the gestation advances. Thus serial ultrasound examination in the second and third trimesters is required in high-risk pregnant women to find HI manifestations. A single ultrasound can be misleading and may miss the diagnosis of Harlequin ichthyosis like in our case which only showed evidence of fetal growth restriction with severe oligohydramnios. Prenatal diagnosis is also possible by chorionic villus sampling, and amniocentesis using skin biopsy at 24 weeks of pregnancy where there is a family history of HI. Postnatal diagnosis of HI relies on both typical physical examination and genetic testing for the ABCA12 gene. Biopsy of the skin may also done to assess the histologic characteristics of the cells. Histology shows the hyperkeratotic cells and and abnormalities of lamellar granules Most cases of HI have preterm birth so was our case. After birth newborns suffer from infection due to fissuring of the hyperkeratotic plates and respiratory distress due to physical restriction of chest wall restriction. Management in most cases is multidisciplinary supportive care in the neonatal intensive care unit. This includes the application of skin emollients multiple times a day, a humidified incubator, intubation, eye care, nutritional support with tube feeds, and sometimes debridement of constrictive bands of hyperkeratotic skin bands. Role of early treatment with oral retinoids like the drug isotretinoin has been shown to improve survival in a few cases. This drug has been shown to soften scales promote desquamation, and heal fissures and plates in a few weeks. Despite the supportive care, most newborns succumb to death within a few days of life due to neonatal complications of systemic infections, dehydration, and respiratory failure. Most infants do not survive past a week but with improved neonatal care and early institution of oral retinoids, survival may be improved.

Conclusion : There is limited information regarding course prognosis and definitive treatment of neonates affected with harlequin ichthyosis. However, it is now evident that these infants depending on the severity may have extended survival potential with supportive measures, the addition of retinoids. It has been linked to ABCA12 gene mutation, so genetic counseling and screening for mutation should be considered especially in families with a consanguinity marriage. The current case adds to the collective clinical knowledge of this rare genetic skin disorder.

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EP33
Medical management of rare interstitial ectopic pregnancy

Prachi Lochab, Y.M. Mala, Poonam Sachdeva, Shakun Tyagi, Sumita Agarwal, Pallavi Gupta, Peuly Das

Introduction: Interstitial pregnancy is a rare form of ectopic pregnancy that usually leads to uterine rupture resulting in sudden life-threatening haemorrhage, need for blood transfusion, and admission to intensive care unit. Mortality rate is 6–7 times higher than that in classical ectopic pregnancy. Uterine rupture has been typically reported to occur at more advanced gestational ages compared to tubal pregnancy. Medical treatment of the rare interstitial ectopic pregnancy with methotrexate has been considered an alternative to surgical resection.

Case presentation : Here we discuss a case of IVF conceived (donor ovum and donor sperm) pregnancy that was diagnosed as interstitial pregnancy .The patuent was managed medically using methotrexate with a successful result . A single dose intravenous methotrexate was given at a serum B-hCG of 87000 and serial monitoring of B-hCG was done where a negative B-hCG was taken as an endpoint of successful outcome .

Discussion : Multiple studies have been carried out to see the effect of medical management of interstitial ectopic pregnancy. Jeremy k. studied 20 interstitial pregnancies and their expectant and medical management . TANG, A studied 13 cases and their outcomes after medical management. No such study has been available from the Indian subcontinent.

Conclusion: The methotrexate regimen used as a one-dose treatment is safe and effective for unruptured interstitial pregnancy, with no side-effects and the advantage of avoiding invasive surgery.

EP34
Heat stroke as rare cause of stillbirth

Kriti Ranga, Y.M. Mala, Poonam Sachdev, Shakun Tyagi, Sumita Agarwal, Pallavi Gupta, Mandakini

Introduction: In Delhi city during peak of summers, temperature goes upto 48 degree Celsius. That can be the cause of heat stroke leading to various complications. Here we are presenting heat stroke as a rare cause of still birth. Due to altered thermoregulatory pathways in pregnancy ineffective heat dissipation is dangerous for both women and their developing babies and may lead to brain, kidney and muscle damage.

Case summary: 26year old G2P1L1 @ 28+1weeks presented with acute gastroenteritis and reddish lesion on body. She had exposure to severe heat because of the high temperature of the city which was 48 degrees.

On examination patient was conscious oriented, afebrile, dehydrated with PR- 114/min and BP-90/56mmHg.

On per abdominal examination- ut 26-28 weeks and FHS was not present.

Investigation- Hb-9.6gm/dl, TLC- 8450units, T.bil-0.56, OT/PT- 534/402, S.E.- 129/4.3 Urea/Creat-156/5.9

Course of stay- Patient was managed conservatively, plenty of fluids given, input output charting done, derma referral taken- miliaria pustulosis for which treatment started. Her KFT also improved with conservative management within 5 days. Patient spontaneously delivered an IUD on day 20 - baby weight 1150gm.

Conclusion: Health impacts from heat in pregnancy are largely preventable and thus needs to be taken care of during pregnancy to prevent dreaded complications like stillbirths and deranged kft.

EP35

Pregnancies Resulting from In-vitro Conception: The Menace for Modern-era Obstetricians

Anuja Chopra, Divya Panday, Jyotsna Suri, Monika Gupta, Sumitra Bachan, Zeba Khanam

Introduction: In vitro fertilisation (IVF) has revolutionised infertility treatment resulting in over a million births since their inception. IVF-conceived pregnancies are at an exceptional risk for adverse maternal and neonatal outcomes. We hereby, discuss varied clinical presentations and management options of three challenging cases of pregnancies resulting from IVF.

The first case, a 32-year-old primigravida treated for endometriosis-related infertility, presented at 22^{+6} weeks POG with severe preeclampsia superimposed on chronic hypertension, grade 4 lower limb and vulval oedema, vulval decubitus ulcers, ascites and pleural effusion. She was admitted to the Obstetric ICU where she was also diagnosed with chronic kidney disease. She was administered anticoagulant and antihypertensive therapy, multiple doses of albumin, in addition to emergent therapy for pulmonary oedema on more than one occasion. An emergency preterm caesarean delivery was done at 30 weeks of gestation for deteriorating maternofetal condition resulting in birth of twin babies weighing 1.2 and 1.4 kg. Intraoperatively, there were dense bowel-bladder adhesions resulting in inadvertent bladder injury. Patient required ICU care for several days and was discharged after prolonged in-patient hospital stay.

The second case, a multigravida, also presented at 31^{+1} weeks POG with chronic hypertension and discordant twins. On evaluation, there was absent end-diastolic flow in the umbilical artery in one of the twins. An elective preterm LSCS was performed at 33 weeks POG and she delivered twins weighing 1.6 kg and 900 g, however, the latter succumbed to neonatal sepsis on day three of delivery.

The third case, a 38-year-old primigravida, presented at 32^{+3} weeks period of gestation (POG) with growth- discordant twin and severe preeclampsia superimposed on chronic hypertension. An elective preterm caesarean section was done at 33 weeks POG due to severe and refractory hypertension. Intraoperatively, she had atonic post-partum haemorrhage requiring surgical management. She also developed severe hypertension (MAP 146 mmHg) for which she required ICU care for several days.

Conclusion: IVF conceived pregnancies are at exceptionally high risk for severe complications require tertiary level care under a multidisciplinary team of fetal medicine and high-risk pregnancy specialists, intensivists, general surgeons, radiologists, cariologists, nephrologists among others.

EP36

A Rare case of ovarian fibroma misdiagnosed as leiomyoma

Aakriti Aggarwal, Aakriti, Preeti, Poonam Sachdeva, Sumita Aggrawal, Y.M.Mala

Abstract-

Introduction: Ovarian fibroma is a benign tumour that belongs to the sex cord -stromal tumours. It is commonly misdiagnosed preoperatively as uterine leiomyoma. Incidence is 1-4% of all ovarian tumours.

Case Summary: 31year old P2L2 with Prev LSCS presented to gynae OPD of Loknayak Hospital with pain abdomen, dull aching in nature with regular menstrual history.

Ultrasound & CECT pelvis shows 7.4*7.8*6.06 cm mass in left adenexa abutting to uterus probably pedunculated/broad ligament fibroid with central degeneration. All Tumour markers were within normal limits.

At laparotomy – a solid ovarian mass 7*6 cm originating from left ovary which was removed with excision of the mass with left side salpingectomy and right sided tubal ligation.

HPE examination confirmed the diagnosis of ovarian fibroma.

Discussion: This case highlights the preoperative misdiagnosis of ovarian fibroma as leiomyoma which is a possibility because of solid nature of the mass.

Ovarian fibroma are generally seen to occur in post menopausal but this case was a young lady of 31 years which is uncommon age group.

1% of ovarian fibroma can present as Meig's syndrome with a triad of benign ovarian tumor, ascites & pleural effusion. Few patients can also have raised Ca 125 levels posing difficulty in preoperative diagnosis of its benign nature.

However frozen section is a good guide to do conservative surgery in young patients as was done in this case.

EP37
Unicentric Castleman Disease: A Case Report

Sharma. A; Dubey. R; Modi. R.D; Srivastava. M

Castleman's disease is a rare nonclonal lymphoproliferative disorder that may affect any part of the body, mediastinum being the common place (67%) and abdomen being the rarest site[1] manifesting commonly as Unicentric (UCD) or Multicentric (MCD).

Case of 44 years old asymptomatic female who underwent routine Ultrasonography which suggestive of ovarian cyst and CA125 was 15.8. MRI suggest of mass of 4.4x4.6x4.9 cm abutting left ovary anterior to uterus and superior to bladder with multiple enhanced lymph nodes. In view of unclear pathology, PET CT was done which reported FDG avid (SUV max 6.5) enhancing exophytic soft tissue mass lesion arising from anterior wall of uterus with few midly FDG avid retroperitoneal lymph nodes and few non FDG avid mesenteric lymph nodes. She underwent staging laparotomy. Intraoperatively about 8x6 cm solid mass present in mesentery of sigmoid colon with enlarged para-aortic, paracaval and aortocaval lymph nodes. Sigmoid colectomy was done. Histopathologic section showed confluent mass of lymph nodes exhibiting numerous lymphoid follicles which on IHC are positive for CD20 and PAX5 while interfollicular zones positive for CD3, CD138 in few and CD30 highlights immunoblasts which is suggestive of Castleman's disease of hyaline vascular type.

Castleman Disease (CD) is characterized by abnormal lymphoid tissue growth. UCD cases are usually asymptomatic or show compressive symptoms due to mass effect, while MCD is associated with systemic symptoms. Histologically, UCD is categorized into hyaline vascular (HV) and plasma cell (PC) variants. Surgical intervention facilitates recovery without adjuvant therapy.

Keywords: Castleman Disease, UCD, Abdominal mass_

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EP38
Placental Site Trophoblastic Tumour - A Rare Case Report

Dubey R ; Sharma A ;Srivastava M ; Modi R.D

Placental site trophoblastic tumour (PSTT) is a rare form of Gestational trophoblastic disease (GTD) representing 0.23 - 3 % of GTDs. It is malignant neoplasm of intermediate trophoblasts at placental implantation site having wide clinical spectrum of presentation and behaviour ranging from a benign condition to an aggressive disease with poor outcome. We report a case of placental site trophoblastic tumour in a 40 year female P4L4A1 with persistent irregular vaginal bleeding with low grade fever under evaluation with anaemia. She complained of menorhagia and dysmenorrhoea since last 6 months. There is history of spontaneous abortion 2 years back which was managed medically. USG pelvis reported heteroechic lesion of size 6.5x4.7x5.1 cm (vol 83.2 ml) seen filling the endometrial cavity with increased vascularity - features likely represent mitotic etiology. MRI pelvis reported an intense enhancing convuluted soft tissue lesion in the endometrial cavity probably arising from the anterior uterine wall with possibility of sessile endometrial polyp with degeneration . Patient was planned for examination under anaesthesia and endometrial biopsy but patient had massive intraoperative PV bleeding and uterine packing was done. Beta HCG was done considering suspicion of trophoblastic disease which reported 4213.99 mIU/ml. CECT abdomen and thorax done reported bulky uterus measuing 7.5x8.7x6.2 cm, endometrial cavity seen distended with a well defined hypodense mass and with strong post contrast enhancement, no metastatic disease seen in lungs. Bilateral uterine artery embolisation was done to control bleeding. Patient improved with above line of management. Beta HCG done post uterine artery embolisation reported 1351 mIU/mL. PET- CT done reported

bulky uterus with heterogeneously enhancing mildly FDG avid irregular heterogenous mass within uterine cavity appears suspicious of neoplasm. Type A Radical hysterectomy with Bilateral salpingo-oophotectomy with bilateral pelvic lymph nodes dissection was done. Post surgery beta HCG reported 25 mIU/mL. HPE reported PSTT FIGO stage 1 with Histomorphology of Intermediate trophoblast showing monomorphous population and Permeative pattern with infiltration of endometrial stroma and myometrium. On IHC studies PCK, CD10 and GATA 3 Positive and Inhibin – weak focal positive and Ki67 labeling: ~ 15%. Patient is being followed up on monthly basis with serial serum Beta HCG levels monitoring. **Keywords-** Gestational trophoblastic disease (GTD), Placental site trophoblastic tumor (PSTT).

EP39

Treatment of recurrent HPV- dependent Vulvar intraepithelial neoplasia (VIN) : A case report

Javalgi S, Shah M, Modi RD

Introduction: Vulvar intraepithelial neoplasia (VIN) is a non-invasive squamous lesion, a pre-malignant condition of squamous cell carcinoma of vulva. WHO classification divides VIN into 'HPV-dependent intraepithelial lesions' and 'HPV-independent VIN'. For definite diagnosis of VIN, a vulvar biopsy is needed. Treatment of VIN is surgical excision. Despite treatment, rate of recurrence is 6 to 50%. Treatment of recurrent lesions is challenging as may require re-surgery and distortion of local anatomy.

Case report: A 55 years-old female who was diagnosed with chronic vulvovaginitis presented with complaints of redness, itching and ulceration on right labia majora extending to labia minora. Vulvar biopsy reported VIN grade III and p16 showed block positivity in dysplastic epithelium suggesting a diagnosis of 'HPV-dependent VIN'. Patient underwent wide local excision of lesion with bilateral inguino-femoral sentinel lymph node biopsy outside. Histopathological examination (HPE) reported VIN grade III; margins - free of tumor, negative nodal involvement with no evidence of invasion. Thirteen months later, she presented to us with ulceration at the same site. Repeat biopsy was taken that reported VIN grade III. Skinning vulvectomy was performed with wide margins. HPE reported high grade squamous intraepithelial neoplasia (VIN III) HPV associated with free margins. Patient was started on 5% Imiquimod local application, initiating with twice weekly increasing to thrice weekly for 16 weeks. Patient is on follow-up with normal local examination and no similar complaints.

Results: Surgical management with free margins and imiquimod application results in good outcome in recurrent VIN with decreased risk of further recurrence and progression to squamous cell carcinoma; with decreased distortion of anatomy and no need for repeated excisions. The prognosis of biopsy-confirmed VIN that receives prompt treatment is uniformly good; there is rarely progression to invasive cancer unless treatment is declined or markedly delayed.

EP40

Spontaneous rupture of a mature ovarian cystic teratoma: A Rare case report

Nikhil Ritolia, Geeta Mediratta, Sharmistha Garg, Huma Ali

Introduction: The main complication of a dermoid cyst is cyst torsion (15%); other reported complications include malignant transformation (1–2%), infection (1%), and rupture (0.3–2%). Prolonged pressure during pregnancy, torsion with infarction, or a direct trauma are the main risk factors for a spontaneous dermoid rupture that can lead to acute or chronic peritonitis. Spontaneous rupture is an extremely rare complication of mature cystic teratoma because of its usually thick capsule. The incidence of chemical peritonitis after a cyst rupture is less than 1%. This condition requires urgent surgical treatment .

Case report: We report a case of 31-year-old P1L1 female, who developed chemical peritonitis resulting from a spontaneous intraperitoneal rupture of a dermoid cyst.

She presented to opd with complaint of pain lower abdomen along with abdominal distention, fever, and gastrointestinal disturbances such an anorexia, nausea, vomiting, and diarrhoea . On per abdominal examination guarding was present along with tenderness in right iliac fossa. On per vaginal examination a vague mass of 10x15 cm was felt in right fornix with restricted mobility. Her lab profile sent reported raised TLC : 13,480 along with DLC neutrophils: 80% , Lymphocyte: 20%. Tumour markers were sent and reports were as follows Ca

125: 154, CA 19.9 : 36.9 , CEA : 1.65 . USG and MRI done was suggestive of right ruptured dermoid cyst.

After adequate counselling laparoscopy was planned. Lap findings was as follows :

Yellowish fluid in pelvic cavity of around 400 cc with hair Shaft floating freely

Uterus and adnexae was covered with omental adhesions Adhesiolysis was done followed by right salpingo-oophorectomy and sample was retrieved in endobag through 10 mm port Extensive peritoneal lavage was done and pelvic drain was placed in situ Histological examination showed right mature dermoid cysts. The section of the right cystic ovary revealed accumulation of various mature tissues such as adipose, muscle tissue, mucous gland, cartilage, hair folicules with focal wall lymphoplasmocitic inflitration, and foreign body giant cells.

The ascitic fluid citology was negative for bacteria. Antibiotic therapy with Inj spacef 1.5 g I/V every 12 h and inj Metronidazol 500 mg I/V every 8 h for 5 days, was given, and prophylaxis of thrombembolism was administered.

The postoperative course was uneventful. The patient was discharged on the fifth postoperative day and sent for further outpatient observation.

Conclusion: Ultrasound and MRI is the imaging modality of choice for a dermoid cyst because it is safe, non-invasive, and quick to perform. Leakage or spillage of dermoid cyst contents can cause chemical peritonitis, which is an aseptic inflammatory peritoneal reaction. Once a rupture of an ovarian cystic teratoma is diagnosed, immediate surgical intervention with prompt removal of the spontaneously ruptured ovarian cyst and thorough peritoneal lavage are required.

EP41
Colorectal Cancer with Enterocutaneous Fistula in Pregnancy: A Case Report

Hooda P; Brijwal R; Mansukhani C; Gujral K

Introduction: Colorectal cancer during pregnancy has an estimated incidence of 0.8 per 100,000 pregnancies and associated with diagnostic challenges. Delayed diagnosis during pregnancy may be due to overlapping symptoms with that of normal physiological changes during pregnancy. Here, we present a case of colon adenocarcinoma in pregnancy with surgery and chemotherapy occurring during pregnancy.

Case Report: A 25 year old female G2A1 referred case at 28 weeks POG with c/o pain and discharge from left flank region. USG showed hyperechoic mass abutting bowel and abscess tract reaching till skin surface s/o ? Neoplastic mass with fistula. MRI reported frond like mass within descending colon likely mucinuous tumor of descending colon. Sigmoidoscopy showed polypoidal growth 25cm from anal verge. Biopsy reported well to moderately differentiated adenocarcinoma. Transverse colostomy was done at 30week of gestation and chemotherapy was given till 33weeks of gestation. At 34 weeks of gestation patient had a vaginal delivery of female baby of 1515grams with apgar of 8/10.

Discussion: Colonoscopy is the most accurate diagnostic test for CRC since it can localise and biopsy lesions. If diagnosis is made later (> 20 weeks), surgery can be postponed until 34 weeks or after delivery. However, waiting until after the fetus is delivered does pose risks to the mother. In second or third trimester, chemotherapy is considered safer but associated with an increased incidence of small for gestational age fetus. Chemotherapy is often continued until three weeks before the expected due date.

Conclusion: Colorectal cancer is a rare but devastating event during pregnancy. It is essential to be aware of the early symptoms in order to distinguish between the characteristics of normal pregnancy and those patients showing signs of CRC that will require further assessment. Diagnostic interventions and treatment should not be delayed due to the pregnancy but a balance between maternal and fetal wellbeing must always be kept in mind.

EP42
Ruptured Corpus luteal cyst in pregnancy Managed conservatively

Mandakini Mogare, Poonam Sachdeva, Shakun Tyagi, Sumita Agarwal, Kriti Ranga, Peuli Das, Y M Mala

Introduction: Ruptured corpus luteal cysts in pregnant women are a rare but important cause of acute abdominal pain during the antenatal period. These cases pose a diagnostic challenge as they can

mimic other obstetric emergencies such as ectopic pregnancy. Management of ruptured corpus luteal cysts in pregnant women depends on the clinical presentation, with conservative management being appropriate for stable patients.

Case Report:_A 28-year-old woman, G6P1L1A4, presented at 5 weeks of gestation with acute onset of severe lower abdominal pain. She was hemodynamically stable with no signs of peritoneal irritation. An urgent transvaginal ultrasound revealed a ruptured corpus luteal cyst on the right ovary with mild free fluid in the pelvic cavity. Her beta-hCG levels were consistent with an intrauterine pregnancy. Given her stable vital signs and minimal hemoperitoneum, conservative management was pursued. The patient was admitted, provided with intravenous fluids and analgesia, and closely monitored for 72 hours. Patient improved symptomatically, and repeat imaging showed no progression of free fluid. She was discharged and continued regular antenatal care.

Discussion:_Ruptured corpus luteal cysts during pregnancy are uncommon but can be effectively managed conservatively in hemodynamically stable patients. This case underscores the importance of differentiating ruptured cysts from other obstetric emergencies that require surgical intervention. Conservative management, including observation and symptomatic treatment, can lead to positive outcomes and prevent unnecessary surgical risks in pregnant patients. Early and accurate diagnosis through ultrasound is key to guiding appropriate treatment

EP43

Case report of tubal molar gestation: A rare occurrence

Mokshita Malhotra, Surbhi, Poonam Sachdeva, Sumita Agarwal, Y.M. Mala

Introduction: Incidence of ectopic pregnancy is 5/1000 pregnancies. Incidence of molar pregnancy is 4/1000 pregnancies. And the combination of both, i.e. ectopic molar gestation is a rare occurrence with very few cases reported in the literature.

We are reporting a case of partial molar tubal ectopic diagnosed at the time of histopathological examination.

Case report: 25 year old woman, presented with history of amenorrhea for 2 months with history of D and C after 1 month of amenorrhea. Patient presented in casualty with complaint of bleeding per vaginum and pain abdomen for two days. Per vaginum examination revealed right forniceal tenderness and ultrasonography showed right tubal ruptured ectopic pregnancy 4.7 *3.4 cm with ring of fire sign and mild hemoperitoneum and b hcg was 5500. Exploratory laparotomy revealed ruptured right tubal ectopic pregnancy and right salpingectomy was done and postoperative period was uneventful. Patient followed up with histopathological report suggestive of partial molar tubal ectopic pregnancy and follow up with b hcg was done.

Conclusion: The case unravels the importance of histopathological examination and b hcg followup in an ectopic pregnancy and including ectopic molar gestation in the differential diagnosis of a suspected ectopic pregnancy.

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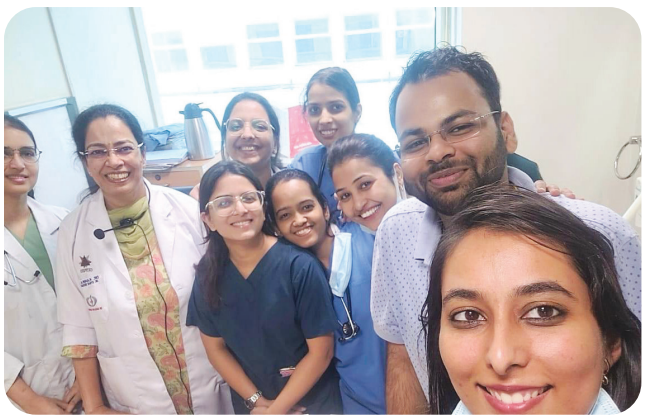


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