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Newsletter of The Indian College of Obstetricians & Gynaecologists

ICOG campus

Advancing Standards of Education and Healthcare Practices

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Message from Vice Chairman, ICOG

Dr. Uday L. Nagarseker
Vice Chairman, ICOG
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Greetings from ICOG!

I am sure, by now many of you have collected enough ICOG Credit Points and you are ready to wear a gown to collect your Credit Points Certificate at ICOG Convocation at Hyderabad!

As the Convenor of ICOG Credit Point System, I am awaiting to receive the requests for allotting the Credit Points to the CMEs those you are conducting at your Society level – What you have to do is to mail the detailed programme of your CME / Workshop with the names of Speakers and the timings. You will get a reply within next 24 hours about the Credit Points allotted to your scientific Session. Please print the Credit Points allotted on the Certificate of Attendance that every attending doctor gets.

With the ICOG Directory and CD in your hand, you must have contacted many of your forgotten friends and must have made new ones!

We are again eagerly awaiting for AICOG 2011 at Hyderabad, where Dr. C. L. Jhaveri ICOG Symposium along with other Scientific Bonanza will enrich your knowledge.

If you are yet to apply for FICOG / MICOG in spite of being eligible, please do it at the earliest – visit www.icogonline.org – download the application form and send it to our Office with the completed formalities as required. A Grand ICOG Convocation awaits you at Hyderabad!

With the initiative taken by our President Dr. Sanjay Gupte, Rules and Regulations of the Indian College Of Obstetricians and Gynaecologists will be redrafted by the special committee formed for this purpose and I see a Bright Future For ICOG!

Dr. Uday L. Nagarseker
Vice Chairman
Uday_goa@sancharnet.in

To all Organizers of Conferences, Workshops and Training courses.

Awarding Credit through Training Courses and Conferences.
If you determine that your course, seminar or conference qualifies for credit points, please send details to **secretary.icog@gmail.com**

Message from Joint Secretary, FOGSI

Dr. Girija Wagh
Joint Secretary, FOGSI
girijawagh@gmail.com

Dear friends,

It is indeed a great privilege to pen here my impressions and activities of the FOGSI as the Joint Secretary. I thank the President Dr. Sanjay Gupte for resting much faith in me and all the Office Bearers and Managing Committee Members for guiding me through my tenure as the Joint Secretary. Each one of them are icons who have achieved in their own rights as professionals and have worked dedicatedly for the great organization that is FOGSI. When I took on the responsibility of the Joint Secretary, the first thing that struck me was the intensity that each one here works with and the fact that there is a lot of scope for everyone and anyone who wished to relentlessly work for the endeavor of the women's health.

As the Joint Secretary, I was fortunate to be in-charge of all the projects initiated by FOGSI under the leadership of the President. The "Reaching the Unreached" initiative was basically based primarily to deal with the maternal health at large. As the convenor of the Critical Care in Obstetrics and Eclampsia Workshops along with Dr. Alpesh Gandhi, it was an eye-opener understanding the needs of all our members to learn about the nuances of critical care and eclampsia. Each and every workshop was attended by 350 participants and that was a great success. The Assisted Vaginal delivery workshops too received popular acclaim which I convened along with Dr. Parag Biniwale. Likewise all the other workshops viz Endofert workshops by Dr. Rishma Pai, PCOS and Birth defect workshops by Dr. Jaideep Malhotra and the Safe Surgical Practices in OBGYN by Dr. Tushar Kar were all received with stupendous response. The risk assessment work mats and the colposcopy workshops also are being satisfactorily executed all across the country.

The National Eclampsia Registry, the Maternal Mortality Registry and the Birth Defect Registry too are paving a way towards accumulating data and I feel we should be able to generate something substantial our of these endeavors. The focused conferences too were a great success which handled various issues such as contraception, the 5 Ps in obstetrics, infertility, safe surgical practices and the GESTOSIS. The Medicolegal Conference and the High Risk pregnancy conference are being planned enthusiastically, which the members can savor. Every member of the Managing Committee has put in his efforts to work towards the realization of the 'Reaching The Unreached' initiative of FOGSI. 'Reaching The Unreached' has been truly achieved through all these efforts. The President has been successful in persistently striking a dialogue with the policy makers and the Government of India and the Governments of States, many NGOs and thus has born the 'Save the Mother' National campaign which is yet another pan-India endeavor, planned to reduce the maternal mortality. The FOGSI website has become one great asset of the Federation, a true platform to understand the organization and to exchange thoughts and display views and an academic portal for all to access. I am inspired by all the members with whom I could interact and have realized the great magnanimity of this organization. Every member should be proud of associating with FOGSI and it indeed has been a year of complete transformation, evolution and a great insight into the working of our Federation and understanding the subject and the needs in the context of our Country.

'Do not let your fire go out, spark by irreplaceable spark, in the hopeless swamps of the approximate, the not quite, the not at all. Do not let the hero in your soul perish in lonely frustration for the life you deserved, but have never been able to reach. Check your road and the nature of your battle. The world you desired can be won. It exists, it is real, it is possible, it is yours'.

– Ayn Rand

Above is the quote which I feel inspires all in the Federation. I thank everyone who has relentlessly worked towards making this organization what it is. I also thank all those who gave me the opportunity to serve the Federation and inspired and guided me. I thank the ICOG campus editorial team for giving me this space to express my thoughts.
Love and respects to all.

Girija Wagh
Joint Secretary, FOGSI

ICOG Chairman's Address

Dr. Duru Shah
Chairman ICOG
chairman.icog@gmail.com

Announcement New Memberships open

To become a **new Member or Fellow** of ICOG ...please log on to **www.icogonline.org** for details.

Your feedback will also be appreciated by e-mail **chairman.icog@gmail.com**

Advances in Technology

In October 2010, the Noble Prize in Physiology and Medicine was awarded to Prof. Robert Edwards, the man who was ridiculed for experimenting with what was considered the greatest threat to humanity since the atomic bomb!

It's hard to believe today, that in the seventies even serious scientists suspected that Louis Brown, the first IVF baby might be born with monstrous birth defects. They wondered, "how can it be possible to mess around with eggs and sperm in a petri dish and not do some kind of serious chromosomal mischief?"

Edwards and his collaborator, Patrick Steptoe, who died in 1988, became notorious after they announced that they had fertilized a human egg outside the mother's womb. In England, reporters camped out on the lawn of the prospective parents, Lesley and John Brown, for weeks before the baby's due date.

When Mrs. Brown got herself admitted in the Maternity Hospital, for her delivery, she did so under an assumed name. But the news was so terrific that reporters sneaked past security dressed as plumbers and priests in hope of getting a glimpse of her. Fortunately, Louise Brown was not born a monster; but rather a healthy, 5- pound, 12-ounce blonde baby girl. She had no birth defects at all, and suddenly her existence seemed to demonstrate that there was nothing to fear about IVF. The birth of the "baby of the century" paved the way for extreme joy and happiness for millions of infertile couples- more than 4 million babies worldwide have been conceived by this technology to date.

Meanwhile, criticism of the pregnancy grew increasingly extreme. Religious groups denounced the two scientists as madmen who were trying to play God. Medical ethicists declared that in vitro fertilization was the first step in the process of development of artificial wombs and baby farms!.

The history of in vitro fertilization demonstrates how easily people accept new technology once it's demonstrated to be safe. It also suggests that the nightmares predicted during its development almost never come true. This is a lesson for us to keep in mind as we debate whether to pursue other promising yet controversial medical advances, from genetic engineering to human cloning. Yet many couples hesitate to take the IVF option. They say they face a moral or ethical dilemma. By consenting to conception in lab petri-dish outside human body, would they be going against God's plan?

The Catholic Church has opined: "Assisted reproduction dissociates the sexual act from the procreative act. IVF might be a practical solution, but the couple needs to consider its moral implications. Religions normally encourage scientific development, but differ with science on moral issues. Science, for instance, is not concerned with the morality of the atom bomb explosion".

The Muslim cleric Maulana Wahiduddin Khan offers the Islamic viewpoint. " A test-tube baby goes against the whole fabric of God's Creation. It is against the spirit of Islam", But he adds that there are exceptions to the rule.

According to Swami Nikhilananda Saraswati of the Chinmaya Mission, he says "there is nothing adharmic or unethical about assisted reproduction. Since time immemorial, man has used his ingenuity to procreate; ancient literature is replete with such stories. Sage Agastya took birth outside his mother's womb, in a pot. So what's wrong with a test tube baby? The jiva waiting to be born wil get a chance to come into this world and enjoy parental love and care".

The usefulness of this new medical technology called IVF has been debated many a times. Because besides being brilliantly used, it has been abused, as every technology is. We approve when a woman in her 30s who otherwise couldn't conceive does so through in vitro fertilization, but we hit back when the same technology is used for a 60 year-old who tries to do the same. As Edwards himself noted in the early 1970s, just because a technology can be abused, does not mean that we should not try to develop new technology. Electricity is a fantastic innovation yet it has lead to the invention of the electric chair. Does that mean that electricity is not good for us?

It is for us as academicians to learn the art of this new science, use it by following the best clinical practices and for the right indications, avoiding any abuse of this wonderful technology and doing what is ethically right.

Chhaya Patel's (name changed) daughter Mehek was born after she and her husband underwent four years of IVF treatment. "Scientists can create flesh and blood, but breathing a soul in that body is entirely God's prerogative, whether in a womb or in a lab." This is so true. Many scientists forget that they are only the means by which a creation is made, they are not the creators themselves.

Dr. Duru Shah
Chairman ICOG

Launching soon

The new **Online Quiz – Infertility** on the website **www.icogonline.org**

Who Can Do Obstetric Ultrasound in India?

Dr Narendra Malhotra
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FOGSI President 2008
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Obstetrician, Ultrasound & the PCPNDT ACT

Ultrasound, today, is the most useful medical equipment in the world across all field of medicine. Since the introduction of ultrasound by Prof. Ian Donald in late fifties and early sixties, the advancements in technology have been profound, so much so that it has been labeled as the find of the century, an invention paralleled to the use of anesthetics. The next century also foresees an unparalleled / progressive advancement of uses of ultrasound in medicine.

Unfortunately due to social reasons this wonderful equipment and investigative tools has also become the most misused and abused, especially for sex determination and sex selective abortions in our country.

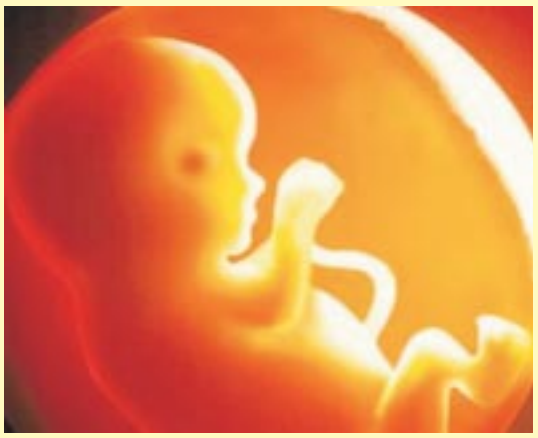
The main fields of ultrasound use are in examination of solid organs, superficial structures and vascular tree. The main clinical fields of application as of today are:
a. Obstetrics and Gynecology
b. Infertility and ART
c. General (Abdominal, small parts & musculoskeletal)
d. Vascular
e. Cardiology
f. Pediatrics

Health professionals who need to be well versed in the science and art of ultrasound are and should be:
a. Obstetrics and Gynecologists
b. Radiologists
c. Physicians
d. Surgeons
e. Cardiologists
f. Registered Medical Practitioners

Of the above, five categories of professionals do not require any further training in ultrasound as per MCI specified syllabus of post graduate students in these subjects, already specifies the request number of hours and months of training, also the D.N.B.E. syllabus of Obs & Gyn specifies the hour and months of training in ultrasound which are fulfilling the criteria for PCPNDT Act Registration.

Only registered medical practitioners with only MBBS Degree or a PG Degree in any other subject, who wishes to do Obstetric Scanning, should be adequately trained as per PCPNDT Act. The PCPNDT Act was formulated with the aim to provide for the prohibition of sex selection before and after conception and for regulation of the prenatal diagnostic techniques and for prevention of misuse of these techniques. Under this act there is a provision for registration in 3 categories:

a. Genetic Counseling Centre (GCC): A Gynecologist or Pediatrician or a medical Geneticist or Doctors with four weeks training as per MCI guidelines. DNBE syllabus and all postgraduate Obs Gyn degrees and diploma holders



are provided four weeks training and acquire six months experience during their residency, hence legally all obstetricians and gynecologists with a postgraduate diploma or degree can register as GCC without any further training.

b. Genetic Laboratory (GL) can be registered by medical geneticist or even Lab Technicians with a B.Sc. degree in biological science with one year experience in conducting prenatal diagnostic tests (Biochemical and/or Chromosomal) provided they fulfill all other criteria of qualified doctors & equipments.

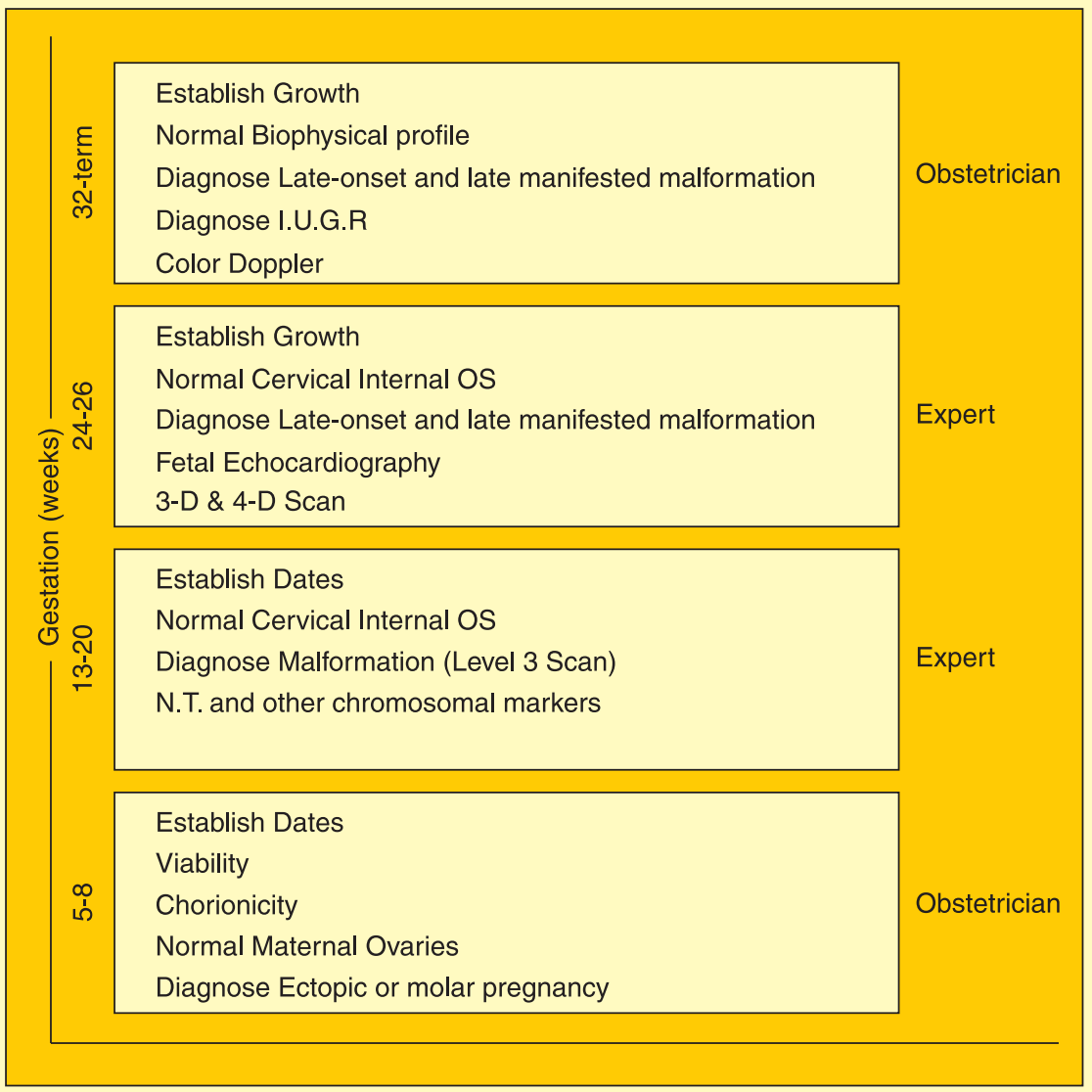
c. Genetic Clinic / Ultrasound Clinic or Imaging Centre can be registered by imaging specialist, radiologist gynecologist or registered medical practitioners with one year experience or six months training in sonography or image scanning. Medical geneticist may also setup genetic clinics / ultrasound clinic or imaging centres.

It is mandatory in India to register in any one of the above categories to carry out prenatal diagnosis or obstetric ultrasound and as per laws of the PCPNDT Act 1996. It is mandatory for all clinics doing obstetric ultrasound to fill forms and records as specified and keep records for two years. Not compiling to the law is a punishable crime.

Physicians who evaluate and interpret obstetric ultrasound should be qualified as specified in the PCPNDT Act and/or should be adequately trained (6 months). These physicians should have an understanding of ultrasound technology and instrumentation they should be able show familiarity with maternal pelvic anatomy and physiology and fetal growth and its abnormalities. They should also be familiar with other complimentary imaging and diagnostic procedures. This chart suggests how a pregnancy should be adequately evaluated and by whom at what stage.

So where is the debate of who can do ultrasound and what training is required?
Obstetricians and FOGSIANS, use this technology for the wellbeing of patient and fetus. Do not abuse it to manipulate gender. Refrain from sex selective procedures and abortions.

"Use sound to see better
Turn on the color to improve your image
& Go to the 3rd & 4th Dimensions"



ICOG Secretary Speaks...

Dr. Hema Divakar
Hon. Secretary, ICOG
secretary.icog@gmail.com

Thoughts and Actions at ICOG

Respected Colleagues and Dear friends ,

"As a race, Indians posses the power of reason and high intellect .But to find an expression, they need to go to the West - The irony" – S. Sharma

The ICOG certification courses

We at Indian College strongly believe that we must equip the future leaders with Competence and Character. We reverse the irony – by making opportunities available to our members and fellows right here! The ICOG certification courses at various centres have churned out candidates competent in the specialities of Perinatology, Ultrasonography, Reproductive Medicine and Minimally Invasive surgery. All co-ordinators have worked really hard to streamline the Syllabus/the fees/ the exam pattern. A visit to the website will lead you to the details of who can apply? How to apply? And also provide the list of centres which are already recognised and all relevant details The experts have an opportunity to teach and our members have a chance to learn at centres of excellence across India.

"Even if you are on the right track, you can get run over if you just sit there" - Will Rogers

ICOG CME

The concept of ICOG Study Hours was a great one!

The objective was to analyse the trends in practice and the knowledge and attitude on select themes (PCOS, GDM, Contraception and Post menopausal metabolic syndrome). Our faculty asked related questions at the Study hour as per the pre-designed questionnaire. This helped us gather the data at every ICOG CME from the participating delegates from all over the country. The GDM data has been analysed and expert comments written out and the survey has been linked to ICOG website. The debate and deliberations on each of these themes have helped us to understand the prevailing trends in practice and would translate into our inputs to the core team working on Good Clinical Practice Recommendations.

"Great things are not done by impulse, but by a series of small things brought together"- Vincent Van Gogh

EmOC GOI partnership

Developing skills for Emergency Obstetric Care by training over 600 medical officers so far under the FOGSI-ICOG EmOC programme and preparing a document for accreditation of healthcare facilities for offering minimum standards is a classic example of working our way with the Government of India over the last couple of years and developing their trust to work in partnership to bring down the maternal mortality in India. "Think Small" is the answer and we need to work on the micro details on how we revitalise healthcare where it is needed the most and transform scarce resources into skilled workforce- This will be a matter of National pride!

"You cannot turn back the clock, but you can wind it up again" - Bonnie Prudden.

Membership and Credit Points

The Joint MICOG MRCOG exams would be implemented from the next academic year , thanks to the continued efforts of senior office bearers .Until then, the membership to ICOG remains open with the modified criteria displayed on the website www.icogonline.org "Toughness" is a phase existing in books. In practice and in organisational work, it comes with experience. Recognising that it is tough to get the papers published, the Governing Council took a decision to introduce "ICOG Credit Points" for various scientific programmes and consider 100 points in three years to upgrade to a Fellow. We urge the organisers to have the Credit Points allotted to their programmes by writing to our Vice Chairman Dr. Uday Nagersekar.

I have laid out brief details of many happenings at ICOG and I wish to lay out a simple formula for all our readers - "Go about things in such a way that you feel proud of what you have contributed to the world, not just to your own life"

Looking forward to my conversation with you through the next issue

Warm regards
Dr Hema Divakar
Hon Sec. ICOG

To participate in FOGSI 2010 initiative
Visit www.fogsi.org & click on
" I want to participate in FOGSI 2010"
To participate in webenabled
National Eclampsia Registry
Visit www.abcofobg.com/Eclampsia

FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights

Dr. Bernard Dickens
Chairman, Committee for the
Ethical Aspects of Human Reproduction and
Women's Health, FIGO
Professor Emeritus of Health Law and Policy at
the Faculty of Law, University of Toronto
Professor Emeritus at the Faculty of Medicine
and the Joint Centre for Bioethics

Ethics and Human Rights regarding Sexual and Reproductive Health:

While human rights are protected by national laws and constitutions and by regional and international treaties, medical ethics are protected by codes monitored primarily by the medical profession. The principles of medical ethics applied to all individuals, such as beneficence (maximize best health outcomes), non-maleficence (do no harm), autonomy (ensure rights of persons to make informed choices about their own health care), and justice, are derived from and consistent with general human rights. The purpose of human rights is to promote human dignity. This translates into the obligation to benefit the patient in the course of health care (in respect both of their mental and physical health) and the commitment to doing no harm. The human rights to the highest attainable standard of health and to the benefits of scientific progress form the basis of the professional commitment to beneficence and justice. The human rights to a private life, to conscience and to liberty and security of the person are also key elements of autonomy that includes the duty to protect confidentiality in health care.

Relationships that underlie sexual and reproductive health are a natural part of life that should be entered into freely and safely, without violence or coercion, for both men and women. The sexual and reproductive rights that arise from human rights in general form an important part of medical ethics and apply to all women regardless of age, marital status, ethnicity, political affiliation, race, religion, economic status, disability, or other status. These rights imply a need to inform public opinion and to promote a respectful public dialogue, including different ethical and religious perspectives and noting that freedom of religion includes the requirement that no one religion or belief can impose its values on others. Thus, member societies must recognize and respect the diversity of cultures and religions that may exist within a country in order to provide culturally sensitive care for all women.

FIGO member societies adopt and promote among their members, the following professional responsibilities, based on their commitment to assuring human rights and ethical principles in the reproductive health care of women:

A. Professional Competence:

1. Attain and maintain the highest standards of professional competence in women's health, utilizing the most current and best available medical evidence within the context of available resources.
2. Assure that professional competence includes offering only services for which one is trained to a recognized standard and referring to suitably skilled professionals as circumstances permit.
3. Assure respectful professional conduct that promotes the dignity and security of every woman
4. Avoid inappropriate relationships with patients or their families, that may be exploited for sexual, emotional, financial, or research purposes.
5. Assure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.
6. Refuse to practice, or support practices, that violate human rights or principles of medical ethics.
7. Maintain and promote the highest standards of integrity and honesty with patients, colleagues and learners and in the conduct of research.
8. Model appropriate interpersonal behavior with patients and others in order to assure that optimal care and learning environments are promoted by all members of the health care team.
9. Advocate for life long learning for health care professionals in regard to reproductive and sexual health, rights, and ethics.

B. Women's Autonomy and Confidentiality:

1. Support a decision-making process, free from bias or coercion, which allows women to make informed choices regarding their sexual and reproductive health. This includes the need to act only on the basis of a fully informed consent or dissent, based on adequate provision of information and education to the patient regarding the nature, management implications, options and outcomes of choices. In this way, healthcare professionals provide women with the opportunity to consider and evaluate treatment options in the context of their own life circumstances and culture.
2. Ensure that confidentiality will prevent privileged information and recorded documents from being shared verbally or otherwise, except as required by law or desired by the patient.
3. Adhere to the principle of non-discrimination in order to assure that every woman is treated respectfully regardless of age, marital status, ethnicity, political affiliation, race, religion, economic status, disability, or other status. Women should be treated with respect for their individual judgment and not that of their partners or family.
4. Assure that adolescent women are treated without age discrimination, according to their evolving capacities - rather than merely their chronological age - in facilitating them to make free and informed decisions regarding their sexual and reproductive health.

C. Responsibility to the Community:

1. Advocate for the right of women to have access to the information and education needed to allow them to determine the timing of their reproduction in keeping with the ethical principle of autonomy and the human right to freely choose if and when to have children.
2. Advocate for the rights of women to make choices about sexual relationships as a natural part of their lives, assisting them to enter into these relationships freely and safely.
3. Advocate for appropriate resources and care for women seeking better reproductive and sexual health to ensure the rights to the highest attainable standard of health and the right to benefit from scientific progress.
4. Inform communities about the issues of sexual and reproductive health and rights in order to promote a broad respectful dialogue based on best health evidence in order to influence health practices, policies, and laws.

Although this document is specific to women, the principles articulated within may be equally applied to men.

This document is designed to complement the: "Recommendations on Ethical Issues in Obstetrics and Gynecology by the FIGO Committee for the Study of Ethical Aspects of Human Reproduction". November 2003.

Acknowledgements to the following member countries who submitted their codes of conduct as a resource:

- Australia/New Zealand
- Brazil
- Ethiopia
- Guatemala
- India
- Indonesia
- Ivory Coast
- Mexico
- Nigeria
- Pakistan
- Philippines
- South Africa
- Sudan

Acknowledgements to the FIGO Committee on Women's Sexual and Reproductive Rights and the FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health.

Key Message

Professionalism in health care of women is the means by which physicians provide ethical care that respects the sexual and reproductive rights of women. FIGO member socieities promote certain professional responsibilities among their members. These are based on their commitment towards assuring human rights and ethical principles in providing reproductive health care to women.

References:

United Nations High Commissioner for Human Rights (UNHCHR)
Web site: www.unhchr.ch
(Includes access to the United Nations Treaty Bodies State Party Reports and Concluding Observations for the Economic Covenant, The Political Covenant, the Women's Convention, the Race Conventions and the
Children's Convention)
Committee against Torture
www.unhchr.ch/html/menu2/6/cat.htm
Committee on Economic, Social and Cultural Rights
www.unhchr.ch/html/menu2/6/cescr.htm
Committee on the Elimination of Discrimination against Women
www.un.org/womenwatch/daw/cedaw
Committee on the Elimination of Racial Discrimination
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Individualizing Contraceptive Choices – ICOG CME

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Introduction:

Humans have tried to avoid pregnancy ever since they began to leave written record, still globally almost half of all pregnancies are unplanned and of these almost half are unwanted. Women risk their lives both times: to terminate an unwanted pregnancy, or to carry it to term

Despite considerable advances in contraceptive technologies, unintended pregnancies remain a substantial health issue. With the advent of 21st century, women have gained access to multitude of contraceptive options.

However, certain women are at high risk for using contraception, since some of the contraceptives methods pose a risk to women with medical disorders. Similarly the risk of pregnancy is much greater than the risk of contraceptive use in women with pathological disorders. The contraceptive needs are changing. There is an earlier onset of lifestyle diseases such as diabetes, cardiac disease, obesity. Women with serious medical disorders have longer and better lives today; some women may have multiple risk factors e.g. old ager, smoking, diabetes and hypertension making both contraceptive use as well as procreation risky for them.

The goal of this update is to focus on individualizing contraceptive choice for a woman with a balanced approach based on her health profile and medical eligibility criteria, lifestyle, reproductive stages and preferences.

What are Medical Eligibility Criteria?

These are updated recommendations based on current evidence to provide guidance for safe provision of contraceptive services with an aim to take care of clients with special needs and / or with known pre-existing medical / pathological conditions.

There are certain conditions that put a woman at an increased risk with contraceptive use, and special precautions are required. These include:

- Age - <16, >40
- Parity
- Postpartum - breast feeding
- Sepsis
- Cancers - breast, cervical
- CIN
- Vaginal Bleeding
- PID - current, past
- STI
- HIV /AIDS
- Smoking
- Hypertension - mild, severe
- DVT - past, current
- CVD - stroke, IHD
- Headache - migraine
- Diabetes
- Liver diseases – tumour, hepatitis
- Drug interactions
- Miscellaneous – obesity, fibroids etc.

There may be conditions that expose a woman to increased risk as a result of unintended pregnancy, thus avoiding conception is important. These include:

- Breast cancer
- Complicated valvular heart disease/ IHD
- IDDM with nephropathy/ retinopathy/neuropathy or other vascular disease; or of > 20 years' duration
- Endometrial /ovarian cancer
- High BP (systolic >160 or diastolic >100 mm Hg)
- Liver malignancy / Schistosomiasis with fibrosis / Severe cirrhosis (decompensated)
- Sickle cell disease
- STI
- Stroke
- Thrombogenic mutations
- TB
- HIV/AIDS

There may also be some clients with special needs with physical disability, mental disability and serious psychiatric disease.

Risk Categories:

All these high risk conditions are divided into various categories based on the risk. The risk for a specific condition varies with different methods of contraception. Accordingly the risk in these high risk situations is categorized as

Category 1
A condition for which there is no restriction for the use of the contraceptive method

Category 2
A condition where the advantages of using a method generally outweigh the theoretical or proven risks

Category 3
A condition where theoretical or proven risks usually outweigh the advantages of using the method

Category 4
A condition which represents an unacceptable health risk if the contraceptive method is used

Besides the risk category for individualizing contraceptive choices, it is also important to take into account the expressed desire of the individual, her social condition, her informed choice and her reproductive rights.

For ease of contraceptive prescribing WHO has designed a MEC Wheel (fig 1) as a useful tool for initiating a contraceptive method. The wheel includes common contraceptive methods viz:
COC - low dose
CIC - Cyclofem & Mesigyna
POP - LNG, Desogestrol
POI - DMPA
Implants
IUD - Copper bearing

By rotating the wheel the contraceptive counselor is able to judge the risk category of an individual for any specific method and is able to guide her to the most appropriate choice.

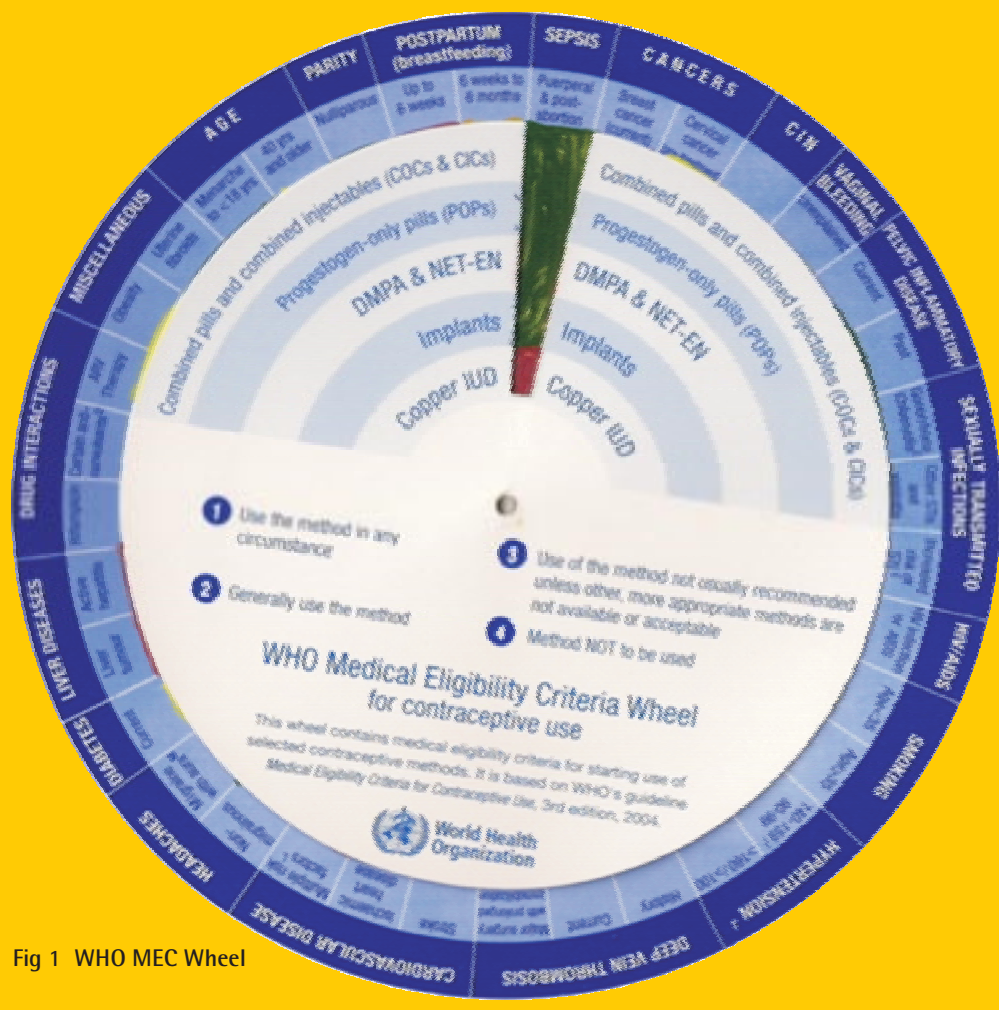


Fig 1 WHO MEC Wheel

Individualizing Contraceptive Choices – ICOG CME

Important to consider women on individual level:
Current focus is on tailoring contraceptive selection through open communication and available evidence. Attitudes and roles have changed for the modern woman. There is more complexity and value independence with individually defined lifestyles. Women are more empowered through increased information access and choices are also influenced by education and career goals. Different contraceptive methods have varied attributes which help a woman in making a choice. The contraceptive choice is also influenced by the reproductive stage of a woman (fig 2)

General guidelines for different stages are provided.

1. Postpartum contraception (Fig 3)
- Method chosen should not interfere with lactation
- Early initiation important - unpredictable return of menstruation & ovulation
- Ovulation may precede menstruation
- No woman should be denied contraception because she is breast feeding
- Time of delivery offers a unique opportunity to address the need for contraception
- Contraception not needed in first 3 wks post partum
- For lactating woman choices include POP, IUD, Injectable, Condoms and Sterilization

2. Post abortion contraception (Fig 4)
- Uncomplicated abortion - All methods can be used immediately
- Complicated abortion
- With infection – Abstinence/ Barrier, Delay IUD/ sterilization
- Genital Injury - Wait till healing, Condom may be used
- Excessive blood loss - Delay IUD/Sterilization, Norplant/ OCP may be used

3. Contraception for teenagers
- Require to adequately provide for infrequent, unpredictable sexual exposures
- Contraceptives with minimal side effects, cheap, easy to use and buy
- COC, POP, barrier methods suitable
- DMPA<18 yrs. not recommended to be used with caution
- Emergency contraception as a backup

4. Contraception for elderly >35 years
- Low dose OCP
- POP
- Sterilization
- Barrier methods: Male and Female
- IUCD's- All new new additions
- Injectables progesterone only contraceptives
- Vaginal sponges

5. Contraception for women with heart disease
- sterilization
- Barrier methods
- Low dose OCP with caution in <35 yrs with CVS risk factors

6. Women with diabetes
- No single appropriate method
- Sterilization
- Barrier
- Low dose OCP/POP in women without other additional risk factor
- ? IUD – some studies have shown no side effects

7. Drug Interaction
It is important to remember that some anti-tubercular and anti-epileptic drugs cross react with hormonal contraception by either lowering contraceptive efficacy or aggravating the side effects, thus other safer methods should be prescribed

8. Women at risk of STI/ HIV
Barriers methods, especially condom (both male & female are good options for these women, however since their contraceptive protection is low, a dual protection is advisable in this group.

For other common conditions the risk categories for common methods are depicted in Fig 5

Conclusion:
Population stabilization is our priority concern at the present time when the country is going through rapid economic development. This is essential for the benefits of the economic development to seep down to every individual of this country. A vibrant and effective contraceptive service with newer and more effective choices in the basket for the couples in need of it becomes the backbone of population stabilization.

"Family Planning could bring more benefits to more people at less cost than any other single technology now available to the human race."
- UNICEF

Fig 2 Reproductive stage and contraceptive need

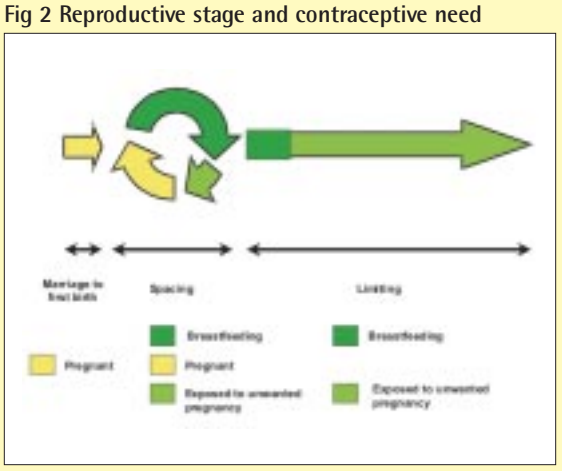


Fig 3 Contraceptive methods suitable in post partum period

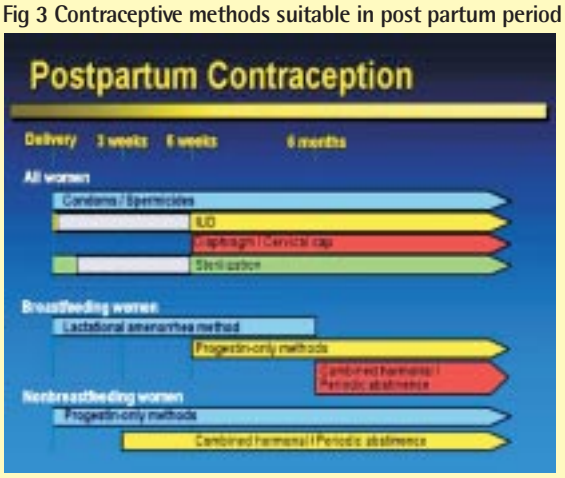


Fig 4 Contraception following an abortion

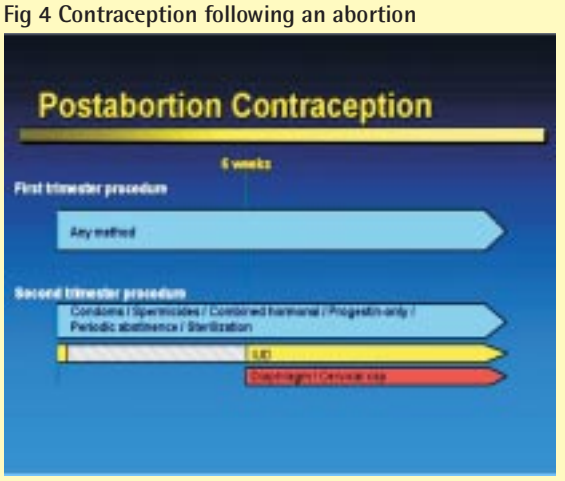
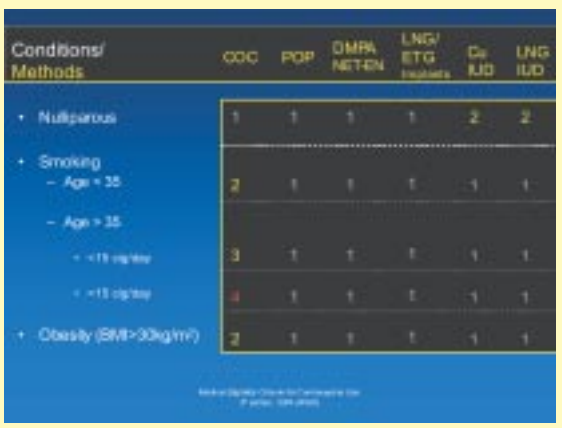
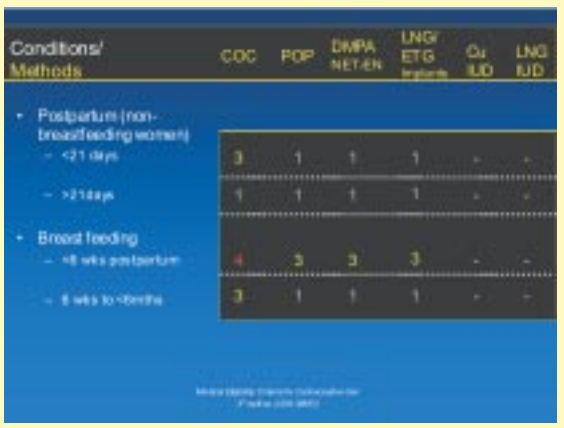


Fig 5 Contraception safety category for different conditions: source Medical Eligibility Criteria for Contraceptive Use. 3rd edition, 2004 (WHO)





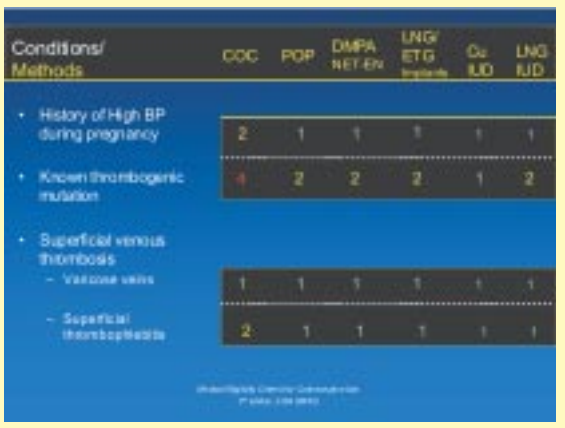
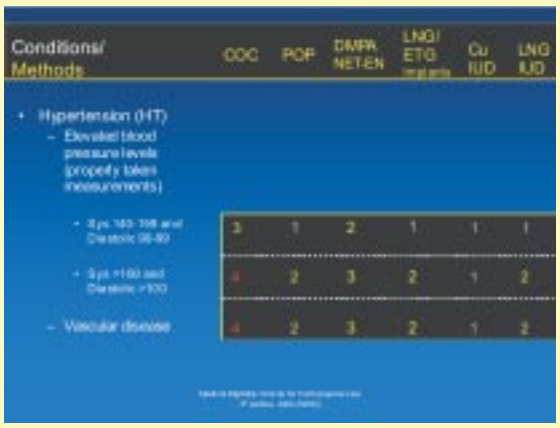
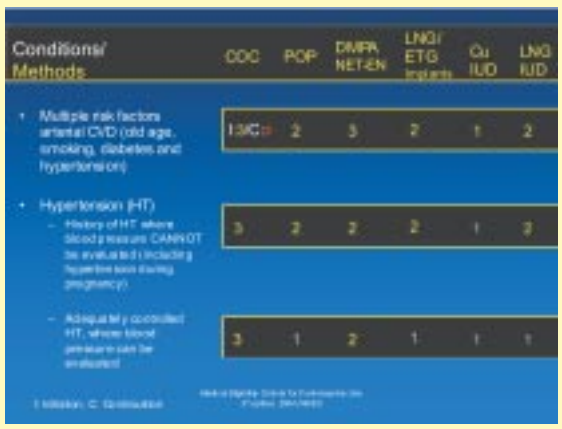
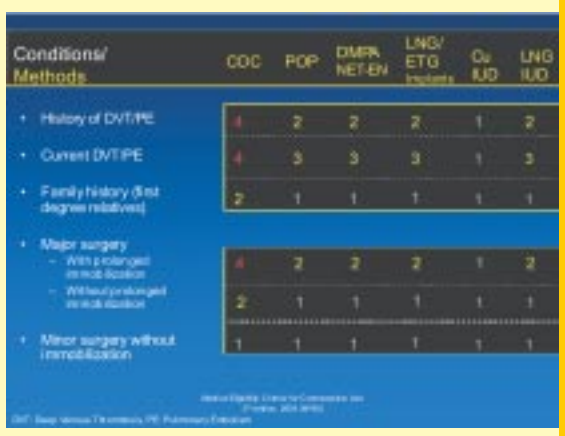
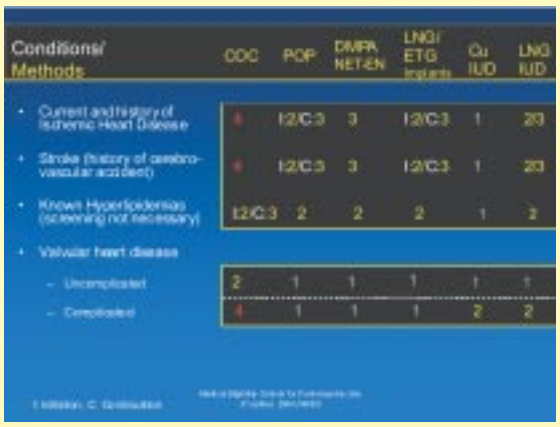


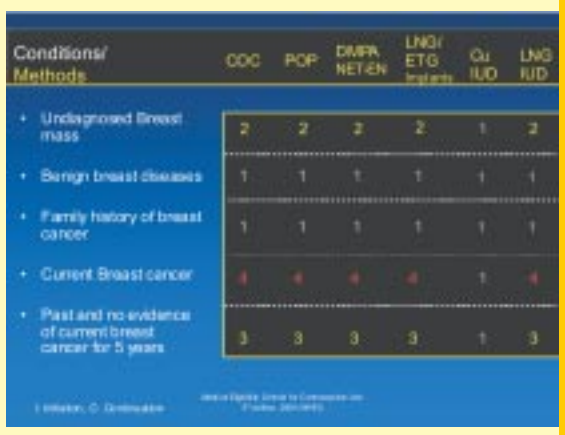
Fig 5 Contraception safety category for different conditions: source Medical Eligibility Criteria for Contraceptive Use. 3rd edition, 2004 (WHO)

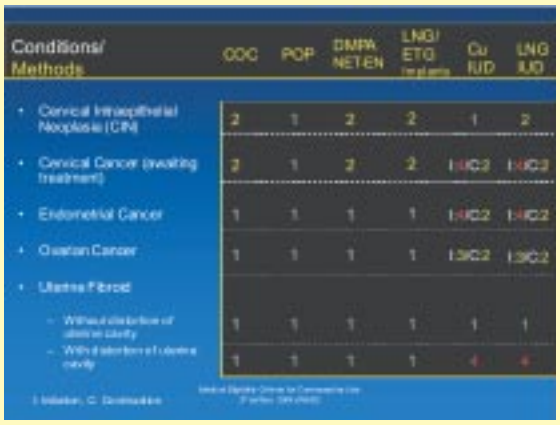












Questions for CME Credit Points

(More than one answer may be correct. Please refer to the answers which will be printed in the following issue of the newsletter. Credit Point Max 2 1 for attempt; 1 for answers > 50% correct) **Mail your answers to ICOG office at icogcme@gmail.com**

1. Contraception

A. is designed to prevent pregnancy
B. may be permanent or temporary, depending on the method
C. is only necessary in the first week following a woman's menstrual period
D. All of the above
E. A and B only

2. Which of the following forms of contraceptives contain hormones?

A. Norplant®
B. Depo Provera®
C. The pill (oral contraceptives)
D. Male and female condoms
E. A, B & C

3. Which of the following statements are true concerning contraception and STDs

A. Any contraceptive method that effectively prevents pregnancy also protects its user from STDs
B. Of the contraceptive options available today, the diaphragm or cervical cap offers the best protection against STDs
C. Male condom and female condoms offer the least protection from STDs
D. All of the above
E. None of the above

4. You may be putting yourself at risk for STDs if you

A. Have multiple sexual partners
B. Don't use barrier contraceptives
C. Use drugs, including alcohol
D. All of the above
E. A & B only

5. How effective is sterilization in protecting against pregnancy?

A. 100%
B. Over 99%
C. 90%
D. 85%
E. 75%

6. Vasectomy protects against sexually transmitted diseases

A. Always
B. Usually
C. Sometimes
D. Never

7. How often does a vasectomy operation fail?

A. 20% of the time
B. 10%
C. 5%
D. less than 1%
E. Never

8. IUD insertion is to be aoided following an induced abortion

A. in presence of infection
B. unsure of completeness of abortion
C. there is excessive blood loss
D. All of the above

9. COC use is contraindicated in all of the following except:

A. woman smoking >15 cigarettes/day
B. woman with known thrombogenic mutation
C. History of thrombophlebitis
D. Breast feeding woman

10. Safest contraceptive for woman with history of Ischemic heart disease is:

A. Oral pills
B. Implants
C. Copper IUD
D. DMPA

Answers: Issue 5 CME MCQ on Cervical Cancer and Its Prevention (Credit Points: 1 for attempt; 1 for answers > 50% correct)

1. d **2.** a
3. c **4.** c
5. a **6.** d
7. b **8.** b
9. b **10.** c

IPPF Charter Facts on Sexual and Reproductive Rights

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In 1995, International planned Parenthood Federation (IPPF) produced its Charter on Sexual and Reproductive Rights. This identified 12 core rights based on international human rights instruments, which are relevant to sexual and reproductive health.

The IPPF Charter Facts highlight factual information and figures that relate to each of the 12 rights of the IPPF Charter on Sexual and Reproductive Rights. There is also advice on how the rights can be used to address sexual and reproductive health and rights issues.

1. THE RIGHT TO LIFE

IPPF recognizes and believes that all persons have a right to life and that no one shall be arbitrarily deprived of their life.

The right can be used to address issues relating to:

- Maternal mortality: women dying due to having too many children, too close together, at too early an age or too late an age
- Safe motherhood: the right to experience pregnancy, childbirth and motherhood free from pain and illness with no long-term damage to the woman's health
- Access to skilled health professionals who can assist with childbirth and deal with possible complications
- Female feticide / infanticide: the killing of female children, occurring in countries where there is, for whatever reason, a marked son preference
- Genocide: measures including family planning are imposed which are intended to prevent births within a national, ethnic, racial, religious or cultural group with the intention of destroying, in whole or in part, that group
- Violence, including gender-based violence

Facts and figures

- As many as 300 million women - more than a quarter of all adult women living in the developing world - currently suffer from short - or long-term illnesses and injuries related to pregnancy and childbirth1.
- More than 500,000 women die each year as a result of pregnancy and childbirth[2].
- The risk of maternal death among pregnant women aged 15-19 is four times higher than among those aged 25-29.[1]

2. THE RIGHT TO LIBERTY AND SECURITY OF THE PERSON

IPPF recognizes and believes that all persons have a right to liberty and security of the person.

The right can be used to address issues relating to:

- Female genital mutilation (FGM) , also referred to as female circumcision (FC) and female genital cutting (FGC)
- Protection of children, women and men from sexual abuse and exploitation
- Protection from medical intervention related to sexual and reproductive health unless it is carried out with the full, free and informed consent of the person
- Forced sterilization
- Forced abortion
- Laws or practices requiring spousal or parental consent for contraception or abortion
- Laws which imprison women for terminating their own pregnancies.
- Externally imposed fear, shame or guilt and false beliefs which inhibit sexual response or impair the capacity to enjoy sexual relationships

Facts & figures

- FC/FGM affects over 90 million women throughout the world.[3]
- Women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a stillborn child than other women.[4]

3. THE RIGHT TO EQUALITY AND TO BE FREE FROM ALL FORMS OF DISCRIMINATION

PPF recognizes and believes that all human beings are born free and equal in dignity and rights; It also recognizes the right of women not to be discriminated against by way of legislation, regulation, customs, practices, social and cultural patterns of conduct or other customs or practices, which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

The right can be used to address issues relating to:

- Gender-based violence
- Laws which prohibit discrimination against any minority group and their effective enforcement
- Discriminatory practices and customs
- Gender-sensitive interpretation of human rights
- Discrimination in access to sexual and reproductive health care information, education and services. For example, where women need spousal consent, young people need parental consent, services are only available to married women
- Discrimination against women which denies them access to appropriate nutrition and care, and legal protection against violence, especially domestic violence
- Discrimination on the grounds of pregnancy or motherhood in social, domestic or employment spheres
- Sexual and reproductive health programmes which have the effect of discriminating against particular population groups

Facts & figures

- Worldwide, at least one woman in three has been beaten, coerced into sex, or otherwise abused in her lifetime.[5]
- The World Bank estimates that in industrialized countries sexual assault and violence take away almost one in five healthy years of life of women aged 15-44.[6]

4 THE RIGHT TO PRIVACY

IPPF recognizes and believes that all persons have the right not to be subject to a arbitrary interference with their privacy, family, home or correspondence.

The right can be used to address issues relating to:

- Legal frameworks which recognize the right of individuals to make autonomous choices related to reproduction and sexuality, including, for women, those related to safe abortion
- Service guidelines which ensure that personal information given will remain confidential
- Sexual and reproductive health information and services for young people that respect their right to privacy and confidentiality
- Persecution, denial of liberty or social interference due to sexual orientation
- Forced pregnancy or continuation thereof
- Breach of confidentiality
- Laws or practices requiring spousal or parental consent for contraception or abortion

Facts & figures

- Each year, approximately 20 million unsafe abortions are carried out worldwide leading to 70,000 maternal deaths.[7]
- Women in Turkey still need spousal consent to have an abortion, even when adult.

5. THE RIGHT TO FREEDOM OF THOUGHT

IPPF recognizes and believes that all persons have the right to freedom of thought, conscience and religion; that the right to freedom of opinion and expression includes the rights to hold opinions without interference and to seek, receive and impart information and ideas via any media and regardless of frontiers.

The right can be used to address issues relating to:

- Interpretations of religious texts, beliefs, philosophies and customs that respect freedom of thought and speech concerning sexual and reproductive health and rights
- Restrictions on the grounds of thought, conscience and religion to access sexual and reproductive health and rights information and services

Facts & figures

- Many young women are faced with the challenge of saying no to unprotected sex, especially when dependent economically and socially on their male partners. The fear of violent consequences contributes to the absence of any negotiating position for protected sex.[8]

6. THE RIGHT TO INFORMATION AND EDUCATOIN

IPPF recognizes and believes that all persons have the right to education and, in particular, to specific

educational information to ensure the health and well-being of persons and families including information and advice on sexual and reproductive health and rights.

The right can be used to address issues relating to:

- Access for young people to full, objective and balanced information on sexual and reproductive health, including HIV/AIDS and other sexually transmitted infections
- Information that is gender-sensitive, pluralistic and free from stereotypes
- Provision of information on potentially harmful side-effects of fertility regulation methods
- Access for all to a guaranteed minimum level of education
- Discrimination against pregnant girls in education

Facts & figures

- A World Health Organization review showed that the most effective sex education programmes were those that taught about contraception, sexually transmitted infections and abstinence, rather than abstinence-only programmes.[9]
- A recent study of 107 countries found that 44 did not include AIDS education in their school curricula.[10]

7. THE RIGHT TO CHOOSE WHETHER OR NOT TO MARRY AND TO FOUND AND PLAN A FAMILY

IPPF recognizes and believes that the right to choose to marry and to found and plan a family is implicit in the right of all persons of full age to marry and to found a family without any limitation due to race, nationality or religion.

The right can be used to address issues relating to:

- Forced marriage, especially child marriage
- Forced pregnancy, or continuation there of
- Non-discriminatory access to sexual and reproductive health services, including family planning, infertility treatment, and the prevention and treatment of sexually transmitted infections, including HIV/AIDS

Facts & figures

- Young girls are often pushed into marriage by their families for economic, social and cultural reasons.[11]
- Girls are often forced to marry men much older than themselves, leaving them particularly vulnerable to an abusive relationship.[12]

8. THE RIGHT TO DECIDE WHETHER OR WHEN TO HAVE CHILDREN

IPPF recognizes and believes that the right to decide whether or when to have children is implied by the right, that all persons have, to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right, and further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth.

The right can be used to address issues relating to:

- Unmet need for information, education and services related to sexual and reproductive health, safe motherhood and safe abortion
- Access to services that are available, affordable, acceptable and convenient
- Campaigning for services that offer the widest possible range of safe, effective and acceptable methods of fertility regulation
- Forced pregnancy
- Discrimination against women in the workplace that makes it difficult for them to have children and remain in employment
- Parental or spousal consent requirements for access to contraception or abortion services

Facts & figures

- More than 350 million couples worldwide do not have access to a full range of contraceptive methods and information.[1]
- Globally, there are an estimated 200 million pregnancies each year. About one third of these - approximately 75 million - are unwanted.[1]
- According to latest estimates a total of 122.7 million married women in the developing world have an unmet need for sexual and reproductive health services.[13]

9. THE RIGHT TO HEALTH CARE AND HEALTH PROTECTION

PPF recognizes and believes that all persons have a right to the enjoyment of the highest attainable standard of physical and mental health.

The right can be used to address issues relating to:

- Access to a full range of quality sexual and reproductive health services
- Access to health professionals
- The prevention, diagnosis and treatment of sexually transmitted infections, including HIV/ AIDS
- Health rights of refugees
- Restrictive abortion laws, especially where continuing the pregnancy would be harmful for the physical or mental health of the woman

Facts & figures

- In many countries of Europe and in North America 99 per cent of all births are attended by skilled personnel. This figure is 47 per cent for Africa and 59 per cent for Asia.[14]

10.THE RIGHT TO THE BENEFITS OF SCIENTIFIC PROGRESS

PPF recognizes and believes that all persons have the right to enjoy the benefits of scientific progress and its applications.

The right can be used to address issues relating to:

- Access to the benefits of all available reproductive health technologies, including newer methods of contraception, abortion and infertility treatment, provided those technologies are safe and acceptable
- Use it or lose it patient provisions, which encourage companies to maximize the use of technologies they have developed
- Gender-sensitive medical research
- Provision of information on any harmful effects of reproductive health care technology

Fact & figures

- Mifepristone has been registered for use as medical abortion in most of Europe, including Austria, Belgium, Denmark, Finland, France, Germany, Great Britain, Greece, Luxembourg, the Netherlands, Norway, Spain, Sweden and Switzerland. This expands a woman's options when having decided to terminate a pregnancy[15].

11. THE RIGHT TO FREEDOM OF ASSEMBLY AND POLITICAL PARTICIPATION

IPPF recognizes and believes that everyone has the right to freedom of peaceful assembly and association.

The right can be used to address issues relating to:

- Community action to improve access to sexual and reproductive health services.
- Community campaigns to change laws related to sexual and reproductive health and rights
- Community action to address issues such as gender-based violence
- The defence of individuals or organizations persecuted for matters relating to sexual and reproductive health and rights

Facts & figures

- Non-governmental organizations (NGOs) and individuals worldwide have campaigned against the Global Gag Rule, which denies U.S. family planning assistance to foreign NGOs that use funding from any source to carry out abortion related activities. The Global Gag Rule restricts lobbying to make abortion legal, or more available.
- Women parliamentarians and NGOs fought for the legalization of the oral contraceptive pill in Japan. The Japanese government, after deliberating for nine years, finally decided to allow its limited sale in 199916.

12 THE RIGHT TO BE FREE FROM TORTURE AND ILL TREATMENT

PPF recognizes and believes that all persons have the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment and not to be subjected to medical or scientific treatment without free and informed consent.

The right can be used to address issues relating to:

- Protection of children from sexual exploitation, prostitution, trafficking, sexual abuse, coercion to engage in any unlawful sexual activity
- Protection of all persons from rape, sexual assault, sexual harassment, violence, including gender violence, medical trials or experimentation related to sexuality or fertility that are conducted without the full, free and informed consent of the persons involved

Continued on page15

Newer Trends in Pelvic Floor Surgery

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Genital prolapse in antiquity finds its roots in the Ebers Papyrus (1500 BC). Soranus of Ephesus (AD 98-138) is commonly considered the foremost gynaecologic authority of yore. He proposed vaginal hysterectomy for uterine prolapse in AD 120. Exactly 100 years ago, Donald and Fothergill started the modern era of prolapse surgery in performing a procedure that after some modifications came to be known as the Manchester procedure. The vaginal reconstructive approach was described by Zweifel in 1892 and involved suspension of the prolapsed vagina to the sacrotuberous ligament. Richter modified this procedure and the current form of sacrospinous colpopexy was born which was later fine tuned and popularised by Randall and Nichols in the early 70's. Results from prolapse surgeries have been disappointing. In the anterior compartment alone recurrence rates of 25-35% are not uncommon in the literature. Additionally underdiagnosis of the severity of Pelvic Organ Prolapse can occur in about a third of cases in outpatient assessments, therefore it follows that when the true severity is revealed under an anaesthetic the pelvic surgeon should have numerous choices available to correct the prolapse without compromising the consent for surgery

Consequently the sub speciality of Urogynaecology and Reconstrucitve Pelvic Surgery has seen an unprecedented and unparalleled explosion of "new technology" in the management of the vexatious problem of Pelvic Organ Prolapse and Female Incontinence. Much of it has been occasioned by a greater and better understanding of the anatomy of the pelvic floor thanks mainly to the seminal work done by Dr. John DeLancey. The profusion of new techniques to match the technology has presented an unique challenge, not only to the sub-specialists dealing with the care of these women but also for the Generalist,who at least for the foreseeable future will deal with the "numbers", that finds it increasingly difficult to keep up to speed with these developments.

The introduction of the TVT procedure by Ulf Ulmsten in the 1990's kick started the quest for the development of newer approaches to the surgical management of Stress urinary incontinence. Not only did it dramatically change our understanding and perception of the cause of this condition, focussing on the mid urethra rather than the classical "urethrovesical hypermobility" but also managed, in one fell swoop, to effectively replace the existing gold standard procedure, Burch colposuspension, as the preferred and minimally invasive option. It also to a large extent invalidated the Laparoscopic version of the Burch. There has been no looking back since then with newer versions focussing on the more minimally invasive transobturator approach rather than the retropubic approach of the TVT. The Transobturator tape (TOT) involves a lesser risk of bladder perforation than its predecessor and also has a flatter learning curve. The fact that a cystoscopy is not a must during or after the procedure is an added bonus besides which the incidence of post-operative voiding dysfunction is lower as well.

The TVT however still retains its relevance and is the procedure of choice in women with low urethral closure pressures on Urodynamic testing. Recently an even more minimally invasive option,aptly named the Mini arc, has been developed that requires a single incision and does not necessitate transgression of the obturator foramen thereby reducing complications besides having the added advantage of being suitable for obese women in whom surgical access can be a problem. Long term data are still not available to confirm the efficacy of this new procedure but initial results are promising. Then there are other biotech companies that have developed adjustable sub-urethral slings for women with recurrence or failure of the primary procedure.

Injectable soft-tissue urethral bulking agents have been developed for treating adult female stress urinary incontinence primarily due to intrinsic sphincter deficiency. These agents are usually made up of two parts, a water-soluble gel and a rubber-like, silicone elastomer implant material that is permanent and not absorbed by the body. This out-patient cystoscopy directed procedure has an added benefit of being an office procedure. In the cases that have frustrated all attempts at achieving continence the Artificial Urinary Sphincter may be the only remaining option. In a significant proportion however addition protection may be required to guard against small urinary leaks though it does afford the patient a degree of continence that allows her to resume her activities of daily living. It does require to be surgically implanted and infection is a real and ongoing concern.

Investigations particularly imaging modalities have also kept pace with improvement in surgical technology. There has been a paradigm shift towards functional imaging directed to detect not just anatomic breaks in the pelvic cellular tissue but also derive their impact on organ function. The role of MRI with or without barium studies,a defaecogram for instance, might help reveal hitherto-unseen rectoceles and also differentiate anterior from posterior rectoceles,the latter might require colo-rectal inputs to enable appropriate surgery like a retrorectal levatorplasty to be performed. MRI is however both equipment intensive and real time images cannot be provided. 3D pelvic floor ultrasound represents an exciting new development and it provides real time inputs with the additional benefit of the ability to digitally reconstruct images as distinct as the ones on a MRI. Moreover these imaging modalities can be used to predict the likelihood of pelvic floor trauma in a pregnant woman and hold considerable promise as a tool in the primordial prevention of levator injuries.

Urodynamics has always been one the cornerstones in the objective assessment of Urinary incontinence. Recent developments in software and equipment has added an element of accuracy that has largely eliminated artefacts innate to laboratory testing. In fact most units nowadays routinely perform transperineal ultrasound imaging and cystoscopy as an adjunct to urodynamics both pre and post operatively. The assessment of injuries to the external anal sphincter may also sometimes fall under the purview of urogynaecologist that need further investigation via Pudendal Nerve Terminal Motor Latency testing and Anal Manometry.

There has been a conceptual shift in surgical management of pelvic organ prolapse both with regards to the anatomic concepts that govern surgeries for prolapse as with the methodology and materials employed to achieve operative correction. Departing from the classical abdominal and vaginal approaches for the management of pelvic organ prolapse, pioneering work revealed the suitability of the obturator foramen as a conduit for driving needle driven mesh kits to achieve levels of support appropriate to the organ prolapsing. These new and exciting developments have heralded a new era in reconstructive pelvic floor surgery. Competing biotech companies have developed mesh kits that essentially work on the principle of an anchoring tissue, for example the sacrospinous ligament or the Arcus tendineus fascia pelvis that serve as a fulcrum for the mesh arms traversing these structures,providing level 1 or level 2 support as the case may be. As a consequence it became necessary to develop an anterior approach to the sacrospinous ligament as well modifying the classical posterior approach that has increasingly become standardised as it has become minimally invasive.

Mesh kits have also mandated modifying techniques of dissection that differ from the classical approaches in

that one is required to dissect deep to the underlying pubovesicocervical and rectovaginal fascia as the mesh should preferably lie in close proximity to the viscus,the bladder or the rectum as the case may be, in order to minimise the possibility of mesh erosion. The most prevalent challenge is that of directional reversals the surgeons have to deal with especially considering the potential for injury to anatomic structures in the narrow confines of the pelvis. The surgeon needs to be mindful of the movements during the driving of needles through the obturator foramen in that when the handle moves outwards its tip correspondingly moves inward. It is useful to remember the fact that patient positioning should be supervised by the surgeon - it is too awkward to change it mid operation and importantly the anatomy also changes with changing patient position! It is equally imperative that the mesh be left under minimal or no tension to allow room for mesh contracture and to reduce complications. In fact as the redundant vaginal wall is rarely excised the end result is not very visually pleasing. This in itself is counter-intuitive in that it represents a departure from the conventional belief that a successful surgical result results from vaginal skinning, trimming of the skin edges and that at the end of the operation one should see a "taut" vaginal wall devoid of "bulges". This requires some degree of re-learning and can usually be overcome by the surgeon through appropriate training.

Although there have better longer term anatomic success rates with lower rates of recurrence these newer techniques have been responsible for complications such as mesh erosion, infection,organ dysfunction and chronic pain syndromes that have necessitated revision surgeries or even removal. And perhaps we do not focus enough on the invariable "his pareunia" in the partner of every woman with dyspareunia secondary usually to an over enthusiastic vaginal trimming or an overtly tensioned mesh. Some sage advice to keep us grounded-every needle, every Kit is DIFFERENT – helical needles, open curve needles, self retrieving needles, needles with inner and outer sheaths all require a detailed knowledge of anatomical safety – preferably demonstrated on cadavers first! Understanding the needle curvatures and pelvic anatomy is paramount to prevent major visceral injuries. This has also occasioned a raging debate on whether this new technology was hastily introduced, aggressively marketed by the biotech majors and even more whole heartedly accepted by the surgical community without the benefit of proper clinical trials. Mesh surgery for prolapse is currently in the 'eye of the storm' and hopefully a large randomised controlled trial(PROSPECT) in the UK may provide some answers. In the meantime there have attempts to develop less invasive techniques that use mesh with special anchors to facilitate attachment but do not require blind needle passes in potentially dangerous anatomic locations in the pelvis. Also biologic meshes have been advanced as an alternative to help reduce some of the problems plaguing their "synthetic" cousins. Despite the pre-eminence of mesh kits in recent years there has been a resurgence in the use of native tissues particularly the uterosacral ligaments for primarily treating apical prolapse and more recently to hitch the rectovaginal fascia thereby surgically repairing rectoceles.

Laparoscopic surgery has kept pace with the march of events and it is possible nowadays to address all levels of support endoscopically. This approach is particularly invaluable in the treatment of vault prolapse by providing a minimally invasive alternative to abdominal sacropexy. Although laparoscopic surgery has been advanced as an alternative to vaginal surgery by enthusiasts its role is likely to be limited. We owe it our patients not to wed ourselves to a particular route of surgery - always do what the patient needs! Even with the introduction of robotics endoscopic and vaginal surgery are likely to remain complementary to each other. Physiotherapists too have contributed with significant inputs and currently there is a multicentre randomised controlled trial, the POPPY trial, under way to compare the effects of exercise with the impact of lifestyle modifications on prolapse. As far as the sub-speciality is concerned the next couple of decades promise to be fascinating; one is likely to witness immense strides being made in the prediction, prevention and treatment of the distressing and debilitating problem of pelvic floor dysfunction.

ICOG CME Reports

Raichur

The **Raichur** Obstetric and Gynaecology Society organized the CME on 4th July 2010. The topics in focus were on GDM and PCOS. Around 35 delegates and over 115 college students attended this programmed organized by Dr. V. G. Kulkarni.

The **Bhilai** Obstetric & Gynecological Society organized a CME programme on 25th July 2010. The organizing Chairperson was Dr Meena Jain and Organizing Secretary, Dr Sangeeta Kamra. The focus topics covered were on Menopause- an overview, Metabolic Syndrome, PCOS in adolescents & Oncology-inappropriate management of gynaecological cancers.

A total of 41 delegates attended the CME who appreciated the programme and efforts taken by the organizers.

Bhilai

Anatomy of Pelvic Floor

Dr. Preeti Bhandari
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Anatomy is the only solid foundation of medicine; it is to the physician and surgeon what geometry is to the astronomer. It discovers and ascertains the truth, overturns superstition and checks the enthusiasm of theorists and sects in medicine, to whom, perhaps, more of the human species have fallen a sacrifice than to the sword itself or to pestilence. (William Hunter.BMJ. 1915;191;277-281)

Introduction

Normal physiological function of the pelvic organs depends on the anatomic integrity of the support components. Pelvic support defects may contribute to pelvic organ prolapse; urinary and anal incontinence and sexual, voiding, defecatory dysfunctions. Thorough knowledge of the normal support anatomy is therefore essential to diagnose and treat pelvic floor dysfunction. The main support of the uterus and vagina is provided by the interaction between the levator ani muscles (LA) and the connective tissue that attaches the cervix and vagina to pelvic walls[1]. The relative contribution of the connective tissue and LA muscles to the normal support anatomy has been the subject of controversy for more than a century.[2-5]

Pelvic floor supports

1. Levator ani muscle support
   LA components
   Levator plate
2. Perineal membrane (urogenital diaphragm)
3. Perineal body
4. Pelvic connective tissue
   Pelvic ligaments - cervical & upper vaginal, mid vaginal, distal vaginal
   Fascia - parietal & visceral

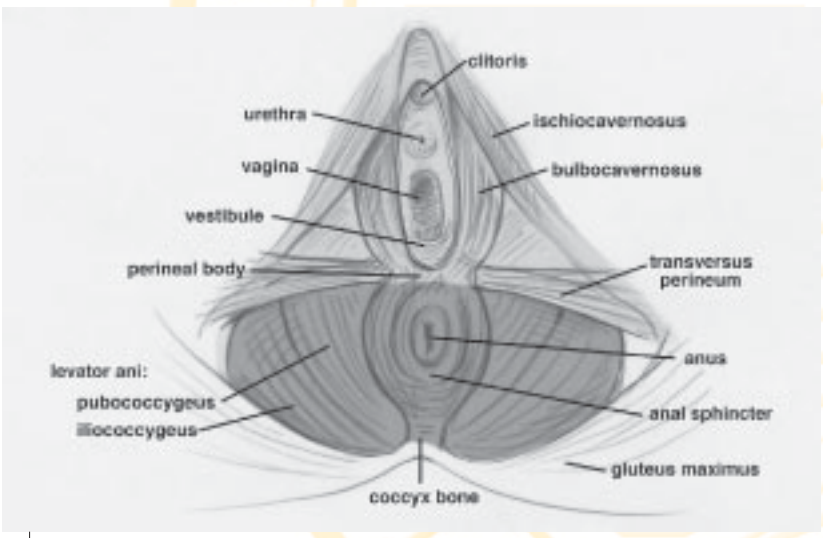
Levator ani muscle support

The LA muscles are the most important muscles in the pelvic floor & represent a critical component of pelvic organ support. The normal levators maintain a constant state of contraction, thus providing an active floor that supports the weight of the abdominopelvic contents against the forces of intra abdominal pressure.[6] This action is thought to prevent constant or excessive strain on the pelvic ligaments & fascia. The normal resting contraction of the levators is maintained by the action of type I (slow twitch) fibres, which predominate in this muscle.[7] This baseline activity of the levators keep the urogenital hiatus (UGH) closed & draws the distal parts of the urethra, vagina & rectum towards the pubic bones. Type II (fast twitch) muscle fibres allow the reflex muscle contraction elicited by sudden increases in abdominal pressure.The levators can also be voluntarily contracted as with Kegel exercises. Relaxation of the levators occurs only briefly & intermittently during the processes of evacuation (voiding, defecation) & parturition.

The pubococcygeus, puborectalis, & iliococcygeus are the three components of the muscle recognized in the terminologia anatomica.[8]

The pubococcygeus is further divided into the pubovaginalis, puboanalis, & puboperineal muscles according to fibre attachments. The anterior ends of the pubococcygeus or pubovisceral muscle arise on either side from the inner surface of the pubic bone. The pubovaginalis refers to the medial fibres that attach to the lateral walls of the vagina. The puboperinealis refers to the fibres that attach to the perineal body & draw this structure towards the pubic symphysis. The puboanalis refers to the fibres that attach to the anus at the intersphincteric groove between the internal & external anal sphincter. This fibres elevate the anus & along with the rest of the pubococcygeus & puborectalis fibres keep the UGH closed. The puborectalis fibres of the LA muscle also arise on either side from the pubic bone & form a U-shaped sling behind the anorectal junction, just above the external anal sphincter muscle. The action of the puborectalis draws the anorectal junction towards the pubis, contributing to the anorectal angle.

The iliococcygeus, the most posterior & thinnest part of the levators, has a primarily supportive role. It arises laterally from the arcus tendenius levator ani (ATLA) & the ischial spines. Muscle fibres from one side join those from the opposite side at the iliococcygeal (anococcygeal) raphe & the coccyx.



Levator Plate

The levator plate is the clinical term used to describe the region between the anus & the coccyx formed primarily by the insertion of the iliococcygeus muscle. This portion of the levators forms a supportive shelf upon which the rectum, the upper vagina, & the uterus rest away from the urogenital hiatus.

Levator ani muscle innervation

Traditionally a dual innervation of the LA has been described where the pelvic or superior surface of the muscles is supplied by direct efferents from S2 – S5 nerve roots & the perineal or inferior surface is supplied by pudendal nerve branches. Recent literature suggests the pudendal nerve does not contribute to LA innervation.[8-9] The pudendal nerve does, however, innervate parts of the striated urethral sphincter & external anal sphincter by way of separate branches. Different innervation of the levators & the striated urethral & anal sphincters may explain why some women pelvic organ prolapse & others develop urinary or fecal incontinence.

Perineal Body

It is a mass of dense connective tissue found between the distal third of the posterior vaginal wall & the anus below the pelvic floor. It is formed primarily by the midline connection between the halves of the perineal membrane.[10]

The perineal body has direct attachments to the posterior vaginal wall anteriorly & the external anal sphincter posteriorly. It contributes to support the distal vagina & rectum.

Pelvic ligaments

The term ligament is most often used to describe dense connective tissue that connects two bones. However, the "ligaments" of the pelvis are variable in composition & function. They range from connective tissue structures that contribute to support the bony pelvis & pelvic organs to smooth muscles, fibrous tissue, & loose areolar tissue structures that have no significant role in support. The sacrospinous, sacrotuberous, & anterior longitudinal ligaments of the sacrum consist of dense connective tissue that joins bony structures & contributes to the stability of bony pelvis. The sacrospinous & anterior longitudinal ligaments serve as suture fixation sites in suspensory procedures used to correct pelvic organ prolapse.

Parietal fascia

It provides muscle attachment to the bony pelvis & serves as anchoring points to the visceral connective tissue known as endopelvic fascia. The arcus tendineous levator ani (ATLA), a condensation of the fascia covering the medial surface of the obturator internus muscle, serves as the point of origin for parts of the LA. The arcus tendineous fascia pelvis (ATFA), a condensation of fascia covering the medial aspect of obturator internus & LA muscles, represents the lateral point of attachment of the posterior vaginal wall. It expands from the inner surface of the pubic bones to the ischial spines. The average length of the ATFA is 9 cm.[11]

Visceral (Endopelvic fascia)

The subperitoneal perivascular connective tissue & loose areolar tissue that exists trroughout the pelvis & connects the pelvic viscera to the pelvic wall is known as endopelvic fascia.

Connective tissue supports

- **Cervical & upper vaginal support (Level I)**
  The cardinal (transverse cervical or Mackenrodt's) ligaments consist primarily of perivascular connective tissue. They attach to the posterolateral pelvic walls near the origin of the internal iliac artery & surround the vessels supplying the uterus & vagina. The uterosacral ligaments attach to a broad area of sacrum posteriorly & form the lateral boundaries of pouch of Douglas. Level I support fibres are vertically oriented. Clinical manifestations of Level I support defects include cervical & posthysterectomy vaginal vault prolapse.

- **Midvaginal support (Level II)**
  The lateral walls of the midportion of the vagina are attached to the pelvic walls on each side by visceral connective tissue. The lateral attachments of the anterior vaginal wall are to the ATAF & to the medial aspects of the LA muscles. These are referred to as Level II support or the attachment axis. Clinical manifestations of Level II support defects include anterior & posterior vaginal wall prolapse & stress urinary incontinence.

- **Distal vaginal support (Level III)**
  The distal third of the vagina is directly attached to its surrounding structures. Anteriorly, the vagina is fused with the urethra, laterally it attaches to the pubovaginalis muscle & perineal membrane, posteriorly to the perineal body. These attachments are referred to as Level III support or fusion axis.[12] They considered the strongest of the vaginal support components. Failure of this level of support can result in distal rectocele or perineal descent.

Summary

The 20th century has witnessed an explosion of scientific study of human diseases. Recent significant contributions about the pathophysiology of pelvic organ prolapse & pelvic floor dysfunction have begun to shed light on the mechanism of these common problems. Understanding the alterations that occur in pelvic connective tissue integrity, pelvic neuromuscular function, & structural biomechanics will allow us to understand the cause of a prolapse treat it based on the specific defects present.

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IPPF Charter Facts on Sexual and Reproductive Rights

Continued from page11

Facts & figures

- An estimated four million women and girls are bought and sold worldwide, either into marriage, prostitution or slavery.[17]
- In India, an estimated two in five sex workers are below age 18.[18]
- Research suggests that one in three girls are sexually abused before age 18 and one in six boys are sexually abused before age 16 in the United States.[19]

Key Message

Human rights are basic standards to which all human beings are entitled. They concern fundamental freedoms and human dignity. They are enshrined in international conventions, agreements, laws and declarations. Further, governments are obliged to respect, protect and fulfill the human rights of all their citizens.

The right to sexual and reproductive health implies that people are able to enjoy a mutually satisfying and safe relationship. It should be free from coercion or violence and without fear of infection or pregnancy. The couple should be able to regulate their fertility without adverse or dangerous consequences. Sexual and reproductive rights provide the frame work within which sexual and reproductive well-being can be achieved.

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Warnings and Precautions: If any of the conditions/risk factors mentioned below is present, the benefits of the use of NuvaRing should be weighed against the possible risks for each individual woman and discussed with the woman before she decides to start using it. In the event of aggravation, exacerbation or first appearance of any of these conditions or risk factors, the woman should contact her physician. The physician should then decide on whether NuvaRing use should be discontinued. All data presented below are based upon epidemiological data obtained with combined oral contraceptives (COC). No epidemiological data are available on vaginal route of administration for the hormones but the warnings are also considered applicable to the use of NuvaRing. 1. Circulatory Disorders: Epidemiological studies have suggested an association between the use of COCs and an increased risk of arterial and venous thrombotic and thromboembolic diseases such as myocardial infarction, stroke, deep venous thrombosis, and pulmonary embolism. These events occur rarely. Use of any combined oral contraceptive carries an increased risk of venous thromboembolism (VTE) compared with no use. The excess risk of VTE is highest during the first year a woman ever uses a combined oral contraceptive. This increased risk is less than the risk of VTE associated with pregnancy which is estimated as 6 cases per 10 000 pregnancies. VTE is fatal in 1-2% of cases. It is not known how NuvaRing influences the risk compared with other combined hormonal contraceptives. Extremely rarely, thrombosis has been reported to occur in other blood vessels, e.g. hepatic, mesenteric, renal, cerebral or retinal veins and arteries, in COC users. There is no consensus as to whether the occurrence of these events is associated with the use of COCs. Symptoms of venous or arterial thrombosis can include: unusual unilateral leg pain and / or swelling; sudden severe pain in the chest, whether or not it radiates to the left arm; sudden breathlessness; sudden onset of coughing; any unusual, severe, prolonged headache; sudden partial or complete loss of vision; diplopia; slurred speech or aphasia; vertigo; collapse with or without focal seizure; weakness or very marked numbness suddenly affecting one side or one part of the body; motor disturbances; 'acute' abdomen. 2.Tumors: The most important risk factor for cervical cancer is persistent human papilloma virus (HPV) infection. Epidemiological studies have indicated that long-term use of COCs contributes to this increased risk, but there continues to be uncertainty about the extent to which this finding is attributable to confounding effects, like increased cervical screening and difference in sexual behavior including use of barrier contraceptives, or a causal association. It is unknown how this effect relates to NuvaRing. A meta-analysis from 54 epidemiological studies reported that there is a slightly increased relative risk (RR = 1.24) of having breast cancer diagnosed in women who are currently using COCs. The excess risk gradually disappears during the course of the 10 years after cessation of COC use. Because breast cancer is rare in women under 40 years of age, the excess number of breast cancer diagnoses in current and recent COC users is small in relation to the overall risk of breast cancer. The breast cancers diagnosed in ever-users tend to be less advanced clinically than the cancers diagnosed in never-users. The observed pattern of increased risk may be due to an earlier diagnosis of breast cancer in COC users, the biological effects of COCs or a combination of both. In rare cases, benign liver tumors, and even more rarely, malignant liver tumors have been reported in users of COCs. In isolated cases, these tumors have led to life-threatening intra-abdominal hemorrhages. Therefore, a hepatic tumor should be considered in the differential diagnosis when severe upper abdominal pain, liver enlargement or signs of intra-abdominal hemorrhage occur in women using NuvaRing. For other conditions, medical examinations, reduced efficacy, reduced cycle control, male exposure to ethinylestradiol and etonogetsrel, broken rings, expulsion and interactions, use during pregnancy, please refer full prescribing information. Undesirable effects: The most serious undesirable effects associated with the use of hormonal contraceptives are listed in Section warnings and precautions. Adverse drug reactions that have been reported in users of NuvaRing are listed in the full prescribing information. The common (1/100) adverse drug reactions are vaginal infection, depression, decreased libido, headache, migraine, abdominal pain, nausea, acne, breast tenderness, female genital pruritus, dysmenorrhoea, pelvic Special precautions for storage: Prior to dispensing: 36 months, store in a refrigerator (2 °C - 8 °C). At the time of dispensing: The dispenser places a date of dispensing on the packaging. The product should not be inserted after 4 months from the date of dispensing or the expiry date, whichever comes first. After dispensing: 4 months, do not store above 30 °C. pain, vaginal discharge, increased Weight, medical device discomfort, vaginal contraceptive device expulsion. For more information on undesirable effects please refer to full prescribing information.

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