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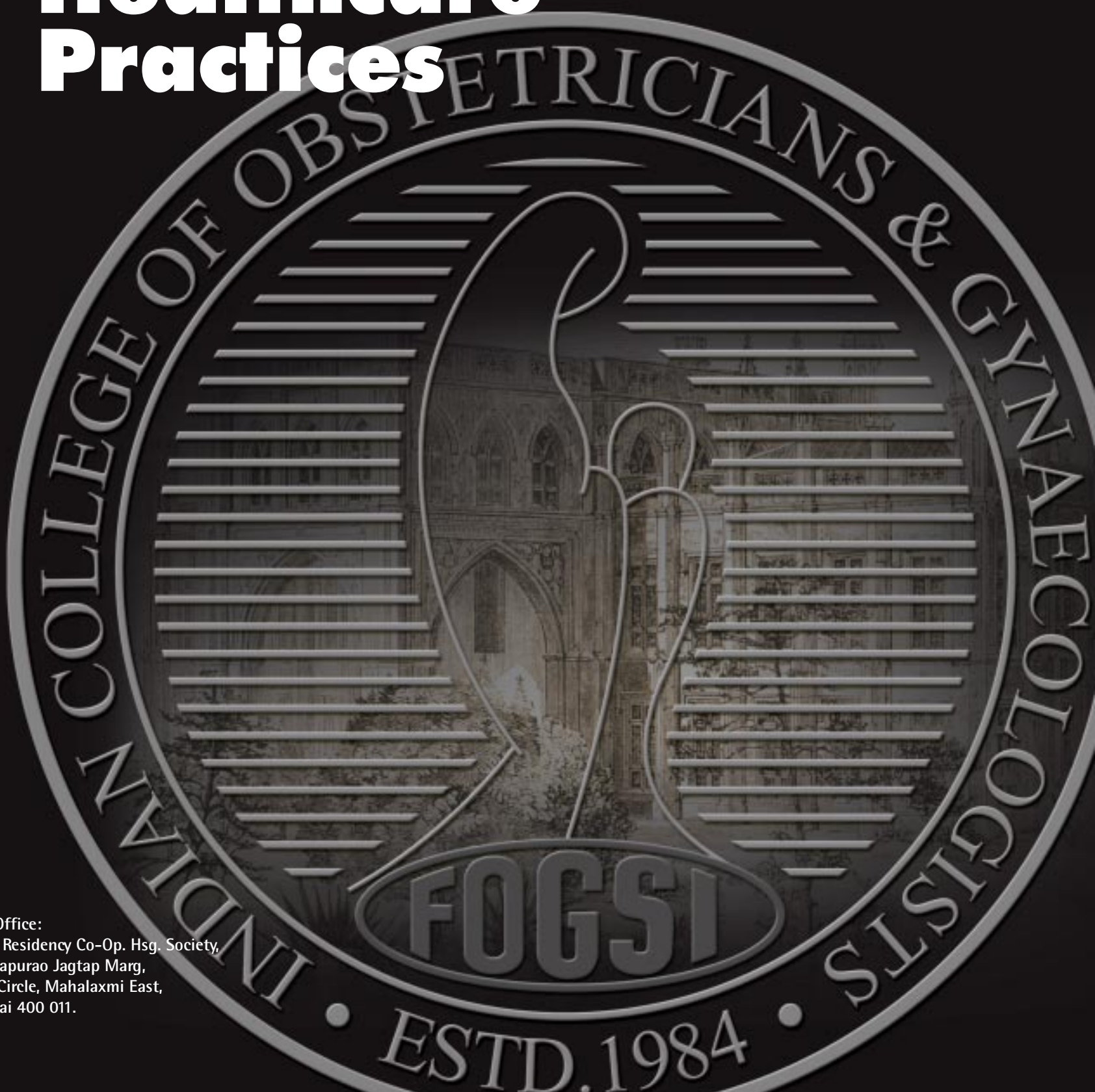
Newsletter of The Indian College of Obstetricians & Gynaecologists

ICOG campus

Advancing Standards of Education and Healthcare Practices



ICOG Office:
Model Residency Co-Op. Hsg. Society,
605, Bapurao Jagtap Marg,
Jacob Circle, Mahalaxmi East,
Mumbai 400 011.

Presidential Address
Excerpts from AICOG 2011, Hyderabad

Dr. P. C. Mahapatra
President, FOGSI

Revered Chief Guest of the evening Sjt. Ghulam Nabi Azad, Hon'ble Minister, Health and F. W. Govt. of India. Hon'ble Guests of Honour Dr. D. Y. Patil - His Excellency Governor of Tripura, Hon'ble Chief Minister of A. P. Sjt. N. Kiran Kumar Reddy, Minister Health A. P. Sjt. D. L. Ravindra Reddy, Hon'ble Member of Parliament A. P. Sjt. Asaduddin Oyaisi, outgoing President Dr. Sanjay Gupte, Secy. General FOGSI Dr. P. K. Shah, outgoing Vice-Presidents Dr. Rishma D. Pai, Dr. Jaideep Malhotra, Dr. P. K. Shekharan and Dr. Tushar Kar, outgoing Jt. Secretary Dr. Girija Wagh, my set of new team members, Vice-presidents, Dr. Nandita Palshetkar, Dr. Milind Shah, Dr. Mala Arora, Dr. Krishnendu Gupta, Jt. Secretary Dr. J. J. Mohapatra, Org. Chairperson of AICOG 2011 and President of Hyderabad OBGYN Society Dr. P. V. Saraschandrica, Org. Secretary, AICOG 2011 and Secretary Hyderabad OBGYN Society Dr. S. Santha Kumari, Past Presidents of FOGSI, Deputy Secretary General Dr. Nozer Sheriar, Treasurer Dr. H. D. Pai, Chairpersons of all the committees of FOGSI, International faculty from various parts of the globe, my beloved members of FOGSI, revered teachers present over here, lovable students, friends and distinguished office bearers and galaxy of experts from different societies of FOGSI from East to West and North to South of India, friends from pharmaceutical industries, my well wishers who have come all the way to attend this ceremony, my family members, all the staffs of the FOGSI office, distinguished members from media and press, ladies and gentlemen.

Who am I?... Where from am I ?... And where I will go:

I strongly believe that:

"To have a dream, sleep is required.
To make a dream into reality, you have to spend sleepless nights."

Its indeed a moment of ecstasy and cheerfulness, a moment of apprehension and anxiety, a moment of thrilling experience and astounding emotions on my part standing before you as 50th President of FOGSI, one of the largest academic and scientific bodies in the World. As a doctor, as a Teacher, and as a Human being coming from a remote place of India Cuttack, Odisha, it gives me a sense of fulfillment of my academic career to head this brilliant academic organization.

Introducing FOGSI:

From few individuals to a brand, FOGSI has emerged as a brilliant and mammoth academic body, for which I am proud of.

FOGSI and FIGO, AOFOG, SAFOG, RCOG:

I am really happy that our previous stalwarths were able to initiate academic relationship and bondage with FIGO, AOFOG, SAFOG and RCOG. Many of the stalwarts and academicians are present at the moment and this signifies the academic bondage of FOGSI with International bodies. My special gratitude to Prof. S. Arul Kumaran Past President RCOG and President FIGO for his inherent love and academic affection towards FOGSI. India and FOGSI has always become a priority of this great visionary.

FOGSI and GOI:

At this juncture, I need not highlight the relevance of maternal mortality and perinatal mortality in India. For years the policy makers, health care providers NGOs and various agencies are striving hard to save the lives of woman, but in true sense we failed to achieve our targets. There is no dearth of programmes and action plan, but I feel the lacunae in implementation and inherent defect in the system should be seriously looked upon. FOGSI is fortunate today that the galaxy of policy makers are amongst us in the dias and more so the dynamic Minister, Health and Family Welfare GOI Mr. Azad is here with us. Sir, I assure you that > 26,000 FOGSIANS are committed to carry forward any strategies by GOI to wipe out maternal and infant deaths. Dr. D. K. Tank, Dr. Sadhana Desai and Dr. Duru Shah had initiated the concept of Public-Private Partnership (FOGSI with GOI) in formulating RCH activities to EmOC Training and now the "Save the Mother" campaign by Dr. Sanjay Gupte has already been started. Sir, we urge you to accelerate the bondage between GOI and FOGSI on various aspects of maternal health. Let FOGSI be a counselor and technical advisor and health planner in the Govt. system. Our members practicing in various parts of the country be actively involved in the process of ultimate healthcare providers by accrediting the private hospitals and utilizing them for maternity purpose. The vision ahead of setting up maternity hospitals by the local societies could possibly be an innovative step towards reducing maternal and perinatal mortality.

"Let us take a pledge today that women should not die in India, Man might."

FOGSI & Other Academic Bodies:

Our members have always been involved with other academic bodies such as IMA, IAP, NNF, ISAR, ISOPAR, IMS, IFMUB, IAGE and other voluntary organisation for improving maternal health. 'Saving the Mother' campaign launched by Dr. Sanjay Gupte is one of the exemplary symbiosis with IAP & NNF. National Organisation of Women & Family Welfare (NOWW) under the leadership of Dr. Meera Agnihotri alongwith FOGSI is going to launch different programmes in the field of Female Foeticide, Adolecent health & Reproductive health. Needless to mention that, many more voluntary & Academic organisation are keen to join hands with FOGSI towards betterment of Women's health.

Vision, Mission & Action 2011:

"The Price of greatness is responsibility"

Introducing my Theme and Logo:

Will – What to Change, Why to Change

Skill - How to Change

The greatest wealth of a Professional is acquiring Skill and it is true that it is in your moments of decision that your destiny is shaped.

" Where the vision is one year - Cultivate Flowers
Where the vision is ten years - Cultivate Trees
Where the vision is Eternity - Cultivate People "

I feel that there are **innumerable operators,** but **very few surgeons** and I am sure this theme is targeted for skill development to transform **operators to surgeons**, from **mechanical to scientific bent of mind.**

What I propose and what you expect - 2011

What you expected and where we failed - 2012

ICOG:

- One of the valued academic wing of FOGSI with teachers and mentors
- Involved in conducting CMEs and Symposia in various societies
- My vision for ICOG will be aimed at education and formulating guidelines / best practice in Obst. & Gynecology
- I propose to start M. D. Course under ICOG with Board of Examination under FOGSI, so as to facilitate our doctors to get avenues for Postgraduate Courses as well as meeting the requirements of Specialists in the peripheral hospitals to cater maternity services. At the same time, fellowship courses on different subspecialities must be opened up in new dimensions.
- My predecessors have initiated the formulation of guidelines / best practice in Obst & Gynaecology. I think a time bound frame has to be thought of so as to streamline this aspect.
- The establishment of Eclampsia Registry by Dr. Sanjay Gupte has been a stimulus for me to march forwarded in documentation in all vital aspects including maternal mortality and I hope ICOG is the best forum for that.

Continued on page 4

ICOG Chairman's Address

Dr. Duru Shah
Chairman ICOG – 2009-2011
chairman.icog@gmail.com

Dear Friends,

As I step down as Chairman of the Indian College of the Obstetricians & Gynaecologists on 15th April 2011 after a period of 2 years, I reflect on what we collectively have been able to contribute to this Institution, which has been built on the strong foundation laid by our esteemed predecessors.

Whatever has been done in the past 2 years has been captured in this 20 page issue of the ICOG Campus. It's like two years have been compressed within these 20 pages! All this work has been accomplished through a team approach, with every member of the Council pitching in to propel ICOG to the forefront. Thus ICOG has become a strong body of Governing Council members surging forward, with the office bearers leading them in a united direction.

With the creation of 10 sub-committees during this 2 year period, with each sub-committee focusing on an ICOG activity, the power generated has been tenfold! And with a very sincere person as Dr. Uday Nagarseker as Vice Chairman and a dynamic Secretary like Dr. Hema Divakar as Honorary Secretary, ICOG has risen to greater heights.

All our previous activities such as the **FOGSI-ICOG Satellite School**, the **FOGSI- ICOG Ethiskills Course**, the **EMOC program** and the **Ecclampsia Registry** continued with full vigour. Below, I have only enumerated the newer activities which were initiated.

Membership and Fellowship criteria have been relaxed and ICOG has opened its arms to enroll more and more FOGSI members into its fold. **The total strength of ICOG Membership and Fellowship** over 27 years is 1022 of which 164 have been added in the past 2 years. The first **digitalized directory of ICOG** has been created in 2010 and sent to all Members and Fellows of ICOG. In the past, to apply for ICOG Membership or Fellowship, FOGSIAN's required a certain number of publications, which was difficult for many to comply with. Through the ICOG **Credit Point System**, the process of becoming a Member or Fellow of ICOG has become much easier.

Postgraduate Education carries great importance for the College and to focus on it, ICOG promoted the 6 months **"Post graduate Certificate Courses"** in Ultra sound, Perinatal Medicine, Reproductive Medicine, Minimally Invasive Surgery and soon to follow is the **"EMOC"** Course! We also added some more such as the **"Post-Graduate Residential Review Course"** for exam going students (the proceedings are available on a CD) and the **"ICOG-Online Quiz"** for desktop learning. Clinical research was encouraged through the **"ICOG study Hour"** held during the CME's supported by ICOG. Software was created to analyze the data retrieved from the Questionnaires on **"Gestational Diabetes"** and **"PCOS in the adolescent"** and the data retrieved has brought forth interesting facts on the **"Knowledge, Attitude and Practices of our members"** in these 2 areas. We have initiated the process of collecting data on 2 more topics, which we hope to complete soon.

In order to document the teaching which were captured on the **FOGSI-ICOG Satellite School,** we have edited and created the **DVD's** which will be available online for all.

The **"ICOG Campus"** the National Newsletter and face of ICOG. Over 2 years, we have released 8 issues, with this issue being the final one during my tenure as Chairman of ICOG.

The **"ICOG website"** is the face of our Organization and by upgrading it and making it more interactive, we have been able to assist many of our members to access information quickly and effectively. Today it gets approximately **1,80,000** hits every **year!**

The **"Current Opinion Series" 2010 and 2011** were both held in Goa, and both in collaboration with International Academic Organizations. They have been extremely successful in terms of imparting knowledge. The feedback forms have been very encouraging and every delegate has enjoyed these small, residential, interactive and focused meetings.

Working in collaboration with the Ministry of Health, Government of India and WHO, ICOG developed the **"Accreditation Criteria"** for private Nursing Home for Reproductive Maternal, Neonatal and Child (RMNCH) and new born health. This has been a mammoth task which ultimately ended with 2 documents being released by the Ministry of Health. It is our agenda to take this forward into the next phase and utilize these criteria's to accredit the nursing homes of FOGSI members towards a cause, which will ultimately lead it to **"Saving mothers lives"**.

Both our **"Convocations"** were brilliant with eminent Global academicians as our Chief Guests and hundreds receiving their certificates.

With all this happening , FOGSI's Constitution related to ICOG's Rules and Regulation underwent 2 changes in 2 years , with the inclusion of all Past Presidents of FOGSI into the Governing Council, with the addition of 2 new office bearers positions **"Chairman Elect"** and **"Vice Chairman Elect"** with the tenure of Chairman and Vice Chairman being reduced to one year, as many wanted an opportunity to serve on the ICOG council!

As Chairman of ICOG I will step down with a feeling of pride that ICOG is progressing in the right direction in order to serve its main purpose of **"Advancing Standards of Education and Healthcare Practices"**.

I would fail in my duty if I do not acknowledge with gratitude the immense love and assistance that I have received from my complete team with special thanks to Drs' Uday Nagarseker, Hema Divakar, Mandakini Parihar, Uday Thanawala, Atul Munshi, Parul Kotdawala, Indrani Ganguli, Mala Arora, Madhuri Patil, Safala Shroff, Ameya Purandare and many more who have kept the momentum at an accelerated pace, the ICOG office staff Varsha and Neelima and my Personal Assistant Rochelle who have always been by my side, and all the Corporates who have offered educational grants for the various activities which we conducted.

Thanks to both the Organizations, **AEPCOS & FIGO Ethics Committee** for adding fantastic Scientific value to both the **"Current Opinions"** and a big thank you to the **FOGSI office bearers and Presidents of ICOG** who have facilitated and encouraged our work.

I do hope that I have made a difference, made some impact, created something special and something meaningful for ICOG. If I have, then that is my most treasured possession today!

Dr. Duru Shah
Chairman ICOG– 2009-2011

Message from Vice Chairman, ICOG

Dr. Uday L. Nagarseker
Vice Chairman, ICOG
uday_goa@sancharnet.in

Dear Colleagues,

Our team was installed in late April 2009 and we had two very fruitful academic years with support from all of you.

When we took over, I was given two specific jobs of the ICOG Directory and Credit Point System. With your co-operation, I could get the ICOG Directory ready as a CD and also as a hard copy. With the support of platinum sponsors of our first 'Current Opinion' held last year, this CD and hard copy was sent to each member and fellow of our College, free of cost. I am sure this Directory has helped to get and communicate with many new friends and revive memories of old friends.

The ICOG Credit Point System was started about 10 years back and these Credit Points were given to members of FOGSI who could fulfil the criteria but these criteria were not in final shape. As I was given the responsibility as Chairman of sub-committee on ICOG Credit Points, with the help of my college office bearers I could streamline this system and give it a final shape. Now, this is available on our dynamic website managed by Dr. Mandakini Parihar.

An important feature of this system is that the members of FOGSI can get Membership or Fellowship of ICOG if 100 Credit Points are collected in 3 years (No publication or presentation but other criteria to be fulfilled). I am sure this Credit Points System will be carried forward by our new executive committee.

To prepare the Good Clinical Practice Recommendations (GCPR) on various subjects in Obstetrics and Gynaecology was started many years back by ICOG and now you have seen that we could finalize many of these GCPRs in our tenure.

The Guidelines for Accreditation of Private Health facilities for providing RCH Services and Guidelines for Antenatal care and skilled attendance at birth prepared by ICOG FOGSI under leadership of Chairman, Dr. Duru Shah have already been published by Ministry of Health and awaiting implementation. Our President, Dr. P. C. Mahapatra has taken a keen interest in this and I am sure he will see that these schemes are implemented during his tenure.

I am hopeful that the Final " Constitution" of our College will be confirmed in the coming Governing Council meet in April 2011 and it will give a stability and autonomy to Indian College of Obstetrics and Gynaecology to carry out the academic activities of FOGSI. Sincere thanks to Dr. Duru Shah, Dr. Hema Divaker and all the office Staff of FOGSI and ICOG.

Dr. Uday L. Nagarseker
Vice Chairman, ICOG

Presidential Address Excerpts

Continued from page 2

JOGI:
The Journal of Obst. and Gynaecology of India has proved itself to be one of the widely circulated read medical specialty journals. I must congratulate the efforts of Dr. M. N. Parikh, the Past Editor and Dr. Adi Dastur, the Present Editor and his dedicated team in revamping the structure and function of the journal. Thanks to the untiring effort of Dr. M. N. Parikh for his PICSEP Workshops and the Conference. This year we are planning to have fifty PICSEP Workshops in various societies involving the Postgraduate students as well as teachers all over India.

Committees of FOGSI:
28 Committees of FOGSI are really the backbones of this organization, where dynamic chairpersons are doing immense activities in their respective fields. Dr. Sanjay Gupte has done the rationalization of different committees last year and opened up newer avenues and newer committees as per the changing needs. I am determined to gear up their activities with my able Vice-Presidents and Joint Secretary.

Last Words...
I am sure with the help of my team members, office bearers of FOGSI and the Chairpersons of the different committees, we will try our best to fulfill the objective of the theme "Will & Skill" and then introspect **what you expected and where we failed.**

The world only responds results, not efforts
Perform or Perish, Choice is yours.
(A Slogan of Current Millennium)

Everyone has a will to win but very few have the will to prepare to win.
– Vince Lombards'

And the small beginning to have **"Will & Skill"** will certainly go a long way in reaching the goal.

Thank You. Jai Hind!!!!

Dr. P. C. Mahapatra
President, FOGSI

The Role of FIGO in the Women's Health

Prof. Gamal Serour
M.D. MRCOG,FRCS, FRCOG
FIGO President,
Professor of Obstetrics and Gynaecology,
Al Azhar University

Dear Colleagues

As we say goodbye to 2010 and look forward to 2011 let me share with you my vision of "The role of FIGO in women's health" for the coming years. In this regards I am guided by FIGO's vision and mission approved by our General Assembly, my inaugural address at the XIX FIGO Congress, Cape Town, South Africa October 9th, 2009 and achievements and challenges experienced in the past. Let me first share with you the impressive global achievements and country specifics successes during the past year. The maternal mortality ratio has been reduced by 34% and the member of maternal deaths dropped from 546.000 in 1990 to an estimated 358.000 in 2008 according to "Trends in maternal mortality". Recent reports on maternal mortality had shown that improvement is possible and achievable with sometimes very simple measures.

Women deliver 2010 conference joined by 3400 representatives from 146 countries with prominent participation from FIGO was a great success in June 2010. The G8/G20 committed to improve maternal health in June 2010. The African heads of states in July 2010 reviewed and revitalized the Maputo plan of 2006. The Global strategy for women's and children's health was officially launched by UN in September at the Global summit on MDGs with a pledged commitment of over US$40 billion for women's and children's health. PMNCH in Delhi in November 2010 discussed translating commitments to actions and Delhi Declaration 2010 emphasized the importance of unity and accountability with the context of the common goal to improve women's newborns' and children's health, development and human rights.

Inspite of all these achievements and successes yet still the path is long and rugged and we still face many challenges to achieve health related MDGs by 2015. We do need all the concerted efforts and contributions of all my fellows obstetricians and gynecologists and related health care professionals to eliminate inequities and huge disparities that still exists between developed and developing countries and the rich and the poor in all countries.

In this regards Professional organizations as FIGO need to take privileges of all these encouraging initiatives, translate our efforts and investments into women's and children lives saved, quality of lives improved, women and children protected from violence and harmful practices and healthy communities at large. FIGO has conducted a large number of activities in this regards.

The annual review meeting of the FIGO-Bill Melinda Gate's (BMGF) project for improving Maternal and Newborn Health in Low resource countries through strengthening the role of obstetric and Gynaecological national associations (LOGIC) was held in Addis Ababa Ethiopia 27-29 October. FIGO leadership, BMGF and country directors of the nine countries; Burkina Faso, Cameroon, Ethiopia, Mozambique, Nigeria and Uganda in Africa, India and Nepal in Asia discussed progress made, challenges faced, successes encountered and how to overcome shortcomings and identify how best we can move the project forward. FIGO's seven committees continued to conduct their valuable activities as indicated in committees' reports.

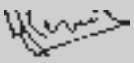
FIGO recognises that lack of training and education is the bottles neck which hampers development of quality health care service at the grass root level to women and newborns. FIGO President launched in Cape Town 2009 an ambitious education and training program which has been running very satisfactory. The annual meeting of FIGO Executive Board was held in Dar es Salam and not in London. The objectives of this move were to strengthen FIGO's collaboration with its member societies, capacity building of member societies in education and training, field visits of FIGO initiatives in Tanzania and to allow EB to have a real feeling of maternal and newborn health conditions in Africa. Africa was chosen as the site of the first Executive Board meeting to be held outside London for several reasons. In Sub-Saharan Africa, there is a pressing unfinished agenda on reproductive and sexual health-particularly family planning, and maternal/newborn mortality and morbidity. The fertility rate averages more than 5 children per woman, ensuring a population growth that will continue well into the 21st century. There is a shortage of more than 1 million healthcare workers in Africa, where 3% of the global healthcare workforce provides health services to 24% of the global burden of disease. The "brain drain" of Africa's healthcare workforce further weakens the continent's already fragile reproductive and sexual health services, and significantly impedes the achievement of health-related MDGs. Tanzania is typical of Sub-Saharan Africa, where levels of maternal and newborn deaths and diseases remain unacceptably high.

The Reproductive Medicine committee held two hands on training workshops on infertility and ART in the developing world in collaboration with Al-Azhar University and WHO, ICMART and Lubeck University in February 13-18, and September 18-22,2010. Eighty five physicians and embryologists from Egypt, Libya, Tanzania, Ghana, Nigeria, and Sudan attended these two workshops. The workshops were extremely successful and feedback from participants was very encouraging. The activities of FIGO committee for capacity building in education and training have been very impressive. A large number of sessions and workshops have been held in collaboration with national and regional Federation's meeting in Paraguay, Barcelona, Kuwait, Tunis, Munich, Milan, China, Algeria, Macao, Lima and Peru. FIGO committee for the ethical aspects of Human Reproduction and women's health held an extra meeting in Cairo 22-23rd November 2010, and developed the contents, work plan and timelines for the development of Bioethics curriculum in reproductive and sexual health for developing countries. FIGO in collaboration with Benenden Hospital Kent UK organised the first FIGO Pelvic Floor surgery workshop for trainers during the period 28-29 November 2010. Twelve senior gynaecologists from Cuba, Ireland, Nepal, Brazil, Uganda Pakistan, Timor-Laste and UK have attended the workshop. Evaluation of the workshop was excellent. Arrangements are being made to hold three workshops on Prevention and treatment of postpartum haemorrhage in Cairo and Alexandria during the period 22-25th January 2011 in collaboration with the Egyptian Representative Committee of the RCOG.

The FIGO working group on the prevention of unsafe abortion held a regional meeting in Cairo during the period 21-22nd October 2010 in collaboration with WHO, regional UNFPA office, IPPF to discuss implementation of the recommendations of the working group on prevention of unsafe abortion.

Arrangements are well on the way to FIGO congress 2012 in Rome 7-12th October 2012. An up to date attractive scientific program has been outlines by the FIGO 2012 Scientific Committee. Education and Training is a new important component of this congress. Precongress post graduate courses and workshops for Ob & Gyn in training are being arranged. Very few cities can compete with Rome for an attractive social program. Please pencil the October 7-12th,2012 in your diary and make sure you shall actively participate in this very important FIGO congress.

I am pleased to say after considering all relevant factors FIGO leadership has chosen Mexico city to host the EB meeting during the period June 10-13, 2011. This is in line with FIGO's policy to strengthen its ties with member societies and regional federations and contribute to capacity building in education and training of its members societies. How about India to host the 2012 EB meeting? Think of it and have a happy and prosperous new year.



Prof. Gamal Serour
FIGO President

Public Private Partnership – Sharing Experiences

– Submitted by Dr. Hema Divakar

I often dream about reaching quality healthcare to women of rural India and dream of saving lives and dream of putting the smile back on their faces !!

Every time I used to express my anguish and concern to my own self - that iam not doing enough about making my dream come true...

The two great men would constantly haunt me towards action

"Be the change you want to see"
would wisper Mahatma Gandhi and
"lead by example" would say Shri Abdul Kalam!

It was not good enough to dream,discuss and debate - it was high time that I acted upon the idea - The idea of Public Private Partnership to deliver quality healthcare to women of India !

The concept translated into concrete action when padmashri Dr. Sudarshan offered an opportunity to partner with him and the government of Karnataka to shoulder the responsibity of running an FRU (First Ref Unit) at chamrajnagar district in a small village called "santemaranali" - the first taste of a public private partnership - when our unit called " PANCHAMI" was launched to offer 24 x 7 maternal health services.

The key to the success was the confidence and commitment – a doctor who is caring and compassionate and always available. The readiness to accept challenges and turn them into great learning opportunities and handle tough situations with maturity. We have raced forward with young champions daring to lead the unit - the reins being in the hands of Dr. Ajay Dhawle from Lathur – a passionate young man - a gold medallist from PGI Chandigarh who stepped into the unit in June 2009 to contribute his bit for "Reaching the Unreached".

The unit which was handling about 80 deliveries per year before the partnership programme, briskly picked up and we now boast of more than a 1000 to 1500 deliveries in a year with a 9% c-section rate. The backbone of the unit are skilled birth attendants who are present round the clock and their diligence and data documentation leaves everybody stunned. Emergency transfers with 108, outsourced anaesthesiologist and paediatricians have strengthened the quality of care at the FRU. This has attracted not only a large number BPL (below the poverty line) patients who can avail of all the government schemes - but a significant number of APL (above the poverty line) have also started making use of all facilities

The monitoring and evaluation, technical training and re-training, helplines and confidence building... That continues to be our major role.

Punch value is added by the ABCDE strategy.

A. Anemia control by IV - sucrose & 100% adherence to AMTSL
B. Building contraceptive choices - PPIUCD & medical abortion pills
C. Convulsion management by use of Magsulf/condom catheter for PPH
D. Decision to intervene by paperless partogram
E. Environment in the labour room/wards and OPD ensuring infection control.

The results speak for themselves:	**2009**	**2010**
1. The Number of OPD Patients Seen	6000	11,000
2. Number of Deliveries	1000	1800
3. Number of C-Sections	120	200

The only case of maternal mortality was a case of PPH transferred to District Hospital who succumbed. The incidence of macerated stillbirths and fresh still births are very few and declining owing to timely antenatal care. Preterm transfers in utero have helped salvage many a neonate. Neoatal mortalities have been a total of 8 in two years.

The experience of Public Private Partnership has been an eye opener, when we move away from world class infrastructural facilities with demanding patients in Urban India move towards the ever greatful and humble women and families in Rural India - These women... Unaware of their rights – Very meagre expectations... Blissfully accepting of any situation - ...They touch our hearts... indeed their lives need to be saved and they really deserve our care.

If the strength of FOGSI-ICOG can be put to test by the Govt. of India - shall we now say "We are ready for a partnership"! As private partners let us organise ourselves and work with passion, enthusiasm and in synergy to strenghthen the public health system and lead the way for better health care for the women of India!

ICOG Secretary Speaks...

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

Lessons learnt !!

ICOG Secretary reflects on the year that was...

You can't have a better tomorrow if you are thinking about yesterday all the time. ***– Charles F. Kettering***

ICOG has been a strong force in allowing myself the opportunities to grow, develop, and find a true sense of purpose. For over two decades, we have heard and talked about problems related to womens healthcare ....

Lesson one
The problems have long been fixed....
It is time to fix the solutions and look for a better tommorrow.

The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn. ***– Alvin Toffler.***

The realities of "knowledge attitudes and practices" the analytics on GDM and PCOS revealed a wide variety of practices – not necessarily evidence based. I realised that one must be capable of changing and rearranging their priorities so that the final goal can be achieved. One must be willing to make sacrifices... The CME team travelled far and wide disseminating information at the ICOG STUDY HOUR and helped make a change to suit the Indian context – culminating in making of the Indian guidelines and working towards the final drafts of GCPRs(Good Clinical Practice Recommendations)

Lesson two
There are times when you must take a few extra chances and come to terms with ground realities....

"There are some people who live in a dream world, and there are some who face reality; and then there are those who turn one into the other. **– Douglas Everett**.

You must feel confident enough within yourself to follow your own dreams. This is what i said to myself when we consolidated the processes related to the certification courses through ICOG.The application process for the candidates and the center the syllabus and the exam pattern, creating a pool of examiners and executing the same to allow candidates a succesful completion of certification - was a long and hard journey – but well worth the efforts.

Lesson three
Be confident enough that you won't settle for a compromise just to get by.

The people that get on in this world are the people that get up and look for the circumstances that they want; and if they can't find them, they make them. **– George Bernard Shaw**

This was the experience with the 24x7 center in partnership with the government - about which i have written at length in this very issue of Campus. This unit has helped in succesfully establishing a model for replication and scale up of public private partnership for womens health care in India.The vision of President P. C. Mahapatra to set up several centers in association with private practitioners in FOGSI in remote areas in partnership with the Government to strengthen the public healthcare is laudable. In synchrony with this idea, Dr Duru Shah's monumental work for healhcare accreditation of these centers has been printed and awaiting implementation. Following this process, many private nursing homes and maternity homes will be able to offer care to the women who are eligible for all the government schemes.

Lesson four
Do more than belong, participate. Do more than care, help. Do more than believe, practice. Do more than be fair, be kind. Do more than forgive, forget. Do more than dream, work. – William Arthur Ward

Befor i sign off for this issue, I wish to express my gratitude to Dr. Duru Shah, who has been an able and inspiring leader as the chirman of ICOG and a promise to Dr. Behram Anklesaria that i will strive to work harder!

I invite all of you dear friends to join us in all the academic/ teaching/training/service initiatives.

Cheers!

Dr. Hema Divakar
Hon. Sec. ICOG

Dr. Duru Shah
Chairman ICOG

Dr. Hema Divakar
Secretary ICOG

Dr. Safala Shroff
Correspondent

Dr. Ameya Purandare
Correspondent

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ICOG Convocation at the AICOG Conference Hyderabad 2011

– Dr. Hema Divakar reports

Age is an issue of mind over matter. If you don't mind, it doesn't matter.

– Mark Twain

A crowd of ALL ages had gathered on the evening of 8th of January 2011 at the Hyderabad International Convention Center... for this special event - The ICOG convocation and one could feel the excitement and enthusiasm rendering the atmosphere vibrant and joyous!

Amidst the gowns and glamour and the music and the march, the office bearers of FOGSI-ICOG escorted Lord Naren Patel, our esteemed chief guest to the dias.

Dr. Mala Arora, the Vice President of FOGSI conducted the procedings with her usual flare and flavour and requested Dr. Duru Shah, Chairman of ICOG to make the welcome remarks. Dr. Duru unfolded eloquently and elaborately the role of ICOG - the academic wing of FOGSI - which has a great potential in leading the way forward for quality healthcare for the women of INDIA.

A **Convocation** (Latin 'calling together', translating the Greek ecclesia) is a group of people formally assembled for a special purpose.

The ICOG Convocation is always a very special event - Not only for the office bearers but also for the Fellows and members to be newly inducted and their near and dear ones who gather to applaud their academic achievements and inspirational for all those who aspire to be into the fold of thr Indian College in the near future.

I am always ready to learn although I do not always like being taught.

– Winston Churchill

And the way forward from ignorance to knowledge was lead by all the dignitories on the dias who proceded to light the inagural lamp. Dr. P. C. Mahapatra, holding the prestigious post of President of FOGSI - ICOG promised to work in synergy with the ICOG team, to help it achieve greater heights. Dr. P. K. Shah, Hon Sec Gen of FOGSI had the pleasure of introducing the chief guest Lord Naren Patel.

Art and science have their meeting point in method.

– Robert Bulwer-Lytton

Lord Naren Patel shared a sound advise to all the new fellows and members as to how important it is to be compassionate and caring. "Formal teaching and tecnical skills apart, the humane aspect should never be forgotten..." So said Dr. Patel and left a lasting impression on all those gathered at the convocation.

The much awaited ceremony of offering honoarary fellowship of ICOG to Dr. Dilip Mavlankar followed by induction of all the Fellows and Members who marched with confidence and pledged to play responsible roles in the organisation - was a treat to watch !

The Ceremony concluded with the vote of thanks offered by Dr. Hema Divakar - Hon. Sec. ICOG in her own inimitable style!

The organisers lead by Drs Balamba/Sharathchandrika/ Shantakumari and team had made sure that the arrangements were flawless and the crowed dispered for high tea with fond memories of the event.

ICOG Chairman Address
ICOG Convocation at the AICOG 2011

Dr. Duru Shah
Chairman ICOG – 2009-2011
chairman.icog@gmail.com

Converting Science into Practice

I congratulate all the new Members and Fellows on the accomplishment of a step ahead in the world of academics and technological advances. It is a matter of pride that you are the few out of the thousands of FOGSI members who are eligible to receive your certificates at the Convocation. But when we leave this room we must remember that Medicine is an endeavour that involves risk and responsibility.

To succeed in medicine we have all put in a lot of effort, diligence, and struggle. Each one of us has our own schedule for the day and we tend to one person at a time. For our patients we are the most important people in their lives, in whom they have entrusted their bodies with complete faith. This gives us tremendous power: the power to prescribe more than 6,600 potentially dangerous drugs, the power to open up human beings whenever we need to, the power to manipulate their DNA. People actually depend on us for their lives!

Life expectancy is increasing and thanks to us people are living longer! Medicine is a system of millions of people rather than one individual, who has made this possible. None of us is irreplaceable, but the machine would not run smoothly if that one single cog is missing So, it is time to ponder "Do I really matter?" In this work of ours we are assisted by our nurses, our medical assistants, our lab technicians our paramedics, our nutritionists etc. Yet no doctor wants to believe that she or he is only a small white coated Cog in an extraordinarily scientific machine!

Each one of us could matter if we choose to matter. We have the capacity to save lives. By simply putting efforts to effectively utilize the abilities that science has given us, we could make a huge difference. Take the example of Prof. Semelweiss – he proposed that by not washing hands, doctors themselves were responsible for puerperal sepsis, which was the commonest cause of maternal death in the era before antibiotics. By the medical attendants simply washing their hands, he observed that maternal mortality could be reduced from 20% to 1%! When we have utilized science to its fullest, by simply following simple protocols, thousands of lives have been saved. Countries spend huge budgets per year on researching new therapies, but if we only focus more on practicing basic standards of care, we can definitely perform better in the next decade! More lives can be saved by good clinical application of Science rather than bench Science, or research on the Genome, or stem cell therapy, or cancer vaccines or all the other laboratory Sciences which we read about. In a country like ours, where there are limited resources, we should focus more on raising our performances and not in expanding research.

ICOG has set its own motto **"Advancing Standards of Education and Healthcare Practices"** By carrying out simple clinical research studies such as KAP studies on common issues like Gestational Diabetes and Polycystic ovaries, and by creating a study hour on those same very subjects, we hope to promote the standards of care in such situations.

A great example of putting research into practice is the use of the Mammogram. Data from a US Breast Cancer Registry has shown that rates of death from Breast Cancer have fallen by 25% in industrialized countries since 1990. Almost 50% of that decline was due to simply increasing screening of women by Mammography. The US Government and private foundations spend close to a billion dollars a year on research for discovery of new treatments in Breast Cancer, but spend hardly anything on improving the comfort during mammography nor access to it. Yet studies have shown that just screening regularly, would reduce deaths related to breast cancer by one third of what occur without the screening.

To live a life as a doctor is to live a life of responsibility. The question then is, not whether one accepts the responsibility. because by becoming doctors, we have already accepted the responsibility. The question is, having accepted this responsibility; we should live up to it. There are 24.3 /1000 births in India each year. (WHO Sept 2010), of which 70,000 mothers die during childbirth and causes deaths related to pregnancy. No matter what the Govt. does, some pregnancies will end badly. As Obstetricians, we cannot accept such high mortality rates and we need to step in and at least reduce this percentage. Standards of antenatal care have been established, training courses have been developed to standardize obstetric care for our members. We have stepped out beyond our territory to create larger human resourses with our EMOC program, and are now on the verge of establishing it as a 6 months EMOC certificate course through ICOG.

We are willing to offer our private nursing homes in the rural areas to safely deliver women from the "below the poverty line" strata of society. ICOG has developed the accreditation criteria for the Ministry of Health, Govt. of India, Let's get our nursing homes accredited and assist in saving lives. Lets choose to matter, because our contribution will matter in the dropping levels of mothers dying due to child birth.

I am happy to share with you that the ICOG team is holding a second "Current Opinion 2011" on the same lines as the PCOS meeting held in March 2010, in collaboration with the Ethics Committee of FIGO and is being held once again in Goa. On behalf of the Organizing team, I invite all of you to attend this meeting on "Evidence, Ethics and Excellence" where the FIGO President will deliver his Oration on "Women's Health in the 21st Century"

I once again congratulate all the new Members and Fellows who have joined the College today and request them to make a promise to themselves that they would practice this science, to make a difference, and not to be just another Cog in the wheel.

Wish all of you all the best.

Dr. Duru Shah
Chairman, ICOG– 2009-2011

ICOG CME

Current Concepts in Ovulation Induction in PCOS with Insulin Resistance

Dr. Mandakini Parihar

Director, Mandakini IVF Centre, Mumbai
Associate Honorary Professor Obs & Gyn.
K. J. Somaiya Medical College, Mumbai
Vice-President Elect 2012,
FOGSI Chairperson
Family Welfare Committee FOGSI (2004-2008)
Member, Managing committee ISAR
Member, governing Council, ICOG
Jt. Treasurer, Indian Menopause Society

One of the most important causes of infertility in women is anovulation management of ovulatory dysfunction and the ability to induce anovulation with the resultant pregnancy was a big milestone in infertility treatments. Polycystic Ovarian Syndrome (PCOS) is a common and heterogeneous disorder of women of reproductive age, characterized by chronic anovulation and hyperandrogenism. Hyperinsulinaemia has proved to be a key link in the enigmatic generation of the symptoms of PCOS. As obesity exaggerates the expression of the symptoms induced by hyperinsulinaemia, a low calorie diet and lifestyle change resulting in loss of weight for obese women with PCOS is capable of reversing these symptoms. Drugs that ameliorate insulin resistance and reduce circulating insulin levels could provide a new therapeutic modality for PCOS who have insulin resistance.

Incidence:
Polycystic ovary syndrome (PCOS) is the commonest cause of anovulatory infertility.

The well-accepted criterion for diagnosis of PCOS is the Rotterdam Criteria, which states that for the diagnosis 2 out of 3 of the following must be present.

1. Appearance of polycystic ovaries on Ultrasound
2. Clinical or biochemical evidence of hyper-androgenism
3. Clinical or biochemical evidence of anovulation.

This definition does not take into account the presence of insulin resistance as a hallmark of PCOS. It however, identifies a subset of women who will be insulin resistant and will benefit from the use of insulin sensitizers. It is important to remember that, 40% of women with oligomenorrhoea, 84% of women with hirsuitism and 100% of women presenting with severe acne, have PCOS as their etiology.

Pathophysiology
Although the fundamental pathphysiologic defect is not known, women with PCOS can be divided into two groups. One group is with evidence hypersecretion of LH and the other group of patients who are uniquely insulin resistant. The recognition of an association between hyperinsulinaemia (presence of Acanthosis Nigricans and HAIR-AN Syndrome) and PCOS has resulted in the use of insulin sensitizing agents, such as metformin, which appear to ameliorate the biochemical profile and improve reproductive function. A subgroup of women with this syndrome have 'metabolic PCOS' which can be considered to be a pre-diabetic state. Clinically, this subgroup is most easily identified in obese women with a strong family history of diabetes in whom menstrual disturbance is the predominant feature. Obesity in PCOS aggravates the underlying insulin resistance.

Table 1: Criteria taken into account when evaluating any therapy for PCOS

Clinical Outcomes
- Body weight Index (BMI) & Waist-hip ratio (WHR)
- Menstrual cyclicity
- Spontaneous ovulation
- Pregnancy
- Acne-severity
- Hirsuitism
- Side-effects experienced by patient

Biochemical outcomes
- Fasting Blood glucose & GTT
- Insulin levels
- LDL &HDL Cholesterol
- Triglyceride levels
- Testosterone & the androgen levels
- Plasminogen Activator Inhibitor levels (PAI-1)
- FSH & LH levels
- LH: FSH ratio

Management of Anovulation
Treatment Plan
The gold standard for improving insulin sensitivity is obese PCOS should be weight loss, by diet and exercise. Weight loss (of as little as 5%of the body weight) alone can improve the fundamental aspects of the endocrine system of PCOS and result in low circulating androgen levels and spontaneous resumption of menses. Women with PCOS are like desert survivors, who fare better with less than their optimum weight.

Clomiphene Citrate is the first drug of choice used in management of anovulatory infertility. It has also been used indiscriminately for many years. However, concerns about possible linkage with later life ovarian cancer, has led the recent RCOG guidelines along with ACOG recommendations state that CC should be used for a maximum of 12 months in patients lifetime and for a maximum of 6 months continuously. Hence, it is necessary that all cycles with CC be carefully monitored for evidence of ovulation

CC Resistance: (Ovulation Failure)
It is a very commonly used terminology and is defined as "failure to ovulate with 3 months of use at 150mg/day of 5 days". The commonest cause for this is PCOS, and is seen in about 20% of patients.

CC Failures: (Conception Failure)
There are patients who ovulate but fail to conceive on CC therapy. If a patient has 3 ovulatory cycles with CC and does not conceive then she is labeled as CC failure. This may also due to antiestrogenic effect of CC on cervical mucous and endometrium, but remains to be proven

Management with Insulin Sensitizing Drugs
The molecular mechanisms of insulin resistance leading to hyperinsulinaemia are now being elucidated. Abnormalities of both insulin secretion and intracellular insulin signaling have both been proposed in women with PCOS. The discovery that insulin resistance has a key role in the pathophysiology of PCOS in some patients has led to a novel and promising form of therapy in the form of the insulin-sensitizing drugs.

Table 2: The decision about the use of the therapy will depend on a number of factors:
- Age of the patient
- Body Mass Index (BMI)
- Menstrual history
- Evidence of Hirsuitism and hyperandrogenism

The gold standard for improving insulin sensitivity in obese PCOS should be weight loss, by diet and exercise, as mentioned above. Many women will show spontaneous resumption of their menstrual cycle with weight loss alone. The mechanism of action of insulin sensitizers is by lowering the circulating insulin levels which results in increased levels of SHBG and hence lowers androgens. This results in improved follicular growth, maturation and eventually ovulation and resumption of cyclical menstruation.

It is now clear that patients with PCOS associated with insulin resistance is the only indication for use of insulin sensitizers. The insulin resistance is due to exaggerated serine phosphorylation of the insulin receptors. This also controls the activity of P-450, an enzyme which regulates androgen biosynthesis. Although no extremely large trials using these drugs for this indication have been performed, many trials have specifically examined the effects of these drugs on ovulation, hyperandrogenemia, and metabolic features in PCOS.

Table 3: Insulin Sensitizers
- **Metformin**
  Is the commonest drug used and has the maximum studies done
- **Pioglitazone**
  (Troglitazone and Rosiglitazone are now no longer recommended for use due to fatal Liver Necrosis seen with their usage)
- **Insositol**
  Newer therapy which may hold some promise. Needs larger studies.

More recently, insulin resistance in PCOS is seen along with an increased prevalence of other features of the "metabolic syndrome", namely glucose intolerance, type 2 diabetes mellitus, and hyperlipidaemia. Hyperinsulinaemia is likely to contribute to the disordered ovarian function and androgen excess of PCOS.

The commonest drug used is Metformin. It is a biguanide which acts in PCOS by lowering the blood insulin levels. The full dose of Metformin is 1500-1700 mg/day given in divided doses, because it may not be tolerated in such doses suddenly, it is usually recommended to start in an incremental dose. The treatment is started at 500 mg at night for first week, than 1000 mg/day for 2nd week and then 1500-1700 mg/day for the subsequent 12 weeks. It does not decrease blood glucose is non diabetic individuals.

Legro's paper in NEJM has shown that Metformin alone on fertility rates is questionable. (comparing CC, Metformin and combination of CC and Metformin, showed that CC alone is as effective in giving live birth rates, as compared to the other two arms). Clomiphene resistant PCOS who have insulin resistance, have shown evidence of ovulation and improved outcome after

metformin therapy. Metformin has also been used with improved outcome in patients on gonadotrophin therapy with decreased incidence of OHSS in this group.

Some studies suggest that metformin will reduce total body weight to a small extent, but with a predominant effect on visceral adipose reduction. The effects of metformin on lipid abnormalities, hypertension or premature vascular disease are unknown, but the relative safety, moderate cost, and efficacy in reducing insulin resistance suggest that metformin may prove to be of benefit in combating these components of the "metabolic" syndrome in PCOS. **Homburg** in his review article suggest a note of caution in the over-judicious use of metformin in PCOS and concludes saying "the honorable intent of lowering high insulin levels in this way prompts the bottom line of this debate to strike a note of cautious optimism that insulin-sensitizing agents will be of some clinical usefulness both in the short-term aiding of infertility treatment and, possibly, in the prevention of the long-term sequelae for this troublesome and very prevalent condition"

In some patients who do not show adequate response with metformin, pioglitazone has been tried with successful results. However, glitazones cannot be continued in pregnancy and hence, therapy should be stopped once induction of ovulation is started.

Inositol

Insulin plays a direct role in the pathogenesis of hyperandrogenemia in PCOS, acting synergistically with LH to enhance androgen production in theca cells. Many investigators have focused both on impaired glucose tolerance, which affects 30%-40% of patients with PCOS, and on insulin resistance, which is present in a significant proportion of women with PCOS. In study of 60 patients randomized into 2 arms, by Enrico Papaleo et al from Italy, show that in patients with PCOS, treatment with myo-inositol reduces germinal vesicles and degenerated oocytes at ovum pick-up without compromising total number of retrieved oocytes.

A number of such small randomized and nonrandomized cohort studies have shown that women with PCOS respond to D-chiro-inositol (DCI) therapy by increasing ovarian activity and menstrual frequency. However, the relationships among treatment outcome, anthropometric changes, and glycemic, metabolic, and lipid profile adjustments were less comprehensively studied and remain unclear. Most of studies where inositol was used are small cohort studies, where these therapies appear to influence steroidogenesis directly, reducing the androgen production in theca cells. Its effectiveness is needed to be proven by large double-blind placebo-controlled trials.

Letrozole – An Aromatase Inhibitor in PCOS

From the studies by Mitwally and Casper, it seems to suggest that an effective alternative to CC in the management of PCOS has been found. The use of aromatase inhibitor is based on the same principal of anti-estrogenic environment and hence seems effective. Letrezole is given in the dose of 2.5 -5 mg/day from day 2 or 3 of the cycle for 5 days. There is no blocking of the estrogen receptors and hence there is no adverse action on the cervical mucous and endometrial lining as seen with CC. Hence, it may explain the increased responsiveness to the drug and its effectiveness in CC resistant patients.

Gonadotropins

It should be borne in mind that 20% of PCOS will be CC resistance. If conception has failed with 6 ovulatory cycles in women, it is assumed that anovulation is not the only cause of their infertility and these patients should be referred to ART center for IVF as option. Also, the lesser the exposure to ovulation inducing drugs in these patients, the better it is. The best treatment is in the form of low dose FSH stimulation for IUI cycles and chronic low dose protocol is the preferred option now. In the presence of concomitant factors affecting fertility, it would be better to shift the patient to ART Clinic for further management.

Conclusion

The mainstay of management of anovulation is to induce regular unifollicular ovulation whilst minimizing risks of OHSS and multiple pregnancies. The original triad described by Stein-Leventhal appears to be at one end of spectrum of disorder called PCOs today. The first drug of choice is still CC and alternative methods are used only in patients who are CC resistant. Unifollicular ovulation induction requires a subtle approach and this should be the norm especially in PCOS. Insulin sensitizers may play an important role in the management of PCOS with insulin resistance. An infertility clinic which offers ART along with preconception counseling and advise as to how to minimize the metabolic sequel of PCOS and in order to minimize the duration of exposure to fertility inducing drugs, may be the best place for treating PCOS.

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. What does Rotterdam criteria not take into account for diagnosis of PCOS ?
- **a.** USG appearance
- **b.** Anovulation
- **c.** Insulin Resistance
- **d.** Hyperandrogenism

2. The hall mark of Insulin Resistance in PCOS is
- **a.** High Blood Sugar Levels
- **b.** Obesity
- **c.** Acanthosis Nigricans
- **d.** Altered Lipid Profile

3. The first line of management of Infertile PCOS is
- **a.** Clomiphene Citrate
- **b.** Letrozole
- **c.** Weight Loss
- **d.** Gonadotropins
- **e.** Insulin Sensitizers

4. Insulin Sensitizers used are:
- **a.** Metformin
- **b.** D Chiro-Inositol
- **c.** Pioglitazone
- **d.** All of the above

5. Insulin Sensitizers like insositol act by
- **a.** Decreasing the LH
- **b.** Improving the Cellular uptake of insulin
- **c.** Decreasing the hyperandrogenemia
- **d.** All of the above
- **e.** None Of the above

6. Metformin is now recommended for use in PCOS –
- **a.** All patients showing PCO ovaries
- **b.** All patients who are CC resistant
- **c.** In presence of Insulin resistance
- **d.** In patients with recurrent Pregnancy loss
- **e.** Obese PCOS

7. The gonadotropin protocol of choice in PCOS should be:
- **a.** Low dose step up protocol
- **b.** Low dose step down protocol
- **c.** Chronic low dose protocol
- **d.** Combination with oral ovulagens
- **e.** Any protocol using FSH is accepted

8. The patients with PCOS will never present with the following clinical picture
- **a.** Recurrent abortions
- **b.** Hirsuitism
- **c.** Irregular cycles
- **d.** Acne
- **e.** Obesity
- **f.** Precocious Puberty

9. The decision about the use of the therapy will depend on a number of factors:
- **a.** Age of the patient
- **b.** Body Mass Index (BMI)
- **c.** Menstrual history
- **d.** Evidence of Hirsuitism and hyperandrogenism
- **e.** All of the above

10. Metabolic PCOS is diagnosed in 20% of PCOS. However, ... level is not affected in Metabolic PCOS:
- **a.** Blood sugar levels
- **b.** LH levels
- **c.** Cholesterol
- **d.** TSH levels

Answers: Issue 7 CME MCQ on PPH (Credit Points: 1 for attempt; 1 for answers > 50% correct)

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

3. a. IM Oxytocin 10 IU within one minute after the delivery of a Fetus ensuring no second fetus by palp ation.
- **b.** Controlled cord traction
- **c.** Uterine massage to ensure uterus remains contracted and retracted.

9. a. Oxytocin - 20 IU /Litre for maximum of three litres
- **b.** Methyl ergometrine - 0.2mg slow IV every 4th hourly for maximum of 5doses(1mg)
- **c.** PGF2 alpha- 250mg every 15 minutes for 8doses=2gms
- **d.** Carbetocin- recommended dose 100mcg.

ICOG Highlights 2009-2011

ICOG CMEs 2009 - 2010

Dr. Uday Thanawalla
Chairman of Sub-committee

These CME's focus on learning evidence based updates which can be applied in clinical practice, making patient care optimal. 16 CME's have been conducted since April 2009 till date. With these CMEs through the " study hour " we have taken a step forward in collecting Indian data, and presenting analytics. Now the CMEs are more interactive - a format enjoyed by the delegates.

Akola
20th December 2009

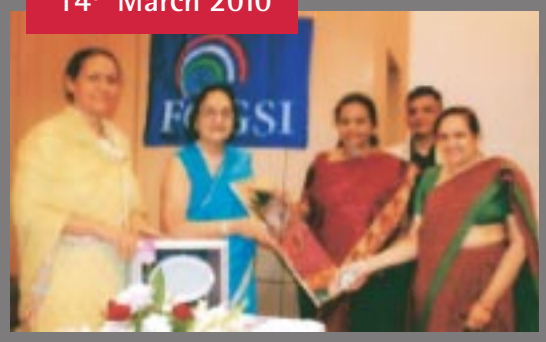
Amravati
13th December 2009

Bellary
24th - 25th October 2009

Bhilai
25th July 2010

Imphal
24th February 2010

Ludhiana
14th March 2010



Nanded
20th September 2009

Kolkata
4th April 2010

Raichur
4th July 2010

Warangal
4th April 2010

Navi Mumbai
28th March 2010

ICOG Directory

– **Dr. Uday Nagarseker,** Vice Chairman, ICOG

The ICOG CD and Directory was a project initiated and undertaken by Dr. Nagarsekar. It was released at the Current Opinion-PCOS update at Goa. It has been well appreciated by all members.

Messages of appreciation recieved by Dr. Uday Nagarsekar

"Received the Directory of members a nd fellows of ICOG. Congratulations. It is very useful as it gives contact details of most of the seniors in our profession. Thanks a lot on behalf of all of us".

With regards,

Dr. V. P. Paily

FOGSI - ICOG Dr. C. L. Jhaveri Endowment Symposium

at 53rd AICOG at Guwahati on 20th January 2010 on "Genital Cancer : Curent Evidence" And at 54th AICOG at Hyderabad on 7th January 2011 on "Reaching The Unreached"

FOGSI-ICOG Ethiskills Programme

– **Dr. Parul Kotdawala,** Chairman of Sub-committee

The aim of the course is not to make "super-surgeons". The aim is to teach a safe and competent technique of achieving good surgical results. The course focuses on prevalent evidence-based teaching. The course utilizes the infrastructure & the facility of 'Ethicon Institute of Surgical Education' in Mumbai, New-Delhi and Chennai. The course began in September 2006 and many post graduate students have benifitted by this programme.

FOGSI-ICOG Satellite School Programme

– **Dr. Atul Munshi,** Chairman of Sub-committee

The "FOGSI-ICOG Satellite School" has been initiated in October 2006. Since then the program has been progressing well and has been found to be extremely useful to a large number of post graduate students. These programmes and live interactions were well appreciated at the down linking centers. This programme was temporarily non-functioning because of technical reasons and non-availability of educational satellite for transmission. Good news is that we are able to restart it from December 2010 from BISAG studio, Ahmedabad with the help of Government of Gujarat. The newly started programme are as follows:

January 2011 -

Topic: Introduction of satellite school & Management of Menopause

Speakers - Dr. Atul Munshi, Dr. Jignesh Shah

February 2011 -

Topic: AUB: yesterday, today and tomorrow Speaker- Dr. Tushar Shah (ex-professor NHL Municipal Medical College)

Topic: Life saving Nutritions in Pregnancy Speaker- Dr. B. S. Anklesaria (ex professor, L.G. General hospital)

We are determined to take this popular programme to a newer height in near future.

ICOG Highlights 2009-2011

Post Graduate Review Course

The objective being to standardize a Review Course, which postgraduates would identify with, prior to appearing for their postgraduate exams and get the maximum benefit in the shortest possible time. Its proceedings are enclosed in a CD and given as course material to the students.

Credit Point Winners

Dr. Uday Nagarseker, Chairman of Sub-committee

100 Credit Points earned over a period of 3 years will entitle to apply for Fellowship / Membership of ICOG in place of publications and presentations, when other criterias are fulfilled.

CREDIT POINTS WINNERS: 2010

On 21st January 2010 at the AICOG convocation, Guwahati.

Name	Credit Points
Dr. Smiti Nanda, Rohtak	**112**
Dr. Nirmala Duhan, Rohtak	**91**

CREDIT POINTS WINNERS: 2011

On 8th January 2011 at the AICOG convocation, Hyderabad.

Name	Credit Points
Dr. Vidya Pancholia, Indore	**106**
Dr. Manila Jain Kaushal, Indore	**146**
Dr. Anupama Dave, Indore	**66**
Dr. Preeti Bhandari, Mumbai	**67**

Travelling (Visiting) Professorship

Dr. Priti Bala Sahay, HOD, Dept. of Obs & Gyn, RIMS, Ranchi visited Dept. Of Obs. & Gyn CSM Medical University, Lucknow from 15.02.10 to 20.02.10 (Monday to Saturday) as visiting Professor under the ICOG Traveling Professorship scheme.

ICOG Online Quiz

An innovative way of learning ; first focus was on contraception and the recent one on infertility.

1st Online Quiz Winners (Topic: Contraception)

Team 1. Dr. Lokam Kusuma and Dr. Krithika

Team 2. Dr. Sathya Lakshmi and Dr. Chaya S. M.

Team 3. Dr. Nidhi and Dr. Amita

2nd Online Quiz Winners (Topic: Infertility)

Dr. Ajay Jain and Dr. Shikha Jain

ICOG Website

Dr. Mandakini Parihar, Chairman of Sub-committee

A face-lift! New Sections... Updated information... "Advancing standard of Education and Healthcare Practices" is the ICOG motto for the last 2 years and we have tried to ensure that all our members and fellows get the latest advances and happenings of ICOG at the click of a mouse button. It gives all the details about the organization along with all the rules and regulations which apply to the members and fellows. The updated Credit Point system now outlines how a FOGSI member can become ICOG member, using these Credit Points, if they are falling short in some of the eligibility criteria. The ICOG CME's now are conducted with 4 specific topics 'ICOG Study Hours'. The 4 topics on GDM, Contraception, Adolescent PCOS and Metabolic Syndrome, each have a KAP form filled by delegates and the analysis the Knowledge Attitude and Practices amongst us gynaecologists will soon be available.

Log on to
www.icogonline.org.

Reaching the unreached – National Eclampsia Registry

– Dr. Sanjay Gupte,
FOGSI President 2010
Chairman of Sub committe

A FOGSI-ICOG initiative, the project is aimed at understanding the prevalence of eclampsia- pregnancy induced hypertension among women in India. It is definitely preventable, but we need to know the prevalence of this condition so that we can go for the standardisation of treatment practices.

The registry will collect data on eclampsia cases with the help of FOGSI's 250 branches and 25,000 gynaecologist members spread all over the country, including the hinterlands. The maternal mortality rate of India is more than 400 in 1,00,000 (1 lakh) of pregnancy cases, which is serious, and eclampsia is the prime reason.

Even in a country like Sri-Lanka, the rate of mortality due to eclampsia is just 24 in one lakh cases. And in western countries, it doesn't exceed 10. We urge all the FOGSI members to contribute data so that all the data can be analysed and best practices can be disseminated. You can view the Newsletter Archives and Analytics on the website by logging on to **www.abcofobg.com/Eclampsia**.

EmOC Programme

– Dr. Sadhana Desai, RCH Convenor, FOGSI

FOGSI/ICOG has set up 5 nodal centres by August 2010. Lucknow - KGMC centre is also ready and approved by GOI to be functioning as 6th nodal centre. However, UP Govt. has not released the funds to operationalize it.

Untill August 2010, total 29 tertiary training centres have been created in 17 states of India. 154 master trainers in medical colleges and 219 district hospital practical trainers are trained and 665 govt. MBBS doctors have taken training in EmOC.

Although FOGSI has far exceeded its target of setting up required numbber of nodal centres, tertiary training centers & practical training district hospital centers, various state govt. of India have not fulfilled their target of sending 24 students per year to each tertiary training centres, (i.e. 1500 students in 5 years). GOI has therefore asked FOGSI/ ICOG to extend the programme for one more year.

Visit www.emocfogsi.in

Current Position –March 2011, Creating the EmOC human resource

	Total in 5 yrs.	Target in 5 yrs.
Nodal Centers	6	4
Tertiary Training Centers	30	20
Master Trainers in Medical Colleges	168	80
District Hospital Training Centers	197	160
District hospital Practical Trainers	231	160
MBBS doctors enrolled for long course	828	1500
MBBS doctors trained in short course	104	

CURRENT OPINION

PCOS & The Syndrome X Conference

Held On: March 19-21st, 2010 – Goa

It was a great success with a multi disciplinary faculty from India and abroad and many delegates. This 3 day update with topics on metabolic and cardiovascular issues, obesity and androgen excess in PCOS was much appreciated by all.

Accreditation of Nursing Homes

– Dr. Duru Shah, Chairman, ICOG

Accreditation project is an ICOG / FOGSI project in collaboration with Government of India -MOHFW and WHO.

Convenor: Dr. Duru Shah

Technical Expert Committee (TEC):
Dr. Sanjay Gupte, Dr. Hema Diwakar, Dr. Hara Pattnaik

Facilitated by: **Avni Health Foundation**

Objectives of the Project

Phase I... Initiated in December 2006 completed in June 2008

A. Developing Accreditation Criteria to Accredit Private Nursing Homes for offering Reproductive and Neonatal Health Services.

B. To Accredit Private Nursing Homes for upgrading the skills of Birth Attendants from the Public Sector.

Phase II... Initiated in April 2011

To utilize the above Criteria to accredit Private Nursing Homes of FOGSI members so that these services can be offered to the Below Poverty Line Sector through the NRHM Scheme. Pilot study to be initiated in 3 States Maharashtra, Karnataka, Orissa.

The Government of India (GoI) has launched the National Rural Health Mission (NRHM) in April 2005, in order to improve the availability of, and access to, quality reproductive healthcare services throughout the country. In India, there are about 27 million births per year; of these, 1.1 million deaths occur before the first year of life, and nearly 77,000 mothers die per year during childbirth. Prevention of these deaths poses a big challenge to the country and has been accorded top priority under NRHM.

To achieve the above goals, GoI is committed to operationalize Community Health Centers as First Referral Units that provide comprehensive Reproductive and Child Health services (RCH). There is a plan to convert at least 50% of all Primary Health Centers into 24hours x 7days operational centers, which will be proficient in providing basic RCH services.

While the ball is set rolling to make the above happen, there is a need to simultaneously accelerate the services under RCH program by broad basing it by involving and accreditating the private sector nursing homes (PNH) that meet the set guidelines/standards.

Advantages to us as FOGSI members:

1. Our nursing homes will be accredited so that the standard of care improves.
2. The activity will be financially gainful to us in the long run.
3. Our Nursing Home will be recognized by the local health society for other government related projects or activities.
4. We will have contributed to the lowering of maternal mortality in the rural sector by offering our services for maternal and neonatal health care and by upgrading the skills of the Skilled Birth Attendants of the public sector.

I hope that ICOG / FOGSI will once again lead the initiative and involve the private sector doctors who meet the accreditation criteria. Thus ICOG / FOGSI will be at the forefront of piloting a model, which will hopefully be adopted by GOI - Ministry of Health and Family Welfare and the respective State Health Departments.

ICOG Highlights 2009-2011

ICOG Convocation at Guwahati – AICOG 2010

Held on 21st January 2010 at Guwahati, led by Dr. Sanjay Gupte (then President FOGSI and ICOG) and Dr. Duru Shah (Chairman ICOG).
Chief Guest was Prof. Liselotte Mettler.

ICOG Campus – 8 issues of the ICOG Campus newsletter have been printed and can be viewed on the ICOG Website.

ICOG CMEs 2011

Hubli

The **Hubli-Dharwar** Obstetric and Gynaecology Society organized the CME on **29th and 30th of January 2011** at the SDM College of Medical Sciences. An Endoscopy workshop was conducted with Dr. Hafeez Rehman. The topics in focus on the 30th were on Recent Advances in OBGYN discussed by Dr. Bandiwad, Dr. Bellad, Dr. Desai, Dr. Hegde, Dr. Bhat, Dr. Patwardhan, Dr. Kurtkoti, Dr. Jamuna K., and Dr. Ramalingappa, Dr. Hiremath, Dr. Gokavi, Dr. Kumar and Dr. Murthy. Around 85 delegates from even places like Gadag, Haveri, Saundatti etc attended this programme. organized by Dr. V. G. Kulkarni.

Bilaspur

The **Bilaspur** Obstetrics and Gynecological Society successfully organised the ICOG CME at the annual conference of Bilaspur OBGY society on **30th January 2011.** The event was inaugurated by the SDM Bilaspur Dist. The organising chairperson was Dr. Sarita Agrawal, Organising secretary, Dr. Rashmi Sharma. The topics discussed were on GDM -Indian Guidelines on screening and diagnosis with mock discussions on "anaemia guidelines" with a panel of clinicians, conducted by Dr. Hema Divakar; a presentation of expert group consensus on HIV by Dr. Sarita Agrawal; a discussion on Adolescent PCOD by Dr. Uday Thanawala amongst other topics like Ovulation Induction, IUI, APLAS, PPH Surgical And Medical Management, PIH , Amnioinfusion and Vault Suspension. The CME attended by 129 delegates, was highly appreciated with good active interaction with the delegates.

Indore

The **Indore** Obstetric and Gynaecology Society organized the CME on **12th of March 2011**. The topics in focus were on anemia, PCOS and GDM. Around 145 delegates attended this programme organized by Dr. Anupama Dave and Dr. Maru with ICOG faculty - Dr. Behram Anklesaria and Dr. Hema Divakar. The programme was a grand success

The GDM Analytics have been published earlier. These are avaliable online. Please log on to **www.icogonline.org**

Academics - ICOG Study Hours

PCOS Analytics

These ICOG Study Hours - Analytics have been brought to you by the collaborative efforts put in by Dr. Duru Shah, Dr. Hema Divakar, Dr. Mandakini Parihar, Dr. Uday Thanawala and Dr. Jaideep Malhotra.

In the ICOG study on PCOS, the majority of the respondents for the knowledge attitude and practice (KAP) questionnaire possessed a post graduate degree (43%) or diploma (33.13%). 68% of these were private practitioners, 23% were attached to medical college and only 10.63% were with corporate hospitals - **indicating that the profile of patient population seen by these could be quite different - with respect to education and socio-economic status.**

How often do you see adolescent patients with menstrual problems?

Frequency	% of respondents
Occasional	18.13
Per Week	61.25
Per Month	25.63

More than 60% of the clinicians remarked that they would see a significant number of adolescents per week, **mainly with problems related to menstrual cycles.**

When would I investigate her?

Visit	% of respondents
First	31.88
Second	60
Third	9.38
Fourth	7.5

31% of clinicians would investigate such a patient at the very first visit. 7% said that they would investigate if there is Hyperandrogenism.

However 69% **would consider investigating only if she has recurrent episodes.**

Which of the following investigations as minimum?

Investigation	% of respondents
USG	92.5
Blood sugar levels	56.88
Reproductive hormone levels	63.75
Androgen hormone levels	46.88
Lipid profile	21.88
Others	25

USG seemed the most recommended first line investigation, requested by 92.5% of the practitioners.63.7% would ask for a reproductive hormone profile, indicating that treating infertility may be the priority.

With the view of assessing the baseline for long term metabolic problems, the practitioners following the RCOG guideline of assessment of Glucose tolerance was only 56% and lipid profile was requested by only 21.8%.

The expert group opines that these should be a part of the baseline assessment, even in young adolescents and their **BMI should be recorded**. In addition, waist circumference and BP measure is also to be documented.

Which is the first line of treatment for menstrual irregularity?

Treatment option	% of respondents
Cyclical Progesterone	35.63
One time Progesterone	10
OCP	51.88
NSAID	10
Metformin	16.25

The **first line treatment for menstrual irregularities was oral contraceptive pills** (51.8%) and progesterone only pill (35.6%). These are the standard accepted short-term treatments. Metformin is used by 16.25% of our clinicians - showing an **emerging trend of understanding insulin resistance as the central factor in PCOS**. 82.5% have opined that they would use metformin only if there is an evidence of insulin resistance.

How do you test for insulin resistance?

Test	% of respondents
BMI	41.88
Waist Hip Ratio	37.5
Presence of acanthosis	11.88
Insulin levels	18.13
Sugar levels	48.75
Insulin-sugar ratio	33.13

On inquiring about how one would assess insulin resistance, 80% said they would check sugar levels and insulin levels and 26.8% said they would measure insulin to sugar ratios. Simple observations of weight/ acanthosis/BMI/ waist hip ratios were done only by 20% of practicing clinicians. These measures add significant value in treatment planning and advice and therefore should be documented routinely.

A clear cut consensus to establish uniformity in treatment is still lacking.

Usage of insulin sensitizing drugs in adolescents?

Usage	% of respondents
No for all	11.88
Yes for all	13.75
Yes, but only if there is evidence of insulin resistance	82.5

If at all they use the drug, **100% of them would use metformin - most commonly accepted for use and gaining popularity and familiarity!**

Preferred drug for insulin resistance?

Drug	% of respondents
Metformin	100
Pioglitazone	0.76
Rosiglitazone	0.76

Less than 1% of the respondents knew of Pioglitazone or Rosiglitazone and were awaiting more information on these before attempting to use them in practice.

Which OCP would be preferred?

OCP	% of respondents
Any one available	5
EE + Levonorgestrel	15
EE + Desogestrel	13.13
EE + Drosperinone	30.63
EE + Cyproterone	31.88
Others	16.25

Duration of OCP treatment?

Time duration (months)	% of respondents
1	4.38
3	67.5
6	26.88
9	0.63
12	3.13

Amidst the OCPs, the common choice was a combination of EE + dosperinone OR EE + cyproteroneacetate (30.5% each group). Most clinicians (67.5%) would prefer to give OCPs at least for three months.26.8% said they would continue for six months and only 3.3% said they would offer it for one year. **Three to six months is the typical short term protocol which is to be spiced with the advice of life style modification**. If irregularity recurs, one may restart the OCPs or progesterone - this has been the trend of practice with 80.8% of the clinicians.

Management options of recurrence of menstrual irregularity?

Management option	% of respondents
Counsel and reassurance, but no active treatment	21.25%
Counsel and reassurance, and repeat OCP	46.88%
Counsel and reassurance, and repeat cyclical progesterone	34.38%

Which patient profile is most important?

Patient profile	% of respondents
Age	62.5
Weight	9.38
S/S Hirsuitism	9.38
Menstrual history	8.75
All of the above	44.38
Random	0

When their understanding about patient profile was tapped, 62.5% said that **age is the only factor that they would give importance**. 40% commented that in addition to age, the patient's **weight**, and presence of **hirsutism, menstrual history - all of these are important. Indeed the expert group agrees with this**.

Lifestyle modification is advised for which patients?

Patient type	% of respondents
Obese PCOS	56.88
Lean PCOS	1.25
Both	44.38

The importance of the advice for lifestyle modification was recognized by 99% of the clinicians. Majority of them - 72.5% said they **would refer for diet and exercise counseling and believe in a multidisciplinary approach**.

What is the recommended further management for all adolescents with PCOS?

Management option	% of respondents
Specialist referral	8.75
Dietician advice	21.88
Dietary advice by doctor	13.13
Exercise	32.5
Multi disciplinary approach	72.5

Routine follow up is advised for all adolescents with PCOS

Time	% of respondents
Once in 3 months	76.88
Once in 6 months	18.13
Once in 12 months	2.5

The trend for a follow up visit seems to be in the range of 76% in favor of three monthly follow up and 18% for a six monthly follow up. This is encouraging because t**he adolescents do require repeated motivation for lifestyle changes and the treatment options need to be individualized and modified frequently.**

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Current Opinion 2011 – Evidence, Ethics, Excellence

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The recently held ICOG-FIGO Current Opinion meeting from 18th to 20th March 2011 was a unique experience for all those who participated in the deliberations. The concept of updating ourselves on issues we deal with in clinical practice, in the format conceived by our Chairman Dr. Duru Shah, was to review the evidence leading to the best practices, debate the ethics of various problems, and learn from the excellence of colleagues who are actually doing the work in different fields.

The conference started off on Friday afternoon, in the luxurious ambience of the Leela Kempinski, tucked away at the tip of South Goa on the Cavelossim Beach. International delegates who had come in earlier for the FIGO Ethics Committee meeting had graciously stayed on to participate in the scientific deliberations, national faculty and delegates came in from different parts of the country, and of course, the local Goa people came in good numbers. What had started off as a small meeting, turned out to have over 200 participants, in fact we ran out of rooms at the Leela and adjacent Holiday Inn, and late-comers had to be accommodated elsewhere! There were a few changes in plans for some, but the scientific sessions were co-ordinated with gracious co-operation of our faculty, some who even stepped in last-minute.

The opening session had remarks by Dr. Duru Shah, Chairman ICOG and Prof Bernard Dickens, Chairman, Ethics Committee FIGO followed by a small but beautiful inauguration. Dr. P. C. Mahapatra delivered the FOGSI Presidential Oration, after which the main scientific sessions kept all captivated till dinner time. The invited videos and the Panel discussions were highly interactive with active audience participation. Despite it being a long day, all of us had a great time at the subsequent cocktails and dinner held on the lawns, with a variety of food and serenades by live Goan folk singers.

Saturday's sessions covered an entire range of topics, from feto-maternal medicine and USG to infertility and modern medicine, ensuring that each participant would find areas relevant to their own practice. Both the Aparanta and Hampi Halls had good attendance, despite the tempting Goan sands and swimming pools! We had about 2 hours break before the evening banquet, for enjoying other facilities in and around the venue. The night program on the lawns had a magical quality, it being a full moon and pre-holi time.... to add flavour and color there was a "mehendi-wali", tarot-card reader, bangle-vendor, caricature artiste... and a 5-piece live band! The gastronomic treats were varied, representing flavours of different Indian cuisines, and were rivalled by the variety of cocktails and desserts offered. Once people got into the swing of things, the dance floor was rocking till the band had to go!

Sunday morning was a quiet affair, it being Holi and some of the participants having to return early. Yet the interaction was vibrant, and the ICOG Oration on Saving Women's Lives by Dr. Sadhana Desai highlighted what each of us can do to make a difference. Out of 20 posters received it had been difficult to select just 3, but this was a platform where people from across the nation could showcase their work and interact. The cherry on the sundae was the Poster Prize presentation session, where the prize winners presented their work, just before the closing ceremony. We all left the conference refreshed and updated, with fond memories of the weekend and gratitude to the ICOG for organizing such a wonderful meeting!

CURRENT OPINION

EVIDENCE
ETHICS
EXCELLENCE

March, 18-20th, 2011 – Goa

Messages of Appreciation

"Warmest congratulations on the success of your splendid Evidence, Ethics and Excellence conference, and profound thanks for all of your thoughtful, generous hospitality, and charming gifts. The setting was ideal, the conference presentations had range, depth and substance, and the audience was engaged and enthusiastic. It was an honour to have been a part of so worthwhile an event. This was a minor part in contrast to the tremendous and greatly appreciated effort you and your staff gave to pulling together everything that had to be done to create the programme and arrange accommodation. All of us who were privileged to participate are indebted to you and your staff for management of the conference in such an efficient, indulgent and enjoyable way."

With repeated thanks, and kindest regards,

Prof. Bernard Dickens

A good mixture of science and ethics and most enjoyable conference, with opportuniites to meet colleagues with mutual interest. It was a pity though that we could not split ourselves in 2 as both room had interesting presentations!

And wonderful environment!

Prof. Francoise Shenfield

Are Women Exploited Through Surrogacy and Oocyte Donation?

Ethical issues in 3rd party reproduction, and cross border reproductive care

Prof. Françoise Shenfield
Infertility Clinician UCLH London, UK,
Member of ESHRE Taskforce for Ethics and Law,
Co chair of FIGO's Ethics Committee

The question of "exploitation" of women in fertility treatments has made headlines worldwide, and mostly concerns disproportionate compensation of surrogates and oocyte donors who, at least in Europe in general, and contrary to other countries like the USA, may not be paid for services by law (both national and through the EU Tissue directive), but compensated for their "services". Because of the wide economic variations between countries, or indeed sometimes areas between countries, especially between high and low income countries or geographical areas, one of the main worries is the exploitation of women of poor socio economic background. The argument is that disproportionate compensation means their consent is compromised by such compensation, verging into payments in relative terms to their usual income. It also renders the human (body and parts) more like an instrument, than an agent, a principles affront against autonomy

Furthermore, techniques like egg donation and surrogacy may involve patients crossing borders to obtain fertility treatment more often than for other ART techniques. Cross border reproductive care (CRBC) has been in the news for several years now, and indeed health professionals prefer this neutral term to the more derogatory terminology of " reproductive tourism" often used by the press (Pennings, 2006). This preference means to stress that most patients who cross borders in search of reproductive treatment do this because they must, and not by choice, or for leisure, as one would for a holiday (Ferraretti et al, 2009). This very point of semantic stigmatisation of patients who feel the need to cross border seeking reproductive care, was also counteracted in one of the considerations of the European Society for Human Reproduction and Embryology (ESHRE) Taskforce for Ethics and law (Taskforce 15, 2008). About the same time, we also decided that it was time to gather some evidence about the numbers of patients crossing borders, their characteristics and reasons, in view of the lack of published evidence amongst a flurry of press articles. We thus set up another Taskforce specifically enquiring into CBRC, a joint endeavour with the ESHRE European IVF Monitoring (EIN) taskforce members.

Many clinicians and other professional involved in infertility treatments, like counsellors for instance, are aware of CRBC movements, and often have no a priori prejudice against this common phenomenon. Indeed it can be said to enhance patients' autonomy. Furthermore, we know that the reasons for CBRC vary between countries (Pennings G, 2006), and most commonly involve: law evasion (when the technique is either forbidden per se, or to a particular population group); access limitations at home, including long waiting lists; the seeking of better quality of care, or cheaper treatment abroad (which then may unwittingly include exploitation of other women). At least for Europe, such reasons, and the national variations linked to local access and varied legislation, were confirmed by our findings, the fruit of a questionnaire aimed at women crossing borders in 6 different recipient European countries (Shenfield et al, 2010). We also stated in that paper that "ESHRE wishe(d) to reflect on the means of increasing the safety of crossing border for our patients", with the possible establishment of a Code of Practice, not forgetting either the safety and lack of abuse of generous third party collaborators.

What we finally decided to call ESHRE's "Good practice guide" (GPG) for CBRC for centres and practitioners" is now in press (Shenfield et al, 2011). This GPG is aimed at clinics and professionals, and outlines common quality standards in order to increase the safety of patients, gametes donors and surrogates, as well as future offspring, and to ensure good professional communication: they consider principles like equity, quality, safety, evidence based care, patient involvement and redress, for all concerned, whether patients, donors and surrogates, the future child or professionals.

In this short summary the emphasis is put on protection of gametes donors and surrogates, whose possible exploitation is an emotive and complex issue (Pande, 2011).

Our recommendations include a stimulation cycle that minimizes egg donors' health risk, and the avoidance of intermediate agencies which may lead to violations of the rules of good clinical practice and, in the worst case, to trafficking. We advise that post-donation care should be provided to the best possible standards at home or abroad.

For the sake of safety of the surrogate we clearly state that single Embryo Transfer (ET) is the only acceptable option in surrogacy. Indeed, the concept of ART pregnancy with a maximum twin pregnancy is essential for the protection of the welfare of the future child, for recipients of all fertility treatment in general. Prevention is always better than cure, and fetal reduction can hardly be described as "therapy": it is always a difficult and poignant decision for the woman, even more difficult if the pregnancy originated form abroad (Mc Kelvey et al, 2009).

Finally, an important international concern is the fact that, at the local level, there is also a danger of shifting scarce local resources to the care of CBRC patients (ESHRE Ethics and Law Taskforce 16, 2009; Serour, 2009). This, which especially applies to low income areas or countries, is a "macro- ethical" consideration within the realm of (international) justice.

PCOS Analytics

Continued from page 17

So, it is worthwhile reassessing at short intervals of three to six months rather than not reviewing for a year or more.

The KAP study brought to light the changing trends in acknowledging **adolescent PCOS as a special entity for management of short term as well as long-term problems**. A lot more needs to be done towards implementing consistent follow up and assessment for long-term metabolic syndrome early in adolescence rather than late in reproductive age group.

This study sets the baseline understanding of practices and attitudes in the Indian context and will lead the way to developing concrete guidelines and practice recommendations.

KEY POINTS:

- The patient population seen could be quite different with respect to education and socio-economic status.
- Problems related to menstrual cycles are main reasons to seek medical advice in adolescent population.
- USG seems to be the most recommended first line investigation.
- BMI should be recorded in all patients.
- The first line treatment for menstrual irregularities was oral contraceptive pills.
- Amidst the OCPs, the common choice was a combination of EE + dosperinone OR EE + cyproterone acetate
- There is an emerging trend of understanding insulin resistance as the central factor in PCOS
- A multidisciplinary approach was employed by most in their management.
- Adolescents require repeated motivation for life style changes and the treatment options need to be individualized and modified frequently.
- Adolescent PCOS should be acknowledged as a special entity and this will lead the way to developing concrete guidelines and practice recommendations in the Indian context.

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