

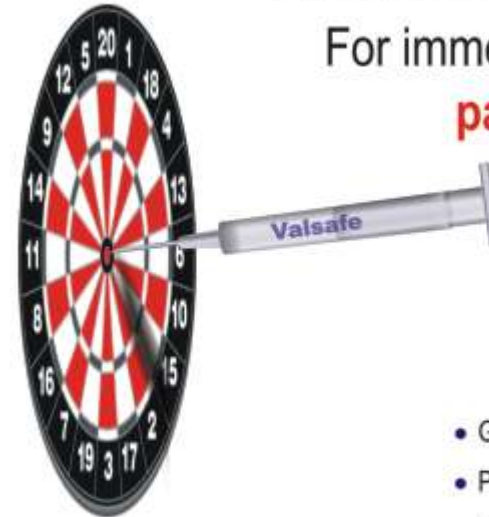
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President's message

- Dr. Shyam Desai



Compliments of the season to all of you.

The Indian College of Obstetrics and Gynaecology (ICOG) was formed as the academic wing of FOGSI in the year 1984 at Durgapur under the Chairmanship of Late Dr. C.S. Dawn and the Secretaryship of Dr. M. N. Parikh with a view to enhance the academic activities of the Federation.

The ICOG has over the years fulfilled the function of promoting academic activities amongst the ICOG Fellows and members of the FOSGI by organizing Continuing Medical Education programs, Correspondence courses and lecture series. It has also enabled us to interact with like minded Gynaecologists all over the country.

As a practicing Obstetrician and Gynaecologist, updating one's knowledge is imperative in today's scenario. The modern day practitioner is required to have knowledge regarding Fetal heart rate monitoring, Ultrasonography and Colour Doppler and Endoscopic surgery at the same time being capable of interpreting a labour

curve, conducting a Breech delivery and performing a routine Hysterectomy. With the changing medico-legal scenario, one should also be aware of the legal and ethical aspects of day to day practice.

Over the next few years activities of the ICOG should be directed to reach out to a larger section of our members by organizing Lecture series and CME programs at Society and Regional conferences.

Instituting fellowships at leading postgraduate institutes in India will be a boon for the eager postgraduates in our specialty. Initiating Visiting Professorships at the Medical colleges and at the Society level would also be a big step in the dissemination of knowledge. This would enable our budding Gynaecologists to interact with doyens in the academic field at a personal level.

With the present office bearers Chairman Dr. Rohit Bhatt, Vice Chairman Dr. Usha Saraiya and

(contd. to page 2)

From the Editor's desk

- Dr. Duru Shah



Dear Members

A very happy New Year to all of you! To usher in the new year I have brought some great news for you! ICOG has created 5 International Observer Fellowships for the year 2005. Three of them are in the UK and two in the USA! The UK Fellowships are in the Department of Reproductive Endocrinology and Infertility with none other than Dr Gordana Prevelic at the Royal Free & University College London whilst the USA Fellowships are in the Department of Maternal Fetal Medicine with our very first International ICOG Fellow

Dr Jyotsna Gandhi at the Mount Sinai Hospital, New York. The details of credentials required for these Fellowships are being worked out,

and applications will soon be invited. So keep a watch on the ICOG website www.icogonline.org in February this year or the April issue of 2005 of ICOG Campus. Don't miss this fantastic opportunity being offered by ICOG to its Members and Fellows!

Wishing you all the best.

Warm regards,

Yours sincerely

Dr Duru Shah

Editor, ICOG Campus

Hon. Secretary, ICOG

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ICOG cannot accept responsibility for the correctness or the accuracy of the opinions expressed by the contributors.

ICOG CME 2004



Tirupati - ICOG - Dr. C. S. Dawn CME, 7th Aug., 2004



Bhagalpur Obs. & Gyn. Society. ICOG CME - 19th Sept., 2004



Muzaffarpur Obs. & Gyn. Society. ICOG - Dr. C. S. Dawn CME - 30 - 31 Oct., 2004

ICOG CME Section

Forthcoming CME's

Aligarh: Last week of January 2005

Yavatmal: 7th November 2004 9Dr.C.S.Dawn CME)

Rewari: 5th December 2004

CME's held (Programme, Photographs and Report enclosed)

Bhagalpur: 19th September 2004

Bihar: 12th September 2004

Pune: 17th October 2004

Patiala: 26th September 2004

Tirupati: 6th & 7th August 2004 (Dr.C.S.Dawn CME)

Muzaffarpur: 30th & 31st October 2004 (Dr.C.S.Dawn CME)



Bihar Obs. & Gyn. Society. ICOG CME - 12th Sept., 2004



The Patiala Obs. & Gyn. Society. 16th Annual Conference & ICOG CME 2004 - 26th Sept., 2004

ICOG CONVOCATION

on the 8th of January at AICOG 2005

All are invited

Log on to
www.icogonline.org

President's message (contd. from page 1)

the Secretary Dr. Duru Shah the ICOG is poised to reach greater heights during the forthcoming year.

I wish you the very best during the year and look forward to your cooperation in the functioning of the ICOG

Regards

Dr Shyam Desai

Postoperative pain management

- Dr. Uday L. Nagarseker

Director, Vasco Clinic & Sanjeevani Hospital
Hon. Consultant, Salgaocar Medical Research Centre
Hon. Consultant, Apollo Victor Hospital, Goa
Email: uday_goa@sanchamnet.in



RATIONALE OF POSTOPERATIVE PAIN RELIEF

Recent years have witnessed with increasing interest in postoperative pain management. The aim of postoperative pain treatment is to provide subjective comfort in addition to inhibiting trauma-induced nociceptive impulses in order to blunt autonomic and somatic reflex responses to pain and subsequently to enhance restoration of normal function.

FACTORS INFLUENCING ANALGESIC NEEDS

- Age of the patient: elderly patients request smaller doses.
- Sex.
- Coexisting medical conditions such as substance abuse or withdrawal, hyperthyroidism, anxiety disorder, affective disorder, hepatic or renal impairments.
- Cultural factors and personality. (e.g., patients vary from being intolerant of any discomfort to surprising self-control or patients consider pain to be a normal part of life).
- Preoperative patient education.
- Site of operation: thoracic and upper abdominal operations are associated with the most oppressive pain.
- Individual variation in response and pain threshold.
- Attitude of the ward staff.

METHODS OF ACHIEVING PAIN RELIEF

Pharmacological Management Treatment modalities now available are:

- Intramuscular, Subcutaneous, or Intravenous injections
- Oral tablets or rectal suppository
- Transdermal and transmucosal analgesics
- continuous infusions of opioids and/or NSAIDs
- patient-controlled administration of opioids and/or NSAIDs
- intermittent boluses and/or continuous infusion of epidural or intrathecal opioids.

NSAIDs (Non-steroidal anti-inflammatory drugs)

Pharmacological management of mild to moderate postoperative pain should begin, unless there is a contraindication, with a NSAID. These decrease levels of inflammatory mediators generated at the site of tissue injury, block prostaglandin synthesis, thus preventing this compensatory response and inhibit platelet aggregation. This raises concern for potential bleeding complications when they are used perioperatively. NSAIDs have several advantages over opioids. They do not have hemodynamic effects, do not cause respiratory depression, or slow gastric emptying or small-bowel transit time. The analgesic and anti-inflammatory effects of conventional NSAIDs are mediated by COX-1 inhibition and cyclooxygenase (COX)-2-specific inhibitors. The conventional NSAIDs inhibit COX-1, resulting in upper GI and hematologic adverse effects, whereas COX-2-specific inhibitors spare COX-1 at therapeutic concentrations and, therefore, have a superior safety and tolerability profile.

Although the COX-2-specific inhibitors and most conventional NSAIDs are orally administered, injectable formulations are preferred in acutely painful conditions, especially in the perioperative setting, and when patients cannot tolerate oral medication or require rapid analgesia. Parecoxib sodium is a novel, inactive prodrug that when parenterally administered is rapidly converted to the COX-2-specific inhibitor, valdecoxib, which spares COX-1 at therapeutic concentrations.

ORAL OPIOIDS

Medicines given by mouth cause less discomfort than injections, but they can work just as well. They are inexpensive, simple to give, but there may be a delay in pain relief. These are the mainstay of pain management in the ambulatory surgical patients.

Codeine phosphate and oxycodone have a place in less extensive surgery. Tramadol, a central analgesic with low affinity for opioid receptors, and with an analgesic potency roughly similar to pethidine, but without relevant cardiovascular or respiratory depressant activity and with a very low dependency liability. It appears to be a well tolerated, oral, intramuscular and intravenous analgesic with very few side effects (nausea and dizziness being most frequently reported).

INTRAMUSCULAR, SUBCUTANEOUS OR INTRAVENOUS INJECTIONS ADMINISTRATION

Opioids, particularly morphine sulphate and pethidine, have been the mainstay of postoperative analgesia. This can be given as a continuous infusion or as periodic injection on demand.

PCA (PATIENT CONTROLLED ANALGESIA)

Patient controlled analgesia allows a patient to receive drugs on demand. A PCA pump administers drugs, usually intravenously, when the patient pushes a button. The equipment is expensive and the technique may allow breakthrough pain on an intermittent basis because when the patient is asleep, the administration ceases.

REGIONAL AND LOCAL ANALGESIA

Infiltration of a wound with a long acting local anaesthetic such as bupivacaine can provide effective analgesia for several hours.

INTRATHECAL BLOCK - Intrathecal block provides analgesia during the postoperative period especially if long acting analgesic drugs such as bupivacaine are used. If opioid drugs are administered before the block wears off, very good pain relief is possible.

EPIDURAL ANALGESIA - Epidural analgesia is a more useful technique for the relief of postoperative period because a catheter can be used to maintain analgesia in the postoperative. "Top up" is done only by doctors and/or administered by programmed pump.

PHYSICAL METHODS

Commonly used physical agents include applications of cold, massage, movement, TENS, and rest or immobilization. Transcutaneous electrical nerve stimulation (TENS) may be effective in reducing pain and improving physical function. This has been used with varying degrees of success in the management of postoperative pain. Evidence is accumulating that TENS acts by increasing CSF levels of beta-endorphins, together with activating of the "pain gate" by counter irritation.

All these different methods can be used for the benefit of our patients in case of intractable pain.

However, for routine pain management, NSAID, form the first line of treatment.

Pregnancy with Diabetes Mellitus

- Prof Dr. (Mrs.) Manju Mataliya
MD. DGO. DFP FICOG.

Hon. Consultant Obst. & Gyn., Nowrosjee Wadia Maternity Hospital, Parel, Mumbai.
Former Hon. Obst. & Gyn., Unit Head Nowrosjee Wadia Maternity Hospital, Parel, Mumbai.
Former Hon. Prof. of Obst. & Gyn. Seth G. S. Medical College, Parel, Mumbai.
Member of Governing Council of ICOG.



Pregnancy with Diabetes Mellitus

Prior to the advent of insulin, the co-existence of diabetes mellitus and pregnancy was a rare event and one likely to be fatal for both the mother and the foetus. Williams reported a maternal mortality of 30% and perinatal loss of 70% in 1909. The discovery of insulin in 1921 by Banting and Best Changed the outlook for the pregnant patient completely. The maternal mortality was reduced to nil and perinatal mortality to 3 to 5%.

Over the years, with strict metabolic control of diabetes with intensive insulin administration and intensive foetal surveillance the perinatal mortality has been reduced to less than 3%, nearly the same as in normal non diabetic pregnancies. Even the high incidence of congenital malformations in diabetic pregnancies has been reduced from 12% to 5 to 6% by pre - pregnancy counselling and strict control of diabetes prior to conception.

Pregnant diabetics are now divided into two main categories :

1. Pregestational Diabetes mellitus (PGDM) when the disease exists prior to pregnancy.
2. Gestational diabetes mellitus (GDM) when the disease is diagnosed during pregnancy for the first time, or develops during pregnancy & resolves after delivery.

Screening for diabetes during pregnancy

Relevance of universal screening

The controversial issue is whether to screen all or offer selective screening. As there is an increase in perinatal mortality by 3 fold in GDM subjects not identified or treated, it is reasonable to assume that establishment of universal screening early identification, and proper treatment with result in lower overall cost as compared to perinatal outcomes due to undetected and untreated diabetes.

Commonly used methods for screening are :-

1. Oral Glucose Tolerance Test (OGTT)
2. O'sullivan's Oral Glucose Challenge Test
3. Random Plasma Glucose Sampling (RPG)

Random Plasma Glucose Sampling is attractive as a screening method as it is simple, reliable and cost effective. We have screened over 27000 women attending ANC at Nowrosjee Wadia Maternity Hospital by RPG. When RPG levels were above 100 mg%. OGTT was carried out using WHO method. Our incidence of positive OGTT was 7.1%.

Acute maternal complications include:

Ketoacidosis, Hypoglycemia, PIH, Urinary tract infections, Hydranmios and emotional stress.

Severe maternal complications include:

Premature labour, diabetic ketoacidosis, nephropathy, retinopathy, Cardio - Vascular problems.

Foetal complications:

Macrosomia, Premature delivery, respiratory distress, increased incidence of congenital malformations and intra uterine foetal death.

The serious maternal complications compounded with foetal complications account for extended hospitalization in pregnancy and increase in the incidence of operative deliveries.

Aims in Management:

1. Normalization of maternal glucose levels.
2. Prevention of obstetric complications by good prenatal care.
3. Early detection and prompt treatment of medical problems.
4. Careful timing and appropriate mode of delivery.
5. Intensive neonatal care.

Metabolic control:

For all types of diabetes in pregnancy current approaches call for managing glucose levels to achieve and maintain near normal glucose levels throughout pregnancy, fasting glucose levels below 100mg% and post lunch glucose levels below 120mg%. This is achieved by proper diet and administration of short and intermediate acting human insulin when required. Dietary therapy includes nutrient meals and meal planning and control of maternal weight gain which should be 10-12kg in second and third trimester.



Insulin therapy:

If diet regulation does not achieve adequate glycemic control, insulin therapy is started. GDM can be managed by single daily injections of insulin. However in women with type I and type II PGDM, multiple daily insulin injections will be required. A mixture of short and intermediate acting insulin is used and the dose is adjusted with multiple glucose level estimations like fasting, 2 hours after breakfast, lunch and dinner and occasionally at night. Preferably during pregnancy human insulin injections should be used, as there is improved maternal metabolic control with it. There is less antibody binding to circulating insulin to cause variations in the levels of free insulin available for the tissues.

Ante partum foetal surveillance and its significance:

Over last two decades, techniques of ante partum foetal surveillance in pregnancies complicated by diabetes, have been developed for the management of patients during the third trimester, the period of greatest risk for foetal demise.

Goals of ante partum surveillance

1. Avoidance of intrauterine death
2. Early detection of foetal compromise
3. Prevention of unnecessary premature delivery
4. Foetal surveillance tests include:

NST, CST, USG with foetal biophysical profile, maternal assessment of foetal activity or foetal kick count. Doppler umbilical artery velocimetry is done for diabetic pregnancies complicated by vasculopathy. IUGR and pre eclampsia and PIH.

Antepartum foetal surveillance tests are started from 30 weeks onwards in PGDM and 32-34 weeks onwards in GDM and are carried out at regular intervals depending upon foetal health till term.

Timing of Delivery in Diabetic Pregnancy

Now a days with the availability of sophisticated methods for antenatal foetal surveillance and with a policy of intensive insulin administration and strict metabolic control using frequent self glucose estimations, pregnancy is continued till term and onset of spontaneous labour is awaited in all cases, provided there is no risk. However, foetal health can suddenly deteriorate in a diabetic pregnancy. Hence Obstetric management should not

(contd. to page 5)

For ICOG Campus New Innovations

Dr. Sudhir R. Shah
M.D.D.G.O.FICOG

Head of Obstetrics and Gynec Department
Dashashrimali Hospital , Kotharia naka , Rajkot

Book "First steps towards Non Descent Vaginal Hysterectomy"

Advantage-SRS short straight needle

In performing Non descent vaginal hysterectomy one of the disturbing step is to ligate or transfix the uterosacral and uterine pedicle deep in narrow vagina where available space to handle the half circle needle is really challenging ,time consuming and gives lots of exercise to surgeon and assistants as well. Turning needle may also injure the surrounding structure and lateral vaginal wall. To avoid this difficult exercise ,we developed 10 mm and 15 mm straight needle with suture material like 1 no centicryl.

40 mm half circle Needle	15 mm Straight Needle
Technically Difficult	Technically Very Easy
Movement Difficult	Movement Easy
Surrounding structures may injured	Surrounding structures not injured
Difficult in transfix Pedicle	Easy in transfix Pedicle
More space required to handle the needle	Less space required to handle the needle



As presently no such suture with needle available ,we made it from 18 no scalp vein in which the thread was passed and then needle was pressed at 15 mm length. We also tried to straighten the available half circle needle of 1 no centicryl and cut the needle at 15 mm length.

Technique

After cutting the pedicle the said SRS needle with 1 no centicryl was inserted from below upwards so the tip of needle emerges anterior in vision and it can be very easily catch. This method is very easy and fast and no extra skill needed and assistants are at ease. Suturing ,ligating and transfixing of any deeply situated pedicle can be done very easily with this new SRS needle with 1 no centicryl. This new technique is very easy for ligating pedicles apart from its high safety.

I wish manufacturing company will come out with such suture material in near future.

American Cancer Society Issues Updated Breast Cancer Screening Guidelines issued in association with ACOG

- UPDATED MAMMOGRAPHY GUIDELINES
On May 15, 2003

The American Cancer Society has issued breast cancer screening guidelines that, for the first time, offer specific guidance for older women, women who have serious health problems, and women at increased risk. The new guidelines also offer greater clarification of the role of physical breast exams. These new guidelines will enable improved discussion between women and their health care providers, helping them make more informed decisions about early detection testing.

"While research related to the ability of CBE or BSE to reduce breast cancer deaths is limited, the exams are still important. When a woman examines her breasts, she becomes more aware of how her breasts normally feel and notice any changes. Having a physical exam by a health care professional is a complement to regular mammography and an opportunity for women and their health care providers to discuss breast changes, risk factors, and early detection testing."

The Society's new guidelines for the early detection of breast cancer are:

- Yearly mammograms starting at age 40 and continuing for as long as a woman is in good health.
- Clinical breast exams (CBE) should be part of a periodic health exam, about every three years for women in their 20s and 30s and every year for women 40 and over.
- Women should report any breast change promptly to their health care providers. Breast self-exam (BSE) is an option for women starting in their 20s.
- Women at increased risk (e.g.: family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (e.g.: breast ultrasound or MRI), or having more frequent exams.



Correspondence Course

This is a Correspondence CME. Please read it carefully. You may answer the accompanying questions and send your answers to Dr. Sanjay Gupte. If you wish to collect Credit Points, please request him to grade it for you. Only ICOG members are eligible to collect Credit Points. This is an innovative educational program for those who are not able to attend CME's and Conferences.



Correspondence Course

Dr. Sanjay Gupte - Co-ordinator

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Modern management of Ectopic pregnancy



- Prof. Sadhana Desai, MD, FRCOG

Professor & Head, Department of Gynecology & Obstetric, Bombay Hospital Institute of Medical Sciences Director, Fertility clinic & IVF center, Mumbai



- Dr. Partha Guha Roy, MD, DGO

Associate Consultant, Fertility Clinic & IVF center, Mumbai

Introduction:

Women of childbearing age has 2% incidence of Ectopic pregnancy. It is a life threatening situation if not timely diagnosed and treated and her future ability to reproduce may be adversely affected.

50% of patients present with the classic clinical triad of pain, amenorrhea, and vaginal bleeding. One should have a high index of suspicion for ectopic pregnancy in any woman who presents with these symptoms and who presents with physical findings of pelvic tenderness, enlarged uterus, adnexal mass, or tenderness. High risk factors for ectopic pregnancy are:- h/o PID, prior ectopic pregnancy, prior tubal surgery and patient undergoing controlled ovarian stimulation as well as h/o use of IUCD.

Fortunately, using modern diagnostic techniques viz- Laparoscopy, quantitative β HCG assay, and high resolution USG with colour Doppler, most ectopic pregnancies can be diagnosed prior to rupturing.

Numerous conditions may have a presentation similar to an extrauterine pregnancy. The most common of these are appendicitis, salpingitis, ruptured corpus luteum cyst or ovarian follicle, spontaneous abortion or threatened abortion, ovarian torsion, and urinary tract disease. Intrauterine pregnancies with other abdominal or pelvic problems such as degenerating fibroids must also be included in the differential diagnosis.

Medical therapy:

Medical therapy of ectopic pregnancy is appealing over surgical options for a number of reasons, including eliminating morbidity from surgery and general anesthesia, potentially less tubal damage, and less cost and need for hospitalization.

Methotrexate is the common drug being used today. It can be used in multiple dose or a single dose.

Factors to be considered for medical therapy:- she must be hemodynamically stable, with no signs or symptoms of active bleeding or hemoperitoneum, she must be reliable, compliant, and able to return for follow-up and another factor is size of the

gestation, which should not exceed 3.5 cm at its greatest dimension on US measurement. She should not have any contraindications to the use of methotrexate.

A β HCG level of greater than 15,000 IU/L, fetal cardiac activity, and free fluid in the cul-de-sac on US (presumably representing tubal rupture) are contraindications. Contraindications to the use of methotrexate include documented hypersensitivity to methotrexate; breastfeeding; immunodeficiency; alcoholism; alcoholic liver disease or any liver disease; blood dyscrasias; leukopenia; thrombocytopenia; anemia; active pulmonary disease; peptic ulcer disease; and renal, hepatic, or hematologic dysfunction. However, in each case, the risk of surgery must be weighed against any relative contraindication.

The single dose injection is the more popular regimen today. It involves injection of methotrexate as 50 mg/m² IM /IV in a single injection or as a divided dose. With smaller dosing and fewer injections, fewer adverse effects are anticipated and the use of leucovorin can be abandoned.



2- 3 days after the injection 2/3rd of the patients experience at least one episode of increased abdominal pain. It can be differentiated from tubal rupture in that it is milder, of limited duration (lasting 24-48 h), and is not associated with signs of acute abdomen or hemodynamic instability.

Patients should be advised to avoid alcoholic beverages, vitamins containing folic acid, nonsteroidal anti-inflammatory drugs, and sexual intercourse until advised otherwise. A signed written consent demonstrating the patient's comprehension of the course of treatment must be obtained. Information pamphlet to be given to all patients receiving methotrexate and it should include a list of adverse effects, a schedule of follow-up visits, and a method of contacting the physician or the hospital in case of emergency.



Before initiating therapy, draw blood to determine baseline laboratory values for renal, hepatic, and bone marrow function, as well as a baseline β HCG level. Determine blood type, Rhesus (Rh) factor, and the presence of antibodies. Patients who are Rh negative should receive Rh immune globulin. Obtain repeat β HCG levels 4 days and 7 days after the methotrexate injection. An initial increase in β HCG levels often occurs by the third day and is not a cause for alarm. A decline in β HCG

levels of at least 15% from days 4-7 postinjection indicates a successful medical response. Monitor the patient's β HCG levels weekly until they become undetectable.

Failure of medical treatment is defined when β HCG levels increase, plateau or fail to decrease adequately by 15% from days 4-7 postinjection. At this time, surgical intervention may be warranted. A repeat single dose of methotrexate can also be a viable option after reevaluation of the patients' indications and contraindications (including repeat US) for medical therapy.

Treatment with methotrexate is an especially attractive option when the pregnancy is located on the cervix, ovary, or in the interstitial or the cornual portion of the tube. Surgical treatment in these cases is often associated with increased risk of hemorrhage, often resulting in hysterectomy or oophorectomy.

Preliminary reports of use of oral methotrexate show promising result. However, efficacy remains to be established. Direct local injection (salpingocentesis) of methotrexate into the ectopic pregnancy under laparoscopic or US guidance has also been reported in the literature; however, reports from these studies have yielded inconsistent results, and its advantage over intramuscular injection remains to be established.

Surgical therapy:

Within the last 2 decades, a more conservative surgical approach to unruptured ectopic pregnancy using minimally invasive surgery has been advocated to preserve tubal function. The conservative approaches include linear salpingostomy and milking the pregnancy out of the distal ampulla. The more radical approach includes resecting the segment of the fallopian tube that contains the gestation with or without reanastomosis.

Laparoscopy has become the recommended approach in most cases. Laparotomy is usually reserved for patients who are hemodynamically unstable or patients with cornual ectopic pregnancies. It also is a preferred method for surgeons inexperienced in laparoscopy and in patients where laparoscopic approach is difficult (eg, secondary to the presence of multiple dense adhesions, obesity or massive hemoperitoneum). Multiple studies have demonstrated that laparoscopic treatment of ectopic pregnancy results in fewer postoperative adhesions than laparotomy. Furthermore, laparoscopy is associated with significantly less blood loss and a reduced need for analgesia. Finally, laparoscopy reduces cost, hospitalization, and convalescence period.

In a patient who has completed childbearing and no longer desires fertility, in a patient with a history of an ectopic pregnancy in the same tube, or in a patient with severely damaged tubes, total salpingectomy is the procedure of choice. The presence of uncontrolled bleeding and hemodynamic instability warrants radical surgery over conservative methods.

Follow-up care:

After surgical excision of the ectopic gestation, weekly monitoring of quantitative β HCG levels is necessary until the level is zero to ensure that treatment is complete. This is especially true following treatment with conservative surgery, i.e., salpingostomy, which carries a 5-15% rate of persistent trophoblastic tissue. The average time for β HCG to clear the system is 2-3 weeks, but up to 6 weeks can be required.

Expectant management

Candidates for successful expectant management are asymptomatic and have no evidence of rupture or hemodynamic instability. Furthermore, they should portray objective evidence of resolution, such as declining β HCG levels. They must be fully compliant and must be willing to accept the potential risks of tubal rupture.

Rupture despite low and declining serum levels of β HCG has been



reported, making close follow-up and patient compliance of paramount importance.

Treatment success rates and future reproductive outcome

Data in the literature have failed to demonstrate substantial and consistent benefit of either salpingostomy or salpingectomy in improving future reproductive outcome. Despite the risk of persistent ectopic pregnancy, some studies have shown salpingostomy to improve reproductive outcome in patients with contralateral tubal damage.

In 1997, Yao and Tulandi concluded from a literature review that laparoscopic salpingostomy had equal or slightly better reproductive performance than salpingectomy; however, slightly higher recurrent ectopic pregnancy rates were noted in the salpingostomy group.

Parker and Bistis (1997) concluded that when the contralateral fallopian tube is normal, the subsequent fertility rate is independent of the type of surgery.

Future fertility rates are similar in patients who were treated surgically by laparoscopy or laparotomy.

The success rates after methotrexate are comparable with laparoscopic salpingostomy, assuming the selection criteria mentioned above are observed. The average success rates using the multiple-dose regimen are in the range of 91-95%, demonstrated by multiple investigators. One study of 77 patients desiring subsequent pregnancy showed intrauterine pregnancies in 64%, and recurrent ectopic pregnancy occurred in 11%. Other studies have demonstrated similar results, with intrauterine pregnancy rates ranging from 20-80%.

The average success rates for the single-dose regimen are reported to be from 88-94%. In a study by Stovall and Ling (1992), 113 patients (94%) were treated successfully, 4 (3.3%) of whom needed a second dose. No adverse effects were encountered. Furthermore, 87.2% of these patients achieved a subsequent intrauterine pregnancy, whereas 12.8% experienced a subsequent ectopic pregnancy. Other studies have reported similar results with some mild adverse effects and lower reproductive outcomes.

Questions:

1. How can one diagnose early ectopic pregnancy?
2. What is the dose of methotrexate in early-unruptured ectopic pregnancy?
3. What precautions patient must observe when methotrexate is given?
4. What are the contraindications of medical therapy?
5. How does one decide, when medical therapy has failed?
6. Who are the ideal candidates for medical therapy?
7. What are the advantages of surgical therapy?
8. When does one do laparotomy in ectopic pregnancy?
9. What are the advantages of laparoscopy over laparotomy?
10. What is the future reproductive outcome of one ectopic pregnancy?

Pregnancy with Diabetes Mellitus (contd. from page 6)

have any set rules but each case must be assessed individually and managed.

Route Delivery

1. Vaginal delivery should be attempted and were carefully monitored for Shoulder dystocia
2. LSCS in about 40-50% of cases

In conclusion, appropriate management including a triad of Medical nutrition therapy intensive insulin administration and cautious obstetric management during pregnancy and during delivery will go in long way towards achieving a successful pregnancy outcome for both mother and her child in cases of pregnancy complicated by "Diabetes Mellitus".