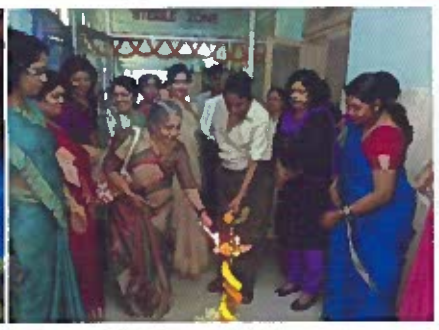
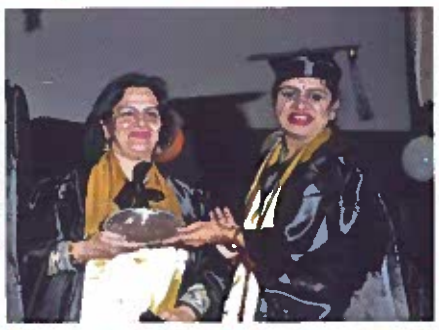
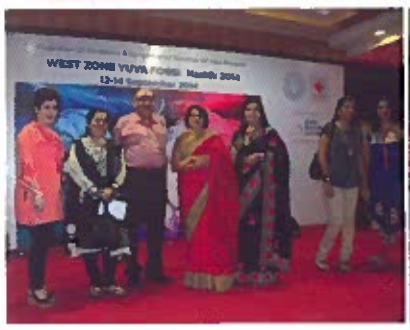
ICOG EVIDENCE

January, 2015




Evidence Changing Practice & Practice Changing Evidence

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TEAM OF FOGSI - ICOG

Out Going

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Dr. Behram Anklesaria (Ahmedabad)

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Dr. Biniwale Parag
Dr. Dutta Dilip Kumar
Dr. Ganguli Indrani
Dr. Kriplani Alka
Dr. Kotdawala Parul
Dr. Munshi Atul
Dr. Pattanaik Hara Prasad
Dr. Patki Amit
Dr. Shrikhande Laxmi
Dr. Trivedi Prakash Harikan
Dr. Tandulwadkar Sunita
Dr. Acharya Prashant
Dr. Balsarkar Geetha
Dr. Das Gokulchandra
Dr. Jha Urvashi
Dr. Konar Hiralal
Dr. Modi Rajesh
Dr. Olyai Roza
Dr. Patel Pravin
Dr. Shah Pragnesh
Dr. S. Shantha Kumari
Dr. Thanawala Uday
Dr. Wagh Girija

FOGSI Office Bearers
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President
Dr. Gokulchandra Das
Vice President Elect No. 1
Dr. Ritu Joshi
Vice President Elect No. 3
Dr. Jaydeep Tank
Treasurer
Dr. Hrishikesh D. Pai
Deputy Secretary General
Dr. Hema Divakar
Immediate Past President
Dr. Indrani Ganguli
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Dr. Sheela Mane
Vice President Elect No. 4
Dr. Nozer Sheriar
Secretary General
Dr. Gorakh Mandrupkar
Jt. Secretary

ICOG Vision

Promote education, training and spread of knowledge in the field of Obs and Gyn.

To popularize the Indian College nationally and internationally.

To help raise the standards of education and practice in our country.

In Coming

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Dr. Kavita Bapat
Dr. Laxmi Shrikhande
Dr. Maninder Ahuja
Dr. Parag Anand Biniwale
Dr. Prashant V. Acharya
Dr. Rajat Kumar Ray
Dr. Sadhana Gupta
Dr. Sushma Pandey
Dr. Suvarna Satish Khadilka
Dr. Urvashi Verma
Dr. Alpesh M. Gandhi
Dr. Basab Mukherjee
Dr. Himanshu Roy
Dr. Krishnendu Gupta
Dr. Mandakini Megh
Dr. Milind Shah
Dr. Pragnesh J. Shah
Dr. Rajat Mohanty
Dr. S. Sampath Kumari
Dr. Sarita Agarwal
Dr. Sunita Tendulwadkar
Dr. Tushar Kar

FOGSI Office Bearers
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Dr. Sujata Mishra
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Secretary General
Dr. Madhuri Patel
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Immediate Past President
Dr. Rekha Kurian
Vice President
Dr. Sarita Agarwal
Vice President
Dr. Uday Thanawala
Vice President
Dr. Jaydeep Tank
Deputy Secretary General
Dr. Bipin Pandit
Jt. Secretary

Message from PRESIDENT FOGSI

Dr. Suchitra Pandit
President, FOGSI

Dear Fellow FOGSIANS & ICOGIANS

ICOG the academic wing of FOGSI was born in 1984 has grown to the current position today where it has 1200 Fellows exclusive of new ones to be added at Chennai.

I must congratulate the ICOG Team 2014 for an excellent performance ,thanks to the very organised chairman Dr. Atul Munshi ,a brilliant Vice Chaiman , Dr.Mala Arora and a dynamic secretary Dr.Jaideep Malhotra and a harmonious working relationship between the ICOG and FOGSI which has also contributed to productive work.

An important development for ICOG was the International collaboration of the MICOG exam with the Royal College of Obstetricians and Gynecologists (RCOG) for Part 1 exam from March 2013 and combination with the Royal College of Physicians of Ireland (RCPI) for part 2 MICOG - MRCPI course. This partnership was initiated thanks to the special efforts put in by Dr. C N Purandare, Dean ICOG.

"The real voyage of discovery consists not in seeking new landscapes but in having new eyes."

....Marcel Proust

The enthusiastic ICOG team have initiated the master class IGNITE on Reproductive Endocrinology (100), FOGSI-ICOG Travelling seminars in 5 cities with the European school of Perinatology and have done several programs across the country with persistent efforts of Dr.Jaideep Malhotra.

This year we have systematically followed a pattern for our GCPR activities and I am overjoyed that the end result has been a standardized Certificate course in Hypertensive Disorders in Pregnancy and 8 good Clinical Practice guidelines where ICOG governing council have contributed.

FOGSI certification course on Emergency Obstetric Care for Govt. MBBS doctors working in First Referral units has been conducted since several years under the leadership of Dr. Sadhana Desai. This has been a very vital course in reduction of maternal mortality in rural parts of India.

Since FOGSI initiates workshops in many important subjects like Hypertensive Disorders in Pregnancy and PPH, I had advised that every Yuva FOGSI should include one Precongress workshop on PPH, one session on Standardized management in HDP, one session on The ICOG Hour and one session on Communication skills. I am glad that we have followed this format and I hope this continues . ICOG can collaborate with ICMR for doing research activities so that we can generate our own database.

Myself and my team 2014 have been requesting colleagues to become FELLOWS of ICOG and I am sure that eventually we will have a huge college of Fellows who will be able to fulfill the Vision and Mission of ICOG. The Vice Chairmans thoughts of Continuing Professional Development (CPD) have been working well and I can see that team ICOG has worked in tandem with the Chairman Dr. Atul Munshi.

I wish the new incoming ICOG team comprising of Dr. Dilip Datta Chairman, Dr. Jaideep Malhotra as Vice Chairman and Dr. Shantha Kumari as Secretary all the best!

My thoughts do go to the departed soul Dr. Uday Nagarsekar who would have been the chairman in 2015 but his untimely death took him away.

I will be leaving my chair as President and Dr. Prakash Trivedi will be taking over. I have enjoyed every minute of my work as it has been productive ,I wish to sincerely thank Team ICOG for making our 2014 such a resounding success!!.

Thanks and Wishing everyone a great year ahead!!

Empower Women Empower India ...Pledge for Excellence !!

Message from CHAIRMAN ICOG

Dr. Atul Munshi
Chairman, ICOG

As we are approaching end of our tenure, it is time to take stock of the situation.

Looking back it was an eventful period. I was fortunate to have enthusiastic team members Dr. Mala Arora, Dr. Jaideep Malhotra and equally active Governing Council Members. FOGSI President Dr. Suchitra Pandit and Dean of the college Dr. C.N. Purandare were quite cooperative.

We were unfortunate to lose two stalwarts – Dr. Uday Nagarseker and Dr. Pravin Patel.

It is time to welcome new team Dr. D.C. Dutta, Dr Jaideep Malhotra and Dr. S. Shantha Kumari and 25 Governing Council Members.

All of them are experienced workers of FOGSI and mix of youth and seniors.

I am sure they will put up a grand show under leadership of Dr. Prakash Trivedi and Dr. D.C. Dutta.

We had basket full of activities throughout the year.

ICOG sessions at all YUVA FOGSI conferences, were well attended and highly appreciated. Apart from detailed information about ICOG, involving young FOGSIans and PGs in debate is a heart-warming experience.

FORCE, our popular post graduate teaching program were arranged at 3 zones and before January other 2 zones will be covered. Dr. Saswati had taken lot of pains for successful FORCE. Dr. Jaideep has managed funding for continuation of this program for next year also.

FOGSI ICOG good clinical practice recommendations – 16 are finalized and 3 are almost ready.

At last academic council meet during Managing committee meeting at Mumbai on 28th September 2014, I was given charge of heading the council for next 3 years.

I have already planned the activities and work to be allotted to current and newly elected Governing council members for next quarter. I will be mailing it to all soon.

Wishing all the best to all FOGSI ICOG members and incoming ICOG Team !

On-going activities:

- Combined MICOG & MRCOG Refreshers Courses are in great demand
- Certificate Courses – Reproductive Medicine, Gynec Endoscopy and Ultrasound are running very well – Perinatology will be a new entry
- ICOG EMOC has already crossed the target of tertiary training. Thanks to Dr. Sadhana Desai.
- Eclampsia registry is working well under able leadership of Dr. Sanjay Gupte.

My immediate task is to ensure:

- Visibility of ICOG, inclusion of office bearers in various FOGSI conferences and other activities.
- Relegating duties to ICOG governing council members

Message from VICE CAIRMAN ICOG

Dr. Mala Arora
Vice Chairman, ICOG

The Indian College was established in 1984 and celebrates its 30th birthday this year. Its aim and vision was

- To promote education training and knowledge in the field of Obstetrics & Gynecology.
- To help raise the standard of practice in our country.
- To popularize the Indian college Nationally & Internationally.

To achieve these goals the College successfully conducts certificate courses in the sub-specialities of Endoscopic surgery, Ultrasound Reproductive Medicine with a new branch of Maternal Fetal Medicine added this year.

The MICOG/MRCOG part 1 examinations are successfully conducted in India. This year, our candidates made us proud with their excellent pass rate. ICOG conducts a refresher course at the Fogsi Office in Mumbai prior to the examination with a faculty from the RCOG UK assisted by local faculty members. We are very hopeful that our members will prove their mettle in forth-coming part 1 as well as MRCPI part 2 examinations that was conducted for the first time this year.

An ICOG session is conducted at the Yuva Fogsi conferences. This year we conducted debates on many controversial issues. It was heart warming to chair these sessions, so passionately debated by our young members. The regular ICOG CME's were a success and the ICOG oration was well received. The collaboration with the European Perinatal Network was fruitful and we should encourage collaborative activities with other International Colleges.

Good Clinical Practice guidelines are helpful for practitioners and we have a few approved guidelines on the website already.

The Indian College stands at a threshold of expanding its vast vista. The growing membership and involvement of youngsters has infused new energy. A team of responsible governing council members and office bearers are set to solidify their commitment to the college. The academia will move from strength to strength by formulating and updating evidence based guidelines for practitioners.

As Vice Chairperson, I enjoyed a very fruitful year. Working with Dr. Suchitra Pandit, Dr. CN Purandare, Dr Atul Munshi and Dr. Jaideep Malhotra has been a pleasure indeed.

We look forward to welcoming you to the FOGSI-ICOG CL Jhaveri Endowment symposium at the AICOG Chennai where the topics have been carefully chosen to be of academic as well as public interest.

Message from SECRETARY ICOG

Dr. Jaideep Malhotra
Secretary, ICOG

Greetings from ICOG and Wishing you all A Very Happy New Year.

I take this opportunity to thank each and everyone of you for giving me an opportunity to serve our Indian college of Obs and Gyn. I have thoroughly enjoyed working as Hon secretary of ICOG for the past three years, which actually gave me a lot of insight into the potential role of our Indian college of Obs and Gyn in the academic scene of our country and how much each one of us can contribute.

The past few years have been quite eventful and I assure you the coming years will be no less. The efforts of ICOG have been quite evident and we only hope to expand our reach in the coming times. This newsletter is just an endaevour to showcase the scope and vision of ICOG and also motivate each and every Fogsian to be an ICOGian too.

ICOG is the academic wing of FOGSI and has the responsibility of updating and upgrading and motivating the academics, so that the overall increase in understanding can have an impact on the management of patient at large. ICOG does many programmes through out the year based on this philosophy and one such programme has been the IGNITE CMEs and more than 100 CMEs were conducted in the last year and were very well received, now all the lectures are available on the website of ICOG. The FOGSI-ICOG European perinatal network travelling seminar has been the highlight of the year and will be organized in the coming year also from 7th 14th November.

We've entered the age of research, our country has produced many stalwarts in every field but a major drawback has always been in producing and publishing good quality research. ICOG understands the importance of research in coming times. Its time now to get into mainstream academics, the potential in our members and this organization is immense. Let us devote part of our valuable time to good quality research and data collection.

Our certificate courses are very popular and this year we will be introducing two more certificate courses one on "Critical care" and other in "Fetal medicine" for our young fellows to join the best centres in the country and learn. Other programme in the pipeline is the "Practitioners skill enhancement programmes", which are being developed and will be rolled out this year as key programme for giving opportunity to the practicing Obstetrician and gynaecologists to upgrade and update knowledge at doorstep.

As I hand over the charge of secretary, I am confident that the ICOG will progress further to greater heights under the able leadership of Chairman Dr Dilip Kumar Dutta and Dr Shantha Kumari.

"At the end of the day let their be no regrets, only a desire to do more tomorrow than you did today."

— Noel DeJesus

Long Live ICOG.

Will be serving in the capacity of Vice Chairman ICOG.

Message from DEAN ICOG

Dr. C. N. Purandare
Dean, ICOG

Dear Friends,

Wish you all a very happy new year and welcome to yet another exciting year of ICOG. ICOG has made great efforts to put together all the academic activities in place. The combined MICOG-MRCOG and MICOG-MRCPI exam had been a dream, which has come true after years of hard work. I am very happy to say that ICOG has done commendable work to bring to you the three day MICOG-MRCOG refreshers course along with the RCOG faculty and also from last year the MICOG-MRCPI refreshers course is being organized with faculty from RCPI. The trainees who have attended these refresher courses have come out with flying colors in all the exams since then, with the pass rate of almost 50% ,which is commendable by any measure. I would like to congratulate the team ICOG-comprising of Dr Atul Munshi, Dr Mala Arora and the very dynamic secretary Dr Jaideep Malhotra for the great work put together for ICOG.

As I take over the helm of affairs of FIGO,I am sure, ICOG will have a greater role to play in the academics of the region and I would like to emphasize that our concentration on getting the Good Clinical Practice guidelines, along with many of these coming up from FIGO, our practice will streamline a lot.

One way to keep momentum going is to have constantly greater goals.

Michael Korda

I wish to achieve greater heights and goals for ICOG.

Wishing you all the best.

C.N Purandare

Message from CHAIRMAN ICOG -2015

Dr. Dilip Kumar Dutta
Chairman ICOG FOGSI 2015

Happy and Prosperous new year 2015 to Team ICOG.

It is my proud privilege and honor to take charge as The Chairman of ICOG, FOGSI, 2015.

ICOG, an academic body of FOGSI has been involved with various academic activities for last couple of years with great success. As the Chairman of ICOG 2015, during my tenure, I will be concentrating mostly on MMR, as presently its stands as one of the most important agenda in our nation.

Objectives to be fulfilled during my tenure as ICOG Chairman 2015:-

On MMR

- To organise CME's on MMR at C and B societies.
- To organise CME and workshop on "near miss" and MMR during Yuva FOGSI.
- To organise first South east asia conference at Hyderabad on MMR July 2015.
- To organise first world congress on "Why mothers die" at Kolkata Dec 2015
- To involve young obstetricians - motivate them to undertake innovative work on PPH, infection prevention.

MEMBERSHIP AND FELOWSHIP

- To increase membership and fellowship by inviting all yuva fogsians.
- Highlight the importance of MICOG and MRCOG examination.

ACADEMIC

- All non teaching gynaecologists who had done excellent work and published papers are to be invited to take part in the academic activity of ICOG.
- To visit SAFOG countries for academic activity and involvement with ICOG.
- To increase International fellowship or training programme oppurtunities for Yuva fogsians.
- To include Yuva Fogsian in ICOG council member.

INSPECTION OF ICOG AFFILIATED CENTRES

- To visit all ICOG affiliated centres to check the infrastructure for continution of their activity.

My Sincere and whole hearted thanks to all ICOG members elected during my tenure. My best wishes for all ICOG Team.

Message from SECRETARY ICOG -2015

Dr. S. Shantha Kumari
Hon. Secretary ICOG (2015-18)

Dear Friends

Wish you all a very Happy New Year

Thank you very much for choosing me to serve ICOG for the next three years in the capacity of Hon. Secretary. ICOG has grown from strength to strength under the dynamic leadership our past presidents of FOGSI and Chairpersons and Hon. Secretary Generals of ICOG.

In the past few years ICOG has become a pillar of academics and a lot of hard work put in by our dean Dr C. N. Purandare, Chairperson Dr. Atul Munshi and extremely hard working Secretary Dr. Jaideep Malhotra.

I know my task is going to be very difficult but my main aim will be to carry on and consolidate the good work done by my predecessors.

Looking forward to many interaction with you all.

Message from SECRETARY ICOG -2015

Dr. Nozer Sheriar
Hon. Secretary FOGSI

Dear ICOGians Friends

Wish you all a very Happy New Year

It is indeed a pleasure for me to see our college coming of age with all the efforts and hard work my sincere congratulations to each and every member of the governing council for taking the vision of ICOG forward.

ICOG has developed the lot of academic value with the collaboration of MICOG MRCOG and MICOG MRCPI.

I am happy to announce that a lot of our academic programmes can now take place in the seminar room of a office complex

Looking forward to ICOG achieving further heights under the new team.

All the best

What's new in ICOG this year

Practitioners **Watch Out** for **Skill Enhancement Courses** Rolling out from April Onwards in your own cities This course is designed to cater to your needs to revise what you have read years back, and what you need to, upgrade and update your practice and Medical & Surgical Management Skills.

New Certificate Courses

Fetal Medicine

&

Critical Care in Obs. & Gynae.

ENDOMETRIOSIS

Dr. Mala Arora
Vice Chairman, ICOG

Daniel Shroen (1690) in Disputatio Inauguralis Medica de Ulceribus Ulceri, described, sores throughout the stomach, bladder, intestines, and broad ligament which had a tendency to form adhesions that linked visceral areas together. This is the first recorded description of endometriosis. A detail monograph was later published by Carl von Rokitansky, a pathologist from Vienna in 1860. He described five conditions associated with endometriosis viz. leiomyoma, adenomyosis, endosalpingiosis, endocervicosis, and mullerianosis. The year 2011 marks 151 years of intense scientific research and innumerable publications on the subject. The **World Endometriosis Research Foundation** is a UK-based global charity organization supporting research into endometriosis. The foundation was set up in 2006 by endometriosis specialists from European Society of Human Reproduction and Embryology (ESHRE), American Society of Reproductive Medicine (ASRM), and World Endometriosis Society (WES).

Endometriosis is a benign condition, which is responsible for considerable morbidity in 5-10% of women in the reproductive age group. It is also reported in adolescents and rarely in premenarcheal and postmenopausal age group. The initial theory of retrograde menstruation explains the preponderance of ovarian and pelvic disease. Mullerian abnormalities with outflow obstruction lead to endometriosis in adolescence. However, adolescent endometriosis, in the absence of outflow tract obstruction, is best explained by presence of "Mullerian rests" that respond to puberty ovarian hormone production. Extrapelvic endometriosis is best understood by metastatic (vascular and lymphatic) spread of "endometrial rests" from the endometrial/myometrial interface. Hyperperistalsis due to a hyperestrogenic state facilitates the spread. Reduced immunological tolerance, and inability to clear ectopic endometrium, seems to be a contributory factor. Endometriotic lesions can be found in any tissue of the body, except the spleen. Endometrium contains stem cells, which are responsible for its regenerative ability and also in the pathogenesis of endometriosis. The side population (SP) cells of the endometrium are multipotent and have unique angiogenic and migratory properties. Hence both pelvic and extrapelvic lesions have the ability to self perpetuate.

There is a genetic predisposition to endometriosis and regions on chromosome 10q26 and 20p13 have been implicated. Epigenetic mechanisms, like DNA methylation, can cause transcriptional activation of SF-1 in endometriotic cells and contribute to increased estrogen production.

The commonest site for endometriotic lesions is the pelvis, and over half the patients develop ovarian endometriomas. Is this because the ovary receives the bulk of retrograde menstruation or does it commonly have Mullerian rests, or is the hyperesterogenic internal milieu of the ovary most congenial for endometrial growth? It could well be a combination of all these factors. Extraovarian lesions are frequently seen in the peritoneum, rectovaginal septum, urinary tract, intestinal tract, chest, and central nervous system. Case reports describe endometriotic lesions in the umbilicus, abdominal wall, extremeties, hernial sacs and incisional sites.

Iatrogenic endometriosis is induced in the peritoneum and at incisional sites. Spillage of endometriotic cyst fluid should be followed by generous peritoneal lavage and cyst specimens should be removed in an endobag to avoid contamination of port site. Scar endometriosis has been described in hysterectomy, cesarean section, hysterotomy, ectopic pregnancy, tubal ligation, and episiotomy scars. Direct inoculation into the rectus sheath and/or subcutaneous tissue is the culprit. It can be avoided by thorough cleaning and vigorous lavage of the incisional site prior to closure, in all gynecological surgeries.

Pelvic pain is the hallmark, which is initially cyclic, and later continuous and crippling. However the amount of pain a woman feels, correlates poorly with the extent of disease. The other symptoms are dysmenorrhea, dyspareunia, dysuria, and dyschezia. The association of infertility with endometriosis is very strong. Fecundity is reduced in all patients with endometriosis and half of the infertile population has endometriosis. Conversely, half of the patients with endometriosis have infertility.

The gold standard diagnostic test is laparoscopy. Transvaginal ultrasound is helpful in pelvic disease and MRI is helpful in extrapelvic disease. Ca125 levels may be elevated in endometriosis but have no value as a diagnostic tool. Diagnosis may be difficult in extrapelvic lesions and cyclicity of symptoms may be the only clue. Examination is best performed during the menstrual cycle.

The disease spectrum in the pelvis varies from presence of a few small spots to the development of large endometriomas and dense pelvic adhesions.

Surgical staging is proposed by American Fertility Society (AFS) and is a complex point scoring system.

Stage I (Minimal): Findings restricted to only superficial lesions and possibly a few filmy adhesions

Stage II (Mild): In addition, some deep infiltrating lesions are present in the cul-de-sacStage III (Moderate): As above, plus presence of endometriomas on the ovary and more adhesions

Stage IV (Severe): As above, plus large endometriomas and extensive adhesions.

Surgery is the main stay of treatments but medical therapy and assisted reproduction are useful adjuncts. Operative video laparoscopy has replaced laparotomy for pelvic and abdominal lesions. Endometriomas in the chest are excised through video thoracoscopy. In fact, to quote Nezhat "whenever and where ever in the body a cavity exists or can be created, operative laparoscopy is indicated and probably preferable." The magnification offered is an advantage over laparotomy and postoperative adhesions and incisional hernia's are reduced. Being minimally invasive, it may be repeated in dealing with recurrences. Recurrences may be due to presence of microscopic disease or incomplete surgical excision.

Endometriosis is known to distort pelvic anatomy, affect tubal motility, cause disordered folliculogenesis, and affect endometrial implantation. Hence, assisted reproductive technologies (ART) need to be employed early and judiciously. Ideally, surgical correction should be followed by ART procedures without losing time. Gonadotropin releasing hormone agonists (GnRH-a) are widely used during ART procedures and improve success rates. They are also used pre- and post-surgical excision of large lesions. Their use is restricted to 6 months for fear of osteoporosis. "Add-back therapy" is advocated to minimize the risk of osteopenia.

Complete surgical excision of ovarian endometrioma, with stripping of the cyst wall, may lead to diminished ovarian reserve and poor reproductive performance in some patients. Hence, drainage of endometrioma with laser/cautery to the cyst wall followed by ART may give better chances of achieving a pregnancy. Needle drainage of endometrioma is only performed prior to an in vitro fertilization (IVF) cycle or post ovum pick up. It is advisable to avoid contamination of retrieved oocytes with endometrioma fluid. Besides, this fluid being thick and viscous will block the ovum pick up needle. A dreaded complication of needle drainage is the development of pelvic abscess and a full course of broad spectrum antibiotics is advisable. The recurrence rates, post-needle drainage, are very high. Flaring up of latent genital tuberculosis and other pelvic infections is also documented in endometriomas, due to altered cell mediated immunity.

Medical therapy consists of pain relief and keeping the disease in abeyance. Pain relief agents of choice are nonsteroidal anti-inflammatory drugs (NSAIDs). They form the first-line therapy for adolescents complaining of dysmenorrhea. Progesterone therapy is widely used. Since long-term oral therapy is required, the choice is medroxy progesterone acetate, dydrogesterone, or norethisterone. The combined oral contraceptive pill and aromatase inhibitors like letrozole are also effective. Danazol and gestrinone, though effective, may have unacceptable androgenic side effects. Levonorgestrel intrauterine system (LNG-IUS) is a promising option, if fertility is not an issue. It has been used in deep infiltrating lesions where complete excision was not possible. Medical therapy has no role if pregnancy is desired, as most medical therapies are contraceptive. Besides, pregnancy is a natural cure.

Dietary modification may result in alleviation of symptoms. A diet rich in omega-3 fatty acids and low in soy proteins i.e. phytoestrogens is helpful. Vitamin B1 and magnesium may help in relieving dysmenorrhoea. Complementary therapies such as homeopathy, reflexology, traditional Chinese medicine, herbal treatments, high frequency TENS, and acupuncture have been tried for relief of symptoms, but evidence from randomized controlled trials is lacking.

Evidence is accumulating that the risk of ovarian malignancy is slightly increased in women with endometriosis, but endometriosis is still not considered a premalignant condition. The increased risk may be due to

- endocrinal factors like pathologic expression of P450 aromatase, triggers constitutive expression of estradiol (E2).
- immunogenic factors like reduced immunity
- genetic mutations like mutations in the tumor-suppressor gene ARID1A
- upregulation of Insulin like growth factor (IGF-1)
- Disturbance in cytokine expression like tumournecrosis factor-α (TNF-α)

Risk of malignant transformation is estimated to be 2.5%, with clear cell and endometroid carcinoma being the commonest types. Less than one quarter of the cases of malignant transformation occur at extragonadal pelvic sites and less than 4% of cases in scars after laparotomy. Studies have been inconsistent on whether endometriosis is linked to melanoma, thyroid cancer, non-Hodgkin's lymphoma's, and brain tumours. Further large epidemiological studies are required to elucidate these linkages.

Future research in endometriosis also targets newer drugs like Rapamycin, which is an inhibitor of angioneogenesis, holds promise as adjuvant therapy. Immune modulating drugs that block TNF-α like infliximab and etanercept are under investigation. Matrix metalloproteinase inhibitors like pentoxyfylline and ioxoribine are also under trial. Use of cytokines (IL-2) injection in endometriotic lesions is a novel concept. All these therapies need large randomized controlled trials.

A Masterclass Medical Education Program

ignite

Icog Glaxo joiNt Initiative Towards educational Excellence

SANPSHOTS FROM IGNITE PHASE 1 CMES

IGNITE an ICOG led initiative supported by gsk was successfully conducted across 65 locations in India.

ICOG is delighted to announce that around

100 IGNITE CMEs

were conducted successfully
under the leadership of ICOG Chairman
Dr. Atul Munshi
& coordinated by Hon. Secretary ICOG
Dr. Jaideep Malhotra

The CMEs were conducted in two phases i.e. **Phase 1** & **Phase 2**

IGNITE PHASE-1
"Reproductive Endocrinology"

Topics covered:
- Physiology of ovulation Induction
- Tackling ovulation induction in endocrinological derangements
- Endocrinology of Early Pregnancy
- Endocrinology of Preterm labour
- Hypertension in pregnancy. Endocrinological and metabolic aspect
- Thyroid disorders in Pregnancy

IGNITE PHASE-2
"Pre and Post Conception Care"

Topics covered:
- Pre conception an opportunity for healthy pregnancy
- Adolescent Nutrition
- Modulating nutrition during pregnancy & lactation
- Fighting Menopausal symptoms with nutrition

A big thanks to Our Expert Team of Chief Coordinators

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CABERGOLINE AND ENDOMETRIOSIS

A new approach to an old disease

Dr. Seema Bebu Pandey
Director, Seema Hospital & EVA Fertility Clinic Azamgarh

Introduction - Endometriosis is a common benign and chronic gynaecological disorder said to be sex-hormone dependent. It affects around 6-10% of general population, the frequency of disease increases up-to 35-50% in women suffering from pelvic pain and infertility. Pain and sub fertility are the usual complaints but its impact is on general physical, mental and social well being [1,2,3].Despite its prevalence and being one of the oldest reported and studied disease of this century the underlying mechanism and pathogenesis of the disease remains poorly understood. No single mechanism or theory can explain the occurrence of endometriosis to all the reported sites [5]. The commonly involved sites are pelvic peritoneal surfaces, recto vaginal pouch, ovaries and rarely on pericardium, pleura and urinary tract.

Patho-physiology- The disease is said to derive from retrograde menstruation of endometrial cells which get implanted on peritoneal surfaces and induce an inflammatory response. But this does not completely explain it as the growth of these implants is dependent on other patho physiological processes like neo angiogenesis, fibrosis, adhesion formation, avoidance of apoptosis, immune dysfunction and neuronal infiltration[1-7]. The endometrium has angiogenic potential and endometriotic lesions grow in areas with a constant and abundant blood supply. This suggests that angiogenesis is a prerequisite for the development of endometriosis [8].

Angiogenesis is a dynamic process involving many factors. Some pro-angiogenic factors are known to be increased in the peritoneal fluid of women with endometriosis, whereas the levels of others with anti-angiogenic properties are lower.

Vascular endothelial growth factor (VEGF), a heparin-binding glycoprotein with angiogenic and endothelial cell-specific mitogenic characteristics and with vascular permeability (VP) properties, is considered to play a pivotal role in both physiologic and pathologic angiogenesis [8,9]. VEGF has said to be released by macrophages present in peritoneal fluid of these patients of endometriosis. There is a positive correlation between the amount of VEGF and the severity of the disease. Furthermore the expression of VEGF and it's receptor VEGFR2 is increased in active red lesions and deep infiltrating disease [Machado et al, 2008]. Binding of VEGF to its type-2 receptor (VEGFR-2) appears to be the main regulator of vasculogenesis, angiogenesis and vascular permeability[9].

Diagnosis- The gold standard for diagnosis remains surgical assessment by laparotomy or laparoscopy with hysto-pathological confirmation of the lesion. A scoring system has been devised and revised by American Fertility Society (AFS) and is being used worldwide. However there is no definite biological marker which can replace the need for surgical staging including CA-125. Endometriosis being a nonspecific disease and the apprehension attached with invasive diagnostic procedure this disease is not diagnosed till late and for the same reason we need to have a biological marker which can be easily assesed and has a positive as well as a negative predictive value and at the same time it would have some prognostic value.

The association between galactorrhoea and endometriosis was established around 30 years ago and certain studies found that the prolactin level was increased in the patients suffering from endometriosis. Two more recent studies have revisited this issue. The first assessed prolactin levels infertile controls, as well as fertile and infertile women with Stages I–II endometriosis. Significantly higher prolactin levels were found in women with endometriosis, compared with controls: 30% of the women with endometriosis-associated infertility had hyperprolactinaemia (>20 ng/ml), but none of the controls or fertile women with endometriosis. The second study showed significantly higher prolactin levels in infertile women with all stages of endometriosis compared with fertile controls [10].Gregoriou et al. observed a direct correlation between prolactin secretion and disease stage, with serum prolactin concentration progressively increasing from stage II to stage IV. This correlation was found to be statistically significant [10].

João P. Bilibio, et al., in study published in Gynecol Obstet Invest May 2014 confirmed the importance of serum prolactin levels and endometriosis and its role as a biomarker of the disease. In this study, a total of 97 women of reproductive age were included out of which infertile group included 32 women who underwent laparoscopy due to infertility and who presented with biopsy-confirmed peritoneal implants. The second group included 31 women who underwent laparoscopy due to pelvic pain and who presented with biopsy confirmed peritoneal implants. Both the groups met the criteria for minimal/mild or moderate/severe endometriosis according to the classification proposed by the American Society for Reproductive Medicine. The control group comprised 34 fertile women who underwent laparoscopy for tubal ligation and were endometriosis free.The median serum prolactin levels were significantly higher in almost all endometriosis groups compared with the control group [12].

serves to increase or decrease the probability of having endometriosis. Its result depends on important variables such as prevalence, sensitivity, specificity, cutoff and predictive values.

The reason for prolactin getting special attention as a biomarker is that it's a strong angiogenic inducer; it exerts a proangiogenic effect through blood vessel receptors so can cause mild to moderate disease without disturbing the considerable anatomical alterations presenting as subfertility.

Management- The goal of treatment in endometriosis pts oscillates between alleviation of pain and a successful achievement of pregnancy. Because endometriosis is an estrogen dependent disease, standard medical treatments aim at inducing hypoestrogenism and then inducing atrophy of ectopic endometrial implants. Medical hormone therapies historically have included oral contraceptives, progestins, and gonadotropin releasing hormone (GnRH) analogues, as well as androgen derivatives, and these have all been used successfully in the treatment of endometriosis. All of these treatment modalities can be used only for a limited time owing to unacceptable side effects, including climacteric syndrome and loss of bone density [13]. In addition, almost all of these treatment modalities fail to treat endometriosis-associated chronic pelvic pain and these drugs cannot cure the disease [14].

Thus Anti-angiogenic drugs hold a promise for both the indications and can change the perspective of endometriosis treatment in near future. There are various subgroups of anti angiogenic drugs but here we are concentrating on the role of dopamine agonist sub group.

Discussion- looking at the available treatment options while surgical removal of the implants and growth is many a times surgically challenging due to its location there are chances of colorectal and urinary complications alond with recurrence of the disease, at the same time available medical treatment modalities provide only temporary symptomatic reliefs and are associated with various unwanted side effects. So the need of this hour is to develop a novel treatment modality which gives a long term symptomatic relief and may help in decreasing the disease process along with lesser side effects. For this purpose, key

Table 1.0- showing the sensitivity and specificity of serum prolactin as a biomarker, alone and in combination with CA-125 in endometriosis patients: sensitivity and specificity increases as the grade of disease increases.

Serum prolactin	Sensitivity for diagnosis	Specificity for diagnosis
Usual cut off(>20 ng/ml)	41%	99%
best cut off(14.8ng/ml)	45%	94%
Best cut off+CA125(35iu/l)	77%	88%

Timing of sampling is particularly important for prolactin, as levels have a diurnal pattern. One study showed that the 8 am decline in prolactin levels (seen in healthy women) failed to occur in women with endometriosis.

The use of diagnostic tests of serum prolactin levels

processes in the pathogenesis of endometriosis have been identified which may serve as a key therapeutic targets [21].

During the last years, several angiogenic growth factors have been identified, which are expressed in endometriotic lesions and released into the peritoneal

Table 2.0. Summary of Medical Treatments for Endometriosis

Agent	Mechanism	Effects
Oral Contraceptives	Decidualization and subsequent atrophy of endometrial tissues	Symptoms relief
GnRH agonist	Downregulation of the pituitary ovarian axis and hypoestrogenism	Symptom relief
Androgens	Hyperandrogenism , inhibits steroidogenesis	Symptom relief
Aromatase inhibitors	Inhibit estrogen synthesis	Symptom relief
GnRH antagonist	GnRH receptor blockade	Decreased disease
Progesterone antagonist	Anti progesterone	Decreased disease
Selective progesterone modulators	Suppress estrogen dependent endometrial growth	Symptom relief
Levonorgestril releasing IUDs	Decidualization and subsequent atrophy of the tissue	Symptom relief
Cabergolin	Antiangiogenesis action of cabergolin is through inhibition of the phosphorylation of VEGFR2 and its endocytosis so preventingVGEF-VGEFR2 binding. Also exerts	Decreased disease + Symptom relief

fluid of patients with endometriosis[21]. One of the most studied and prominent is vascular endothelial growth factor(VEGF) known to act as selective endothelial mitogen and survival factor[].Accordingly angiogenesis of the native endometriotic lesions has become an attractive target for novel medical therapeutics and strategies to inhibit vascular endothelial growth factor action [22]

Few years ago, Basu et al. [19] stated that the neurotransmitter dopamine selectively inhibits the vascular permeability and angiogenic activity of VEGF at non-toxic levels, revealing a new link between the nervous system and angiogenesis. This led to the idea to use dopamine agonists for anti-angiogenic therapy.

In gynecology,dopamine agonists, such as Cabergoline, are currently used for the suppression of breastfeeding and treatment of hyperprolactinaemia . Importantly, Cabergoline treatment during pregnancy does not increase the risk of spontaneous miscarriage, premature delivery or congenital abnormalities (Robert et al., 1996; Ricci et al., 2002)

Novella maestre and collegues published their study in 2012 where they had tested the effect of antiangiogenic treatment on experimental endometriotic lesion nerve fibers in an experimental mouse model and concluded that Antiangiogenic treatment statistically significantly diminishes new blood vessel formation after macrophage, mast cell, and nerve fiber reduction, providing a rationale to test antiangiogenic agents as a novel therapeutic approach to severe pelvic pain associated with human peritoneal endometriosis[18]. They found that daily oral treatment with Cabergoline over 14 days causes the regression of endometriotic lesions by suppression of cell proliferation and VEGF-mediated angiogenesis. They could further demonstrate that Cabergoline treatment results in a significantly lower expression of VEGF and VEGFR-2 in endometriotic lesions [17].

Possible mechanism of action of cabergolin is postulated as following, 1-it decreases the cell proliferation.2-cabergolin impairs the neoangiogenesis which is must for the survival of these endometriotic implants.3- cabergolin has the modulation effect on genes responsible for angiogenesis in the lesions.4- the antiangiogenesis action of cabergolin is through inhibition of the phosphorylation of VEGFR2 and its endocytosis so preventingVGEF-VGEFR2 binding . Vascular endothelial growth factor(VEGF) concentrations were found to be particularly high in hemorrhagic and red implants [10], and in endometriomas [11]. High concentrations of soluble VEGF accumulates in the pelvic fluid in patients with endometriosis. In addition to its production by endometriotic implants [12], activated peritoneal macrophages and neutrophils also have the capacity to synthesize and secrete VEGF [13, 14]. The conditions for the development of endometriosis are estrogen-dependent growth of endometrial cells, induction of angiogenesis, and lymphangiogenesis [12].

The efficacy of Cabergoline is not limited to peritoneal endometriosis but also to extra peritoneal endometriosis or severe endometriosis and endometriomas as well which was very well documented by Hamid and collegues, in their prospective randomized study on 171 patients divided into two groups and they concluded that Cabergoline (dostinex) yields better results in decreasing the size of endometrioma, compared to LHRH agonist by exerting antiangiogenic effects through vascular endothelial growth factor receptor-2 (VEGFR-2) inactivation. It has no major side effects, easier to administer, and cheaper than LHRH agonists[17].

The recommended dose is 0.5 mg twice weekly at least for three months. Cabergoline can be used preoperatively, post operatively, alone or in combination with other therapies like GnRH analogues or COCs[17]. We can use cabergoline alone in those patients who desire fertility at the same time and this is a clear cut advantage over other forms of therapies available, all of them delay conception by their mechanism of actions and they usually don't give pain relief while dopamine agonist through their action on nerve fibres they decrease the pain as well. No adjuvant therapy is needed as it does not bring hypoestrogenic and bone density changes in these patients[17].

As mentioned earlier the level of prolactin is raised in patients of endometriosis and use of cabergoline decreases it. In patients with normal prolactin levels but presenting with galactorrhoea and infertility, cabergoline does affect the outcome favourably[24]. The study of patients with OHSS, who were given cabergoline ,disease process could be halted in dose dependent manner without affecting the implantation and growth of embryo and this point goes indirectly in favour of its use in these patients[25]. Side effects are well tolerated and in a recent study done by Herring and colleagues they concluded that the incidence of valvular heart disease was not greater in these patients who were taking cabergoline for years in the dose prescribed for prolactinimas[26].Importantly, Cabergoline treatment during pregnancy does not increase the risk of spontaneous miscarriage, premature delivery or congenital abnormalities (Robert et al., 1996; Ricci et al., 2002).

Conclusion- A comprehensive synthesis of the complex pathogenesis of endometriosis remains elusive, but it is clear thats its a multi factorial disease and the development and maintenance of endometriotic implants depend on their invasive capacity and angiogenic potential.

This angiogenic potential has been viewed and targeted as a potential new target for future therapeutic interventions but further studies especially well designed RCTs are needed before these novel agents like cabergoline can be introduced into main clinical streem.

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MCQs

1) Endometriosis is

a) a familial disorder

b) a disorder with complex multi factorial origin

c) infectious disease

d) autoimmune disease

2) Level of prolactin

a) is raised

b) may be raised or normal in endometriosis

c) may prove a novel biomarker in undiagnosed cases of endometriosis

d) sensitivity and specificity raises if prolactin and CA-125 both are measured.

3) Recommended dose of cabergoline in endometriosis is-

a) 0.25-0.5 mg bi weekly x 3 months

b) 0.5 mg daily x 3 months

c) 0.25 mg daily x 3 months

4) The mechanism of action of cabergoline in endometriosis is-

a) It acts directly at hypothalamus and controls the dopamine receptors.

b) it is a COX-2 inhibitor.

c) it acts on VGEF and VGEF-Receptors and prevents neo angiogenesis.

d) it causes hypo estrogenemia.

5) One advantage of cabergoline treatment over other type of medical modalities is-

a) it doesn't stop ovulation so pregnancy is possible.

b) it causes severe climactic changes.

c) it makes cervical mucous hostile.

d) it may be co-prescribed with GnRH analogue.

6) Does cabergoline affect the implantation?

a) yes b) no

7) Major side effects of cabergoline

a) nausea,vomiting and gastritis

b) cardiogenic arrythemias at prescribed dosage.

c) hypo estrogenemia

d) bone density changes

Send your answers to ICOG Secretary at icogoffice@gmail.com

ICOG Joins hands with RCOG

Royal College of Obstetricians and Gynaecologists

RCOG India Liaison Group

Dr. R. Walavalkar
Chairman RILG

Dr. Sameer Umranikar
Secretary RILG

Many members of the RCOG India Liaison Group are Members and Fellows of the ICOG. Some of the activities the group have done are as follows:

1. Members of the RILG volunteered and participated in the International Rotary - CALMED project in November 2014 in India. 4 members of the RILG were chosen and couple more were short listed to volunteer for a training the trainer program in Bhuj, India.
2. CALMED phase 2 in Maharashtra will have RILG participation
3. A member of the group attended the Public Health Conference in India in October 2013 and is hoping to develop some epidemiological projects with the Indian Public Health.
4. Members of RILG have served as faculty on the MRCOG part 1 course of FOGSI since Jan 13- twice a year.
5. A member of RILG has been Involvement with IGNITE CME program of ICOG - FOGSI as faculty.
6. RILG has extended support to INVITRO society of India. INVITRO works to promote evidence based ART training through CMEs and training programs for trainees and young consultants.
7. AICOG 2014 at Patna was attended by members of RILG in order to increase liaison with local O&G societies
8. RILG members will be attending the AICOG 2015 in Chennai.
9. A RILG member has been involved in a fertility awareness program for lay public in the state of Maharashtra called 'Fertility Aware Maharashtra' in association with Yuva Pratishthan – a Mumbai based NGO. This is also being supported by Tanishka - women's empowerment movement and Saam News and TV channel. One event is conducted every 2/3 months.
10. A fair number of the members attended the RCOG World Congress in India earlier this year.
11. A fair number of members volunteered to review abstracts for the RCOG World Congress held at Hyderabad earlier this year.
12. Members appraised Guidelines for the Government of India.

As many member of the RILG are also Members and Fellows of the ICOG, we could like to strengthen our bond between the group and the ICOG. Many members are actively involved with activities in India and this relationship will be fruitful in the forthcoming years.

Refresher Course Feedback:

The best part of the course for me was the understanding of structural approach of the exam. I didn't know earlier what to read, how much to read, and from where in a short span of time. Dr. Andrew's guidance was in fact very valuable. Secondly, we could form a group where we could share our study advances and doubts, which really helped us. Myself, Dr. Varun and Dr. Shilpa were in touch, I being the central coordinating man.
Lastly Madam, your untiring efforts, sitting at the back and planning the course for us, from 9am to 5pm, so that we dont miss anything

MICOG-MRCOG Preparatory Course

MRCOG Part I preparatory course in Mumbai, India

Dr. N. Mukhopadhya

I was appointed into the post of Convenor, International MRCOG part 1 courses by the Royal College of Obstetricians and Gynaecologists in the summer of 2014.

It was indeed a pleasure to conduct the 1st "Training the trainers" course for MRCOG part 1 in Mumbai on the 19th of July 2014. Over 40 senior obstetricians and gynaecologists particularly keen academicians attended this course from all over India. Having done this course in other parts of the world, it was interesting for me to appreciate the level of interest, motivation and the knowledge of basic sciences that these senior clinicians had. Overall it was a fantastic and enjoyable day. And of course they had to do a mock paper which despite initial hesitation created a unique excitement!

The three day preparatory course started on the 20th July and many of the ICOG members delivered excellent and high quality talks. With some very positive feedback from the students, there was a whopping 60% pass rate (over average compared with other outside UK centres).

Working with Jaideep (Dr Jaideep Malhotra, secretary ICOG), a keen and energetic academician and educationist, it was indeed a great experience. The course was well organised and co-ordinated by her despite several challenges. Prof Purandare's overarching support in this educational initiative was felt all throughout.

I look forward to the next course in January (30th January to 1st February) 2015. I would like to thank the staff at the ICOG office for all the background support.

Practice Single Best Answer (SBA) questions
For MRCOG Part 2 examination
Edited by Dr Neela Mukhopadhaya FRCOG

The first book to be released with the new style questions, it has over 200 questions arranged in ten topic-specific chapters that cover obstetrics and gynaecology. The ninth chapter is a sample question paper consisting of 50 questions.

This book aims to give a clear Idea of the examination style and assist in the overall preparation for the entire examination.

To be published by Jaypee Brothers, New Delhi. Estimated release January 2015

Congratulations

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ICOG JOINS HANDS WITH MRCPI

Revision Course
MICOG-MRCPI

In conduct of the MICOG-MRCPI combined examination, the first set of Examiners Dr C.N Purandare, Dr Suchitra Pandit, Dr Bhaskar Pal, Dr Basab Mukherji, Dr Jaideep Malhotra, Dr Shanta Kumari, Dr Samir and Dr Nikhil Purandare attended the MRCPI Examination at Dublin in October 2013.The second set comprising of Dr Hema Divakar, Dr Hiralal Konar, Dr Geeta Balsarkar, Dr Sarita Bhalerao ,Dr Neela Mukhopadhyay will visit for the same in April 2014. Also a Revision Course for the MICOG- MRCPI was conducted in July 2014.The first combined MICOG-MRCPI examination was held on 9th September 2014.

Watch Out for next dates of **MICOG-MRCPI Revision Course** in **July 2015**

Fees for the same is : **Rs. 30,000/-**

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Chairman IOG RCPI.

Prof. Mike O Connell

Although separated by thousands of miles, Ireland and India have much in common.

There are common themes in our rich and diverse histories. Before the rise and fall of the Roman Empire, our respective ancestors were building pre-historical archaeological wonders, whether New grange in County Meath or the magnificent city of Mohenjo-Daro in the Indus Valley. The modern states of Ireland and India have been bound since their inception by common struggles for independence, and marked by cordial relations between the two countries

As both countries now look forward to a bright future in the 21st century, our similarities make us stronger and enable us to tackle the challenges inherent in this new age together, as they have done throughout history. This is particularly true in the pursuance of excellence in the delivery of healthcare to women, and the maintenance of high standards of practice in obstetrics and gynaecology.

Over the past decade Prof C. N. Purandare has nurtured the relationship between the Federation of Obstetric and Gynaecological Societies of India (FOGSI- ICOG) and the Institute of Obstetricians and Gynaecologists, one of the six training bodies in The Royal College of Physicians of Ireland.

As President of FOGSI in 2009, Prof Purandare opened discussions with Prof Mike O Connell and Prof Mike O Dowd on the possibility of bringing the Membership exam of the Royal College of Physicians of Ireland (MRCPI) in O&G to India. These have continued during the present Institute Chairmanship of Professor Robbie Harrison. The MRCPI is recognised by the Irish Medical Council and is an international benchmark postgraduate qualification. Those discussions have led to a memorandum of understanding being signed between both organisations in 2010 and a delegation from FOGSI travelling to Ireland to observe the 2013/2014 diets of the MRCPI O&G exam. This was followed by the successful organisation of the first revision course coordinated by ICOG Secretary Dr. Jaideep Malhotra and conducted by Prof. Mike O Connell in July 2014.

Holders of MRCOG part one receive an exemption from MRCPI (O&G) part 1. At present candidates are required to have completed two years of post-registration training in recognised posts, one year in Obstetrics and one year in Gynaecology (or two years in combined posts) to be eligible to sit MRCPI part II. We are pleased to announce that the next diets of the MRCPI part II O&G written take place in Mumbai on 3rd September 2015. All details and up to date information on exam regulations are available on the RCPI website www.rcpi.ie

ICOG - FIGO - FOGSI JOINT ACTIVITIES

Dr. Sabaratnam Arulkumaran
President, FIGO

Dear members and fellows of the Indian College of Obstetricians and Gynaecolgists,

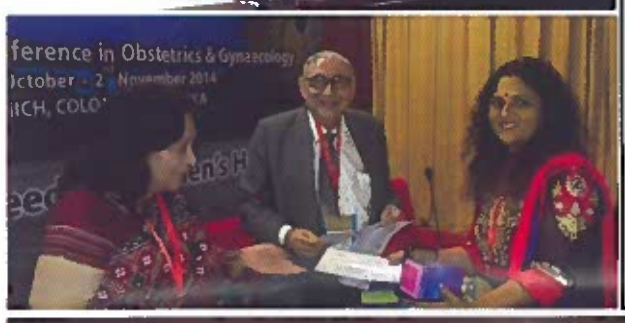
My sincere best wishes on behalf of FIGO to each and every one of you for a Healthy, Wealthy and Happy New year. The Indian College of O&G – the educational arm of FOGSI has grown from strength to strength under the able leadership of eminent Chairmans' and Secretaries' of the College.

FIGO has been interacting with FOGSI in a number of educational conferences and projects at the grass root level such as the LOGIC project in Rajasthan, Safe abortion care project and recently the postpartum IUD project.

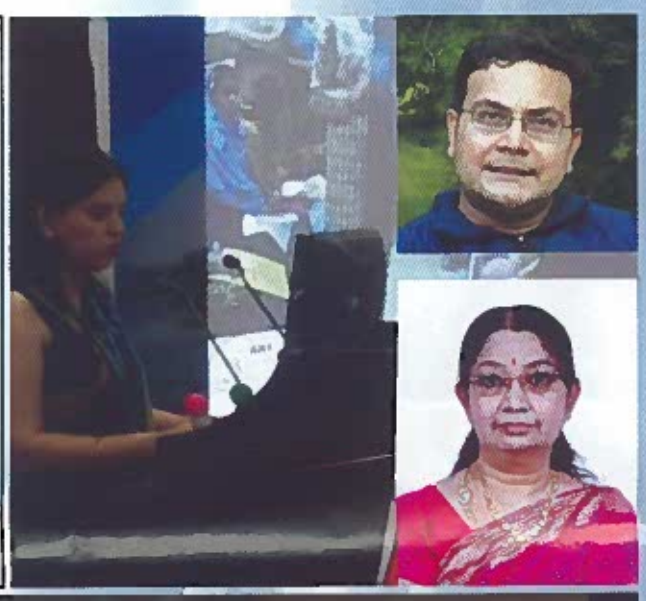
The educational platform of FIGO is a web based resource 'Global Library of Women's Medicine' – www.glowm.com. It consists of several text books, wall charts, color atlases including obstetric and gynecology ultrasound, 440 chapters as the main resource, video and educational films and master classes on various topics. There are special sections on contraception and abortion, sexual and reproductive rights and another on safe mother hood. All the WHO publications related to women's heath are also available from the portal. In some places internet is not available freely or the speed is slow. To overcome this FIGO has packed all these into a small USB stick and posted it to the Presidents of national Societies for them to produce several hundreds or thousands and give it to hospitals, medical schools and individual o& G specialists. We believe the Indian College of O&G can take a lead on this and see for dissemination of the information and distribution of this precious resource. 'Knowledge Transfer' is a powerful weapon to reduce maternal and neonatal morbidity and mortality.

With very best wishes and kindest regards

ICOG Goes to
FIGO SLCOG CONFERENCE COLOMBO



ICOG participated in the FIGO - SLCOG Conference at Colombo from 3oth Oct to 2nd Nov. 14. In the 90 minutes session conducted by ICOG. The session comprised of two topics for debate were "ART Pregnancies should be treated differently" by Dr Diksha Goswami and Dr. Ramani Devi and the other topic was "Should Endometrial sampling be perform on Asymptomatic Woman", participants were Dr. Basab Mukherjee and Dr. Vaishali Chavan. The Debates were moderated by Dr. P. C. Mahapatra & Dr. Atul Munshi. A Quiz on "Surgical procedure in Obs & Gynae" was conducted by Dr. Aswath Kumar and Dr. Narendra Malhotra. This session was very well received by all the delegates from the region.



FIGO-ICOG BUILDING RELATIONSHIPS

Prof. Gian Carlo DiRenzo
Secretary Elect, FIGO

Recent developments have changed many previous assumptions about the best options for management of pregnancy and childbirth, therefore FIGO aims to provide leadership and clarity for the application of the new (and relatively new) techniques and clinical options that are now available to clinicians for the successful management of the pregnant mother and her fetus/newborn. Although these issues apply universally, they are particularly important in industrialized and semi-industrialized countries, where they are already part of much clinical practice and where, therefore, authoritative guidance is urgently needed to establish best practice.

FIGO has therefore constituted a new Working Group on " Best practice in maternal-fetal medicine" to address these issues (see composition below) . The recent developed guidelines present best practice advices in maternal–fetal medicine regarding:

1. Screening for chromosomal abnormalities and noninvasive prenatal diagnosis and testing.
2. Periconceptional folic acid for the prevention of neural tube defects.
3. Cervical length and progesterone for the prediction and prevention of pre-term birth.
4. Thyroid disease in Pregnancy
6. Hyperglycemia in Pregnancy
7. Appropriate ultrasound use in obstetrics

The first three have been published just recently in the IJGO (official journal of FIGO) and the others are awaiting the endorsement from the Executive Board. Representative from ICOG FOGSI in the WG is prof Narendra Malhotra, whose contribution on item 4 has been pivotal. Alll these new advices will be presented at the next FIGO Congress in vancouver in october 2015.

Group composition: Gian Carlo Di Renzo (Chair)*; Eduardo Fonseca, Brazil; Sonia Hassan, USA; Mark Kurtzer, Russia; Shilpa Nambiar, Malaysia; Nancy Sierra, Mexico; Narendra Malhotra, India; Kypros Nicolaides, UK; Huixa Yang, China (members). Sabaratnam Arulkumaran, UK (FIGO President,ex officio); Pierpaolo Mastroiacovo, Italy (Director, International Clearinghouse for Birth Defects); Moshe Hod, Israel (European Assocaition of Perinatal Medicine); Yves Ville, France (International Society of Ultrasound in Obstetrics and Gynecology); Luis Cabero, Spain (Chair, FIGO Committee for Capacity Building in Education and Training); Claudia Hanson, UK and Tanzania (FIGO Safe Motherhood and Newborn Health Committee); Joe Leigh Simpson, USA (Vice President, March of Dimes).

FIGO-ICOG Logic Project

International Federation of Gynecology and Obstetrics (FIGO) was awarded a grant by the Bill and Melinda Gates Foundation to implement a project on "Improving Maternal and Newborn Health in low resource countries through Strengthening the Roles of Obstetric and Gynaecological National Associations" as a major maternal and newborn health Initiative. FIGO introduced the Leadership in Obstetrics and Gynaecology for Impact and Change Initiative (LOGIC) for this purpose. The project was funded over a time scale of five years (2008-2013).

Eight Partner Organizations from Asia and Africa were selected to participate in this initiative, and The Federation of Obstetric and Gynecological Societies of India (FOGSI) was selected to lead the initiative in India. The project goal was to improve policy and practice by strengthening FIGO member associations and using their position and knowledge to facilitate and contribute to such improvements, leading to better maternal and newborn health for underserved populations in low and middle resource countries.

As part of the project FOGSI in partnership with Government of India – Maternal Health Division, Ministry of Health and Family Welfare and AVNI for the following initiatives.

Emergency Obstetric Care Curriculum

Emergency Obstetric Care (EmOC) training curriculum was revised. The curriculum dovetails other Government Maternal and Child Health and Reproductive and Child Health programme guidelines into EmOC. The curriculum has been released in 2013 for implementation across India.

Maternal Near Miss Reviews

FOGSI worked with GoI and six medical colleges in six States across India to develop contextual near miss definitions and tools with the aim to have these definitions and tools approved by the GoI and implemented across India. The definitions and tools will assist health facilities with investigating causes of and circumstances surrounding maternal near misses, that is, when women survive obstetric complications. The guidelines have been firmed up and submitted to GOI for its implementation in 2013.

Maternal Death Review Programme

Maternal death review programme was implemented in two districts of Rajasthan (Sikar and Jhunjhunu). The maternal death review reports are analysed and the findings shared with the District and State authorities. The review programme in these two districts has identified that women die due to the following: delay in seeking care; death during transfer to a health facility with better facilities and in which health workers with necessary skills are present; and inability of the health facility to provide services due to lack of blood storage, skilled health professionals and/or availability of drugs.

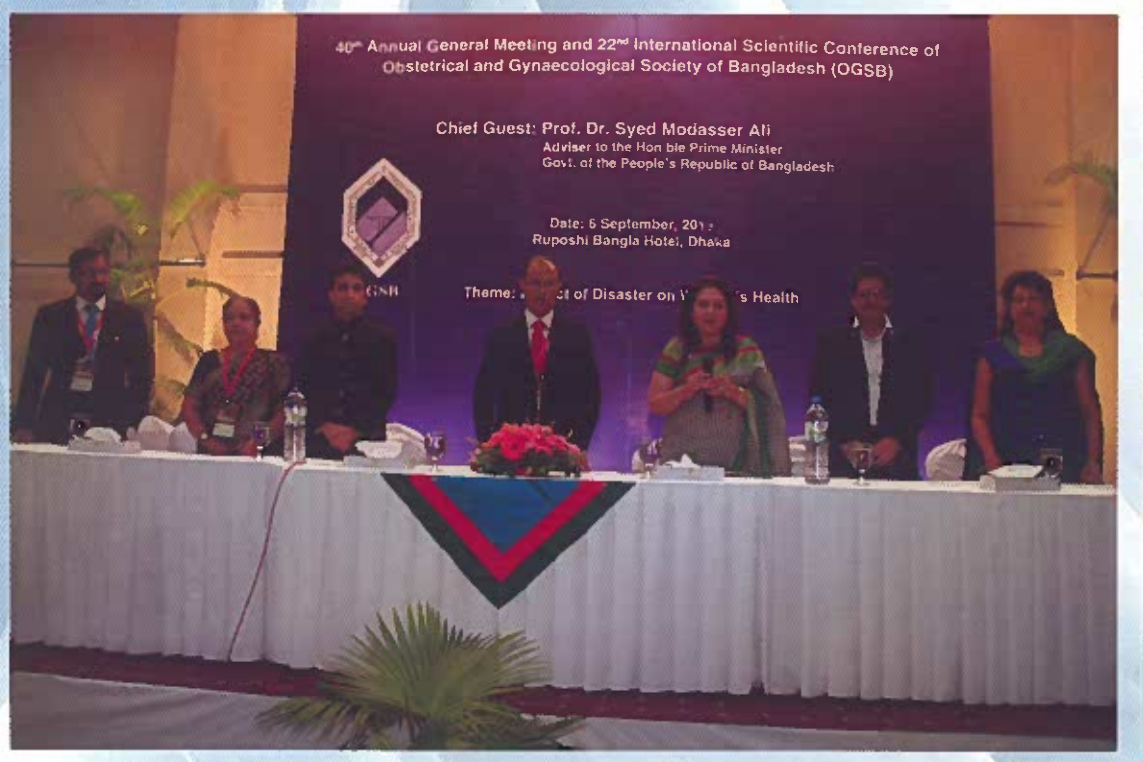
Maternal Death Review Software

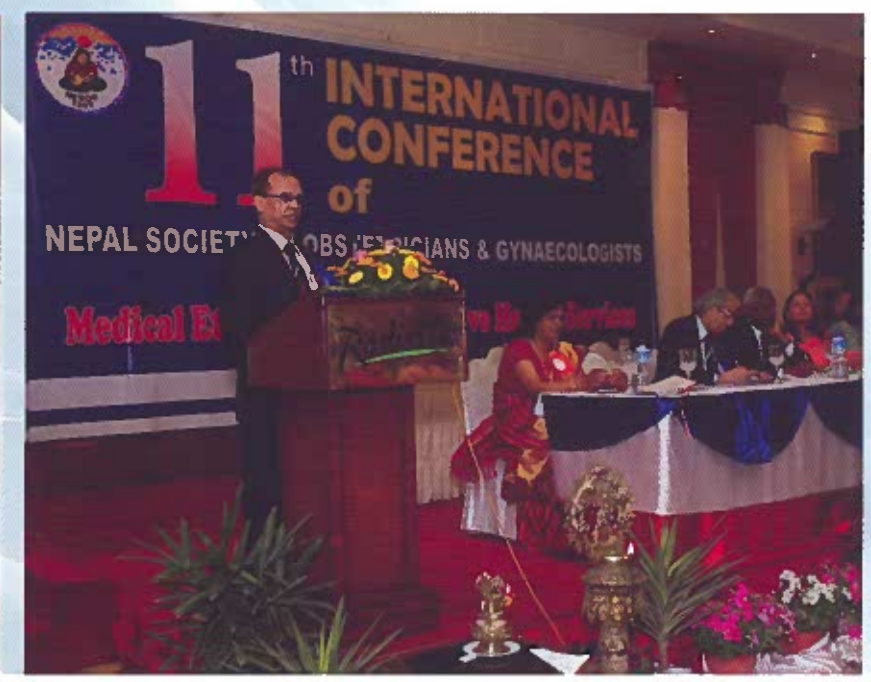
A maternal death review software was developed and implemented in India. The software enables GoI and health facilities across the country to analyse the causes of maternal deaths and identify the delays that contribute to maternal deaths at various levels. Based on the findings, GoI then initiates steps to help overcome the causes leading to a maternal death. The software currently being implemented across India.

ICOG Goes International

ICOG has been in constant collobration and liasing with the neighbouring countries, has done many programms in Nepal, Bangladesh and Sri Lanka, which were very popular and well accepted. In April 2013 FOGSI - ICOG with NESOG. Then September 2013

with society of OBGYN - Bangladesh and in October 2014 with FIGO - SLCOG at Colombo.

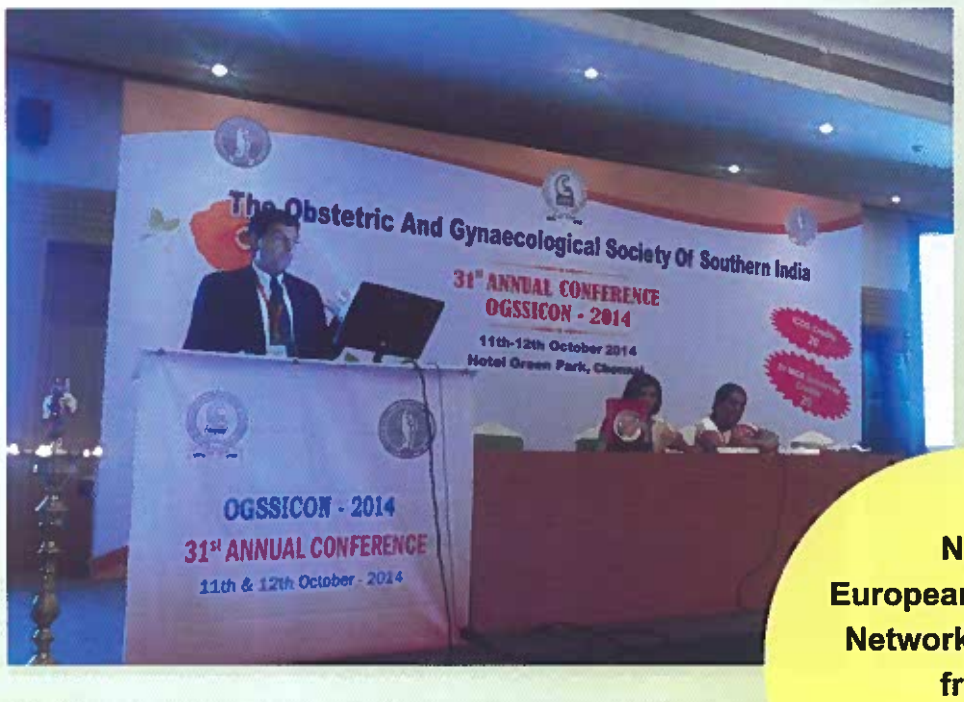


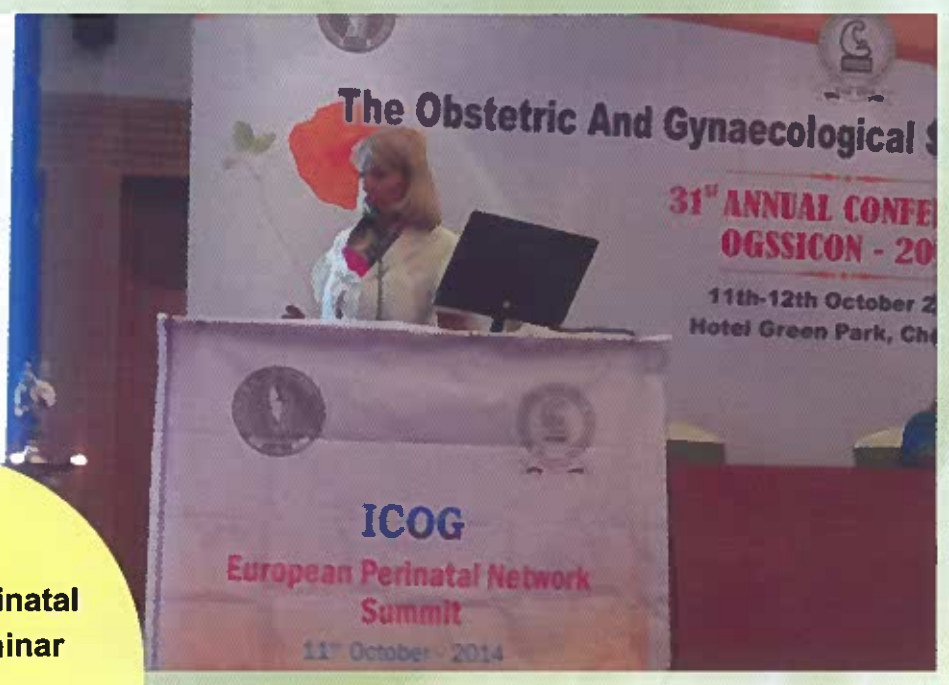


FOGSI-ICOG

EUROPEAN PERINATAL NETWORK

Our international liaising resulted in a high academic quality travelling seminar from 9th to 14th October 2014. This seminar had faculty from the European perinatal network head by Prof. Gian Carlo DiRenzo, Prof. Corinne Hubinont and Prof Gerard Visser along with faculty from ICOG Prof. Atul Munshi, Dr. Mala Arora, Prof. C.N. Purandare, Prof P.K. Shah, Dr. Amit Patki, Dr. Rajlaxmi Walvalkar, Dr Nozer Sheriar, Dr. Usha Krishna, Dr. Shanta Kumari, Dr. Rekha Kurian, Dr. Hema Diwakar, Dr. Malini KV, Dr. Padmini Issac, Dr. Barun Sarkar, Dr. Narendra Malhotra, Dr. Madhu Rajpal, Dr. Saroj Singh, Dr.Mukesh Chandra, Dr. Aruna Rachel, Dr. Indira Devi and Dr. Pushpa Srinivas. Special thanks to Dr. Suchitra Pandit president FOGSI, Dr. C.N. Purandare, Prof Gian Carlo DiRenzo, Besins Healthcare- Mr. Kawaljit Mehta, Roshan Mane, Nitin Keluskar and team. This Program was coordinated for ICOG by Hon. Sec. Dr Jaideep Malhotra.





Next European Perinatal Network Seminar from 7th to 14th Nov. 2015

FOGSI ICOG Report

National Eclampsia Registry

Dr. Girija Wagh

The final aim is to have an eclampsia free country and therefore our efforts must go on . It is only achievable with all the members joining together and helping the cause of eclampsia eradication . And yes it is possible.

The total number of doctors registered in this registry are 107 at present.The total number of delieveries in the year 2014-2015 were 89504. Out of this the total number of **Eclampsia patients were 1182** and Pre-eclampsia 2616.

This year we saw that the maximum cases of Eclampsia occurred mostly in the Age group of 20-30years(80%) and more so in Primigravidas (71%).Self diagnosis and Referral was most common but there has been an **increasing trend in referrals from PHC and Medical officers.** The credit certainly goes to the government programs and FOGSI outreach to this sector. Patients which give past history of Eclampsia or PIH have an increase incidence of Eclampsia in the present pregnancy (85%).Commonly PIH developed after 34 weeks in maximum number of cases (57%) and between 26-34 weeks about 39% implying that maternal health status prior to pregnancy if improved can be of help.

Fetal outcome has been improving. Live births have been 81% with a weight of more than 2000 gm in 28.8% and more than 2500gm 24.68%.

Most commonly used drug has been Nifedipine (47%) and methyldopa (30%). Mgso4 has been used in almost all cases of Eclampsia (99%) with the **Pritchard regimen being 75%** and Zuspan 7.5% and low dose 17 %.

Dr. Sanjay Gupte

We have seen a few complications in these cases. Maximum incidence was HELLP 19% and also Abruptio placenta 11^%.other complications such as $MgSO_4$ toxicity, ARF, Pulmonary oedema and Coma were all less than 5 %.Prostaglandins remain the choice for Induction (86%).

The registry urges more members to participate in this activity .It is simple .Just log in at www.ner-fogsi.in and become a reporter. We soon wish to start the online news letter and all the mebers are requested to contribute any article, any important guideline ,case report which will help in increasing our insights in management of this disease.

EMOCs Report

Dr. Sadhana Desai

In the year 2014, ICOG/FOGSI set up 10 new district hospital training centers and trained 22 new district hospital doctors to impart practical training in EMOC. In the year 2014, 185 new Govt. MBBS doctors working in FRU's took training in EMOC. Examination was also conducted and certificates were given away to those doctors who had finished their training and whose examination was pending. The examination was held in medical colleges (EmOC tertiary training centers).

Till date, 1610 Govt. MBBS doctors working in FRU's have been trained. Thus, all the targets have been achieved of EmOC training set by Govt. of India. The Govt. wishes to continue EmOC training for further period of three years and has sent a letter for extending the training programme till March, 2017.

A Report on the Academic Council

Looking Back Moving Forward

Dr. Hema Divakar
Conveynor , Academic Council
FOGSI ICOG

Looking Back ..... the Academic council was established in 2011.

The Academic council was established in 2011 , when dr Behram Anklesaria was the chairman of ICOG. A group of members from the Governing council who volunteered to serve on the academic council , were invited to the FOGSI ICOG SAFOMS meet at Bengaluru on 11th November 2011.

VISION - To ensure that the candidates trained at the FOGSI ICOG Centers on the SIX MONTHS CERTIFICATION COURSE ,would develop outstanding professionalism in all matters affecting the provision of quality health care for women better healthcare for women, everywhere. The ramifications for education and training are obvious. In keeping with the vision of FOGSI ICOG to enhance access to trained specialists ensuring high quality care for women at all times, the following were discussed and debated at the very first meeting

- Accrediting centers for training - To develop a system of accrediting centers for training and to demonstrate best practice in the field of REPRODUCTIVE MEDICINE, PERINATOLOGY, ULTRASONOGRAPHY AND MINIMALLY INVASIVE SURGERIES.
- Curriculum development - Working with experts to agree on curriculum development - A curriculum to support the education of high quality specialists in the niche segments , after their post graduation.
- Examination Pattern - To keep to strict standards of setting questions and and provision for practical assessment at these centers – both theory and practical.

Thus began our journey to dream and discuss the following and get set to implement the same, after conveying it to the esteemed office bearers and members of Governing council.

Moving Forward

The five-year strategy focuses on the College's key strengths in standard setting, education and training, setting objectives and outcome measures to ensure that investment in academic initiatives will have a lasting impact on women's health in India.

A degree of continuity was achieved, with the new Chairman Dr Aloke Debdas , The academic council team has been refocused on establishing new courses – shorter and fast track courses , and Explore the provision of e-learning resources without compromising on quality .

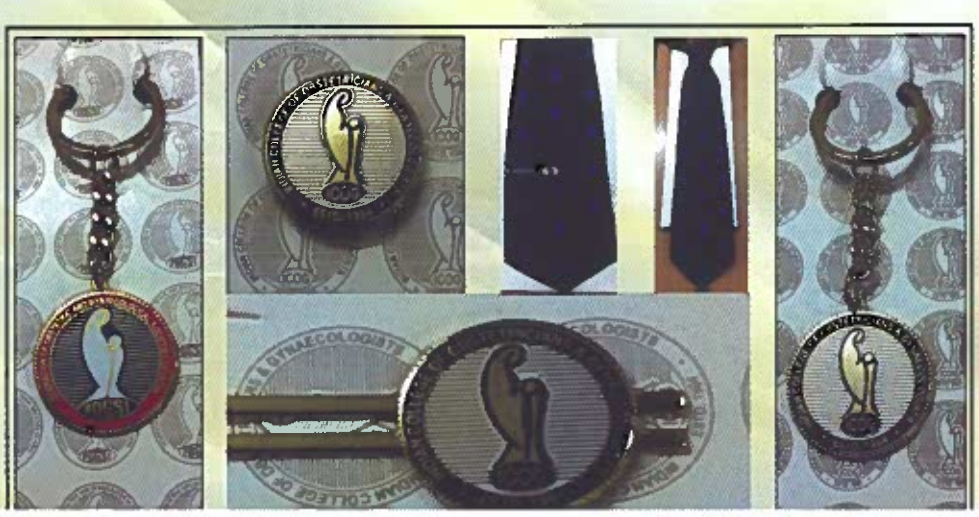
The long term vision of the academic council is on building on the established centers to implement uniform protocols, data collection , Research and Clinical Audit, and clinical outcome data using currently available data .

"So often you find that the students whom you are trying to inspire , are the ones who end up inspiring you" Sean Junkins

We are thankful to the students who make us feel that our efforts are worthwhile . We gratefully acknowledge all members of the Academic counsel for their persistent efforts in meeting various challenges expected in start ups and congratulate all the center heads and their teams who have travelled the extra mile with us in this endeavor.

BRANDING MERCHANDISE

ICOG decided that it is mature enough to now roll out its branding merchandise and a few articles were designed by Mr. Ajay Agarwal and Dr. Jaideep Malhotra and were sent for manufacturing in Taiwan and India. They have been very well appreciated and accepted ICOG request each and every member of FOGSI to become a fellow of ICOG and don the ICOG merchandise with pride.



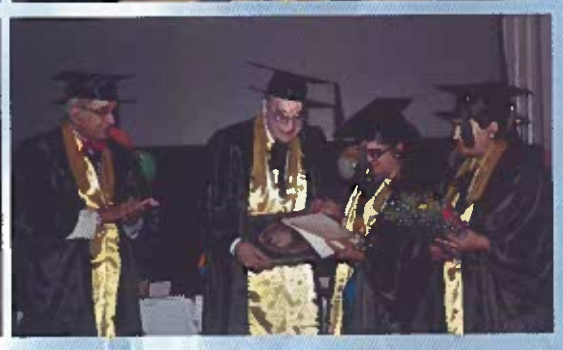
All About ICOG

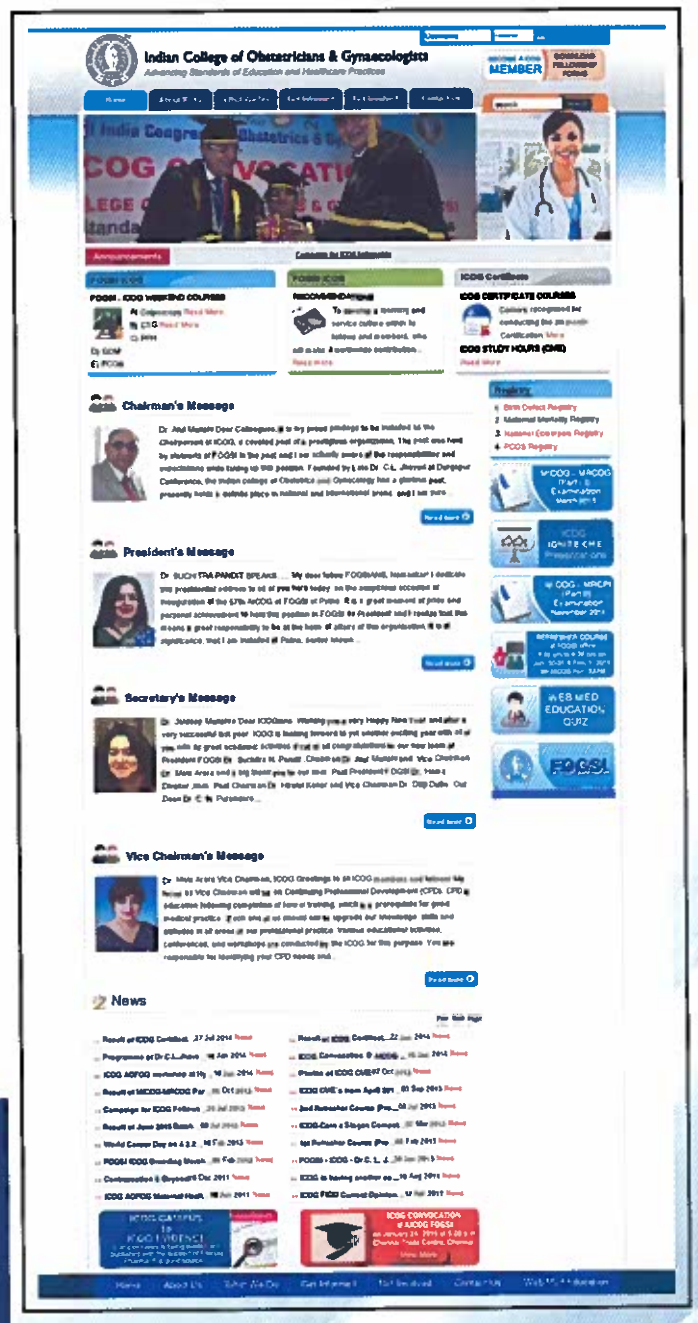
CONVOCATION

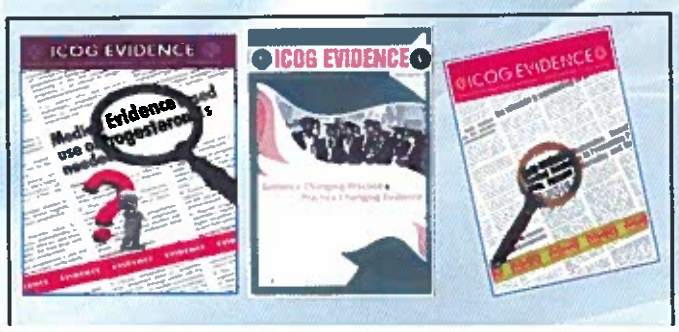
Every year during the All India Conference of Obstetricians & Gynaecologist, ICOG Convocation is held during which Honorary Fellowships and also the fellowships of the college are conferred.

In 2013 Prof. Benigiano from Italy and Prof. Mike O Dowd
In 2014 Prof. John J. Sciarra and Dr. Himanshu Bhushan

Everyone is cordially invited to attend the ICOG Convocation on 24th Jan. 5:00pm at Bhaskar Rao Hall







ICOG Certificate Course

ICOG conduct six monthly certificate courses at the ICOG recognized centers on the following:

1. Reproductive Medicine
2. Gynaecological Endoscopy
3. Ultrasound
4. Perinatology (Now change to Fetal Medicine)
5. Starting new course on Critical Care in Obs. & Gynae

ICOG thanks Dr. Hema Divakar, Late. Dr. Behram Anklesaria, Dr. Aloke Debdas, Dr. Hiralal Konar, Dr. Atul Munshi, Dr. Sanjay Gupte, Dr. Suchitra Pandit, Dr. Prakash Trivedi, Dr. Duru Shah, Dr. P. C. Mahapatra, Dr. Alka Kriplani, Dr. Jaideep Malhotra, Dr. Madhuri Patil, Dr. Sunita Tendulwadkar, Dr. Ameet Patki, Dr. Kamini Rao, Dr. Shyam Desai, Dr. Parul Kotadwala, Dr. Alpesh Gandhi, Dr. Jayam Kanan, Dr. P. K. Shah, Dr. Rajlaxmi Walvalkar, Dr. Pragnesh Shah, Dr. Narendra Malhotra, Dr. H. D. Pai, Dr. Nozer Sheriar, Dr. Dilip Dutta, Dr. Mala Arora, Dr. Prashant Acharya & Dr. Indrani Ganguli for their unconditional support to the academic council of ICOG for the conduct of the Examination, Setting of the Question Papers and Question Bank.

Congratulations to the Toppers

January 2014 Batch

Dr. Priyadarshini Neha, Dhanbad from Dr. Jaideep Malhotra's Centre.
Dr. Vidyashree, Bangalore from Dr. Vidya Bhat's centre.
Dr. Parul Arora, Agra from Dr. Narendra Malhotra's centre.
Dr. Varsha Mahajan, Indore from Dr. Ratna Thakur's centre

June 2014 Batch

Dr. Pallam Apoorva Reddy, Nellore from Madhuri Patil's centre.
Dr. Mann Sonika, Rohtak from Dr. Nutan Jain's centre.
Dr. Kailash P. Ochwani, Gujarat from Dr. Jayprakash Shah's centre.

New Hopes New Horizon

Dr. Apoorva Pallam

Infertilty might be defined as inability to conceive after 1 year of intercourse by WHO, but it is identified by many other names in India. Impotency, Bad karma(Sins of past life) , women's fault, so on and so forth. In order to overcome this social and mental stigma men, women and couples are willing to turn every card possible. Be it tying threads to tree, to fasting, to even getting an unwarranted D & C from a quack if he/she promises a conception.

It is ironical that the second most populous country in the world has over 15 million couples suffering from infertility. Since the invention of IVF technique in 1978 by Prof Robert Edwards everyone has looked up to it as the miracle or the cure for infertility.

With the increasing success rates , there has been a tremendous shift in the interest over infertility in the past two decades. There are more number of couples approaching doctors for treatment, overcoming the taboos. This was a trend shifter in the field of ObGyn. Overnight everyone was a specialist in the field of reproductive medicine. Being a doctor was considered synonymous to infertility specialist. This was putting not only the patient at risk of misjudgment, but also the doctor at risk of malpractice. And even those who wanted to get trained in it didn't have many choices.

When I was doing my post graduation, I used to dread the site of an infertility couple. I always looked at it as a field with half glass empty. Not knowing how to investigate, counsel or manage them I always used to refer them to a senior consultant. But once I started practice I realized that Infertility has already become endemic problem and there is no turning away from it. I am sure many of us have crossed this path at some point in our life. As Oscar Wilde said "You can never be overdressed or overeducated." So I decided to get trained in the subject that I never loved. I joined ICOG fellowship at Patils fertility clinic.

Ethical practice, evidence based management, Practice what you preach are only few of the many statements that would describe work at The Patil's fertility clinic. The best way to learn it is to learn it write the first time. Some say 6 months is too short a time to learn infertility. I say even a lifetimes journey begins with one single step. Today I am in love with the field that has half glass full. In love with the great work, dedication and contribution people have given to Reproductive medicine. I am a more confident doctor. Understanding our limitations, making realistic promises, being compassionate with patients feelings and being updated of the everyday chances in the field of reproductive medicine is the only way forward. After all, "Educating the mind without educating the heart is no education at all".

No matter what Aamir khan says, he will always be indebted to someone from OUR fraternity to have filled his home with joy. Amidst all the chaos of medicolegal issues, PCPNDT and poor regulations for ART there are many doctors all over the country who are striving to do their best and beyond for the patients, who dedicate their much valued time to educate the next generation, who sleep an hour less so that they can keep themselves updated of recent advances. As long as there are these kind of doctors we will always have new hopes and a new horizon. And Once you choose hope, anything's possible.

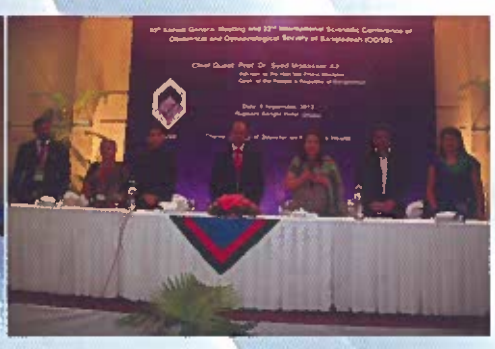
I would like to thank FOGSI and ICOG for this extremely beneficial courses in various fields of ObGyn. It is indeed a privilege to get trained under stalwarts like Dr Madhuri Patil, who never seize to inspire us all.

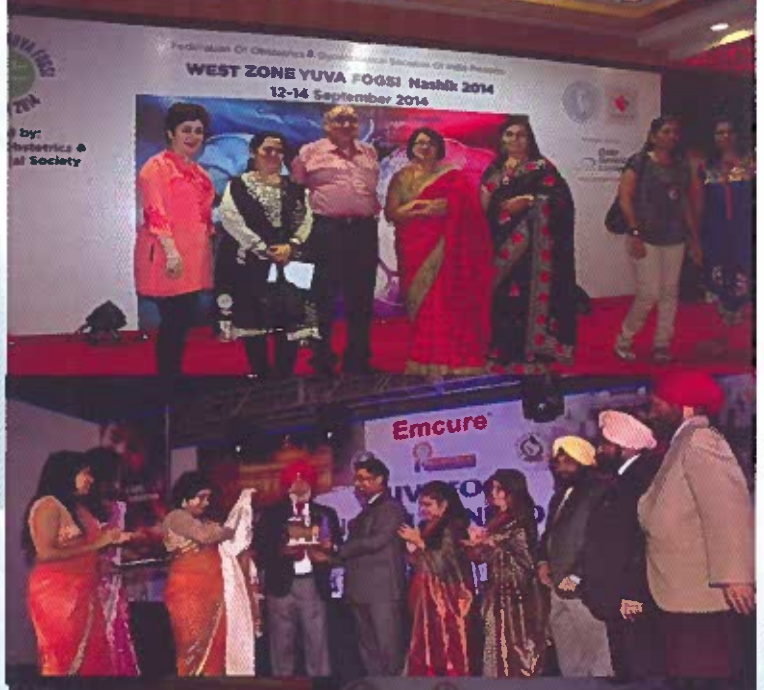
Dr. C. L. Jhaveri Endowment Symposium

Every year during AICOG, ICOG pays tribute to one of our finest President of FOGSI & Founder Chairperson of ICOG with the conduct of the prestigious C. L. Jhaveri Endowment Symposium.
Which gives an opportunity to our young scientists and clinicians whose work has made an impact on the population at large

Empowering women for better healthcare!
Screening protocol for breast and Gynaecological malignancies in the women.
Coupling the Adult and Neonatal Immunization schedules.
Low resource setting – safety during delivery
Contraception - strategies to increase the couple protection rate.

Dr. Indrani Ganguli, New Delhi
Dr. Kavita N. Singh, Jabalpur
Dr. Mala Arora, Faridabad
Dr. S. Sampath Kumari, Chennai
Dr. Shobha N. Gudi, Bengaluru





DR. C. S. DAWN GUEST ORATION 2014:

Dr. C. S. Dawn Guest Oration for the year 2014 was delivered by Dr. Hiralal Konar, Imm. Past Chairperson of ICOG on October 12, 2014 at Bhilai society.

DR. USHA SARAIYA GUEST ORATION 2014 :

Dr. Harshad Parasnis, Pune was delivered the Dr. Usha Saraiya Guest Oration for the year 2013 at Agra on April 6, 2014. Oration for the year 2014 is yet to deliver by selected orator Dr. Amita Maheshwari, Mumbai.

ICOG Session at every YUVA FOGSI zonal conference:

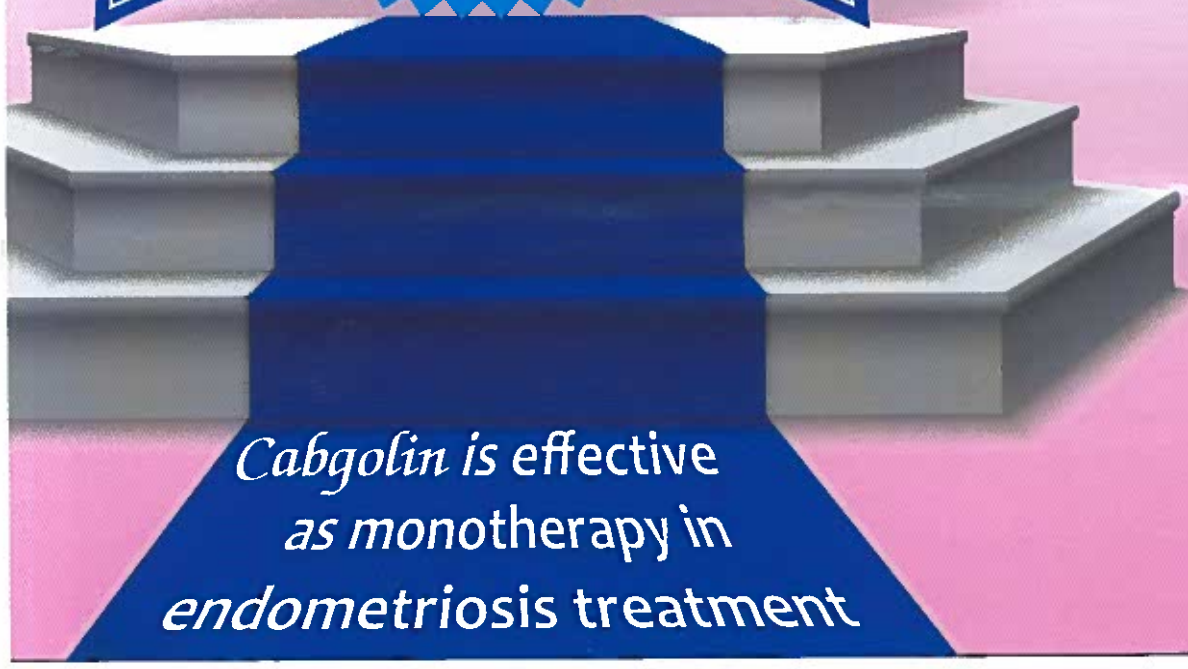
ICOG sessions for one hr has been successfully conducted at every YUVA FOGSI conference as follows: Dr. Atul Munshi, Dr. Mala Arora, Dr. Suchitra N. Pandit, Dr. Indrani Ganguli, Dr. Tarini Taneja, Dr. G C Das, Dr. Dilip K. Dutta, Dr. Sheela Mane, Dr. Roza Olyai, Dr. Hema Divakar, Dr. Maninder Ahuja and many other ICOG members from respective place attended the programme. ICOG has given Rs. 10,000/- to each zone for the ICOG session carried out.

1. North Zone-2014, Faridabad on April 11-13, 2014
2. South Zone, Mysore on June 6-8, 2014
3. East Zone, Bhubaneswar on September 5-7, 2014.
4. Nashik on September 12-14, 2014

Cabgolin 0.5
Cabergoline 0.5mg tablets

Cabgolin in Endometriosis

A new approach to an old disease



- Prevents angiogenesis
- Reduces endometriotic lesions
- Relieves pain
- Most promising non-hormonal therapy

Cabgolin is effective *as mono*therapy in *endometriosis* treatment

SPECTRA
A Division of
Sun Pharma Laboratories Ltd.

Educational Initiative by

SPECTRA
A Division of
Sun Pharma Laboratories Ltd.

makers of

Susten
Natural Micronised Progesterone

Designed by
Prabandhan
Planning to Perfection
020 - 67224475

Item Code : L2119290