Issue 1, 2012

NEWS & VIEWS

Newsletter of
The Mumbai Obstetric
& Gynecological Society

Reproductive Health is Wealth – It needs Planning and Investment!

www.mogsonline.org

Highlights in this Issue

Editorial

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- Ex Asso. Prof. & Unit Chief Grant Medical College & Cama & Albless Hospital, Mumbai.
- Assistant Editor, Journal of Ob Gyn of India 2012-14
- Chairperson Reproductive Endocrinolgy Committee of FOGSI 2011-13

We have a great pleasure in placing before you the first issue of MOGS 'News and Views' of the year 2012-13. On behalf of the editorial team, we would like to thank Dr Ashwini Bhalerao Gandhi, President MOGS, for giving us an opportunity to edit this issue. We hope you will enjoy reading this as much as we enjoyed editing and making of the first 'News and Views' issue of this year.

MOGS is a vibrant organization carrying out numerous activities throughout the year. This issue focuses on articles on micronutrients. We hope that the readers find them interesting. Apart from scientific articles, this 'News and Views' will bring forth news related to various activities of MOGS to all of you. As MOGS member, we require your active involvement, suggestions & comments about various programmes & other activities carried out by MOGS.

An interview with Dr M. N. Parikh, a legendary figure in the field of obstetrics and gynaecology of Mumbai, may inspire readers to carry out good work in their respective areas of interest.

Early next year in January 2013, MOGS is hosting ' AICOG' at Bandra Kurla Complex. We expect very active participation from all MOGS members to make this event successful & memorable. We have included the synopsis about the conference as given by the Organizing Chairperson Dr Hrishikesh Pai.

We sincerely thank all contributors, designers of this edition of MOGS 'News and Views'.

We would also like to thank our partners/ sponsors for their support in organizing various programmes in general & making of this issue in particular.

With best wishes & warm regards,

Long Live MOGS,

Dr Shailesh Kore **Dr Suvarna Khadilkar**

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News and Views Editorial Team

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President, MOGS

Dr Arun Nayak
Secretary, MOGS

Dr Shailesh Kore
Correspondent

Dr Suvarna Khadilkar
Correspondent

President's Message

Dr Ashwini Bhalerao-Gandhi

Dear Friends,

The new managing council of the Mumbai Obst. & Gynec society was installed on 15th April 2012. We have already organized 3 major academic events so far. The very first programme was held on 22nd April at Y. B. Chavan Auditorium in collaboration with FOGSI. MOGS is a very active, committed, strong and vibrant organization comprising of 2200 gynaecologists residing not only in Mumbai, but also in Thane, Dombivali, Kalyan, Navi Mumbai etc. For the first time in the history of MOGS, we organized a major academic conference in Thane on 13th May 2012.

Our theme for the year is 'Reproductive Health is Wealth; It needs planning & Investment!' MOGS will organize health talks at various women's organizations, Mahila Mandals, Corporate offices etc. Many promotive & preventive concepts like Adolescent care, premarriage & preconceptional counselling, contraception, safe abortion, early detection of cancer, post menopausal care will be discussed.

MOGS organizes conferences at various venues. We have decided to name the halls in memory of our senior diseased members. So far, halls were dedicated to late Dr Jayashree Jhaveri, Dr Vijaya Patil, Dr G. B. Belvi, and Dr T. K. Buch. This is to pay our tributes to their contribution to the society in general and to MOGS in particular.

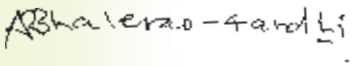
MOGS tries to present environmentally friendly bags and folders during conferences and workshops. This year we are also going to be friends of mentally and physically challenged citizens. We purchased delegate bags from NGO Kshitij, Sadhana School, as well as Shraddha Charitable Trust which work for developmentally handicapped adults as well as autistic and mentally challenged young adults. We have already started Dr N. A. Purandare PG teaching programmes and our out reach CMEs. This year we will be organizing focussed outreach CMEs.

News from the FOGSI Front –

Dr P. K. Shah – President FOGSI & Dr Mandakini Megh – Vice President FOGSI collaborated with MOGS for the symposium on Population Stabilization & Family Welfare. We are thankful to both of them. MOGS has nominated Dr Suchitra Pandit for the post of President FOGSI. I wish her all the best for the forthcoming election. I am sure that all our members will support her candidature. Dr Shailesh Kore's name is nominated for the post of FOGSI Chairperson of Genetic and Fetal medicine committee. He has always helped MOGS in organizing conferences & PG programmes.

In case any of our members wants to take part in CMEs/ Health awareness talks/community service activities of MOGS, do let us know, by a letter/email or even a phone call!. We shall be very happy to include our members in various academic as well as social activities of MOGS. Please do apply for various MOGS prizes and attend our Annual Conference in large numbers.

Yours sincerely,



Dr Ashwini Bhalerao-Gandhi
President, MOGS

From Secretary's Desk

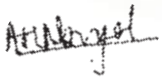
Dr Arun Nayak

Dear Friends,

I am aware of difficulties faced by a lot of our colleagues and the anxiety and agony faced by many while dealing with the sensitive issues like PCPNDT, FDA inspection and NOC from Fire Department for the renewal of Nursing Homes. We are already discussing these issues with our colleagues from other Associations and collectively we have to safeguard our profession. What is most important at this point is keeping our records, registers, documents etc in order and second most important point is to remain united. Do write to us if you want to share your experience or if you have faced any problems and as an organization, collectively we will try and help you in dealing with these sensitive issues.

As a Secretary of MOGS, I am fortunate to have a great team of dedicated colleagues, who have worked tirelessly for bringing out our CMEs and other programmes. Our Trustees have always guided us in smooth functioning of our Society and also in organizing and fine tuning our programmes and their suggestions and encouragement have always been very helpful. And finally, dear friends, A BIG THANK YOU to all of you for attending our programmes in a large number and giving us the satisfaction and vigour to organise more programmes in future. I am sure with your continued love and support for MOGS, we will scale new heights in future.

Warm Regards,



Dr Arun Nayak
Secretary, MOGS

MOGS-FOGSI symposium on

"Population Stabilization & Reproductive Health"

Sunday 22nd April 2012, Yashwantrao Chavan Pratisthan Auditorium near Mantralaya
Convenors: **Dr Ameya Purandare, Dr Sujata Dalvi** and **Dr Ashok Shukla**

The MOGS- FOGSI Symposium on 'Population Stabilization & Reproductive Health' was held on Sunday, 22nd April 2012 at the Yashwantrao Chavan Pratisthan Auditorium near Mantralaya. The conference had a good response of 150 registrations.

Dr Ashwini Bhalerao Gandhi welcomed the delegates and urged all to take up the issue of reproductive health. The chief guest Mrs Vandana Krishna, principal secretary, women and child development department, inaugurated the conference. The guest of honour was by Mrs Shomita Biswas, Member secretary, Maharashtra state commission for women. Dr P. K. Shah, President FOGSI spoke about the efforts of FOGSI in reducing maternal mortality and promoting reproductive and child health.

The first keynote address was delivered by Dr P. K. Shah, who spoke on 'Reducing maternal mortality – a holistic approach'. In second keynote address, Mrs Vandana Krishna spoke on 'policy decisions of women and child department regarding reproductive and child health'. The third keynote address was delivered by Mrs Shomita Biswas on 'The role of women commission in combating sexual harassment at the workplace'.

The MOGS – Dr Dossibai J. R. Dadabhoy Silver Jubilee Oration was delivered by Mrs Anna Dani, IAS, Additional Chief Secretary, GAD, Govt. of Maharashtra who spoke on "Reproductive and Child Health Programme in India". This was followed by the MOGS – Dr Bhanuben Nanavati Golden Jubilee Oration delivered by Dr Kalpana Apte, Assistant Secretary General, FPA India who spoke on the topic "Achieving Population Stabilization and Realizing Reproductive Rights in India – Where are we?"

Various eminent speakers from MOGS, esteemed teachers and faculty from NGOs and Govt. organisations delivered lectures on important topics related to reproductive and child health and population stabilisation ranging from newer contraceptives, RTIs and STDs, and MTP policies and practices. This was followed by a panel discussion on MTP complications in which the audience actively participated.

MOGS thanks the trustees of Yashwantrao Chavan Pratishthan Auditorium for their support and help in ensuring that the programme was carried out smoothly.

MOGS symposium on

"Management of Infertility – Practical Aspects"

Sunday 13th May 2012, United 21 club, Thane west

Convenors: **Dr Kedar Ganla, Dr Ganpat Sawant, Dr Atul Ganatra, Dr Sudha Tandon, Dr Krishna Kumar** and **Dr Datta Panandikar**

The symposium on 'Management of Infertility – Practical Aspects' was held at United 21 club, Thane west on 13th May 2012.

On 12th may 2012 in the evening the workshop on **Semen Preparation and IUI** was held at the same venue which was attended by 100 delegates.

Symposium covered all the aspects of Management of infertility over a span of 6 sessions which had lectures, panel discussion and a novel idea called patient centric approach. The programme was attended by 271 delegates.

The first session covered recent advances and evidence based investigations like hormonal evaluation, ultrasound evaluation and follicular study.

The 2nd session covered uncommon topics like management of oligoasthenospermia, when to refer patients for IVF, medico-legal aspects of infertility and lifestyle management.

The 3rd session was on recent advances and stepwise clinical approach on endometriosis, PCOS, unexplained infertility and poor ovarian reserve.

Next session was on practical aspects of ovulation induction, use of gonadotrophins, GnRH antagonist, ovulation trigger and luteal phase support.

This was followed by interesting panel discussion on evidence based endoscopic surgery to optimize fertility.

Last session was a skit – **'Hairan Doctor Pareshan Patient'** which was an innovative way of learning about psychological aspects and counseling in infertility in a fun filled hilarious skit presentation.

Report of Outreach CME

"Endocrinology update in Obstetrics and Gynecology"

Wednesday 24th June, 2012, Hotel Grand Central, Avenue Road, Chembur (E), Mumbai
Conveners: **Dr Suvarna Khadilkar and Dr Reena Wani,** Co-ordinator: **Dr Sachin Dalal**

On 24th June, 2012 the Outreach CME was conducted at Hotel Grand Central, Avenue Road, Chembur (E), Mumbai. Dr Suvarana Khadilkar, Dr Reena Wani were the Conveners & Dr Sachin Dalal was Co- Ordinator. There were 75 Registrations. The first Scientific Session was chaired by Dr Shubhada Gupta, Dr Surendra Upadhyay & Second Session was chaired by Dr Jasmine Lopez, Dr Smita Orke. Dr Anjali Talwalkar spoke on Oral Iron Therapy, Dr Sudha Tandon spoke on Micro Nutrients In Infertility, Dr Cherry Shah spoke on "Management of Menopause: Current Views" The endocrinologist Dr Parmar from Hinduja hospital enlightened the audience with his speech on Thyroid Problems During Pregnancy, Dr Kartik Bhagat spoke on Diabetes during pregnancy, Dr Sachin Dalal gave an overview of various relevant articles in literature in Journal Scan. There was an interactive Panel Discussion on 'Perimenopausal Bleeding: Controversies and Consensus: Case Based Situational Analysis'. Dr Suvarna Khadilkar was the Moderator. Dr Ashwini Bhalerao Gandhi, Dr Ganpat Sawant, Dr Archana Bhosale, Dr Anoop Gupta, Dr Sangeeta Deshpande were panelists. It was appreciated by one and all who attended.

Public forum was conducted by Dr Ashwini Bhalerao during post lunch session. There was an active interaction with the social leaders from Lion's club etc for betterment of women's health. A plan of future activities was discussed. Tea and snacks were served to all attendees and the programme ended with vote of thanks.

Association of Medical Women of India, Mumbai Branch, and Reproductive Endocrinology Committee of FOGSI actively participated in this Programme.

Report of Pre-Congress Workshop on
"Adolescent & Youth Friendly Health Services – The Need of the Hour!"

Saturday 9th June 2012, Nair Hospital, Mumbai

Convenors: **Dr Reena Wani** and **Dr S. D. Shirodkar**, Co-Convenors: **Dr Danny Laliwala** and **Dr Sachin Ajmera**

This workshop was designed to sensitize not only the practising gynaecologists, but also other branches to Adolescent friendly health services. The format was kept interactive with lively discussion and participation from audience, chairpersons and faculty.

The morning session on Common Concerns & Clinical Situations covered menstrual problems and PCOS, and had a special

lecture on Immunization by Dr Tuteja, President Elect IAP (Mumbai). The afternoon session On Practical Problems had Dr Roza Olyai, Chairperson FOGSI Adolescent health committee discussing Government guidelines for AFHS and activities at National level. Endocrinologist Dr Chadha, Psychiatrist Dr Alka Subramanyam, and Dr Uday Thanawala shared their knowledge in management of young girls. The finale was a panel Discussion conducted by Dr Reena Wani in which challenging practical situations were discussed by learned Panellists. Dr Ashwini Bhalerao-Gandhi, President MOGS summed up the workshop and mentioned it would be a pilot/ model for nation-wide adolescent health workshops in the future.

This was attended by 81 participants, including 18 faculty and the academic content, refreshments and Auditorium arrangements were appreciated by all. All participants were given handouts of adolescence Magazine, CD and booklet on Smart diet for teens in environment friendly ethnic bags.

Report of Pre-Congress Workshop on
"Recurrent Pregnancy Loss"

Saturday 9th June 2012, Sion Hospital, Mumbai

Convener: **Dr Niranjan Chavan** and **Dr Rahul Mayekar,** Co-Conveners : **Dr Sejal Desai** and **Dr Sachin Dalal**

Pre- Congress RPL Workshop of "The Changing Trends In Obstetrics & Gynecology" was Conducted at Lokmanya Tilak Medical Collage, Sion Hospital, Mumbai 22 on 9th June 2012 at Physiology Auditorium from 9.30 am to 4.30 pm.

Scientific Programme had 3 Scientific Sessions & one Panel Discussion. Inauguration & Lightening of Lamp was done by Dean Dr Sandhya Kamath followed

by Welcome Address by President, MOGS Dr Ashwini Bhalerao Gandhi & Y. S. Nandanwar, Prof & HOD, Department of Obgyn. Topics covered were as follows:

Etiology, Diagnosis & Management of Recurrent Pregnancy Loss (11 Lectures by our MOGS Members) The Panel Discussion had 5 Case Scenario's of RPL with interactive audience participation. Dr Sharad Gogate, Dr Mohan Gadam, Dr Geetha Balsarkar & Dr Umesh Athavale (Sonologist) were the panelists. Total 85 Delegates took Part in the Scientific Deliberations.

MOGS Conference on

"The Changing Trends in Obstetrics and Gynecology"

Sunday 10th June 2012, J W Marriott, Juhu, Mumbai
Convenors: **Dr Mukesh Gupta** and **Dr Nikhil Datar**

About 220 delegates attended the conference on **' The Changing Trends in Obstetrics and Gynecology**' which was held at J W Marriott, Juhu, Mumbai.

As per the theme, various sessions were conducted highlighting the changing trends from past to the most recent developments. This was amazingly reflected in the MOGS-Dr R. D. Pandit Oration on "HRT...Then, Now and Ahead" by Dr Geeta Pandya and MOGS-Dr Subhash J. Penkar and Dr Marie Pereira Silver Jubilee Oration on" Changing Trends in IVF "by Dr Indira Hinduja.

The day had started with discussions on Urogynaecology with eminent urologists

like Dr Anita Patel, Dr Umesh Oza and Dr Ajit Vaze enlightening the delegates with the changing scenario in diagnosis and treatment of SUI. Dr Shyam Desai talked about the changing trends in surgical steps of LSCS. Dr Sudhir Naik and Dr Richa Jagtap spoke on co morbid conditions with pregnancy like Thyroid disorders and PCOS with Pregnancy.

Newer advent of Robotics and Single port Laparoscopy were interestingly covered by Dr Neeta Warty and Dr Pritish Naik. Emerging discussions on Role of Calcium and VitD3 were deliberated by Dr Suvarna Khadilkar. Dr Ragini Agarwal highlighted the Role of Thromboprophylaxis. Modern technology in management of Breast Cancer was discussed by Dr Vinay Deshmane. Dr Priti Sharma highlighted the present developments in Stem Cell Therapies.

Post Lunch session became lively with the interactive session of panel discussion on Labor Room Protocols for 2nd Stage Management. Moderators were Dr Arun Nayak and Dr Mukesh Gupta with an expert panel comprising of Dr Mohan Gadam, Dr Kusum Zaveri, Dr Kiran Coelho, Dr Vinita Salvi, Dr Reena Wani and Dr Kartik Bhagat. The delegates enthusiastically participated in the various controversies involved in the subject.

The day ended with the Medico legal session with Dr Nikhil Datar highlighting the issues concerning consent and Dr Sugandhi Iyer discussing the importance of Documentation. Dr Gopinath Shenoy gave the winning final stroke for the day giving wonderful tips on this delicate issue.

First MOGS

Dr N. A. Purandare Teaching Programme

Sunday 1st July 2012, Jaslok hospital & research Centre

Convenors: **Dr Sudeshna Ray, Dr Pournima Satoskar** and **Dr Danny Laliwala**

First MOGS – Dr N. A. Purandare teaching Programme was held at Jaslok hospital & research Centre on Sunday, 1st July 2012.

Conveners of the programme were Dr Sudeshna Ray, Dr Pournima Satoskar & Dr Danny Laliwala. Programme was attended by 104 post-graduates.

Topics for this programme were Pre-eclampsia & uterovaginal prolapse. Case presentations on these two topics were followed by capsules on various aspects of the subject. Fourteen eminent faculties from various hospitals of Mumbai enriched the academic programme.

FOGSI-FIGO Workshop on Women's Health and International Congress on Recent Advances in Obstetrics and Gynecology

6th - 8th April, 2012, At Hyatt Regency, Mumbai

Long Journey of a Living Legend Interview with Dr M. N. Parikh, Recipient of FOGSI Life Time Achievement Award

Interviewer: **Dr Suvarna Khadilkar.** This interview took place at sir's residence; Cuff Parade, Mumbai on 6th June 2012.

SSK: *Sir, on behalf of managing council, MOGS and its general body I congratulate you for having received this lifetime achievement award. We thought that the life sketch of an extremely successful teacher, researcher, clinician and administrator like you would be inspiring and interesting to our readership.*

MNP: I am not sure if my story would be interesting to others but it certainly has been a most enjoyable journey for me.

SSK: *Sir tell us about your, child hood in your native place and youth.*

MNP: I was born on 16th December, 1926 in Pethapur, and was the eldest of 7 siblings. As a child I studied in Sangli High School, later took admission in Willingdon College of Science in Sangli. I was Chess Champion in college. There were many national and state chess champions from Sangli and there was pro-chess atmosphere in Sangli.

SSK: *How did you join medicine? Were there any doctors in your family?*

MNP: In 1945, I had to decide to become an engineer or a doctor. I had 199 out of 200 marks in mathematics and more than adequate marks to study medicine. I chose medicine, which then, as today was more difficult because it's such a lengthy course. My decision of taking up medicine did not appeal to my father who wanted me to take engineering, but he was kind enough to support my decision. I was the eldest, three of my brothers took up engineering and three of my sisters became doctors.

SSK: *We are thankful to your father for supporting your decision to become a doctor otherwise we would have missed out on a sound clinician and great academician like you.*

MNP: Every father should support his child's decision

SSK: *Why did you leave sangli?*

MNP: I left my hometown Sangli, to join the Seth G. S. Medical College in Mumbai. I did well in my studies and passed M.D. in 1956. I was trained under senior reputed teachers like Dr K. M. Masani and Dr C. G. Saraiya.

SSK: *I feel proud that a senior respected leader of FOGSI like you was associated with the institution where I learned my medicine, my alma mater," Grant Medical College". Sir when did you join Grant Medical College?*

MNP: In 1961 I joined The Grant Medical College, Bombay, as an Assistant Professor and worked there till 1964. The students at both the Grant Medical College and the Seth G. S. Medical College were very bright and fun to work with.

SSK: *Sir any memories or any role models you had then?*

MNP: The honoraries at hospitals like Wadia Maternity, KEM, JJ hospital became my role models. Thereafter I worked as an Assistant Honorary at the Nowrosjee Wadia Maternity Hospital. In due course I became Associate Professor and then Professor. I retired as Honorary Obstetrician and Gynecologist at Nowrosjee Wadia Maternity Hospital in 1988.

SSK: *Sir, you have held many important positions. Tell us more about them!*

MNP: Yes, I was president of the Bombay Obstetric & Gynecological society in 1979-80. I became the President of FOGSI in 1984. I became the Chairman of Indian College of Obstetricians and Gynecologists in 2000 and I have thoroughly enjoyed working with these organizations.

SSK: *It was a pleasure working with you for the prestigious journal of FOGSI, Journal of Obstetric and Gynecology of India[JOGI] I have learned so much by just observing your work. Sir, as the editor you have been a dedicated worker. It has been part of your life Tell us about your experiences and publications.*

MNP: I joined the journal as Assistant Editor in 1974 and became the Editor in Chief between 2003 and 2007. After that I was honored as Editor Emeritus of these prestigious Journal. However, I fees sad in spite of high standard the journal has still not been indexed in pub med and still has not received the world wide recognition.

As regards publications, I have not got the exact number of publications, but there are many books edited by me and I have authored many book chapters particularly on Infertility and microsurgery.

Continued on page 17

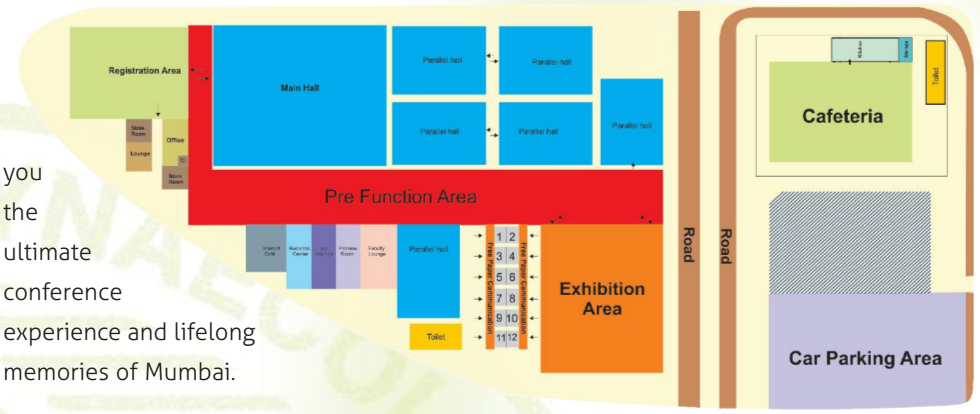
About AICOG 2013

Dr Hrishikesh Pai
Organizing Chairperson

Greetings from the AICOG 2013 Mumbai! The capital of Maharashtra state and the most modern city in India, the city makes you addicted to the spirit of living. The fast paced life, thriving culture, glistening skyscrapers, chaotic streets, delightful shopping destinations and the hordes of "fast-food outlets" on almost every road offering lip-smacking choices of Mumbai's very own pavbhaji, bhelpuri and kababs is all here for you to savor and enjoy! The 56th All India Congress of Obstetrics and Gynecology, AICOG 2013 will be held from January 16th to 20th, 2013 at the AICOG Convention Center, Bandra Kurla Complex, Mumbai.

The AICOG is the most important annual event on the academic calendar of the Federation of Obstetric and Gynecological Societies of India and thereby every specialist is involved with women's health in India. Each year FOGSI assigns the grand responsibility of organizing the AICOG to one of its 218 constituent member societies.

The Mumbai Obstetric and Gynecological Society, a founder member and with a membership of 2,200, the largest constituent of FOGSI has been selected to organize the 56th AICOG. MOGS with a dedicated Conference Organizing Committee is determined to set benchmarks for AICOG going forward and is expected that a record number of over 10,000 delegates will participate in this academic event and social gathering. The goal of the Organizing Committee is to give you the ultimate conference experience and lifelong memories of Mumbai.



AICOG 2013 Programme Overview

The AICOG conference has continued to grow in both scope and global impact. This year is looking to be the best yet. AICOG 2013 will be held in the AICOG Convention Center, the structure of which is constructed on a massive space of 32,000 sq. mtrs and is a perfect venue to accommodate the anticipated delegates! With an estimated 10,000 delegates, 500 invited specialists, 1,000 scientific abstracts and 100 exhibitors expected to be in attendance, this is an exciting time for professionals around the world in the field of Obstetrics & Gynecology who will have a prospect of directly interacting and sharing the most up-to-date information regarding the science and advances with top medical decision-makers in the field. The AICOG 2013 Convention Center will house registration counters, lounges, a unique cafeteria, preview rooms, free paper halls, poster areas, ample clean toilets, a pre-function area, the exhibition trade area, an internet café and parking space for more than 2,500 cars. The 56th AICOG is dedicated to 7 remarkable individuals Dr N. A. Purandare, Dr V. N. Shirodkar, Dr B. N. Purandare, Dr C. L. Jhaveri, Dr R. D. Pandit, Dr D. K. Tank and Dr M. D. Hansotia who have made great contributions to MOGS and FOGSI.

The conference will be an interesting mix of lectures, symposia, social events, panel discussions and paper presentations by experts from different parts of India and the world, promising to offer exciting insights into the most recent research findings in all aspects of Obstetrics and Gynaecology. AICOG 2013 will also provide delegates with a choice of lively, engaging and exciting workshops like Operative Obstetrics, Operative Hysteroscopy, Operative Laparoscopy, Vaginal Surgery, Reproductive Endocrinology, Advanced Infertility Management & ART, Fetal Surveillance, Gynecological Oncology, Imaging and Urogynecology that they can select from to learn a new skill, enhance their knowledge and gather information about a specific topic. These workshops are meant to update the delegates and resolve any queries that they might have by

discussions with the experts. The Scientific Committee of the 56th AICOG has formulated a comprehensive and balanced scientific programme with exceptional international and national faculty. Leading speakers have been carefully selected to present the findings and innovations of the latest research. The AICOG 2013 Organizing Committee has also arranged pre and post congress tours to enable delegates experience the magic of India while exploring her beauty and diversity, being enriched with her culture, embraced with her warmth and being overwhelmed with her hospitality.

AICOG Entertainment Programme

AICOG 2013 has also organized exciting networking functions for the conference to give delegates lots of opportunities to network and forge strong relationships within the Obstetric and Gynecological community while making new contacts and ren ewing acquaintances. Presenters, delegates, sponsors and exhibitors will be captivated at the Conference during a musical evening by Sonu Nigam while being treated to the grandeur of the magnificent Andheri Sports Complex. Delegates will be delighted while bearing witness to the amazing Talent Show being put up by the doctors. The highlight of the social programme will be the Fashion Show by Neeta Lulla, Shaina NC and the other designers of the fashion world while enjoying fine food and beverages.

Salient Features of AICOG 2013 Mumbai:

- AICOG 2013 allows delegates to register at any desk thus speeding up the check-in time instead of waiting in long queues.
- All conference areas, parking facilities and scientific halls within a close proximity of a 200 meter radius to make the conference experience of the delegates extraordinary.
- Unique spouse programme cooking classes by Chef Sanjeev Kapoor to make delegates feel special.
- Delegates can create their own conference itineraries and access the AICOG 2013 conference schedule on their mobile app's while receiving conference information and updates anytime at their finger tips.
- Easy access to shopping areas in Bandra where everything is available to suit every pocket. The Elco market, Linking road in Bandra and Colaba Causeway are a blessing for any shopaholic across the world. Delegates can visit the Phoenix Market city, Kurla which is in close proximity to the conference venue.

With all the exciting programmes that have been planned, AICOG 2013 will truly be a global experience, an extravaganza socially, culturally and professionally. The Mumbai Obstetric & Gynecological Society and people of Mumbai look forward to welcoming the delegates hailing from various parts of the country to be a part of AICOG 2013!

Scientific Free Communications: Call for Abstract Submission

Scientific Committee of AICOG-2013 invites Abstract Submission from Registered Delegates for Free Paper/Poster & Interesting Case presentation on Theme & Miscellaneous topics. Last date for submission of Abstract in Triplicate to FOGSI office & Conference secretariat is 30th September 2012.

Theme Topics:

- Pregnancy at Risk
- The Uterus in Focus
- Advanceed Infertility Management
- Contemporary Contraception
- Miscellaneous
- Interesting Cases

For further details & online submission of abstract, Log on to **www.aicog2013.com**

Importance of Micronutrients During Pregnancy

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Micronutrients and trace elements have an important influence on the health of both mother and fetus. Pregnancy is a period of increased metabolic demands, with changes in the woman's physiology and the requirements of a growing fetus[1]. During this period inadequate intake of vitamins or minerals, which are collectively called as "Micronutrients" can have adverse effects on the mother and fetus. The main cause of multiple micronutrient deficiencies is a poor quality diet, often due to an inadequate intake of animal source foods (ASF) especially in developing countries.

The essential nature of micronutrients has been recognized through the identification of clinical condition associated with severe deficiencies of particular vitamins or minerals and also through subsequent animal studies. Effect of deficiency of specific vitamin and mineral vary by stage of life, season, ethnic group, economic status and individuals in the same community. This variability is due to consumption of diets with differing content and bioavailability of micronutrients and differing losses or requirements for micronutrients in individuals[2].

Micronutrients though required in small amounts, can play a vital role in pregnancy, childbirth and later development of the child. Recently the need for optimum amounts of key micronutrients at critical stages such as periovulatory period, subsequent embryonic and fetal life has become the focus of research activity.

Importance of Different Micronutrients During Pregnancy:

During pregnancy, due to expansion of plasma volume causing hemodilution, levels of most of micronutrients decrease. In woman who is already deficient, this hemodilution caused by pregnancy tilts balance further on negative side showing overt effects.

In addition to folic acid, the minerals like zinc, iron and copper and the antioxidant like vitamin A and E are of particular importance during pregnancy. Both excesses and deficiencies of these micronutrients can have profound and sometimes persistent effects on many fetal tissues and organs, without showing any clinical signs of deficiency in the mother. Supplementary micronutrients provided later in gestation or during postnatal life cannot completely reverse the detrimental effects of earlier micronutrient imbalance.

Micronutrient imbalance can affect pregnancy outcome through alterations in maternal and fetal metabolism, as a consequence of their essential role in enzymes and transcription factors and through their involvement in signal transduction pathways that regulate development. Micronutrient deficiency may induce disturbances in the balance between the generation of free oxygen radicals and the production of antioxidants that scavenge free radicals. The detrimental effects of many micronutrient deficiencies, particularly zinc and copper, can be alleviated by supplementary antioxidants, whereas deficiencies of antioxidant like vitamins A and E likely to reduce defense against free radical damage.

The common problems seen in mother are anemia, hypertension, complications of labor and sometimes even maternal death. The effects on fetus can be preterm delivery, intrauterine growth restriction, congenital malformations, reduced immunocompetence, abnormal organ development and increased perinatal deaths. Because of the possible occurrence of multiple micronutrient deficiencies in pregnant women, correction of a single micronutrient deficiency may not allow demonstration of its desirable beneficial effects in the persistence or presence of other micronutrient deficiency[3].

A. Folic acid: Pregnancy can put women at risk of folic acid deficiency as the fetus normally depletes mother's nutrient reserves. Folic acid deficiency during pregnancy increases the risk of Neural tube defects (NTDs) like cleft palate, spina bifida, anencephaly and brain damage. It may also contribute to preterm delivery and low birth weight. Apart from these abnormalities, folate deficiency can result in anemia. In most of the western countries, where periconception folate supplementation is routinely practiced, the incidence of NTDs has decreased significantly. Even in developing countries, studies have demonstrated that folic acid supplementation during pregnancy has led to improved fetal growth and reduced the incidence of low birth weight[4].

B. Iron: Iron deficiency in anemia is highly prevalent in women in developing countries leading to increased maternal morbidity and mortality. Increased iron requirements in pregnancy are often not

met by diet thus emphasizing need for supplementation.

In fetus, iron deficiency anemia can cause intrauterine growth restriction, low birth weight, increased neonatal mortality and decreased immunocompetence [5]. Iron supplementation during pregnancy has been shown to improve iron stores and reduce anemia, which in turn can reduce the maternal and fetal morbidity and mortality[6]. Necessary steps should be taken to ensure that maternal iron status is adequate early in pregnancy, throughout pregnancy and during the postpartum period.

C. Zinc: Zinc is recognized as an important factor required for normal fetal growth and development.

Zinc deficiency has been associated with complications of pregnancy and delivery such as preeclampsia, premature rupture of membranes, preterm delivery, intrauterine growth restriction and congenital malformation. Zinc deficiency also has adverse effects on the development of fetal immune system. Because of this, zinc supplementation during pregnancy is very essential. Many trials of zinc supplement carried out in developing countries have also found significant benefits of zinc on pregnancy and birth outcome and also improvement in immune function of the fetus[7]. Acrodermatitis enteropathica is an autosomal genetic recessive defect in zinc metabolism and causes a marked inhibition of zinc absorption. The outcomes of pregnancies with acrodermatitis enteropatica vary from spontaneous abortion, anencephaly, achondroplastic dwarfism and low birth weight infants.

D. Calcium: Deficiency of calcium may be associated with abnormal fetal development, preeclampsia and preterm delivery. It is believed that calcium supplementation of 1500 to 2000 mg daily can lower the risk of preeclampsia significantly [8].

E. Iodine: Iodine deficiency is a primary cause of preventable mental retardation and brain damage, having the most devastating impact on the brain of the developing fetus in form of cretinism[9]. Various studies support that the administration of iodine to pregnant women during 2nd trimester of pregnancy has improved the neurologic and psychological development in the children. These children, who are treated prenatally, had fewer neurologic abnormalities, higher head growth and an improved developmental quotient.

F. Magnesium: Magnesium deficiency is associated with preeclampsia, preterm labor and possibly low birth weight. Some of the trials carried out in developed countries have shown decreased incidence of preterm births and intrauterine growth restriction with magnesium supplementation during pregnancy[10].

G. Selenium: Selenium has been implicated in the protection of tissues against oxidative stress, maintenance of defenses against infection and modulation of growth and development, It also plays an important role in cell division and there by strengthen the process of fetal brain development.

H. Copper: Copper deficiency may be associated with adverse pregnancy outcome and reduced fetal growth.

I) Vitamins: Vitamin A deficiency during pregnancy can lead to fetal wastage,

Table-1: Requirements of Key Nutrients & Their Sources:

Nutrients	Requirement	Dietary Source
Folic Acid	400 mcg	Liver, Green leafy vegetables, yeast
Iron	30-40 mg	Liver, red meat, egg yolk, leafy vegetables, whole grains, nuts dry fruits, prunes & apple juice
Zinc	15 mg	Liver, meat, egg & sea food
Iodine	175 mcg	Sea food & iodized salt
Calcium	1000 mg	Milk, Cheese, egg yolk, vegetables, whole grains, fish,
Phosphorus	1200mg	Milk, Cheese, meats
Magnesium	320 mg	Nuts, green vegetables, Whole grains, Beans & peas
Vitamin -C	40 mg	Citrus fruits, melons, tomatoes, berries, green vegetables
Vitamin-D	10 mcg	Fortified milk, fish liver oil, sunlight
Vitamin B-12	2-2.5 mcg	Milk, Cheese, Liver, meat, egg

although high doses of vitamin A in early pregnancy can be teratogenic as well. A controlled trial from Nepal[11] revealed striking findings that weekly vitamin A or beta carotene supplements led to reduce maternal mortality by almost 50%. This has led to plans to replicate these findings in trials with vitamin A or combinations of micronutrients.

Thiamine, vitamin B6 and vitamin B12 are important vitamins required for optimum pregnancy outcome and fetal development.

A recent controlled trial in HIV infected women using high doses of vitamins B, Vitamin C and E, found reductions in intrauterine growth restriction and preterm birth, as well as a reduction in perinatal mortality[12].

One such recent trial found that provision of vitamins C and E resulted in a 60% of lower rate of preeclampsia[13].

Conclusion:

Micronutrient adequacy at the time of conception and during pregnancy is clearly important for optimum pregnancy outcome. The need for specific micronutrients such as folic acid and possibly zinc, at the time of conception to prevent birth defects poses a challenge since an effective intervention would need to improve the status of all reproductive age women or at least those at high risk of conception. The common approach to improve the micronutrient(iron and folic acid) status is supplementation during pregnancy . While the addition of other micronutrients to such supplements would have marginal cost increase, it would not necessarily improve adherence to therapy. Additional research is needed on the possible beneficial and harmful effects of multiple or more selective micronutrient supplements in pregnancy before universal recommendations can be made for developing country populations. In addition, more attention should be focused on dietary approaches, including fortification of foods with micronutrients, which may prove to be more beneficial and sustainable than provision of supplements during pregnancy.

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Long Journey of a Living Legend... *Continued from page 11*

These two topics are very close to my heart. I have visited USA, Europe for short courses in infertility. I loved working in the field of infertility and microsurgery

SSK: *Sir tell us about your family.*

MNP: One of my sons, Dr Rajesh Parikh is a renowned neuropsychiatrist and the other, Ashish is in business. Firuza, my daughter-in-law is an internationally renowned fertility specialist and stem cell research pioneer. My daughter Pinky is married and settled in USA. My wife Shobha was very supportive and helpful to me in all my endeavors. There were no doctors before me in my family but all my three younger sisters became doctors. Over the years we are over 35 doctors in our extended family.

SSK: *Sir tell us your secretes of preserving unlimited stocks of energy, persistence and perseverance*

MNP: I enjoy my work even today and that keeps me going.. I enjoy being professionally active and being associated with our institutions and journals. My experience as a medical teacher has been the most pleasing aspect of my professional life.

SSK: *Sir, any message to upcoming stars of FOGSI and MOGS?*

MNP: I would like to tell them that they should focus on a particular topic of their interest and do dedicated work sincerely in that field. I am sure some original work will certainly follow and naturally one will shine and achieve great heights.

SSK: *Sir we are truly inspired and impressed with your life sketch and there will be many young and upcoming stars who will look at you as role model in future.*

SSK: I sincerely thank on behalf of the President and the members of Managing Council for sparing your valuable time in giving this memorable interview.

Iron Sucrose in Pregnancy

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Iron deficiency is the most common deficiency state in the world, affecting more than 2 billion people i.e. 24.8% of the world population[1] (McLean et al, 2009). Iron deficiency represents a spectrum ranging from iron depletion to iron deficiency anaemia. The World Health Organisation (WHO) defines anaemia in pregnancy as a haemoglobin concentration of <11g/dL (WHO, 2001). In view of the relative plasma expansion being particularly marked in the second trimester, it would seem reasonable to take 10.5g/dL as the cut-off from 12 weeks, as suggested by the US Centers for disease control and prevention (CDC)[2] (Dowdle, 1989; Ramsey et al, 2000) (1B). The WHO defines postpartum anaemia as Hb <10.0g/dl (2B).

Prevalence of anemia has been reported to be very high in India-87.65% in a study covering 11 states in an ICMR study[3], 85.4% in a study of women in urban Delhi slums[4] and 72.3% in our institution[5]. Hence it is of utmost importance that all obstetricians be aware of the rational use of iron therapy including parenteral iron therapy for treating iron deficiency anemia in pregnancy. Effective management is needed to prevent adverse maternal and pregnancy outcomes, including the need for red cell transfusion.

A Cochrane review on treatments for iron-deficiency anemia during pregnancy stated that despite the high incidence and burden of disease associated with this condition, there is a paucity of good quality studies evaluating clinical maternal and neonatal effects of iron administration in pregnant women with anemia. Daily oral iron therapy improves hematological indices but is associated with gastrointestinal adverse effects. Intramuscular and intravenous iron therapy enhances hematological response, compared with oral iron, but there are concerns regarding possible important adverse effects[6].

Management of Iron Deficiency

Dietary Advice

Physiological iron requirements are 3 times higher in pregnancy[7] (Tapiero et al, 2001), and recommended daily intake (RDA) of iron for the latter half of pregnancy is 30mg.

Oral Iron Supplements

Once women become iron deficient in pregnancy it is not possible to ensure repletion through diet alone and oral supplementation is needed. Oral iron is an effective, cheap and safe way to replace iron. The recommended dose of elemental iron for treatment is 100-200mg daily[8] (1A). Higher doses should not be given, as absorption is saturated and side effects increased.

Parenteral Iron Therapy

Parenteral iron therapy is indicated when there is absolute non-compliance with, or intolerance to, oral iron therapy or proven malabsorption[9] (RCOG, 2007). It circumvents the natural gastrointestinal regulatory mechanisms to deliver non-protein bound iron to the red cells.

Several authors have now reported on their experience with use of parenteral iron therapy for iron deficiency anaemia in pregnancy, with faster increases in Hb and better replenishment of iron stores in comparison with oral therapy, particularly demonstrated for iron sucrose[10] (Al et al, 2005; Bhandal et al, 2006) and iron (III) carboxymaltose[11] (Van Wyk et al, 2007; Breymann et al, 2007). A large retrospective study reported fewer postpartum transfusions in the group treated with intravenous (IV) iron[12] (Broche, 2005). However, there is a paucity of good quality trials that assess clinical outcomes and safety of these preparations[13] (Reveiz et al, 2007).

As free iron may lead to the production of hydroxyl radicals with potential toxicity to tissues, iron deficiency should be confirmed by ferritin levels before use of parenteral preparations.

Contraindications include a history of anaphylaxis or reactions to parenteral iron therapy, first trimester of pregnancy, active acute or chronic infection and chronic liver disease[14] (Perewusnyk et al, 2002). Facilities and staff trained in management of anaphylaxis should be available.

Parenteral Iron Therapy Indications

Even though in most of the cases of iron deficiency anemia in pregnancy in most circumstances oral iron preparations are appropriate and sufficient parenteral administration of iron is necessary under certain circumstances[15]:

- Inability to tolerate the side effects of orally administered iron
- Patient with a disorder of the gastrointestinal tract, such as ulcerative colitis, in which symptoms may be aggravated by oral iron therapy
- Noncompliance with oral regimens
- Documented iron malabsorption
- It is also indicated in late pregnancy when an assured response to iron is needed e.g. when a pregnant woman presents with Hb 6-8g/dL after 32 weeks of pregnancy.

Recommendations:

- Parenteral iron should be considered from the 2nd trimester onwards and

postpartum period in women with iron deficiency anaemia who fail to respond to or are intolerant of oral iron (1A).
- The dose of parenteral iron should be calculated on the basis of pre-pregnancy weight, aiming for a target Hb of 11 g/dl (1B).
- The choice of parenteral iron preparation should be based on local facilities, taking into consideration not only drug costs but also facilities and staff required for administration.

Dose calculation

Total iron deficit (TID) can be calculated using the Ganzoni's formula5:

TID [mg] = body weight [kg] x (target Hb-actual Hb) [g/dl] x 2.4* + depot iron** [mg]

*2.4 is a factor that takes into account the patient's blood volume, hemoglobin iron content, and conversion from g/ dl to mg/l.

2.4 = 0.07 x 0.0034 x 10000;

Where:
- Blood volume: ~7% of body weight
- Iron content of hemoglobin ~0.34%
- Conversion from g/dl to mg/l =10000

**Depot iron =500 mg.

Depot iron refers to the approximately 20% of the total iron content in the body stored in ferritin and hemosiderin in the reticuloendothelial system (liver, spleen, bone marrow).

Injectable Iron Preparations

Three types of injectable iron preparations are available in the market
- Iron dextran
- Iron sorbitol
- Iron sucrose

Iron dextran has the highest incidence of modest and severe life-threatening side effects.

Iron sucrose is safest however head-to-head analysis of the different preparations is not available.

Oral iron preparations should be discontinued before administering parenteral iron products.

Iron Sucrose

Iron sucrose injection was FDA approved in November of 2000. Iron sucrose is an iron hydroxide sucrose complex in water. The molecular mass of iron sucrose is 34,000-60,000 daltons. Iron sucrose is administered by intravenous injection or infusion. The recommended schedule is to administer 100 mg intravenously over 5 min, 1-3 times weekly until 1,000 mg has been administered. The rate of administration should not exceed 20 mg per minute. Chandler et al.[16] examined the optimal doses of iron sucrose and found doses of 200-300 mg intravenously over 2 hr were well tolerated and safe. Patients that received doses of 400-500 mg intravenously over 2 hr experienced hypotension, nausea, and lower back pain. In the North American Clinical Trial, patients with documented iron dextran sensitivity were successfully treated with iron sucrose without a test dose[17].

Recommendations
- The newer preparations of iron sucrose are believed to be free of the side effects and are very effective in raising hemoglobin level. A test dose is not required before it is administered however strict vigilance as when administering any intravenous iron product is recommended[18].
- Following a single IV injection of 100 mg iron sucrose to anemic patients, up to 95% of the injected iron is utilized within 2-4 wk[18].
- Single doses of 100-200 mg can be given as an IV injection over 2-5 minutes or up to 500 mg is given as an infusion in 250 ml of 0.9% sodium chloride over 3.5-4 hrs[18].
- Maximal recommended dosage is 600 mg/week (200 mg iron as iron sucrose injected or infused intravenously no more than three times a week)[18].

Safety issues with iron sucrose
- Iron sucrose is currently considered as the safest IV iron preparation. Its use has been associated with a less than 0.5 percent incidence of minor reactions during pregnancy. Guidelines from the American College of Obstetricians and Gynecologists on anemia of pregnancy note that in comparison with patients who take iron dextran, patients who take ferrous sucrose have fewer allergic reactions (8.7 versus 3.3 allergic events per 1 million doses) and a significantly lower fatality rate 31 versus 0, $p < 0.001$)[19].
- If the infusion speed of iron sucrose is fast or the single total iron dose too high, non-transferrin bound labile iron may cause transient hypotension, tachycardia, and dyspnea.

Response to therapy

A randomized controlled clinical study comparing oral versus intravenous iron sucrose for postpartum anemia reported that women treated with intravenous iron had higher hemoglobin levels in the short term (on days 5 and 14) but that by day 40, there was no significant difference in the hemoglobin levels of the two groups. However it is associated with faster replenishment of body iron stores[9].

Iron sucrose has a higher availability for erythropoiesis than iron dextran and experience suggests a good safety profile in pregnancy[20] (Bayoumeu et al, 2005). Its use is limited by the total dose that can be administered in one infusion, requiring

multiple infusions. The newer preparations, Iron III carboxymaltose and Iron III isomaltoside aim to overcome this problem, with single dose administration in an hour or less (Lyseng-Williamson et al, 2009; Gozzard, 2011).

Recent Advances

Fast acting intravenous iron preparations

Iron III carboxymaltose is a ferric hydroxide carbohydrate complex, which allows for controlled delivery of iron within the cells of the reticuloendothelial system (primarily bone marrow) and subsequent delivery to the iron binding proteins ferritin and transferrin. It is administered intravenously, as a single dose of 1000mg over 15 minutes (maximum 15mg/kg by injection or 20 mg/kg by infusion). Randomised controlled trials have shown non-inferiority[11] (Van Wyk et al, 2007; Breymann et al, 2007) and superiority (Seid et al, 2008) to oral ferrous sulphate in the treatment of iron deficiency anaemia in the postpartum period, with rapid and sustained increases in Hb. Animal studies have shown it to be rapidly eliminated from the plasma, giving minimal risk of large amounts of ionic iron in the plasma. By 28 days, in iron deficient rats most of the iron has been incorporated into new erythrocytes (Funk et al, 2010).

Iron III isomaltoside is an intravenous preparation with strongly bound iron in spheroid iron-carbohydrate particles, providing slow release of bioavailable iron to iron binding proteins. There is rapid uptake by the reticuloendothelial system and little risk of release of free iron. An erythropoietic response is seen in a few days, with an increased reticulocyte count. Ferritin levels return to the normal range by 3 weeks as iron is incorporated into new erythrocytes. Doses >1000mg iron can be administered in a single infusion[21] (Gozzard, 2011), although there is little data on its use in the obstetrics setting.

Other considerations

A recent Cochrane review on treatments for iron deficiency in anaemia[13] (Reviez et al, 2007) highlighted the need for good quality randomised controlled trials in this setting, in particular to assess clinical outcomes and adverse events. Pending further good quality evidence, there is a need for centres to review their policies and systems for use of parenteral therapy in iron deficiency anaemia in pregnancy.

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The Emerging Role of Vitamin D 3 in Health and Diseases

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The Vitamin D 3, often called the "sunshine Vitamin", is a very important nutrient for women's health. Despite its discovery a hundred years ago, Vit D has emerged as one of the most controversial nutrients and pro hormones of the 21st century, and a lot of research has been in place on this molecule the research leads us to newer therapies with newer concepts. Research has now shown Vit D's indisputable role in both innate and adaptive immunity.

Table 1: Facts already known about Vit D:

- It is a Steroid pro hormone ("conditional" Vitamin)
- Endogenous synthesis in skin takes place under UVB exposure
- Quantity (intensity) and quality (appropriate wavelength) of sunlight are both important
- 7-Dehydrocholesterol present in the skin absorbs UV light over wavelengths 290 - 300 nm, to synthesize Vit D3
- Synthesis in the skin epidermis takes place over several days

But biosynthesis can be inadequate. There is high rate of Vit D deficiency even amongst urban population. In urban & polluted areas, the UV light of 290-300 nm wave length gets filtered out hence skin may not get enough of this light. Hence Foods and dietary supplements are necessary.

There are two major forms of dietary Vit D Cholecalciferol (Vit D3) and Ergocalciferol (Vit D2)

Table 2. Dietary sources of Vit D

Food	IU Vit D/Serving
Cod liver oil, 1 Tbsp	1,300
Salmon, cooked, 3.5o z	360
Sardines canned in oil 1.75 oz	250
Fortified milk, 1 cup	100
1 Egg	20
fortified Yogurt, 6 oz	80

Traditional role:

Traditionally Vit D3, Cholecalceferol, Calcitriol (1,25(OH)2D3) had role in only calcium metabolism. And bone mineral metabolism. It works with parathyroid hormone (PTH) acts on kidneys, bone, and intestine, and influences gene expression. It regulates its own synthesis by decreasing synthesis of mRNA for 1-alpha hydroxylase. It influences bone mineral metabolism and Calcium/phosphorus homeostasis by increasing synthesis of mRNA for calbindin-D, alkaline phosphatase and other proteins. It maintains calcium and phosphorus homeostasis.

For decades, it was thought that only the kidney has the capacity to metabolize 25(OH)D; however, now extrarenal metabolism has been demonstrated in every organ system in the body[1]. VDR and MARR receptors for Vit D are present in all tissues. During pregnancy, the placenta is probably the most prominent site for extra-renal activation of Vit D[2]. It appears that the extrarenal function of Vit D has more to do with immune function than with calcium metabolism and homeostasis. The observations of Mellanby and others supported this fact[3].

Table 3 The Emerging Roles Of Vit D:

- Important role in cell differentiation, proliferation, and immune function
- Important factor in prevention/treatment of:
  - Some forms of cancer
  - Osteoporosis
  - Rheumatoid arthritis
  - Multiple sclerosis
  - Hypertension
  - Cardiovascular disease
  - Obesity??
  - Psoriasis
  - Psychiatric diseases

Beyond childhood, severe Vit D deficiency can occur in young women, including those who are pregnant, with higher risk with advancing age in a woman's lifecycle. While there can be some calcium loss during pregnancy through fetal demands and increased urinary calcium excretion which increases with advancing pregnancy. Throughout gestation, if a woman is Vit D deficient, it appears to impact fetal bone health more than maternal[4,5,6]. There are different deficiency levels: the risk of rickets increases significantly when total circulating 25(OH)D falls below 10 ng/mL (25 nmol/L) whereas cathelicidin mRNA expression as a marker of immune function continues to be suppressed until 25(OH)D circulating levels reach at least 20 ng/mL (50 nmol/L)[7]. The recently revised Institute of Medicine's (IOM) 2010 criterion for Vit D deficiency of total circulating 25(OH)D is < 20 ng/mL (50 nmol/L)[8],

Table 4: Optimal serum concentrations of 25(OH)D3

- Vit D deficiency = < 20 ng/mL (< 50 nmol/L)
- Vit D insufficiency = 20-29 ng/mL (52-72 nmol/L)
- Vit D sufficiency = ≥ 30 ng/mL (≥ 75 nmol/L)
- Vit D toxicity = ≥ 150 ng/mL (374 nmol/L)

Conversions:

- 1 IU = 0.025 ug
- 40 IU = 1 ug

Rates of deficiency of Vit D are more with women darker pigmentation, women who have limited access to sunlight, either through limited activity outdoors, type of clothing, cultural practices, or thorough use of sunscreen when outdoors[9]. Vit D exists in higher percentage in obese women. Women-including pregnant women, with a BMI greater than 30 are at increased risk of Vit D deficiency[9]. The adipose tissue serves as a repository for Vit D that does not get into the circulation. The problem may be further compounded by limited sunlight exposure and calorically rich but nutrient-poor diets such that multiple nutrients may be deficient, affecting both mother and her developing fetus.

Vit D and Pregnancy:

Current guidelines for daily Vit D intake during pregnancy range from 200 international units (IU) per day to 400 IU, the amount found in most preparations. We have always worried that too much Vit D during pregnancy could cause birth defects, and under current guidelines anything over 2,000 IU per day is still considered potentially unsafe for anyone, not just pregnant women. As per recent research higher dosages of Vit D is not only safe during pregnancy, but doubling it may actually reduce the risk of complications.

In the study, 500 women who were at least 12 weeks pregnant took 400, 2,000, or 4,000 IU of Vit D per day. The women who took 4,000 IU were less prone to go into labor early, give birth prematurely, or develop infections. Vit D intoxication is extremely rare and easy to treat. pregnant women who get too little Vit D are more likely to develop life-threatening high blood pressure (preeclampsia) and are also more likely to require a Cesarean section. They concluded that giving 4,000 IU a day to pregnant women doesn't cause any toxicity, but actually may improve birth outcomes[10].

Pregnant women with a serum level of 25-OH Vit D less than 75 nmol/L are considered to be Vit D3 deficient[11].

Until recently, it was thought that Vit D deficiency was common only in high risk women (women with dark skin and those with minimal exposed skin), but it is quite high even in low risk women.

All women therefore should be offered testing for Vit D status in early pregnancy and recommended supplementation if deficient[12]. Women with a 25-OH Vit D3 < 75 nmol/L are considered Vit D deficient and should have a dietary assessment for calcium intake.they should receive higher dose upto 1000 international units (IU). They should be offered re-testing at 28 weeks of pregnancy. Pregnant women should have enough Vit D at the time of delivery to ensure sufficient Vit D levels in their baby for the first 4-6 months of life.

Transplacental passage of maternal 25-OH Vit D3 is the sole source of Vit D in the developing fetus. Therefore infants are wholly dependent on their mother for their Vit D status. Infants born to Vit D deficient mothers will be Vit D deficient, and hence will require supplementation [cholecalciferol bolus (50,000 IU) dose orally.]

If the high dose of Vit D does not improve the serum Vit D levels, then rule out malabsorption syndrome (such as coeliac disease),or else she is non compliant.

To summarize Vit D deficiency is highly prevalent, and contributes to risk for skeletal and many non-skeletal problems. Newer reports are changing our ideas about optimal Vit D status and the role of Vit D in health, especially in relation to modern chronic diseases. Vit D is emerging as an important regulator of the immune system; its deficiency is linked with a number of inflammation-related disease states. Vit D may have important effects on specific tissues (brain, adipose tissue, many others). The relationship between Vit D and obesity needs to be further studied. Some reliable non-oral preparations for treatment of Vit D deficiency in malabsorptive populations are required. It must be remembered that some populations are still very much undertreated, and pregnancy associated complications can be reduced with correction of deficient state.

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Continued on page 26

Dos and Don'ts about PCPNDT Act

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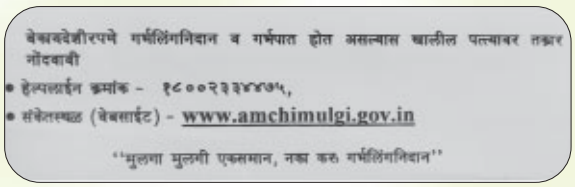
In spite of PCPNDT act amendment in 2003, Sex ratio is on downward trend in our country. Health authorities from state & central government have taken this issue seriously & inspection of all sonography clinics is being carried out. All obstetricians owning & using sonography machine need to adhere to PCPNDT law in true spirit & follow the guidelines to avoid being caught on the wrong side.

- All clinics/nursing homes/ maternity homes/ general hospitals including ICCU, wherever sonography or any type of imaging machine including 3D/4D sonography, color doppler, CT/MRI machine is being used, should be registered under PCPNDT act.
- Application form "A" in duplicate along with documents of place, machine & personnel and undertaking duly notarized stating 'Sex Selection/ & Sex Detection is not done in this Centre' and Centre will display the message in English & Local language that 'Sex Selection & Detection will not be done at this Centre which is punishable under the act' should be submitted along with registration fee. (Demand draft payable to 'appropriate authority')
- As per new GR, registration fees have been increased to Rs. 25000/ (For only clinic/centre/lab) or Rs. 35000/ for combined centre having all facilities.
- There should be minimum one machine per center. Portability of machine is banned. Hospital having more than one machine, should get notified all machines mentioning name & make of the machine.
- Name/s of all doctors (radiologist / sonologist /Gynecologists) using machines, should be entered in the PCPNDT certificate. In case of hospital having many doctors using same machine (Where all names cannot be added in the registration certificate, separate sheet mentioning all names approved by appropriate authority should be displayed along with PCPNDT registration certificate.)
- No doctor other than registered in that particular centre should use that machine. Other qualified doctor is allowed to use that machine only after getting approved & notifying his/her name in the registration certificate.
- As per new GR, one doctor is allowed to perform sonography maximum at two places.
- Registration Certificate in Original should be displayed in duplicate in waiting area and USG room.
- Notice/Poster board stating the message in English and local language that "Sex Selection and Detection is not done in this Centre" and 'is punishable under the act' should be displayed in Waiting Area and USG Room.

  Also following helpline number should be displayed .



- Copy of PCPNDT Act book should be kept in the centre.
- Register mentioning details of all patients undergoing scans should be kept in the centre.
- Various Forms in PCPNDT Act:
  - **A:** Application Form
  - **B:** Registration
  - **C:** If application is rejected, reason for rejection given in form-C
  - **D:** Form for Genetic Counseling Centre
  - **E:** Form for Genetic laboratory
  - **F:** Form for Genetic Clinic/ Sonography center, to be filled for only ANC cases (Obstetric Scans)/ Invasive procedure on pregnant woman
  - **G:** Genetic Clinic: Consent form for invasive procedure
  - **H:** To be maintained by appropriate authority – Summary of 'A' forms of all PCPNDT centers in the area.
- In case of USG Centre / Genetic Clinic, "F" Form to be filled up in triplicate for all obstetric scans (Done on pregnant woman).
  - All column mentioned in "F" form should be filled up completely; no column should kept blank, added or deleted. Whichever column is not required must be filled up as 'Not applicable'
  - Previous Obstetric History of patients with number of children with sex of each child should be mentioned in "F" Form.
  - Name of referral doctor, indication, results of USG must be mentioned
  - "F" form should be signed by doctor conducting sonography & not by the owner of the centre.
  - Declaration of the patient and doctor should be signed after explaining the patient in her own language before doing the Sonography.
  - One copy of 'F' form should be given to Appropriate Authority i.e., (M.O.H. of the Wards.) with monthly report, while one copy should be given to the patient with the sonography report.

- All centers must register online on www.pcpndtmumbai.org. Clinic should have computer & internet facility for online 'E' filling of 'F' Form.

- The responsibility for following the standard procedure & maintenance of proper record/ filling of 'F' Form will be that of the qualified registered medical practitioner performing the scan/test.
- Monthly report with copies of 'F' form (of scans done in that month) should be sent in time by 1st of month by all PNDT registered centers to Appropriate Authority. If online registration is done, automatic F form & monthly report will get submitted.
- All records of the patients are to be maintained for minimum 2 years. If any legal case against the centre is pending then records to be maintained till the same case is disposed off.
- As per new GR, any change in place, names of doctors using the machine or equipment (new machine/up gradation of existing machine) should be notified to appropriate authority 30 days in advance of the change & necessary changes should be done on the certificate and in records at office of 'Appropriate authority('H' register) before starting the actual use .
- For renewal of registration, application (Form-A) along with all necessary documents, affidavit/ undertaking and D/ D of renewal fee (half of original registration Fee) should be submitted one month in advance (before expiry date of certificate) to 'Appropriate authority'.
- Sex of the fetus should never be disclosed to the patient, her relative or attendant, or any third party at any time or for any reason in any form.
- Even while doing scan, sex of the fetus should not be uttered/discussed or recorded anywhere even if it has been noticed during anomaly scan done for detection of congenital anomalies. This precaution should be particularly observed in teaching institutes where sex of the foetus may get inadvertently uttered & disclosed during academic enthusiasm.
- Advertisement of any sort is prohibited in any form, even on internet, or coding form – This act is punishable (Rs. 1 Lac fine with 5 years imprisonment).

Prevent Female Foeticide:
Save Baby Girl

A daughter is someone we turn to,
When our spirits need a lift.
A daughter is someone we treasure,
For our friendship is a gift.
A daughter is someone who fills our lives,
With beauty, joy, and grace.
And makes the world we live in,
A better and happier place.

The Emerging Role of Vitamin D 3..... *Continued from page 23*

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Prizes and Awards of the Mumbai Obstetric and Gynaecological Society

(For Detail Information log on to www.mogsonline.org)

1. Prizes for thesis/papers (Deadline on 30th November 2012)

	Subject	Eligibility	Award
MOGS Dr H. Desa Silver Jubilee Prize	Candidate's choice	Less than five years from MMC Registration	₹ 1,500/-
MOGS – Dr Kamal S. Jain Prize	High risk pregnancy	Less than ten years from MMC registration, Postgraduate qualification in OBGYN	₹ 1,500/-
MOGS – Dr N. K. Allahabadia Research Award	Imaging modalities in OBGYN	Age less than 35 years	₹ 1,500/-
MOGS – Dr Pramila Bhatia Young Scientist Award	Original work of candidate's choice/ recent scientific work	Age less than 40 years	₹ 2,000/- Two awards
MOGS – Dr. H. S. Palep Prize	Recurrent Pregnancy Loss	Life member of MOGS or ordinary member for 3 yrs Age less than 50 yrs Postgraduate degree or diploma in OBGY	₹ 2,000/-
MOGS – Dr G. B. Belvi Prize	Operative & emergency obstetrics	Life member of MOGS or ordinary member for 2 yrs Age less than 40 years	₹ 2,000/-

2. Prizes for Continuing Professional Development (Deadline on 30th November 2012)

	Subject	Eligibility	Award
MOGS – Dr. Shantabai Gulabchand Travelling Fellowship Award (2012-2013)	Training abroad in specialized areas in OBGYN	Age not be more than 35 years, Life member of the Society or an ordinary Member for at least the last 5 continuous years Post graduate qualification in the subject of Obstetrics & Gynecology (or allied subject like Neonatology).	₹ 1,00,000/-
MOGS Dr Bhanuben M. Nanavati Scholarship for Overseas Studies	Training abroad in specialized areas in OBGYN	MOGS member for 3 years, Age less than 40 years, Not received the award earlier, Well acquainted with the subject and country of study	Certificate & interest free loan of ₹ 75,000/-
MOGS Dr C. G. Saraiya Traveling Fellowship	Training in India in specialized areas in OBGYN	Postgraduate qualification, Age less than 40 years	Certificate & ₹ 10,000/-

3. Prize for Essay Competition: (Deadline on 30th January 2013)

	Subject	Eligibility	Award
MOGS Dr. R. D Pandit Essay Competition	1500 words essay on Topic : **Reproductive Health is wealth! It needs Planning & Investment**	Senior Category: age more than 40 yrs Junior Category: Age less than 40 yrs	Plaque

4. MOGS Managing Council Prizes

	Subject	Eligibility	Award
MOGS – Dr Duru Shah Prize	MOGS Managing Council Member	For outstanding work in organization, social and other activities during the year	Two /Three prizes Plaque
MOGS – Prof. Khurshed and Dr. Soonu Sheriar Best Youth Member Award	MOGS Youth council Member (age less than 40 yrs)	Selection based on participation and contribution to academic, organization, social and other activities during the year.	Plaque (Three prizes)

5.Prizes at the Annual Conference of the MOGS (Deadline for Abstract submission: 15th February 2013)

	Subject	Eligibility	Award
MOGS Dr Ashok S. Mehra Prize	Endoscopy	Junior: Less than five years after completion of internship Senior: More than five years after completion of internship	Junior: ₹ 2,000 and certificate Senior: ₹ 3,000 and certificate
MOGS Dr Duru Shah Award for Best Poster	Poster	Registered delegates at the Annual Conference	Silver plaque and certificate
MOGS Dr D. K. Tank Prize	Interesting cases – podium presentation	Registered delegates at the Annual Conference	Rs 5000 to be distributed amongst winners in each hall and certificates
MOGS Dr L. M. Shah Prize	Official subjects of the Conference	Less than five years after completion of internship	Rs 500, Three prizes, certificate
MOGS Dr N. A. Purandare Prizes	Official subjects of the Conference and Miscellaneous papers (Runners Up)	Junior: Less than five years after completion of internship Senior: More than five years after completion of internship	Rs 500, Eight prizes, certificate
MOGS Dr Shraddha D. Upasani Prize	Official subjects of the Conference and Miscellaneous papers	More than five years after completion of internship	Rs 500 and certificate, Four prizes

MOGS – Dr Hrishikesh and Dr Rishma Pai Quiz 2012

This year the MOGS – Dr Hrishikesh Pai & Dr Rishma Pai Quiz will be held on Sunday 16, September, 2012 at the ITC Hotel, Parel. The quiz will be held along with the MOGS – Dr Ganatra CME .

This year the theme of the quiz is **'Medical Disorders in Pregnancy'**. Participants should be MOGS members who have completed internship on or after 1st January 2005.

A multiple choice round will be held first in the morning at 9 am. Those who qualify will then be required to participate in the audiovisual round at 11.30 am.

The winners of the final round will represent The MOGS at the West zone final. The winners of all the 4 zones will then participate in the National final to be held in Mumbai at the AICOG 2013.

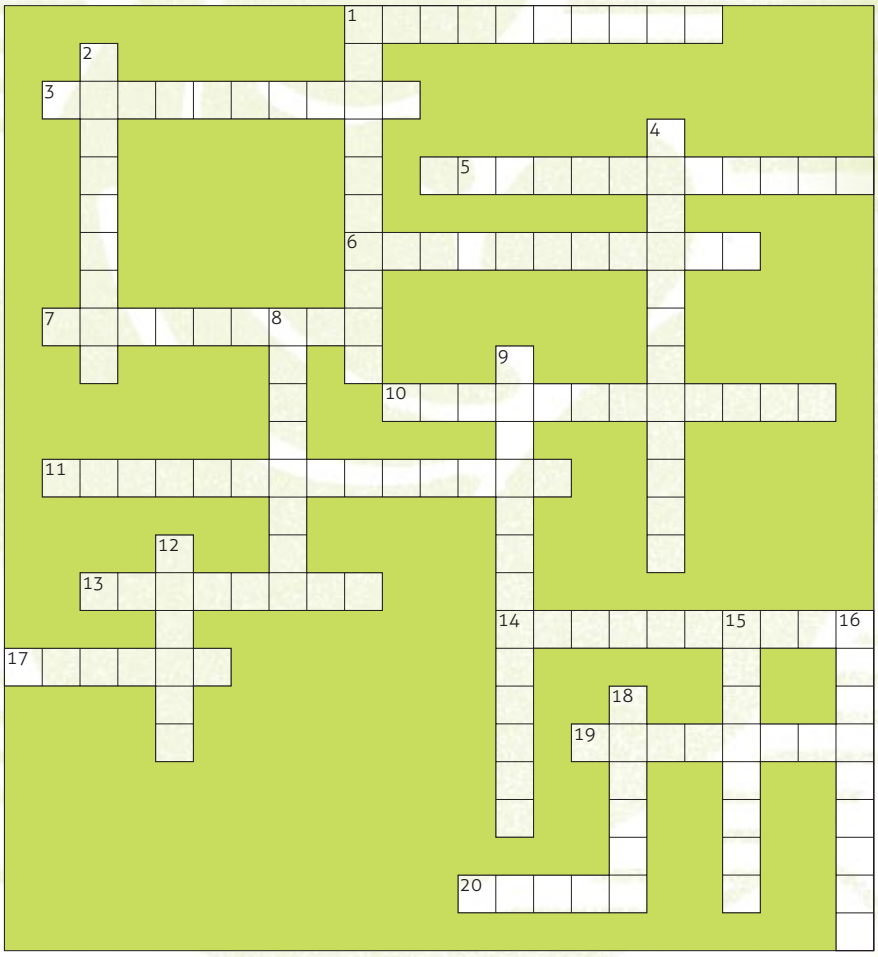
There are exciting prizes to be won including AICOG registration. The quiz programme will be lively and entertaining academic programme.

Conveners & Quiz masters of the event will be Dr Aswath Kumar (FOGSI-Quiz Committee Chairperson), Dr Sarita Bhalerao, Dr Shailesh Kore & Dr Ameya Purandare.

We invite our young members to participate enthusiastically.

For registration for the quiz please contact Divyaben at MOGS office on 23093122.

Crossword



ACROSS:

1. A plug of pink tinged mucous that is discharged when the cervix begins to dilate
3. An umbilical cord that is wrapped around an infants neck
5. A woman who has had previous pregnancies
6. The fluid filled bag like membrane in which the fetus develops
7. A woman who has had one live birth
10. A woman who is experiencing her first pregnancy
11. A condition in which the placenta develops over and covers the cervix
13. Tissue attached to the uterine wall that nourishes the fetus through the umbilical cord
14. A scoring system for assessing the status of a newborn that assigns a number value to each of five areas of assessment
17. The lower one-third or neck of the uterus
19. The area of skin between the vagina and the anus
20. The developing unborn infant inside the uterus

DOWN:

1. The vagina and cervix
2. A woman who has had more than one live birth
4. The position in which an infant is born, the part of the infant that appears first
8. Delivery of the fetus and placenta before 20 weeks; miscarriage
9. The conduit connecting mother to infant via the placenta, contains two arteries and one vein
12. A muscular distensible tube that connects the uterus with the vulva (the external female genitalia), also called the birth canal
15. The appearance of the infant's head at the vaginal opening during labour
16. Convulsions (seizures) resulting from severe hypertension in the pregnant woman
18. The muscular organ where the fetus grows, also called the womb, responsible for the contractions during labour

See answers on page 31

Answers to Crossword

across:

1 bloody show
3 nuchal cord
5 multigravida
6 amniotic sac
7 primipara
10 primigravida
11 placentaprevia
13 placenta
14 apgarscore
17 cervix
19 perineum
20 fetus

down:

1 birthcanal
2 multipara
4 presentation
8 abortion
9 umbilical cord
12 vagina
15 crowning
16 eclampsia
18 uterus

IMPORTANT

- *For the information of all MOGS members – The Drugs and Cosmetics Act and the FDA Commissioner's Circular has been uploaded on the MOGS website.Kindly visit the MOGS website for further details. (http://www.mogsonline.org/).*
- *Please keep the Receipts, Bills, Invoices of all your medicines purchased with the details like Date of purchase, Batch no., Quantity, Date of manufacturing and Date of expiry.*
- *Keep records of patients to whom these medicines have been dispensed like Patient's name, date on which dispensed and quantity and Indication (e.g. For Misoprostol tablet, used for MTP, PPH, For ripening of cervix etc)*
- *Maintain MTP Register as per MTP Act and take consent for MTP in Form I & Form C only (even in cases of medical abortion)*

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Supporting Scientific, Academic and Social Service Activities

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