
You Are
Most Welcome!

With Covid we have made to the Life Raft But dry land is still far away.

INSTEAD OF SOCIAL DISTANCING LET'S CALL IT VIRTUAL CONNECTING!

@renawren


DHEERA
No To V
FOGSI FOR ALL, ALWAYS
DHEERA
OGSH

Congratulations
Shanthakumari Sekaran
on being elected as Treasurer of the esteemed FIGO; another great milestone after FOGSI Presidency and a stepping stone for future FIGO Presidency.


Knowledge
NUGGETS

- MBBS and DGO from LLRM medical college, Meerut .
- Clinical Director, Priyadarshi Hospital and Priyadarshi IVF and Kidney care
- President, PAHAL-ek prayas-Modinagar: an NGO dedicated towards clean and green city

MANAGEMENT OF CESAREAN SCAR PREGNANCY

DR SARITA TYAGI

MBBS, DGO

CLINICAL DIRECTOR, PRIYADARSHI HOSPITAL AND RESEARCH CENTRE,

PRIYADARSHI IVF AND KIDNEY CARE

CASE

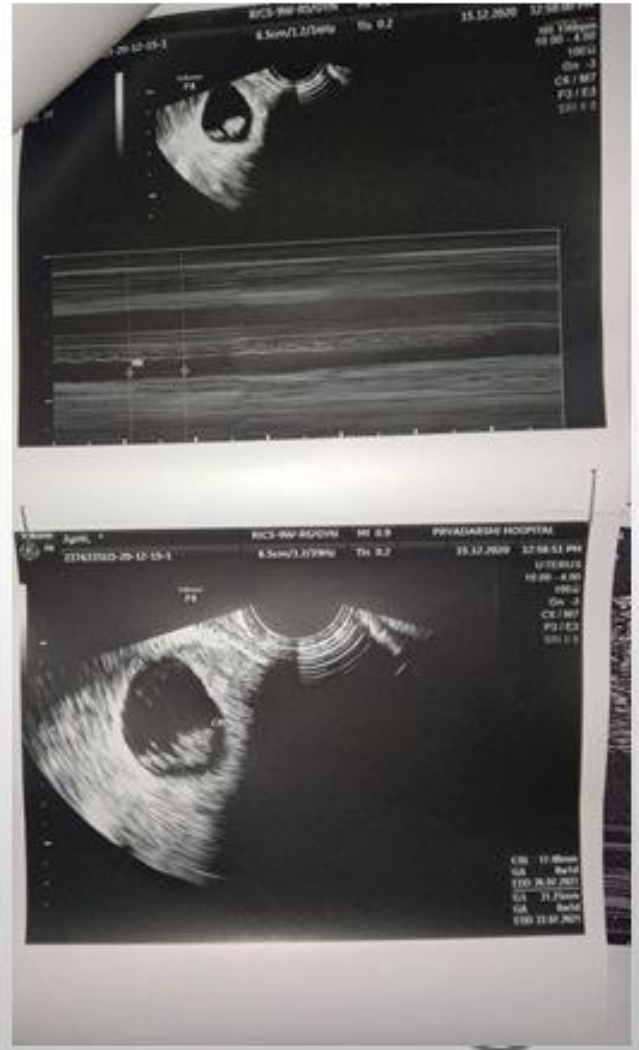
- Mrs X, 32 years old, P2L2A1 with history of 3 weeks overdue, presented with complaints of nausea and vomiting

- TVS showed a low lying gestational sac near previous scar with increased vascularity on doppler with empty uterine cavity (scar ecotopic) with myometrial thickness 3mm

CASE

- Sac size was 7 weeks and 2 days and cardiac pulsation was present
- Serum beta hcg was 1,02,000 mIU/ml.

USG FINDINGS



MANAGEMENT

- After high risk consent and baseline investigations, **systemic Methotrexate** was administered at the dose of 1.5mg/kg in RL over 2-3 hours (can be given IM also)
- Mtx in conventional dose (1mg/kg) wasn't effective in 2 other cases when cardiac pulsation was not present

MANAGEMENT

- In another case when cardiac pulsation was not present, increased dose of Mtx (1.5mg/kg) was effective in terminating pregnancy. Hence our protocol.
- However in this case even after 24 hours the sac and cardiac pulsation were intact.
- The same picture was seen after 48hrs also . myometrium thickness was good

MANAGEMENT

- 48 hours after first dose of Mtx we decided to give 600mg of **Mifepristone** followed by 48 hrs of observation
- After a gap of 48 hrs of mifepristone we gave **Misoprostol** 200 mcg sublingual and per vaginal each

MANAGEMENT

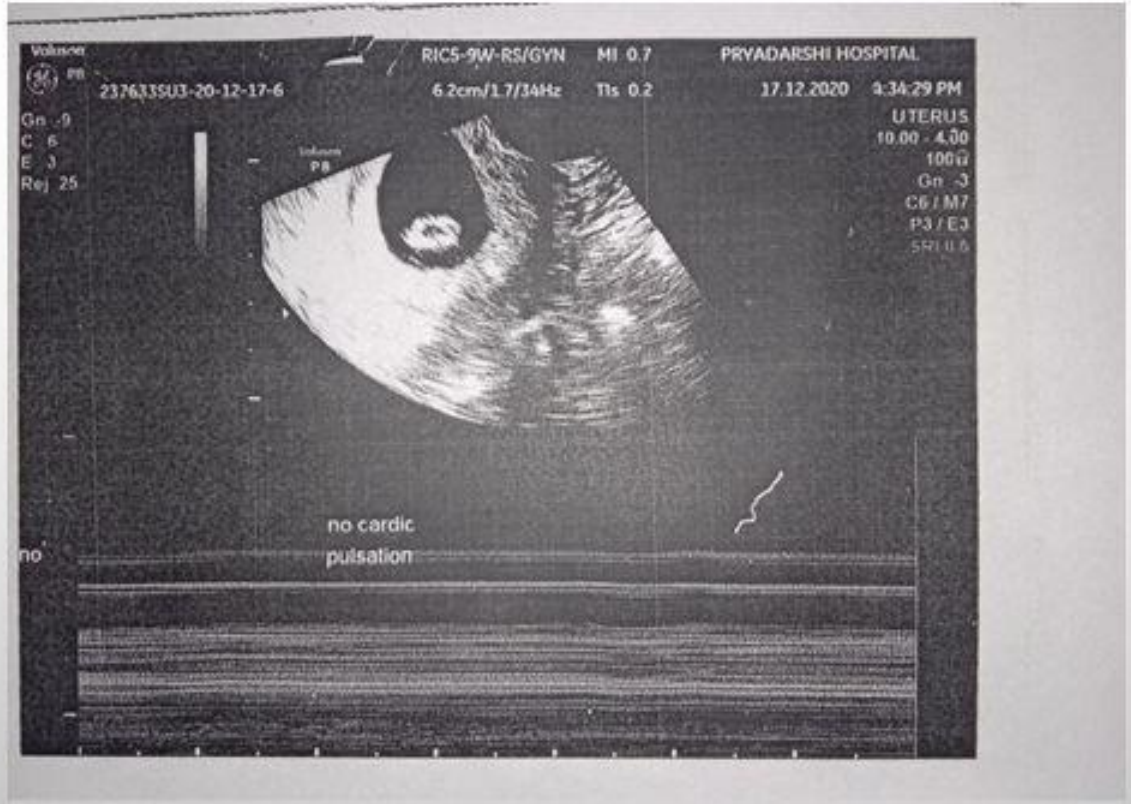
- Cardiac pulsation was still present after 8 hours of monitoring
- We decided to insert an **intracervical foley's** (10 no) and the bulb was inflated with 5ml saline

MANAGEMENT

- After 8 hours of foley's insertion it was gently pulled out confirming cervical dilatation.
- The bulb was deflated slowly with 1-2 ml saline remaining in the bulb
- However cardiac pulsation was still present on the scan

MANAGEMENT

- A decision for local administration of methotrexate in gestational sac was taken.
- Patient was shifted to OT and given short GA
- 20mg injection **methotrexate was inserted in the sac** through intracervical route using an 18 no spinal needle under TAS guidance


RIC5-9W-RS/GYN
MI 0.7
PRYADARSHI HOSPITAL
237633SU3-20-12-17-6
6.2cm/1.7/34Hz
TIs 0.2
17.12.2020
9:34:29 PM
UTERUS
Gn -9
C 6
E 3
Rej 25
Gn -3
C6 / M7
P3 / E3
no cardic
pulsation
no

MANAGEMENT

- USG showed absent cardiac pulsation
- The patient was taken for **suction and evacuation**
- USG was done which confirmed the completion of procedure
- Patient was discharged in satisfactory condition

INDICATION OF MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY

- Serum beta hcg < 10,000 mIU/ml
- Absent cardiac pulsation
- G sac size <3 cm

OUR EXPERIENCE

- We managed a total of 10 cases at our center, and 5 cases were managed by other doctors under my guidance following the same protocol.
- This protocol helped us avoid surgical intervention

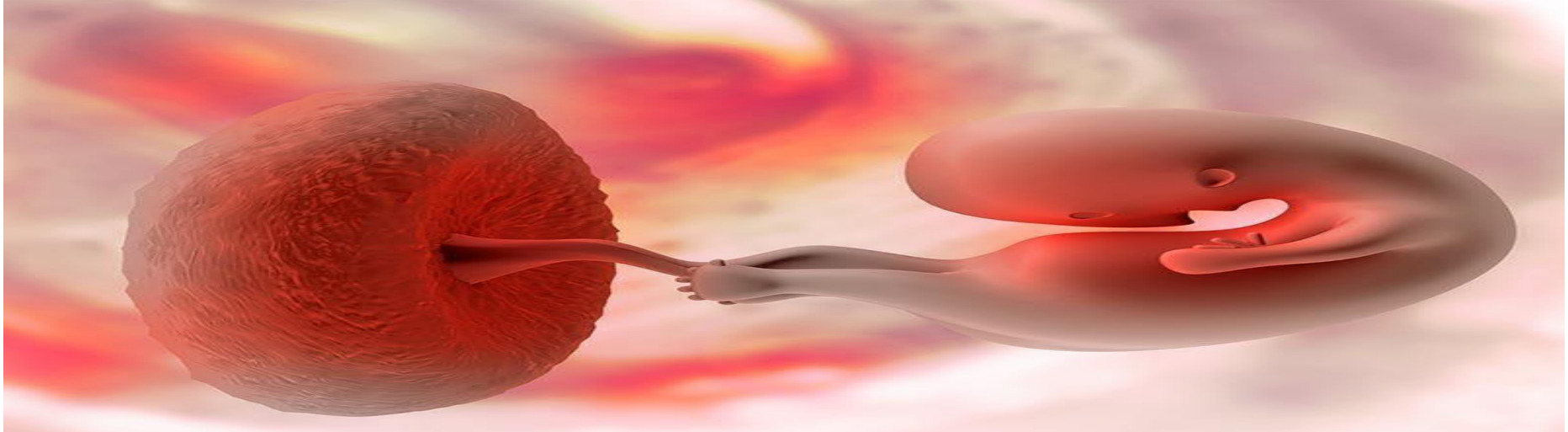
TAKE HOME MESSAGE

- In patients with no cardiac pulsation Mtx can work in high dose
- However in cases with cardiac pulsation, we had to give Mtx, mifepristone, misoprostol, ballooning with catheter and then intrasac Methotrexate followed by suction evacuation

TAKE HOME MESSAGE

- Don't give up hope if your first attempt or even third attempt does not work
- There is no evidence based protocol and we must all learn from each other's experiences

THANK YOU



What Causes SLOW FETAL GROWTH DURING PREGNANCY?

MomJunction

DR. SHELLY AGARWAL
M.B.B.S., M.S., FICOG

- Currently working as Professor, OBG , School of Medical Science & Research , Greater Noida.
- Graduate & Post-graduate from M.L.B. Medical College , Jhansi . (Gold Medalist)
- Faculty in various national & international conferences.
- Numerous publications in various journals.
- AREA OF INTEREST : High Risk Pregnancy & Critical care .

Dr Alpana Agrawal

Medical Superintendent
Professor (Obs & Gyn)
Santosh Medical College, Ghaziabad

Special Awards & Achievements:-

Academic excellence award by Santosh University: 2015
Transformational Leader award by Santosh University
Best Scientific Activity award by IMA Gzb: 2015, 2017
Member of UNESCO Bioethics Chair

Publications :-

Teaching experience- 24 yrs
Presented & Published several papers in national and international journals
Contributed chapters in books
Special interest- Fetal medicine, High risk pregnancy

Dr Shilpi Singhal

Trained in Fetal Medicine from– Indraprastha Apollo Hospitals , New Delhi
Fetal Medicine Foundation (FMF) ,UK,Certified
Consultant Fetal Medicine
Singhal Diagnostic Centre,Hapur
MBBS,DGO (ObGyn) Delhi University, Tr. Fetal Medicine ,Apollo Hospitals,N.Delhi.
agrawalshilpisinghal@gmail.com

- Training in Fetal Medicine from Indraprastha Apollo Hospitals , New Delhi (2018), FMF UK Certified.
- Certification in one year Fetal Ultrasound programme (2017).
- Proficient and special interest at performing various advanced obstetric scans including Growth scans,dopplers,3D,4D and NT scans.
- 16 years of experience in performing obstetric and gynecological scans.
- Active member GOGS since 2006. Presently holding the post of Jt. Treasurer, GOGS
- Member- GOGS, IMA, IFUMB, SFM, FUP, FOGSI.
- Postgraduation – R & R, Army Hospital (Delhi University), N.Delhi
- Graduation – LLRM Medical College, Meerut

DR PARIDHI GARG

- Associate Professor -
  - Rama Medical College & Research Centre, Hapur
- M.B.B.S.(VMMC & SJH, N. Delhi), M.S.(Dr RML Hospital & PGIMER, N. Delhi)
- Published papers & reviewed articles in indexed National & International Journals
- Guest speaker as faculty in UPCOG 2017
- Special interest: Infertility & High Risk Obstetrics

DR VANI PURI RAWAT

CONSULTANT OBSTETRICIAN AND GYNAECOLOGIST

NZ CO-ORDINATOR SEXUAL MEDICINE COMMITTEE FOGSI

SECRETARY GOGS – 2018-2019

TREASURER GOGS -2017-2018

SECRETARY IMA GHZIABAD - 2019-2021

JOINT TREASURER –IMA UP STATE

MEMBER OF CULTURAL COMMITTEE NATIONAL IMA

MEGHA SHARMA

- OBSTETRICIAN AND GYNAECOLOGIST, SAINT JOSEPH'S HOSPITAL, GHAZIABAD.
- MBBS, MD (OBST & GYNAE).
- DIPLOMA IN ASSISTED REPRODUCTIVE TECHNOLOGIES.
- FELLOWSHIP IN MINIMAL ACCESS SURGERY, FELLOWSHIP IN ULTRASONOGRAPHY.

Dr. Noopur Sharma

Gynaecologist

QUALIFICATIONS

- MBBS
- M.S Gold Medalist
- Trained in IVF , Hysteroscopy and Laparoscopy

FIELD OF INTEREST

- Infertility
- High Risk Obstretrics

DR. APARNA ARYA TYAGI

- Consultant -Obs & Gynae (Yashoda Hospital Nehru Nagar)
- MBBS (L.H.M.C New Delhi)
- MS (OBG) (L.H.M.C New Delhi)
- DNB, MNAMS
- Fellowship in Colposcopy & Preventive Oncology
- Awards & Recognitions
  - ✓- Awarded for Max. "Post Placental Cu-T Insertion" (200+)
  - ✓- Awarded 3rd prize in "Paper Presentation" in FENIX (AIIMS- 2015)
  - ✓- Awarded 2nd Prize in Debate on "WORLD POPULATION DAY"
- Special Interest In Laparoscopy & Hysteroscopy Surgeries & High Risk Obstetrics

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Question 2

- What are the consequences of FGR and why are we so worried?

DR MEGHA

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Question 3

- What are the various phases of fetal growth and how can we classify FGR?

DR SHILPI

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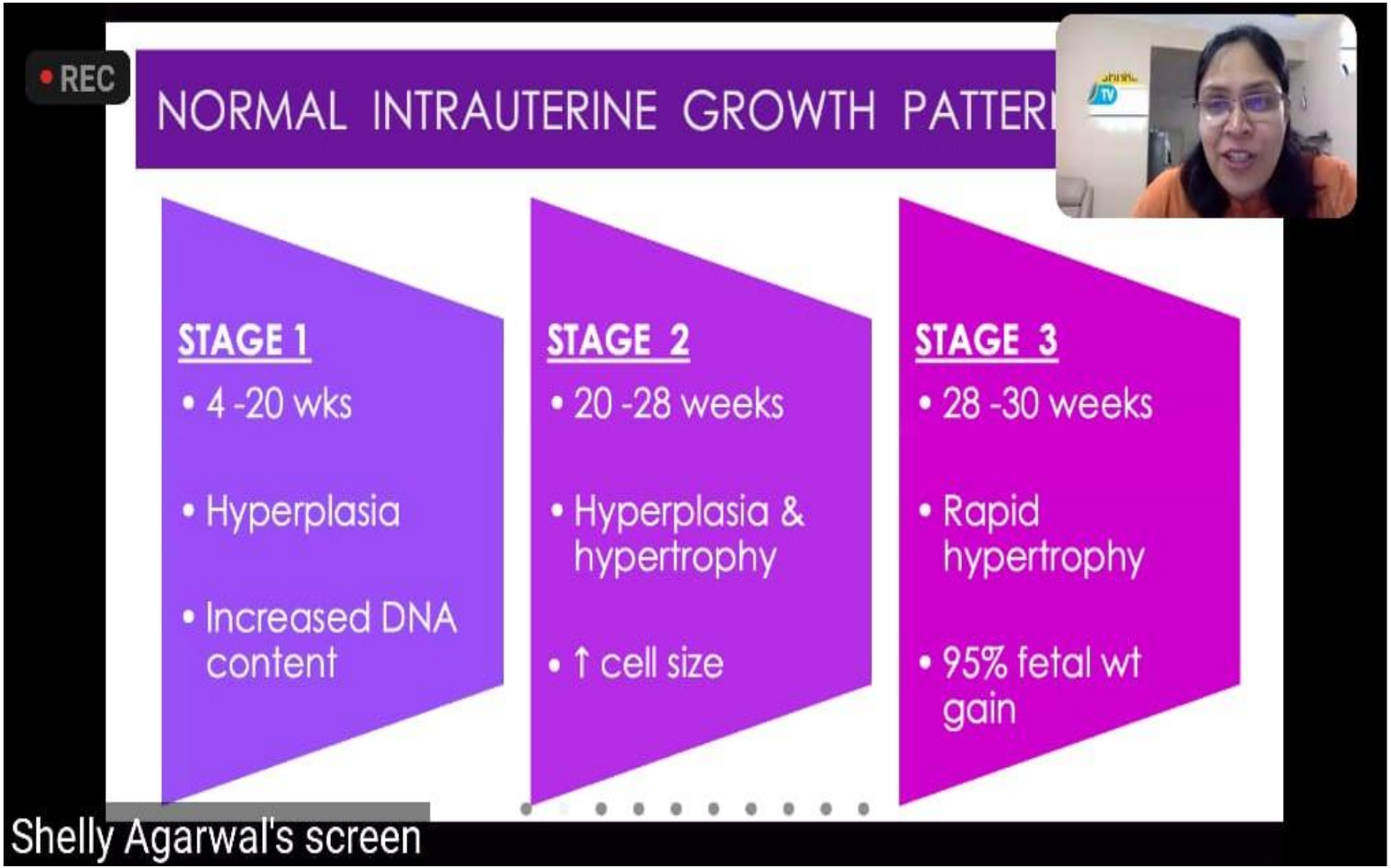
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NORMAL INTRAUTERINE GROWTH PATTERN
STAGE 1
• 4 -20 wks
• Hyperplasia
• Increased DNA content
STAGE 2
• 20 -28 weeks
• Hyperplasia & hypertrophy
• ↑ cell size
STAGE 3
• 28 -30 weeks
• Rapid hypertrophy
• 95% fetal wt gain
Shelly Agarwal's screen

Early and late onset FGR – main differences

Early-onset FGR (1–2%)	Late-onset FGR (3–5%)
Problem: management	Problem: diagnosis
Placental disease: severe (UA Doppler abnormal, high association with preeclampsia)	Placental disease: mild (UA Doppler normal, low association with preeclampsia)
Hypoxia ++: systemic cardiovascular adaptation	Hypoxia +/–: central cardiovascular adaptation
Immature fetus = higher tolerance to hypoxia = natural history	Mature fetus = lower tolerance to hypoxia = no (or very short) natural history
High mortality and morbidity; lower prevalence	Lower mortality (but common cause of late stillbirth); poor long-term outcome; affects large fraction of pregnancies

Figuros F and Gratacos E [illegible] Diagn Ther. 2014; 36:86–98

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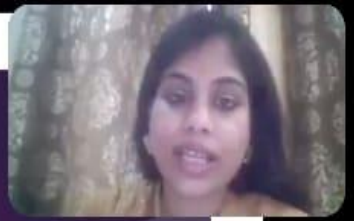

Question 4

- What are the factors affecting fetal growth (etiology)?

DR APARNA

Shelly Agarwal's screen

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Question 5

What are the Risk factors for SGA ?

DR PARIDHI

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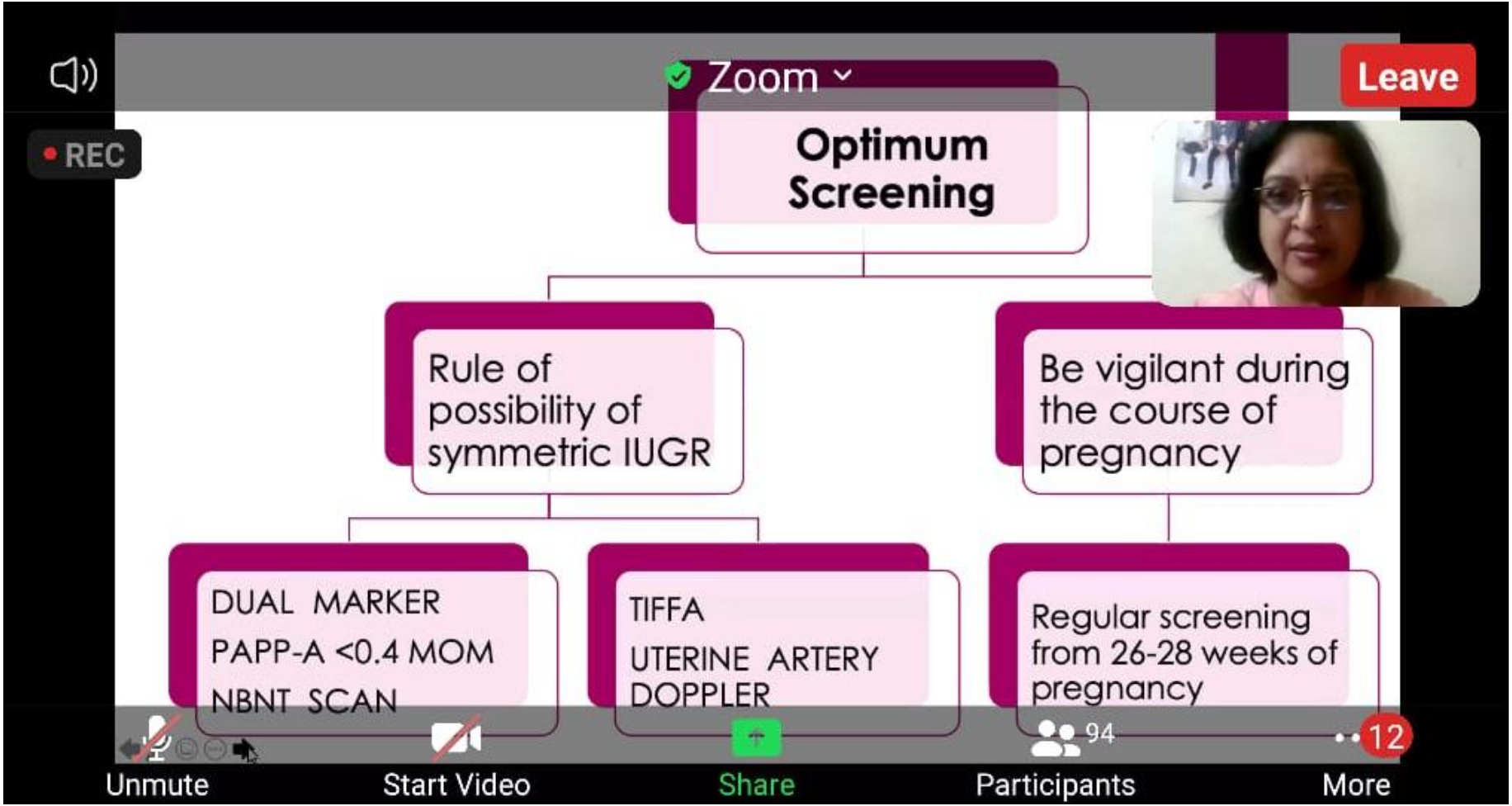
MAJOR FACTORS	MINOR FACTORS
Maternal age >40 years.	Maternal age > 35 years
Smoker >11 cig/day , Cocaine	IVF Pregnancy
Paternal SGA	Nulliparity
Daily vigorous exercise.	BMI <20
Previous SGA/ Still birth.	BMI 25 -34.9
Chronic hypertension	Smoker <10 cigarettes / day
Diabetes with vascular disease	Previous pre-eclampsia
Renal impairment	Pregnancy interval < 6 months
APLA	Pregnancy interval >60 months
PAPP-A < 0.4 MOM	

Question 6

Once U have identified major & minor risk factors ,

What are the optimal screening methods?

DR NOOPUR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REC
Optimum Screening
Rule of possibility of symmetric IUGR
Be vigilant during the course of pregnancy
DUAL MARKER
PAPP-A <0.4 MOM
NBNT SCAN
TIFFA
UTERINE ARTERY DOPPLER
Regular screening from 26-28 weeks of pregnancy
94
12
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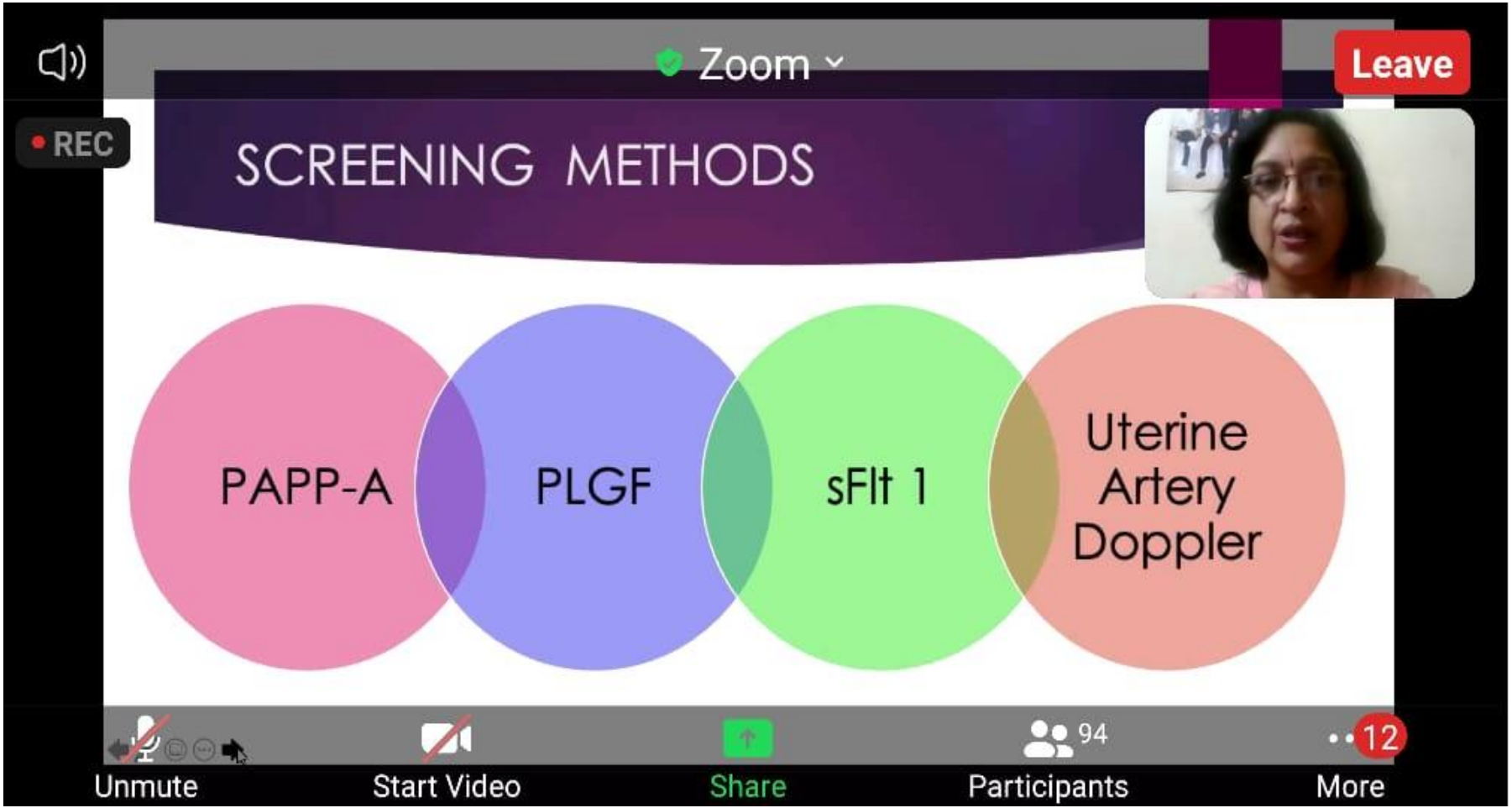
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SCREENING METHODS
PAPP-A
PLGF
sFlt 1
Uterine Artery Doppler
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Share
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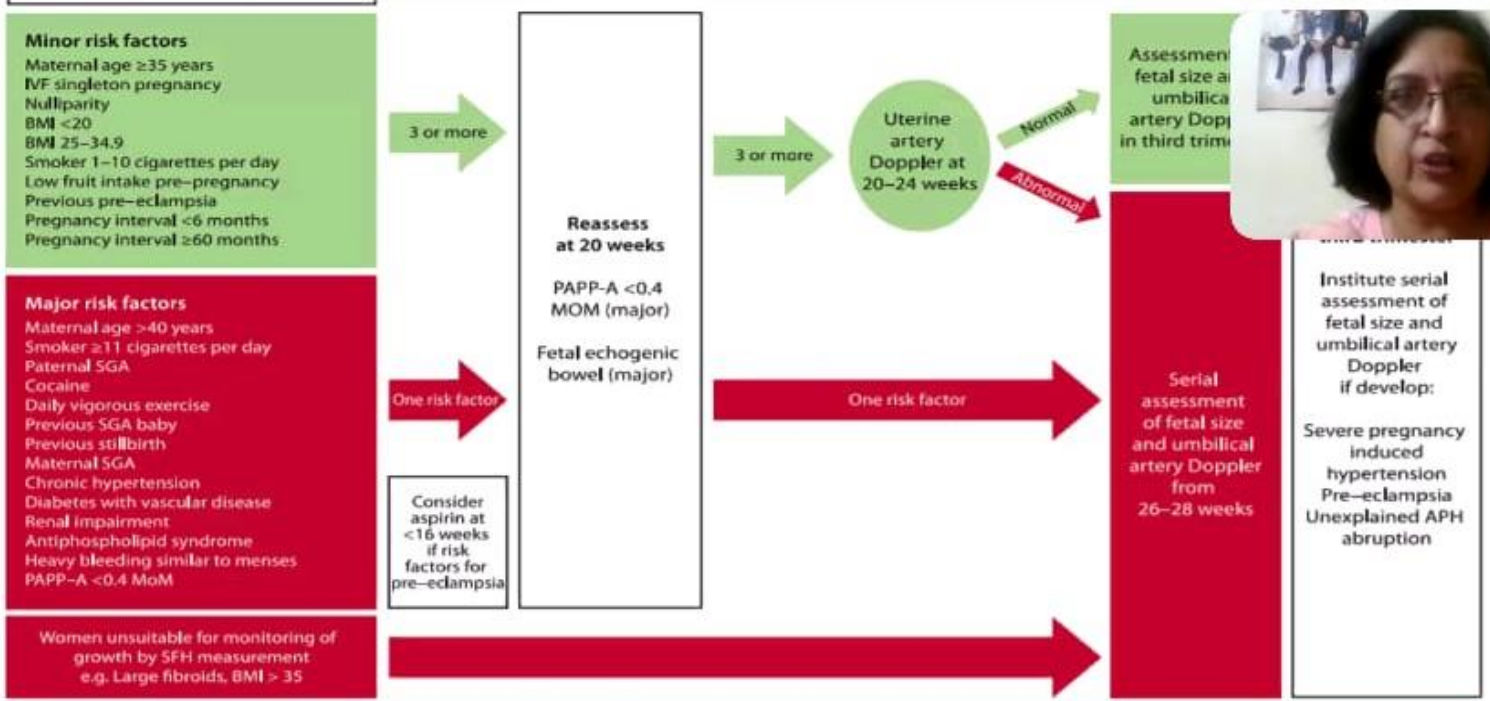
Participants
12
More



Question 7

- Mrs X. age 25 years presented to ANC OPD by
  - LMP POG – 10 wks 5 days
  - USG POG – 9 wks 1 days
- How will we date the pregnancy ?

DR. MEGHA

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Question 8

- If same Mrs X. would have presented in early second trimester
- With POG of 17 wks 5 days by LMP
- By POG 16 wks 4 days by composite biometry on USG

Dating?

DR SHILPI

93

12

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Other Investigations:

- **Detailed fetal anatomy scan** for severe SGA, esp if identified before 18-20 weeks.
- **Karyotyping** for severe SGA fetus with structural anomalies, especially if identified before 23 weeks .
- **Serological screening** of mother for CMV, Toxoplasmosis.
- **Tests for syphilis and malaria** in high risk populations

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Question 10

What is the role of doppler in FGR?

Which vessels need to be studied ?

What are the various doppler indices?

DR APARNA

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Uterine Artery Doppler

12 weeks	20 weeks	28-40 weeks
• More accurate with PAPP-A + Maternal Age + BMI + Previous history • Window of intervention	• Pre-eclampsia • FGR • IUFD	IIIIII

Shelly Agarwal's screen

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Question 15

- What interventions should be considered in prevention of SGA & interventions in preterm SGA?

- Is there any antenatal treatment?

DR VANI

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be well,
be safe.

WE CAN GET THROUGH THIS