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NEWS LETTER

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From the Editors Desk.....

Greetings from KJK hospital

As we bring about our first edition newsletter in the year 2018, I would like to draw your attention to my experience in the most looked after congregation of reproductive specialist of India, fondly called - ISAR. ISAR this time was hosted in the city of joy none other than our very own Kolkata. Apart from the grand colonial culture, Victorian buildings and art galleries. Kolkata had the scorching heat effects of summer at its peak which I must say pounded and cooled after a worth watching Gayle storm experience in IPL at Eden gardens. ISAR proved the best of scientific and learning experience. Amongst the widely discussed topics the idea of MACS and its future prospects bragged to be the outstanding one.

MACS - Magnetic Activated Cell Sorting (MACS) as a sperm selection technique improves ART success rates in couples undergoing IUI and IVF. MACS appear to be a safe and efficient method to select functional sperm with consistently good results. This technique may improve pregnancy rates when used to complement standard sperm selection methods in ART Sperm DNA fragmentation has recently become the most widely studied complementary test. Studies have demonstrated that sperm with genetic defects are directly associated with infertility. However, there is controversy regarding the role of sperm DNA fragmentation in assisted reproduction techniques because this method detects late apoptosis in sperm, and understanding all of the stages of apoptosis is far more informative Therefore, annexin V (used as an apoptotic sperm marker) conjugated with magnetic microspheres, which are exposed to a magnetic field in an affinity column, can separate apoptotic from non-apoptotic sperm. This procedure is called magnetic activated cell sorting (MACS). This technique was used in 1995 by Pesce and De Felici to isolate and purify the primordial germ cells (PGCs) from mouse embryos (MiniMACS Magnetic Separation System). By selecting non-apoptotic sperm by MACS, we can achieve very acceptable pregnancy and implantation rates; being a good option for couples with high sperm DNA fragmentation and repeated assisted reproduction failures.

Dr. K. Jayakrishnan at ISAR 2018 Venue: Kolkata

Moving on to the newsletter, As always we have ensured that our newsletter is composed with the most interesting case scenarios. Which hopefully will render a scholastic reading experience to our patents. Wishing you all a wonderful reading experience.

OVARIAN ECTOPIC PREGNANCY & MANAGEMENT

Dr Ashwin Jayakrishnan

Case Report

32 year old Mrs S, case of primary infertility, post myomectomy 4 months ago had undergone IVF at our center in December 2017. Her Bhcg values showed a rising trend. Scan done subsequently showed the presence of area with a hyper echoic rim close to the right ovary showing peripheral vascularity along with multiple corpus luteal cyst and minimal hemoperitoneum. Since she was also symptomatic with complaints of right sided abdominal pain, she was taken up for operative laparoscopy. Intraoperatively there was the presence of a 2cm ectopic gestation over the right ovary. Multiple CL cyst were seen in both ovaries. The ectopic gestation was excised using harmonic scalpel and removed through 10 mm umbilical port. She was then placed on Bhcg follow up weekly till values became negligible. Histopathology confirmed ovarian ectopic pregnancy.

Discussion

Ovarian pregnancy is a rare event with incidence between 1-3% of all ectopic pregnancies. Ovarian pregnancy is frequently misdiagnosed clinically as a tubal ectopic pregnancy. Intraoperative, it is difficult to differentiate ovarian pregnancy, ruptured corpus luteal cyst or hemorrhagic ovarian cyst. Spiegelberg described criteria for an ovarian pregnancy. They were: the fallopian tubes, including fimbria, must be intact and separate from the ovary; the gestational sac must occupy the normal position of the ovary; the ovary must be attached to the uterus through the utero-ovarian ligament; and there must be ovarian tissue attached to the pregnancy in the specimen. Laparoscopy remains the gold standard for diagnosis of an ovarian ectopic pregnancy. Early bleeding for small lesion has been managed by ovarian wedge resection or cystectomy while larger lesions oophorectomy is most often performed. Role of methotrexate has also been described in literature and has been recommended in cases in which the gestational sac is lower than 30 mm, without fetal cardiac activity, less than 6-weeks old & without presence of hemoperitoneum.

OVARIAN CYST - EXPECT THE UNEXPECTED

Dr. Danu C

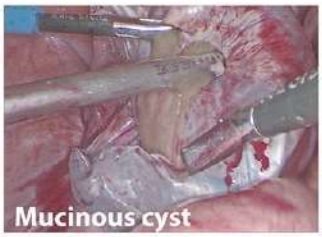
A 29yr old lady presented to our OPD with primary infertility of 2yr duration. Her cycles were regular with normal flow and spasmodic dysmenorrhea. Her baseline blood investigations were normal. Her day2 TVS revealed a left multiloculated endometriotic cyst with papillary excrescences. Tumour markers like CA-125, CEA, LDH and AFP came out to be normal. So she was posted for Laparoscopic cystectomy.

Intra-operatively, left ovary was enlarged with multiloculated cyst of 5x4cm. Endobag was introduced and cyst decompressed. Cyst had mucinous material and papillary excrescences, capsule was intact, no surface deposits and no free fluid in POD. Suspecting a mucinous tumour of ovary, left salpingo-oophorectomy was done and in-bag morcellation done without any spillage. Thorough inspection of the abdominal cavity was done and there were no suspicious lesions. Post-op period was uneventful. The histo-pathological report came as Ovarian mucinous neoplasm of borderline malignancy.

DISCUSSION:

About 1.8 % females develop some form of ovarian malignancy in their lifetime. Borderline ovarian tumours (BOTs) make up approximately 15% of all epithelial ovarian tumours. The mean age of occurrence is about 10yrs younger than that of women with frankly malignant ovarian cancer. CA-125 levels are not shown to aid in diagnosis or follow-up care of the patients with BOT. Although, USS is useful in identifying the mass, it is not currently able to identify the pathology of the tumour. It is neither sensitive nor specific enough to be used as a screening tool in normal populations. Even a frozen section of the tumour cannot surely confirm a borderline nature.

BOTs are staged according to FIGO classification. These women have a 60% chance of having stage 1 disease when diagnosed. Many sources recommend a complete staging if a BOT is found. The accepted initial treatment of BOT is surgical removal of tumour and performance of biopsies. Given the excellent prognosis of the disease, in stage 1 disease, hysterectomy and contralateral oophorectomy are not necessary if the patient wishes to preserve her fertility. In such cases a higher recurrence was found in patients who had cystectomy (58%) as opposed to patients treated with oophorectomy (23%). A higher stage is associated with a worse prognosis. Patients with stage 1 disease have a recurrence rate of 15%. The 5 yr survival rate for such patients approaches to almost 100%.

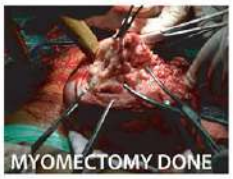


Mucinous cyst

Papillary excrescences

A RARE CASE OF ADHESIONS TO THE ADHESION BARRIER!!!

Dr Rajani S



Mrs X, 46 Year old nullipara presented with heavy menstrual bleeding and scan report of large intra mural fibroid, for further management. P/A- uterus 26 weeks size. She was taken up for Laparoscopic Myomectomy. But intraoperatively, due to the large size of the anterior IMF (16 x 14cm), conversion to laparotomy and myomectomy was done. Myoma bed was sutured in 2 layers with 1-0 vicryl. Hemostasis achieved, interceed kept anteriorly for adhesion prevention. Drain placed and abdomen closed in layers. Post operatively she was put on cefoperazone + sulbactum and tinidazole. Bowel sounds assessed and oral diet started after 6 hours. On 3 rd post op day drain and catheter was removed. Patient was tolerating oral diet and passing stools.

On post day 5, she developed abdominal distension and multiple episodes of vomiting. Investigations sent were within normal limits. By next day distension increased and diminished bowel sounds were noted. She was kept NPO, flatus tube placed. Ultrasound done showed distended bowel loops, decreased peristalsis suggestive of paralytic ileus/intestinal obstruction. Gastrosurgeon was called in and Ryle's tube inserted. 1100ml of bilious contents aspirated and patient was started with levosulpiride 25mg IV BD. Post op day 7, bowel sounds were still sluggish. CT scan done suggestive of mid ileal loop adhesion to the left rectus sheath.

In view of suspected intestinal obstruction, she was taken up for re exploratory laparoscopy. Intra op- Dilated jejunum and proximal ileum. Mid segment of small bowel was adherent to the myomectomy scar over the interceed!!! Omental band was seen causing obstruction and the distal loops were collapsed- so it was a case of adhesions to the adhesion barrier!!! Adhesions were carefully released by blunt dissection from the scar, omental band cut, drain placed and Ryles tube retained. She improved steadily, bowel movements were regained. Ryles tube could be removed 6 days later and she was discharged in a stable condition.

DISCUSSION

It is estimated that 90% of those undergoing major abdominal surgery and 55-100% of those undergoing pelvic surgeries develop adhesions. Within hours, fibrin is deposited over the area of surgery which either gets resorbed or gets organized forming adhesions depending on the tissue injury and inflammatory response. Majority are asymptomatic. But some develop chronic abdominal or pelvic pain, bowel obstruction, infertility, complications in subsequent surgeries.

Methods of adhesion prevention has to be adopted by every surgeon to prevent these complications. Meticulous surgical technique avoiding tissue trauma, gentle handling of tissue, preventing thermal injury,reducing the number of surgeries, opting for minimally invasive methods is essential.

Barrier agents such as oxidized regenerated cellulose (interceed), polytetrafluoroethylene (Gore-tex), chemically modified sodium hyaluronate/ carboxymethylcellulose (Seprafilm), are the currently available FDA approved methods. These create a synthetic barrier between opposing pelvic structures during tissue healing that prevents adhesion formation. Adept is a solution of icodextrin that when instilled in a large volume causes organs to float apart, reducing the possibility of attachment.

Interceed when applied to damaged peritoneum, transforms into a gel that covers the area and prevents adhesions, used both in open and laparoscopic procedures, applied as a single layer, completely absorbed within 2 weeks. But it must not be placed if strict hemostasis is not achieved. When mixed with blood it increases fibrin deposition leading to increase in adhesions.

Hence meticulous surgical techniques, good hemostasis, appropriate use of adhesion barriers during surgery and careful monitoring of the post operative patients is important to prevent, identify and treat complications at the earliest.

Dr Revathy Panicker

A Dexterous handling of "You Know who".....

41 year Mrs X, P2L2, Previous 2 LSCS, With a past history of lap endometriotic cystectomy 6 years back reported to KJK hospital for routine evaluation and follow up. She gave a history of pain associated with menstruation. TVS showed Uterus normal sized, Right ovary was posterior and adherent to uterus and was consistent with a biloculated endometriotic cyst of size 4.5 cm. Left ovary appeared normal. However both ovaries seemed adherent to each other showing a kissing ovary pattern. Following her complaints, patient was taken up for Operative laparoscopy after PAC evaluation and fitness.

Intra Op findings were at par with the scan details. Right tube adherent to the right ovary. Bowel adhesions seen laterally to the right ovary. Both ovaries were adherent to the uterosacrals. The surgery was conducted meticulously by separating the previous surgery related bowel adhesions. Therafter retroperitoneum was opened on the right side and ureter traced till it entered uretric tunnel and was proceeded with right salpingo oophorectomy.

Discussion

Endometriosis is an enigmatic disease as known, when dealt surgically it offers to be the toughest of the lot. Diagnosis and treatment of endometriosis by laparoscopy requires a surgeon with expertise in laparoscopic surgery as endometriosis can present with classic lesions as well as have non-classical appearance. In such situations laparoscopy provides an ideal setup with its benefits of good visualization of pelvic anatomy and magnification. This helps to identify non-classic lesions and visualize clearly the lesions on bladder, bowel, ureters, and POD. Also, there is minimum tissue handling and desiccation and precise haemostasis during laparoscopy. Thus the chances of adhesions postoperatively are less. Minimal suturing and small incisions on the abdomen leads to minimal postoperative pain and faster patient recovery. The surgical treatment in severe endometriosis varies according to patient's age, fertility status, symptomatology and desires. Here we have primarily dealt with ureter and bladder related injuries as our surgical experience in this case were pertained to ureteric kind.

Urinary Tract Complications include ureteric injuries, bladder injuries, fistulas. Bladder injuries are identified more often (87%) than ureteric injuries. The rate increase with the difficulty of technique. Risk increases according to spread and depth of endometriosis. Ureter is vulnerable - at the fossa ovarica, uterine artery level, at the uterosacral/cardinal ligament, at the infundibulo-pelvic ligament.

Rules for atraumatic dissection and prevention of ureter injuries include careful handling of ureter by use of atraumatic forceps. Also that the ureter must be localized at all moments during laparoscopy by identification under the peritoneum, by dissection, pre-operative catherization (stenting), IVP, cystoscopy. At the end of the surgery see ureteric peristalsis and absence of dilatation. Mechanical trauma to bladder can occur during adhesiolysis, resection of endometriosis implants. The history of previous laparotomy increases the risk of concomitant injury to the vital structures. We can always reduce the impending risks by foley catheter insertion, bowel preparation, lysis of adhesions between bowel and anterior or lateral abdominal wall, lysis of sigmoid adhesions and ofcourse by maintaining the hawk eyed vision in surgery.

Dr Sija Chandran L J

FIBROID COMPLICATING PREGNANCY

Case: Mrs. X, aged 50 years, conceived after 21 years of primary infertility with ODP+ICSI treatment (4th attempt). She had multiple uterine fibroids, with the largest one measuring 7x7cm in the posterior wall lower segment. Her 20 week's scan did not reveal any gross fetal anomalies, but there was a low lying anterior placenta, which persisted in subsequent ultrasound scan at the 28th, 32nd & 34th weeks. Serial fetal biometry revealed fetal growth appropriate for gestational age.

We counselled her regarding the need of caesarean delivery in view of major placenta praevia, breech, elderly primi, multiple fibroid uterus and a high risk informed consent, with arrangement of multiple blood products. Chances of caesarean hysterectomy was explained and Hb level was optimised to 12g%. Her pregnancy was also complicated with chronic hypertension and GDM.

Elective LSCS was carried out at 36W 5D gestation after giving 2 doses Betnesol 24 hrs apart, under combined spinal epidural anesthesia. Midline subumbilical vertical incision was put. The uterus was enlarged to 28 weeks size (post delivery of baby) with multiple fibroids, largest in the cervical region 7x7 cm with type II anterior placenta praevia.

Multiple Fibroid uterus, 28 wk size, proceeded with caesarean hysterectomy

A healthy baby of 2.91 kg weight was born and was delivered out as extended breech. Proceeded with obstetric hysterectomy (TAH). 1 pint PRBC and 4 pint FFP were given intraop, and 1 pint PRBC was given in the post-operative period. Specimen weighed 2.5 Kg. Mother and baby doing well now.

Discussion: Fibroids are benign smooth muscle tumors of the uterus. They are extremely common, with an overall incidence of 40-60% by age 35 years and 70-80% by age 50 years. The precise etiology of uterine fibroids remains unclear. Majority of fibroids do not change their size during pregnancy; but one-third of them may grow in the first trimester. Uterine fibroids are associated with increased rate of miscarriage, preterm labour, placenta abruption, malpresentation, labour dystocia, caesarean delivery and post partum hemorrhage (PPH).

Reflecting the growing trend of delayed child bearing, the incidence of fibroids in older women undergoing infertility treatment is reportedly 12-25%. Approximately 10-30% of women with uterine fibroids develop complication during pregnancy. Presence of fibroids is associated with a two-fold increased risk of Placenta praevia. There is increased risk of malpresentation in women with fibroids, with a 3.7 fold increase in caesarean section. Fibroids may also distort the uterine architecture and interfere with myometrial contractions leading to uterine atony and PPH.

Prior to pregnancy, myomectomy can be considered in women with unexplained infertility or recurrent pregnancy loss (RPL), although it remains unclear whether such surgical intervention actually improves fertility rates and perinatal outcome. Women with a previous history of myomectomy may need to be delivered by elective caesarean delivery prior to the onset of labour, particularly if cavity was entered.

Dr Abhilash

HETEROTOPIC PREGNANCY: IS IT REALLY A RARE EVENT?

Heterotopic pregnancy is the simultaneous coexistence of an intrauterine and an extra uterine gestation. Heterotopic pregnancy is a rare complication usually seen in populations at risk for ectopic pregnancy or those undergoing fertility treatments. It is a potentially dangerous condition occurring in only 1 in 30,000 spontaneous pregnancies. With the advent of Assisted Reproduction Techniques (ART) and ovulation induction, the overall incidence of heterotopic pregnancy has risen to approximately 1 in 3,900 pregnancies. Other risk factors include a history of pelvic inflammatory disease (PID), tubal damage, pelvic surgery, uterine Mullerian abnormalities, and prior tubal surgery. Heterotopic pregnancy is a potentially fatal condition, rarely occurring in natural conception cycles. Most commonly, heterotopic pregnancy is diagnosed at the time of rupture when surgical management is required. Heterotopic pregnancy should be suspected in patients with an adnexal mass, even in the absence of risk factors. Clinicians must be alert to the fact that confirming an intrauterine pregnancy clinically or by ultrasound does not exclude the coexistence of an ectopic pregnancy.

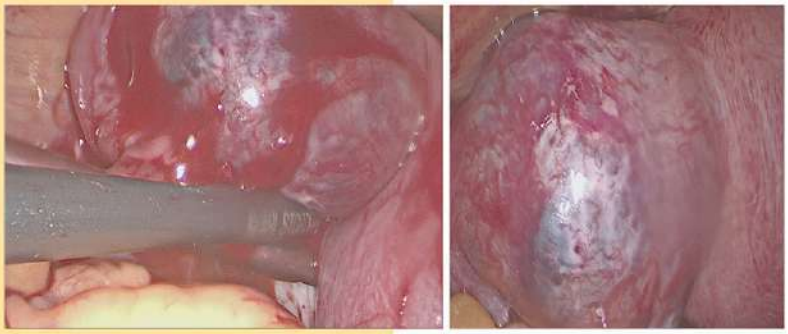
Transvaginal ultrasound is the key to diagnosing heterotopic pregnancy. However, it continues to have a low sensitivity because the diagnosis is often missed or overlooked. Therefore the diagnosis is often delayed leading to serious consequences. The goal is to remove the ectopic pregnancy without jeopardizing the intrauterine pregnancy. Laparoscopic salpingectomy is the standard surgical approach of heterotopic pregnancy. Other management options mentioned in the literature include local injection of potassium chloride, hyperosmolar glucose, or methotrexate into the sac under ultrasound guidance followed by aspiration of the ectopic pregnancy.

This is a case report eliciting occurrence of heterotopic pregnancy after frozen embryo transfer and the subsequent obstetrical outcome of the patient.

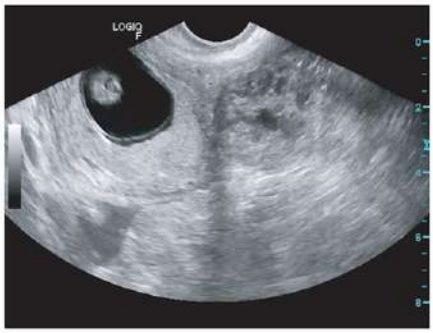
28 year old primi gravida of 9 weeks gestation, conceived after frozen embryo transfer (2 embryos transferred) for male factor infertility reported to emergency department with complaining of giddiness and sudden loss of consciousness .She denied any history of vaginal bleeding, urinary symptoms, fever, chills, dizziness, palpations, or any other symptoms. Upon presentation to emergency department, the patient was noted to be pale and her abdomen was tender more on the left side. On vaginal exam, the cervix was found to be closed, long, and posterior, with cervical motion tenderness and bilateral adnexal tenderness. No adnexal masses were appreciated. There were no other pertinent significant physical findings. Pelvic ultrasound revealed a single live intrauterine pregnancy of 9 weeks with good cardiac activity and an ectopic pregnancy was seen in the left adnexa. A large amount of free fluid was present, consistent with the blood loss.

Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic gestation was suggested in view of clinical history, moderate amount of free intraperitoneal fluid, and an intrauterine gestation. The patient underwent emergency laparoscopy. There was ruptured left-sided isthmic tubal pregnancy very close to left cornua mimicking the cornual pregnancy with moderate haemoperitoneum. Vasopressin was injected to the ectopic mass and carefully dissected the whole mass and interrupted stiches put close to uterus. The intrauterine live gestation was allowed to continue. Now she is in her third trimester without any other antepartum complications.

These cases highlight the fact that as clinicians, we should be aware of the possibility of a heterotopic pregnancy in any patient presenting with pelvic pain, even when an intrauterine pregnancy has been confirmed. This is even more imperative after induction of ovulation or ART procedures. We would also like to emphasise that an early diagnosis is critical to safeguard the intrauterine pregnancy and avoid maternal morbidity and mortality due to the ectopic pregnancy.



Left isthmal tubal ectopic mimicking cornual pregnancy

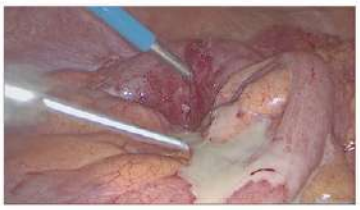


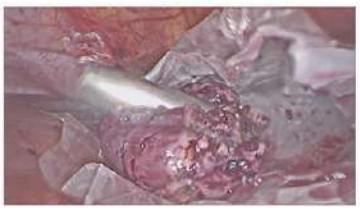
USS showing live intrauterine gestation with left tubal ectopic

AN INTERESTING CASE OF TUBO OVARIAN ABSCESS

Dr. Aiswarya

Mrs. X, aged 47 years, P2L2A1, both normal vaginal deliveries, presented to our OPD with fever and complaints of severe right sided lower abdomen pain since 2 months. She also gave a history of increased weight loss and loss of appetite. Her menstrual cycles were regular with normal flow, but she had severe congestive dysmenorrhea. Ultrasonography was done outside which revealed a heterogenous mass lesion in POD ?ovarian dermoid ?Chocolate cyst- measuring 7 x 4.5 cm. She was referred to KJK hospital for laparoscopy. On examination, her vital signs were stable. Per abdomen examination- abdomen was soft. Per speculum showed yellowish discharge from the os. On per vaginal examination, uterus had restricted mobility and a mass of hard to variable consistency felt in the right fornix, with no tenderness.





Ultrasonography done here showed right adnexal mass of about 6 cm ?ovarian abscess ?dermoid cyst. Her blood and urine investigations were normal and she was treated for suspected ovarian abscess by IV antibiotics. An opinion of Gastro surgeon was taken who advised an MRI, which showed a complex 7 x 7 cm cystic lesion in the left adnexa with mildly thick incomplete internal septa; left hydroureteronephrosis and lesion indenting the anterior wall of rectum. She was posted for operative laparoscopy.

Intraoperatively, dense pelvic adhesions were noted. Bowels were adherent anteriorly to the fundus of the uterus. Right tube and ovary were not seen separately. Left tubo ovarian abscess with pus draining was seen over the left adnexa with bowel adhesions over the lateral surface. Gastro surgeon was called in, in view of suspected rectal extension of the abscess. Omentoplasty was done. Post operative period was uneventful and she was discharged on the 7th post op day. HPR showed ruptured tubal abscess.

Discussion:

Tubo ovarian abscesses are one of the late complications of PID and can be life threatening if the abscess ruptures and results in sepsis. It consists of an encapsulated or confined 'pocket of pus' with defined boundaries that forms during an infection of a fallopian tube and ovary.

These abscesses are found most commonly in reproductive age women and typically result from upper genital tract infection. It is an inflammatory mass involving the fallopian tube, ovary and occasionally, other adjacent pelvic organs. A TO abscess can also develop as a complication of a hysterectomy.

Patients typically present with fever, elevated WBC count, lower abdominal- pelvic pain, and or vaginal discharge. Fever and leukocytosis may be absent. TO abscesses are often polymicrobial with a high percentage of anaerobic bacteria. Though rare, TO abscess can occur without a preceding episode of PID or sexual activity.

Signs and symptoms of TO abscess are the same as with PID with the exception that the abcess can be found with MRI, USG and X ray. It also differs from PID in that it can create symptoms of acute- onset pelvic pain.

Cause : The development of TO abscess is thought to begin with the pathogens spreading from the cervix to the endometrium, through the salpinx, into the peritoneal cavity and forming the TO abscess with (in some cases) pelvic peritonitis. TO abscess can develop from the lymphatic system with infection of the parametrium from an Intrauterine device. Bacteria recovered from TO abscesses are Escherichia coli, Bacteroides fragilis, other Bacteroides species, peptostreptococcus, peptococcus and anaerobic streptococci. Actinomyces is also recovered from TO abscess.

Diagnosis : Laparoscopy and other imaging tools can visualize the abscess. Physicians are able to make the diagnosis if the abscess ruptures when the woman begins to have lower abdomen pain that then begins to spread. The symptoms then become the same as the symptoms for peritonitis. Sepsis occurs if left untreated. USG is a sensitive enough imaging tool that it can accurately differentiate between pregnancy, haemorrhagic ovarian cysts, endometriosis, ovarian torsion and TO abscess.

Treatment : Treatment for TO abscess differs from PID in that patients with TO abscesses need to have at least 24 hours of inpatient parental treatment with antibiotics, correction of dehydration and acidosis by IV fluids and that they may require surgery. If surgery is needed, pre operative administration of broad spectrum antibiotics is started and removal of the abscess, the affected ovary and fallopian tube is done. After discharge from the hospital, oral antibiotics are continued for the length of time prescribed by the physician.

Treatment is different if the TOA is discovered before it ruptures and can be treated with oral antibiotics. During this treatment, IV antibiotics are usually replaced with oral antibiotics on an outpatient basis. Patients are usually seen three days after hospital discharge and then again one to two weeks later to confirm that the infection has cleared. Ampicillin/ Sulbactum plus doxycycline is effective against Chlamydia trachomatis, Neisseria gonorrhea, and anaerobes in women with TO abscess. Parenteral regimens described by the CDC are Ampicillin/ Sulbactum 3g IV every 6 hours and Doxycycline 200 mg orally or IV every 24 hours, though other regimens that are used for PID have been effective.

Complications : Important complications of TOA are abscess rupture leading to peritonitis and sepsis.

STATISTICS

JANUARY, FEBRUARY & MARCH -2018

TOTAL SURGICAL PROCEDURES	255
TOTAL LAPROSCOPY	83
TOTAL HYSTEROSCOPY	65
DIAGNOSTIC	51
OPERATIVE	15
HYSTEROSCOPIC PROCEDURES	
SEPTAL RESECTION	02
SMF RESECTION	01
POLYPECTOMY	07
ENDOMETRIAL SAMPLING	05
ADHESIOLYSIS	01
LAPROSCOPIC PROCDEDURES	
TLH	03
TLH +BSO	06
LAP MYOMECTOMY	20
LAP STERILIZATION	01
OVARIAN CYSTECTOMY	07
ADENOMYOMECTOMY	04
BILATERAL OVARIOLYSIS	01
ADHESIOLYSIS	
PCO DRILLING	07
LAVH+SALPINGECTOMY+ ANTERIOR COLPORRHAPHY	01
LAVH+BSO	01
SACRO OVARIOPEXY	02
LAP COLPOPEXY	01
ECTOPIC SURGERIES	
SALPINGECTOMY	06
SALPINGOSTOMY	02
ENDOMETRIOTIC SURGERIES	
CHOCOLATE CYSTECTOMY	07
FULGURATION OF ENDOMETRIOTIC	08
DEPOSITS	
FULGURATION AND PCO PUNCTURING	05
ADNEXECTOMY+URETERIC STENTING +ADHESIOLYSIS+OMENTOPLASTY	01
ADNEXECTOMY+ADHESIOLYSIS+ TUBAL STERILISATION	01
OTHER MAJOR SURGERIES	
OPEN MYOMECTOMY	01
VH+PFR	01
TAH+BSO	02
REEXPLORATORY LAPAROSCOPY +ADHESIOLYSIS	01
MINOR PROCEDURE	
SUCTION EVACUATION	06
CERVICAL- ENCERCLAGE	13
MIRENA INSERTION	02
FRACTIONAL CURRETTAGE	01
OBSTETRICS	
TOTAL DELIVERIES	75
LSCS	58
FTNVD	7
VACCUM DELIVERY	10
MALE SURGERIES	
TESA	04
PESA	02
TESE	03
EXCISION OF OVARIAN ECTOPIC	01
DIAGNOSTIC LAPAROSCOPY	02

IVF/ICSI STATISTICS	
TOTAL NO. OF CASES	93
FROZEN ET DONE	24
CONCEPTION RATE IVF	42 %
FET CONCEPTION NO. OF CASES	10
CONCEPTION RATE AFTER FROZEN ET	41.6 %
CONCEPTION + IUI STATISTICS	
TOTAL CONCEPTION CASES	85
TOTAL IUI CONCEPTION CASES	18
IUI CONCEPTION RATE	11.6 %
SPONTANEOUS	13
COH ONLY	17

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