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# KJK HOSPITAL

FERTILITY RESEARCH AND GYNAEC CENTRE

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## From the Editors Desk.....

Hello Everyone!

### Welcome to Advances 2017 the 18th Annual meeting of Trivandrum OBGYN club.

ADVANCES 2017 COMES DURING August every year and I often feel what is the motivating factor for holding Advances. On analyzing I have found that it is the audience which stimulate me to hold this meeting year after year.

ESHRE comes round again, now in its 33rd year and still with the reliable regularity of a cuckoo clock. Back at the first edition, 500 pioneers registered; now, attendance seems to have settled at around 9000-10,000.

Something entirely path breaking news is new hope for primary ovarian insufficiency was presented by K..Kawamura from Stanford group USA and Japan on In Vitro activation of oocytes in Primary Ovarian insufficiency (IVA)

In patients with primary ovarian insufficiency (POI), early exhaustion of ovarian follicles was evident due to genetic, immunological, iatrogenic, or other causes. POI affects 1% of women and is characterized by high circulating levels of gonadotropins along with amenorrhea before 40 years of age. They are infertile due to a lack of follicle growth and ovulation; oocyte donation is the only effective treatment option, because residual ovarian follicles in these patients are not responsive to traditional gonadotropin treatments. They developed a method for activation of dormant follicles by using in vitro culture of ovarian fragments treated with PI3K stimulators following disruption of Hippo signaling pathway (IVA, in vitro activation). Under laparoscopic surgery, ovaries were removed and cut into strips. Ovarian strips from POI patients were vitrified. After thawing, strips were fragmented into 1-2 mm cubes before treatment with PI3K stimulators. Two days later, cubes were autografted under laparoscopic surgery beneath serosa of Fallopian tubes. Follicle growth was monitored via transvaginal ultrasound and serum estrogen levels. After detection of antral follicles, patients were



**Dr. K. Jayakrishnan at 33rd Annual Meeting European Society of Human Reproduction & Embryology - Eshre. Geneva, Switzerland 2 to 5 July 2017**

treated with FSH followed by hCG when preovulatory follicles were found. Mature oocytes were then retrieved and fertilized with the husband's sperm in vitro before cryopreservation of four-cell stage embryos. Patients then received hormonal treatments to prepare the endometrium for implantation followed by transferring of thawed embryos. When we published second paper in Human Reproduction (2015 Mar;30(3):608- 15), three pregnancies were achieved based on serum hCG after IVF and embryo transfer. Although one was a miscarriage, two healthy IVA babies have been born with the first one being more than four year of age now. Two other pregnancies by two other centers have also been achieved.

Several women with primary ovarian insufficiency who underwent the IVA procedure have achieved live births. IVA might also be applicable to women with pathological diminished ovarian reserve and those with physiological diminished reserve due to natural aging. Cancer patients with cryopreserved ovarian tissue also might benefit from IVA. Based on future studies, IVA could prove to be a revolutionary tool for assisted reproduction.

As you browse through the pages wishing you a happy time in Trivandrum and enjoy the academic feast at Advances 2017. Please do not hesitate to take active part in discussions..

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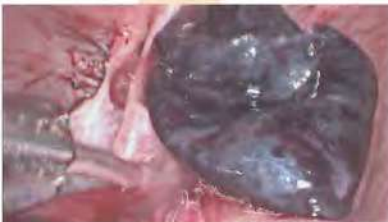
# AN UNCOMMON TWIST: A CASE OF TORSION OF PARATUBAL CYST

**Dr Aswin Jayakrishann**

Torsion of uterine adnexa is an important cause of acute abdominal pain. Torsion of ovarian masses is quite common and isolated torsion of the fallopian tube has also been reported in the literature. However, torsion of paratubal cyst is a rare entity. We report a rare case of a 19 year girl who presented with complaints of acute abdominal pain of 1 day duration diagnosed as a case of right ovarian cyst referred to us for laparoscopic management of the same. A repeat ultrasound showed the presence of a bilateral ovarian cyst- A clear cyst of 6 cm with reduced peripheral vascularity and another cyst of around 4 cm. She was taken up for operative laparoscopy. Intraoperative - there was a right paratubal cyst of 7 x 7 cm and had undergone torsion on itself around 4 times. Also along with it was an adjacent right ovarian corpus luteal cyst of around 3 cm. Right paratubal cystectomy was done after detorsion. Subsequent to detorsion, the tube regained its colour and vascularity of around 80 percent and hence it could be salvaged. Laparoscopy is the gold standard in the diagnosis and management of paratubal cysts. Adnexal detorsion with resection of the paratubal cyst and preservation of the fallopian tube (if not gangrenous) is the procedure of choice. Fixation of the detorted tube is controversial. Gynaecologists need to maintain a high index of suspicion for this uncommon and often difficult to diagnose cause of abdominal pain and help in timely management.



Torsion- Paratubal cyst



Detorsion and cystectomy



Normal colour regained

# A CASE OF HETEROTOPIC PREGNANCY:



Dr Surbhi Gupta

A 27 year old, G3A1E1, with history of previous left laparoscopic salpingostomy for ectopic pregnancy, conceived after ovulation induction with clomiphene citrate.

She was completely asymptomatic at the initial consultation. A transvaginal scan showed an intrauterine gestational sac of approximately 6 weeks with fetal pole having evidence of cardiac activity. There was a corpus luteal cyst noted in the left ovary, the right ovary was normal with no obvious adnexal masses seen. However, a week later the patient presented as an emergency with acute abdomino-pelvic pain and generally feeling unwell. She had no vaginal bleeding. On examination, she was cold, clammy and hypotensive. Abdominal examination was suggestive of an acute abdomen with guarding and rigidity. On TVS, a live intrauterine gestation of 7weeks noted with mixed echogenic area in pelvis surrounding left ovary s/o blood clot. Clinical differential diagnosis at that stage was a possible bleed from the corpus luteal cyst, which was seen, in the initial scan or an ectopic (Heterotopic) pregnancy.

The patient underwent emergency laparoscopy after informed high risk consent. Left tube was the seat of unruptured ectopic near ampullary end with around 500cc hemoperitoneum and laparoscopic left salpingectomy was performed; the intrauterine live gestation continued thereafter.

The important learning point from our case was that the diagnosis was not suspected at the initial presentation and the patient presented subsequently with acute abdominal pain with intra peritoneal haemorrhage. The finding of an intrauterine gestational sac was a red herring and led to false assurances. In women with a previous ectopic gestation treated surgically or non surgically, increased vigilance is required even if they are asymptomatic and an intrauterine gestation is confirmed. Similarly if a patient continues to have ongoing abdominal or pelvic pain with a confirmed intrauterine pregnancy, one of the differential diagnosis should be heterotopic pregnancy.



Hemoperitoneum with left tubal ectopic



Left salpingectomy done

The incidence of heterotopic pregnancy was originally estimated on theoretical basis to be 1 in 30,000 pregnancies. However, more recent data indicate that the rate is higher due to assisted reproduction and is approximately 1 in 7000 overall and as high as 1 in 900 with ovulation induction. There may be an increased risk in patients with previous tubal surgeries.

A heterotopic pregnancy requires a high index of suspicion for early and timely diagnosis, especially in patients whom ultrasound findings are consistent with intrauterine gestation sac. It can be a life threatening condition and can be easily missed with the diagnosis being overlooked. Intrauterine pregnancy with hemorrhagic corpus luteum can simulate heterotopic pregnancy or ectopic gestation both clinically and on sonography. A timely intervention can result in a successful outcome of the intrauterine fetus.

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.

Surgical intervention plays a key role in the management of heterotopic pregnancy. The goal is to remove the ectopic pregnancy without jeopardizing the intrauterine pregnancy. Laparoscopic salpingectomy is the standard surgical approach of heterotopic pregnancy.

# RECURRENT PREGNANCY LOSS

Dr. DANU C



## CASE:

A 28 year old lady presented to our OPD in 2010 as a case of recurrent early pregnancy loss and secondary infertility. She was married for 6 years and had 3 abortions- 2 were spontaneous conception and one was IUI conception done for oligoasthenospermia.

Investigation results were:

APLA-negative, Karyotyping of 2nd abortus-45 XO, Karyotyping of both partners-normal; RBS, TFT, Prolactin-normal, aPTT-normal.

Husband was given treatment for improving semen parameters and IUI was done for 3 cycles, all of which failed. Diagnostic Laparoscopy + Hysteroscopy was done which showed mild endometriosis, bilateral patent tubes and normal hysteroscopy. She again had 4 cycles of IUI post laparoscopy which also failed. Her AMH was 0.73ng/ml and AFC-5.

She was advised to undergo IVF from next cycle. She didn't conceive from 3 IVF cycles. An endometrial sampling was done and sent for TB-PCR which came out as negative. Repeat APLA was negative. She conceived in the fourth IVF cycle but aborted at 6 weeks. She conceived again in sixth IVF attempt (DCDA twins). Based on her previous history, she was empirically started on aspirin and heparin, despite her APLA screen coming as negative. Her antenatal period was uneventful. Elective LSCS was done at 36+ weeks and she delivered 2 babies weighing 2.5kg and 2.2kg.

## DISCUSSION:

Recurrent miscarriage, defined as loss of 3 or more consecutive pregnancies, affects 1% of couples trying to conceive. About 1-2% of 2nd trimester miscarriage occurs before 24wks of gestation. Risk factors for recurrent miscarriage includes maternal age >35y, paternal age >40y, previous h/o miscarriage, smoking, alcohol, high caffeine intake, obesity, antiphospholipid syndrome (APS), parental chromosomal rearrangements, embryonic chromosomal abnormalities, uterine malformations, cervical weakness, diabetes, thyroid disease, immune factors, bacterial vaginosis and thrombophilias.

RCOG recommends the following investigations-APLA screening, karyotyping of conceptus of 3rd and subsequent consecutive miscarriage, parental Karyotyping where testing of products of conception reports an unbalanced structural chromosomal abnormality, pelvic USS to assess uterine anatomy and screening for inherited thrombophilias including Factor V Leiden, Prothrombin gene mutation and Protein S.

Pregnant women with APS should be considered for treatment with Low dose aspirin (LDA) + Heparin. This treatment combination significantly reduces the miscarriage rate by 54%. Neither corticosteroids nor intravenous immunoglobulins improve live birth rate in women with APS. Their use may provoke significant maternal and fetal morbidity. There are no adverse fetal outcomes for LDA and heparin. 2 prospective studies have shown that loss of bone mineral density at lumbar spine associated with long term heparin therapy is similar to that which occurs physiologically during normal pregnancy.

Reproductive options in couples with chromosomal rearrangements include proceeding to a further natural pregnancy with or without prenatal diagnosis test, gamete donation and adoption. Patients who are translocation carriers should be informed that they have a higher chance (50-70%) of a healthy live birth in future untreated pregnancies following natural conception than is achieved after pre-implantation genetic diagnosis/IVF (30%). The live birth rate of women with unexplained recurrent miscarriage who conceive naturally is significantly higher than currently achieved after pre-implantation genetic screening/IVF. In women with h/o 2nd trimester miscarriage attributable to cervical factors, an ultrasound indicated cerclage should be offered if cervical length is <25mm before 24wks of gestation. Heparin therapy may improve live birth rate of women with second trimester (not first trimester) miscarriage associated with inherited thrombophilias.

There is insufficient evidence to evaluate the effect of uterine septal resection, progesterone, hCG, suppression of high LH levels in PCOS, metformin, paternal cell immunisation, third-party donor leucocytes, trophoblast membranes and IVIG.

# NOW YOU SEE ME - A SERENDIPITOUS DISASTER



**Dr Revathy Panicker**

26 Year old Mrs X, married for 3 years presented to KJK hospital for infertility work up. After routine history, evaluation and investigation, both partners were found to be on the normal side. In view of the long period of married history, the couple was subjected to a course of IUI. In view of IUI failure after 3 attempts, patient was taken up for operative laparoscopy + diagnostic hysteroscopy to rule out tubal and associated factors. During the procedure, hysteroscopy showed a normal cavity with left ostia being occluded with periosteal adhesions. In view of periosteal adhesions sample was taken for gene expert and culture (MGIT). Right ostia appeared normal. While in laparoscopy uterus appeared normal, Tubal spill was seen only on the right side. Minimal endometrioitic deposits seen over the

posterior surface of uterus and also on the retro ovarian surface, same fulgurated. After peritoneal lavage and check laparoscopy, liver appeared bulky and nodular. Owing to this finding post operatively she was subjected to USG abdomen and LFT test. Liver enzymes were on the normal side while in USG there was a diffuse alteration in texture and RT hepatic vein was suspected to be occluded, radiologist advised for a CT confirmation. Hence forth patient was advised a Gastro consultation at discharge. When the patient later on reported for post operative follow up she had her CT scan and gastro consultation done and was diagnosed with Budd Chiari syndrome.



## **Discussion :**

Budd-Chiari syndrome is a congestive hepatopathy caused by blockage of hepatic veins. This syndrome occurs in 1/100 000 in the general population. Hypercoagulable state could be identified in 75% of the patients; more than one etiologic factor may play a role in 25% of the patients. Primary myeloproliferative diseases are the leading causes of the disease. Two of the hepatic veins must be blocked for clinically evident disease. Liver congestion and hypoxic damage of hepatocytes eventually result in predominantly centrilobular fibrosis. Doppler ultrasonography of the liver should be the initial diagnostic procedure. Hepatic venography is the reference procedure if required. Additionally liver biopsy may be helpful for differential diagnosis.

Budd-Chiari syndrome (BCS) is an uncommon disorder characterized by obstruction of hepatic venous outflow. The obstruction may be thrombotic or non-thrombotic anywhere along the venous course from the hepatic venules to junction of the inferior vena cava (IVC) and the right atrium. Hepatic veno-occlusive disease and cardiac disorders are excluded from this definition. BCS is a heterogeneous clinical condition-it may be curable or potentially lethal. The patients have an acceptable prognosis with appropriate management compared to other chronic liver diseases. It is a rare but important syndrome because many disorders, such as hematologic or malignant diseases, may be complicated with BCS.

Patients may present with acute signs and symptoms of abdominal pain, ascites and hepatomegaly or more chronic symptoms related to long-standing portal hypertension.



# Fibroid Complicating Pregnancy: A Case Report

Dr. Abhilash Antony

Uterine leiomyomas are benign smooth muscle tumors of the uterus. They are present in approximately 20-50 % of women of reproductive age. Presence of myoma during pregnancy is potentially a serious problem and of frequent clinical concern since fibroids are commonly detected in women of reproduction age, and have long been implicated as a cause of adverse pregnancy outcome. The incidence of leiomyoma during pregnancy is approximately 2 % and the cited range depends on the frequency of routine sonography and population characteristics. The stimulatory effects of pregnancy on myoma growth are unpredictable and can be impressive. These tumors respond differently in individual women and may grow, regress or remain unchanged in size during pregnancy. Though in some cases it does not affect the outcome of pregnancy majority are associated with complications like abortion, Preterm labor, IUGR, PROM, Placental abruption, uterine dysfunction and obstructed labor. So careful monitoring of the patient is needed during antenatal, intranatal and postnatal period. Here we are reporting a case of myoma complicating pregnancy which ended up in caesarean hysterectomy.

## CASE REPORT

34 year old G2 P1 L1 who conceived spontaneously with previous history of laparoscopic myomectomy (cavity not opened) and previous caserean myomectomy and who had a regular antenatal evaluation from our hospital was diagnosed to have multiple fibroid uterus during her first visit. Ultrasonography was suggestive of lower segment intra mural fibroid around 10x 10 cm, anterior and fundal fibroids around 7 and 6 cm along with multiple small fibroids. She had her first antenatal visit at 2 months amenorrhoea in KJK hospital. Large fibroids were diagnosed along with pregnancy. Patient was explained all risks of obstetric complications for large fibroid with pregnancy. She decided to continue the pregnancy. Patient was admitted at 32 week due to abdominal pain and was treated symptomatically and supportively. Sonography showed normal single foetus with 30-32 weeks gestational age. She was counselled regarding further course of management. Steroids were administered. With tocolytics and careful monitoring in the hospital, she continued till 34 weeks gestation. An elective caesarean was planned for her in view of possible complications especially atonic PPH. Blood and blood products were arranged prior to the surgery. An informed consent was taken for caesarean and if needed classical CS as she had a large cervical fibroid. Consent was taken for myomectomy as well as hysterectomy prior to the procedure. Just after 34 weeks, an elective LSCS was done in the presence of senior gynaecologist and anaesthetist and delivered a live, female baby weighing 2.14 kg with good appgar.

**Intraoperative findings:** Uterus enlarged to around 28-30 weeks with multiple intramural to subserous fibroids. The largest was a cervical fibroid of 12 x 10 cm. Although the initial plan was to avoid myomectomy along with CS, there were large fibroids in the lower segment and particularly at the incision site. So the larger fibroids were removed to enable closure of uterine incision. Prophylactic oxytocics were given but inspite of these measures, there was a steady oozing from posterior uterine wall. An early decision for hysterectomy was taken in view of the large size of the uterus and persistent hemorrhage and also as she had no future fertility desires. A subtotal hysterectomy was then performed. Intraoperatively 4 units of PBC and 5 units of FFP were transfused.

Specimen weighed 3 kg and was sent for HPE. Postoperative period was uneventful.

## DISCUSSION

Uterine leiomyoma are the most common benign solid pelvic tumours encountered during pregnancy. Majority of leiomyomas are asymptomatic in pregnancy. Leiomyomas in pregnancy can cause premature labor, abruptio placentae, malpresentation, labor dystocia, intrauterine growth retardation and pelvic pain. Adequate blood and optimal hydration status should be ensured preoperatively. Surgeon must be prepared to deal with the extent of tumour which involves not only hysterectomy but also management of bowel or ureteric involvement or injury rarely. Caesarean Myomectomy is currently advocated for small and medium size fibroids. For big fibroids large raw area with increased vascularity due to pregnancy poses a problem. Leaving behind the fibroid at caesarean section and treatment at later stage is also an option. In our case as the patient goes to atonic PPH, it led to increased bleeding and decision for hysterectomy was taken. Although rare, emergency encounters with such masses continue to be the surgeon's nightmare. Fibroids during pregnancy lead to increase in rate of Caesarean Section due to high incidence of dysfunctional labor and malpresentations.



They are also associated with increased risk of postpartum haemorrhage, thus the obstetrician dealing with such patients should be experienced to deal with any untoward events during management. Pain is the most common complication of fibroids during pregnancy. The symptoms can usually be controlled by conservative treatment. Some women with a previous myomectomy may need to be delivered by elective cesarean delivery prior to the onset of labor, particularly if the uterine cavity was entered. UAE is an alternative procedure to operative intervention for the treatment of symptomatic fibroids, but is absolutely contraindicated in pregnancy and in women desiring future fertility.

#### Main Points

- o Uterine fibroids are very common in women of reproductive age. Most are asymptomatic; however, severe localized abdominal pain can occur if a fibroid undergoes so-called "red degeneration," torsion, or impaction. Pain is the most common complication of fibroids in pregnancy, and is seen most often in women with fibroids > 5 cm during the second and third trimesters of pregnancy.
- o Approximately 10% to 30% of women with fibroids develop complications during pregnancy.
- o In early pregnancy, spontaneous miscarriage rates are greatly increased in pregnant women with fibroids compared with those without fibroids, and bleeding is significantly more common if the placenta implants close to the fibroid. In late pregnancy, such complications include preterm labor, placental abruption, placenta previa, and fetal anomalies.
- o Pain is the most common complication of fibroids during pregnancy. The symptoms can usually be controlled by conservative treatment (bed rest, hydration, and analgesics), but may require definitive surgical resection in rare instances.
- o Prior to pregnancy, myomectomy can be considered in women with unexplained infertility or recurrent pregnancy loss, although whether this intervention improves fertility rates and perinatal outcome remains unclear. Uterine artery embolization is an alternative procedure to operative intervention, but is contraindicated in pregnancy and in women desiring future fertility.

## RESIDUAL OVARY SYNDROME

Dr. AISHWARYA



Mrs. X, aged 53 years, para 2 live 2 with previous 2 LSCS and history of Total abdominal hysterectomy 16 years back, presented with complaints of low backache for one year. An MRI was done as requested by an Orthopaedician which showed an ovarian cyst of 7 cm, and she was referred to us for laparoscopy. Total abdominal hysterectomy was done for Fibroid uterus in 2001. She also has a history of fibroadenoma left breast for which lumpectomy was done in 1990. Her mother had a history of mucinous cystadenoma ovary.

Ultrasound at KJK hospital showed a cyst of size 5.7 x 6.4 cm with internal echoes and normal vascularity in left ovary. Right ovary was obscured. Operative laparoscopy was planned in view of large symptomatic ovarian cyst. Her CA 125 was 34 and CEA was 0.95 ng/ml.

Intra operative findings - A large ovarian cyst of size 7cm on the left side was seen engulfed with dense bowel adhesions covering posteriorly and with the lateral pelvic wall. Right ovary looked atrophic and was adherent to the lateral pelvic wall. Left ovarian cyst was separated from the adhesions by careful dissection and oophorectomy was performed. Right ovary was released from the lateral pelvic wall and oophorectomy was done.

#### Residual ovary syndrome:

When a woman presents with pelvic pain or a pelvic mass or dyspareunia post hysterectomy, a thorough clinical examination should be performed. An ultrasound examination often gives a diagnosis if there is an ovarian cyst or a mass. A CT or MRI may be done in difficult cases. Arguments continue as to remove or retain the ovaries at the time of hysterectomy. NICE Guidelines recommends that healthy ovaries may be left behind during a hysterectomy, and removal of ovaries should only be undertaken with the expressed wish and consent of the woman. Women with significant family history of breast or ovarian cancer should be referred for genetic counseling prior to a decision about oophorectomy. According to NICE Guidelines, if removal of ovaries is being considered, the impact of this on the woman's wellbeing and, for example, the possible need for hormone replacement therapy should be discussed.

Relief of pain may be achieved by ovarian suppression with hormones (high dose progestins or GnRH agonists). This is only for temporary relief and the final and definitive treatment is the removal of ovaries either by laparoscopy or open surgery. Difficult surgery should be anticipated due to the formation of adhesions around the ovaries involving the bowel and ureters which can be damaged in the process. Ureteric stenting may be planned keeping in mind the distorted anatomy due to adhesions before proceeding to oophorectomy. Ovaries must be sent for histopathological examination to rule out malignancy, and surgery should be followed by supervised hormone replacement therapy.



Left ovarian cyst engulfed in dense adhesions



Left ovarian cyst separated from the base

# STATISTICS

APRIL, MAY, JUNE

TOTAL SURGICAL PROCEDURES	257	LAP TUBAL RECANALISATION	1	EUA	1
TOTAL LAPAROSCOPY	72	OVARIOLYSIS + ADHESIOYSIS	1	<b>OBSTETRICS</b>	
OPERATIVE LAPAROSCOPY	60	LAVH+ BSO	1	TOTAL	64
DIAGNOSTIC LAPAROSCOPY	12	ADNEXECTOMY + URETERIC STENTING	1	ELECTIVE CS	21
TOTAL HYSTEROSCOPY	74	PARATUBAL CYSTECTOMY	1	EMERGENCY CS	26
OPERATIVE HYSTEROSCOPY	11	RESIDUAL OVARIAN SYNDROME	2	FTND	12
DIAGNOSTIC HYSTEROSCOPY	63	PCO DRILLING	2	VACUUM DELIVERY	4
<b>HYSTEROSCOPIC PROCEDURES</b>		FULGURATION OF ENDOMETRIOTIC DEPOSITS	1	CAESAREAN HYSTERECTOMY	1
SEPTUM RESECTION	4	<b>SURGERY FOR ECTOPIC</b>		<b>CONCEPTION + IUI STATISTICS</b>	
POLYPECTOMY	2	SALPINGECTOMY	5	TOTAL CONCEPTION	81
ENDOMETRIAL SAMPLING	2	SALPINGOSTOMY	2	TOTAL IUI CONCEPTION	21
ADHESIOYSIS	1	<b>SURGERY FOR ENDOMETRIOSIS</b>		IUI CONCEPTION %	25.9 %
SMF RESECTION	2	CC	10	SPONTANEOUS	10
<b>LAPAROSCOPIC PROCEDURES</b>		FULGURATION OF DEPOSITS	1	COH ONLY	13
TLH	13	<b>OTHER MAJOR SURGERIES</b>		<b>IVF/ICSI STATISTICS</b>	
TLH+ BSO	4	VH + PFR	1	TOTAL NO OF CASES	106
LAP MYOMECTOMY	11	MINOR PROCEDURES	44	FET	27
LAP STERILIZATION	1	SE	10	CONCEPTION THROUGH IVF	37
OVARIAN CYSTECTOMY	13	ENCIRCLAGE	23	IVF CONCEPTION RATE	34.9 %
RIGHT ADNEXECTOMY+ MIRENA INSERTION	1	MIRENA INSERTION	1	FET CONCEPTIONS	14
ADHESIOYSIS + B/L SALPINGECTOMY	1	MALE SURGERY (PESA/ TESE)	12	FET CONCEPTION RATE	51.8 %

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