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NEWS LETTER

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GYNAECOLOGICAL CANCERS - AN AWARENESS

September is the month of awareness for gynaecological cancers. The gynaecologic cancers include cancers of cervix, endometrium, ovary, vulva and vagina. The goal of Foundation for Women's cancer is to reach out to more and more people each year. As we all know, of all these five cancers, the most effective screening tests are available for cervical cancer.

The ACS 2020 guideline recommends cervical cancer screening with an HPV test alone every 5 years for everyone with a cervix starting from the age of 25 years until 65 years. If HPV testing alone is not available, people can get an HPV/ Pap cotest every 5 years or a Pap test every 3 years.

In our country where sexual debut of a girl usually happens later, the age to start screening has been recommended by WHO/ FOGSI as 30 years. If HPV / Pap cotest is done, the interval between screenings can be kept at 5 years. Annual screening with Pap smear unnecessarily increases the burden of additional tests without much benefit.

Dr. K. Jayakrishnan

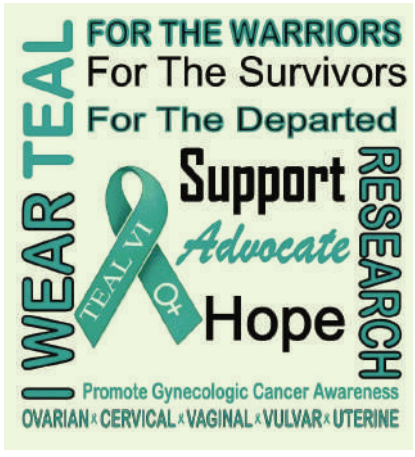
EDITORIAL

As far as ovarian and uterine cancers are concerned, an education to women about the symptoms and risk factors is very essential. An unhealthy life style with increasing obesity among the youngsters has definitely put ovarian and endometrial cancers ahead of Ca Cervix in the Indian scenario too.

Moreover, as there are genes associated with breast, ovarian and uterine cancers, those women with a positive family history must be made aware of BSE (Breast self-examination) and screening for ovarian cancers with ultrasound and CA 125, although this is not as effective as screening for cervical cancers.

Those women with polycystic ovaries and irregular cycles are at a higher risk for uterine cancer. So regularisation of periods is something that has to be given due importance to.

In general, the Foundation for Women's cancer highlights the importance to LEARN (with more educational programmes about symptoms and risk factors), LISTEN (to one's own body when there are early warning symptoms) and ACT (never neglect symptoms and do regular screenings and health check-ups) to keep these cancers away.



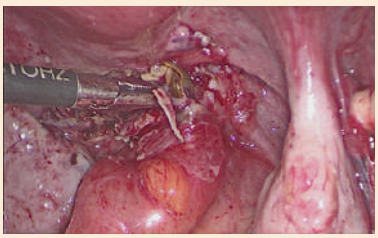
INCARCERATED MERSILENE TAPE, A RARE COMPLICATION OF ABDOMINAL ENCERCLAGE

Dr Reshma R

Mrs X, 37 yrs old presented to OPD with complaints of feeling of foreign body in anal canal while straining on stools. She gives history of 3 miscarriages following which she underwent Laparoscopic abdominal encerclage. Then she had 2 LSCS and laparoscopic sterilization.

On per rectal examination the mersilene tape knot felt inside the anal canal 4 cm from anal opening. She underwent ultrasound and CT pelvis with contrast. USG showed suture material in lower uterine segment. It was located 4.8 cm from uterine fundus and 2.6 cm from external os. CT pelvis did not show any abnormalities. Gastrosurgery consultation done and she was posted for laparoscopy.

Laparoscopy done with gastrosurgery assistance. On laparoscopy uterus visualised normally, both fallopian tubes showed evidence of sterilization. Both ovaries adherent to uterus. Posteriorly rectosigmoid densely adherent at the level of uterosacrals. Bowel adhesions released by sharp and blunt dissection. Rectal probe introduced. Knot of mersilene tape identified and traced from the uterine end and same divided. Other end was traversing through the bowel wall. Bowel wall end of the tape was removed. Bowel wall repair done with 2-0 vicryl as interrupted mattress sutures. Mersilene tape retrieved in endobag and bowel integrity checked.



DISCUSSION

Cervical insufficiency has become one of the leading causes of recurrent abortion and premature labor in the second or the third trimester. Cervical insufficiency or cervical incompetence is defined as asymptomatic cervical shortening and dilatation in the absence of detectable uterine contractions.

In the absence of the classic recurrence, it is a diagnosis of exclusion, after eliminating other causes of preterm delivery/abortion. High risk of cervical insufficiency may result from developmental abnormality (abnormal collagen, diethylstilbestrol exposure), previous surgery (amputation or conisation) and laceration from previous transvaginal cerclage or cervical rupture. Laparoscopic abdominal cerclage is emerging as the preferred treatment option for patients with refractory cervical insufficiency.

Nowadays, the transabdominal cerclage is performed either by laparotomy or by laparoscopy approach or even by robotic techniques, consisting in the placement of a synthetic mesh around the uterine isthmus. Laparoscopic procedures appear to be safe for both mother and fetus. Laparoscopy provides superior views of the uterine cervicoisthmic junction compared with vaginal or abdominal surgery, leads to fewer bowel adhesions and presents reduced abdominal wall trauma, blood loss, postoperative pain, thus offering a faster recovery time with a reduced hospitalization period.

Many types of synthetic meshes are commercially available, each having different qualities, but all having the same common major advantage represented by the zero potential for infectious disease transmission. They are generally characterized by pore size, filament type, local tissue durability (absorbable or non-absorbable) and stiffness. The pore size is a parameter that dictates whether host cells can infiltrate and integrate with the mesh. It has been suggested that multifilament synthetic grafts may be correlated with higher erosion rates. The rigidity or stiffness is the parameter that shows the balance that the graft must demonstrate in order to correct the disease while complying with the patient's anatomy. In terms of selecting the most appropriate tape type to use for cervical cerclage, some factors must be taken into consideration. The absorbable polylactic acid and polyglycolic acid products, despite of having a low erosion rate and not showing to promote infection, dissolve rapidly, in 30- 90 days, losing so their tensile strength and limiting their advantage for cervical cerclage. Synthetic meshes are characterized based on pore size and filament structure. Macroporous meshes (pores > 75µm) allow the admission of macrophages, fibroblasts, blood vessels and collagen fibres into the pores, thus lowering the infection risk of graft

materials and promoting the graft's long-term biocompatibility, thus making microporous meshes (<10 µm) that do not integrate into tissue preferred in cases of cervical cerclage. Monofilament meshes do not have small interstices like multifilament meshes do, this preventing the small bacteria (<1 µm) replication within the interstice and allowing the host immune system to reach and combat the bacterial colonization of the graft. For all this reasons, we consider that the synthetic microporous monofilament tapes are the most appropriate ones to use for cervical cerclage.

PROCEDURE

After checking the abdominal cavity, the vesicouterine peritoneum is opened and the bladder is dissected from the lower uterine segment, exposing the uterine vessels in the front on both sides. A nonabsorbable suture, with adjacent straightened blunt needles to allow passage through the trocar, is introduced into the abdominal cavity. The thread is placed by passing each needle medial to the uterine vessels from posterior to anterior or anterior to posterior, at the internal cervical os level bilaterally. The landmarks for this placement include the uterosacral. The ends of the stitch are trimmed and a silk suture is used to secure the knot to the lower uterine segment in an effort to minimize protrusion of the knot. The vesicouterine peritoneum is then reapproximated over the laparoscopic cerclage ligaments; a distance of 1.5 cm superior and 1 cm lateral to the insertion of the uterosacral ligament on the posterior uterus is initial a good guide for needle placement. After checking the correct placement of the tape medially from the uterine artery and aloof from the ureter, the tape will be knotted five or six times anterior or posterior at the cervicoisthmic junction.

The complications assessed included wound infection, hemorrhage and fetal loss. Migration of the synthetic band through the cervical wall (maybe a result of the pressure from the enlarging and possibly contracting uterus) seems to occur rarely. Incidence of wound infections, bladder or bowel damage and necessity for hysterectomy at the time of the TAC appears to be rare.

PUSHING THE BOUNDARIES OF LAPAROSCOPIC MYOMECTOMY!

Dr Nairuti Sompura

INTRODUCTION

Around 25-30% women of reproductive age present with uterine leiomyomas which are the most common benign tumours of the female pelvis. More than 50% patients are asymptomatic not requiring any treatment. Management of symptomatic myoma depends on the patient's age, size and location of the myoma and future fertility issues. Myomectomy is the best option in women requiring further fertility and uterine conservation. The advantages of laparoscopic approach are well proven and include smaller incision, shorter hospital stay, less subjectively reported postoperative pain, faster recovery and better assessment of the abdominal organs. Limitations to laparoscopic approach include surgical expertise and need of suturing. Power morcellation further adds to the advantages of minimally invasive surgery to remove large myomas. Laparoscopic approach to huge myomas remains controversial and technically challenging. Presenting a case of Nulliparous woman with 22-24 weeks sized uterus with multiple myomas that were removed successfully through laparoscopy.

CASE REPORT

A 42 year old nulliparous woman with complaint of heavy menstrual bleeding with passage of clots since 1 year diagnosed to have multiple fibroids on ultrasound. Her BMI was 35.88 kg/m2.There was no other associated changes in bowel or bladder habits. No other history of nausea, vomiting, anorexia or loss of weight. There was no significant medical, surgical, and family history. On per abdomen a firm mass of 22-24 weeks was palpable. On speculum examination cervix appeared healthy but owing to bleeding smear could not be taken. On bimanual examination Uterus was found to be enlarged to 22-24 weeks size. Ultrasonography was done which showed markedly enlarged uterus with 7 x 8 cm Subserous fibroid and Posterior lower segment intramural fibroid of 5 cm. Bilateral ovaries appeared cystic with internal echoes with left ovary adherent to the uterus. MRI showed enlarged uterus with multiple fibroids SSF in right iliac fossa 9 x 9 x 8 cm, Largest IMF in right lateral wall 3x 4 cm, SMF 2.2 x 2 cm and posterior wall fibroid of 3.6 x 2.7 cm and chocolate cyst in the left ovary with bilateral utero-ovarian adhesions. Endometrial thickness was 10 mm.

The case was challenging in terms of gigantic size of myoma and route of surgery in this morbidly obese patient. After discussing the options with the patient, complete pre-anaesthetic investigations and check-up was done. Laparoscopic myomectomy was planned keeping adequate blood products ready. The need and risk of laparotomy and hysterectomy was explained. Since putting the primary trocar above

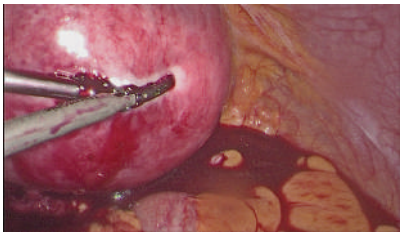
the fibroid was not possible, it was decided to put the primary port supra-umbilically mid-way between upper and lower margin of fibroid so that uterine attachment and feeding vessels can be visualized properly. Intra-operative findings revealed an exceptionally enlarged uterus with multiple intra-mural and sub-serosal myomas largest in the posterior wall of 7 cm with posterior bowel adhesions.

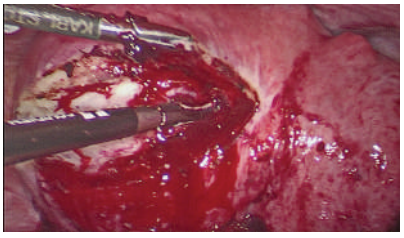
Diluted vasopressin was injected into the myometrium until blanching was achieved. Oblique incision was kept and cleavage plane was identified and myoma was enucleated from its bed by traction- counter traction method. Manipulation of myoma was a big challenge. Total of 12 fibroids from anterior and posterior wall were removed largest measuring 7 cm. Bleeding points were coagulated using bipolar cautery. The defect was closed in two layers, inner layer with 1-0 vicryl in interrupted manner and outer with V-loc barbed sutures in continuous manner. Intra-operatively scan was done and when no other large fibroid was visualised, fibroids were removed using 12 mm Rotocut morcellator and sent for histopathology. The overall time taken for surgery was 400 minutes. Intraoperatively patient was transfused 2 pint PRBC and FFP. The weight of the specimen retrieved was 1000 g. Despite the difficulties faced there were no major intraoperative or post -operative complications. Patient was discharged on 6 th post-operative day on oral antibiotics and analgesics.

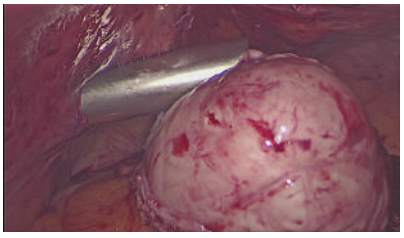
DISCUSSION

Uterine leiomyomas are the most common benign smooth muscle tumours arising from the female pelvis. Mostly, myomas are asymptomatic and small, but in some cases, they can reach >10 cm in size. Asymptomatic myomas usually require no treatment. For symptomatic myoma, hysterectomy is a definitive solution, but for those women of reproductive age group, infertility, and who wish to conserve their uterus, laparoscopic myomectomy remains the gold standard approach. Semm et al. performed the first laparoscopic myomectomy and the largest myoma removed till date with laparoscopy is of 21 cm. The advantages of laparoscopic myomectomy over abdominal myomectomy are a short hospital stay, early recovery, fewer adhesions, minimal blood loss, and better cosmetic value. Laparoscopic myomectomy is a challenging method especially in cases of large myomas.

Placement of trocar is very important in case of large myomas reaching up to the umbilicus. It is suggested to place trocar superior to umbilicus that is high epigastric port placement technique for such type of giant myomas. Major hurdles and challenges in removing a gigantic myoma of this size are difficulties in finding the uterine attachment, finding cleavage plane, narrow operating space, specimen retrieval, repairing the myometrial defect, increased operative time, vascular injury to adjacent structures and conversion to laparotomy. Another major concern in removal of large uterine myomas laparoscopically, is specimen retrieval. Morcellation can lead to inadvertent dispersal of myoma fragments in the abdominal cavity leading to benign and malignant complications e.g. parasitic myoma, disseminated leiomyomatosis and even occult malignancy and leiomyosarcoma. Surgical options and approaches are not standardized, and the appropriate management of these very large myomas is complex and requires exceptional surgical skill, laparoscopic suturing and anaesthesia back up. This case emphasizes that size does not pose a limit to remove these gigantic myomas laparoscopically when surgical expertise and good anaesthesia facility is available







CONCLUSION

The case emphasizes that size does not pose a limit to removing these gigantic myomas laparoscopically when surgical expertise, efficient energy sources and anaesthesia is available. Laparoscopic myomectomy is technically challenging and difficult for giant myomas and should be performed by an experienced surgeon.

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MANAGING SUBMUCOUS FIBROIDS DO'S AND DONT'S

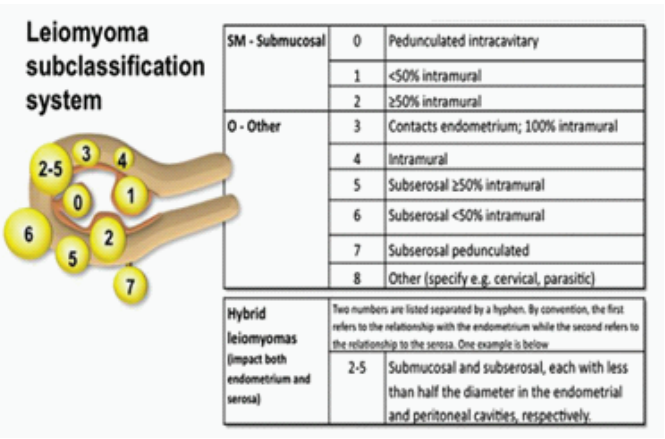
Dr Silpa P

32yr old lady, P2L2, previos 2 LSCS, with history of hypothyroidism, presented to our OPD with history of heavy menstrual bleeding for past 1.5 yrs. She consulted a local hospital 1 month back where Dilatation and curettage was done and HPR showed Secretory phase endometrium, occasional polypoidal and haemorrhagic, endometrial tissue fragments seen, followed by insertion of Emily and was put on T. Primolut N. Patient continued to have bleeding PV even while on Primolut N 2-2-2-2 due to which she came to our OPD, USS showed bulky uterus with a large posterior SMF 6x 4.6 cm abutting endometrium, anterior wall SMF 2.8 x 2.6 cm, completely in to the canly. both ovaries were normal. Her Hb was 8 mg %, anaemia corrected with 2 dose orofer injection and final Hb was 10.3 mg%. 2 doses of Lupride injection taken as anaemia correction was needed before surgery. After anaemia correction was done proceeded with Laparoscopic Myomectomy and operative hysteroscopy.

During Hysteroscopy, cavity showed pedunculated SMF 4 x 4.5 cm and another fibroid seen projecting into the cavity, Intraoperative scan done. This fibroid was found to be posterior IMF 6x5 cm<50% into the cavity. The fully Sub mucous fibroid was well delineated by scan during hysteroscopy. Due to its large size, part of it only was removed hysteroscopically. As fluid overload was a possibility, it was decided to remove the rest laparoscopically. During laparoscopy, uterus enlarged 14 wk, posterior IMF 6 x 5 cm with SM extension removed and also part of SMF (after hysteroscopic resection) removed. Cavity entered, sutured in 2 layers, inner layer with sub endometrial interrupted suture and outer layer with base -ball sutures. Myoma retrieved through morcellation through left lateral port. Patient recovered well post surgery and was discharged in Post operative day 3. HPR reveals - Leiomyoma.

DISCUSSION:

Uterine fibroids, or leiomyomas, are the most common benign tumors in women of reproductive age. Their prevalence is age dependent; they can be detected in up to 80% of women by 50 years of age. Submucosal leiomyomas are estimated to be the cause of 5-10% of cases of abnormal uterine bleeding, pain, subfertility and infertility.



INDICATIONS FOR SURGERY

1. Menorrhagia 2. Subfertility / Infertility

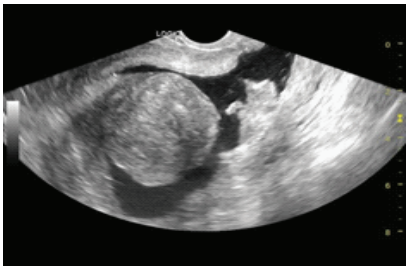
Surgical treatment remains the main stay of treatment in symptomatic submucosal fibroids. Medical therapy with GnRHa appears useful in short term but side effects limits their long term use. medical management of fibroids delay effort s to conceive and is not recommended for the management of infertility associated with fibroids. However newer, novel therapies like aromatase inhibitors, mifepristone, SERM, SPRM have shown promise in symptom improvement and fibroid regression without hypoestrogenic symptoms assossiated with GnRH analogues and also alternatives to surgery like UAE, MRgFUS, myolysis, RFA all are still being investigated for long term use. Hysteroscopic myomectomy is the least invasive surgery for fibroid removal. It is most effective in type 0 and type 1 fibroids. Type 2 are more difficult to resect completely by hysteroscopy and may have to be combined with laparoscopy/laparotomy.

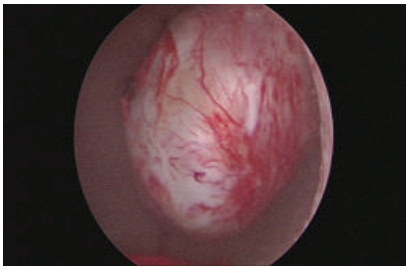
COMPLICATIONS

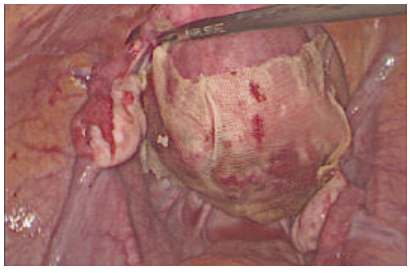
1. Excessive fluid absorption 2. Uterine perforation
3. Haemorrhage 4. Thermal burns 5. Adhesions

INFERENCES

Dilatation and Curettage is not recommended for sub mucous fibroids. Emily / Mirena insertion is not advised for fibroids especially when cavity is distorted. Sub mucous fibroids causing heavy menstrual bleeding and dysmenorrhoea needs removal. Sub mucous fibroids are best removed hysteroscopically if less than 2 cm. Large sub mucous fibroids and those with less than 50% extension to cavity (Type 2) are better tackled laparoscopically.



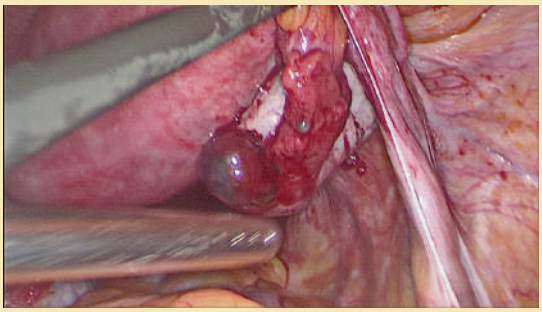




OVARIAN ECTOPIC PREGNANCY

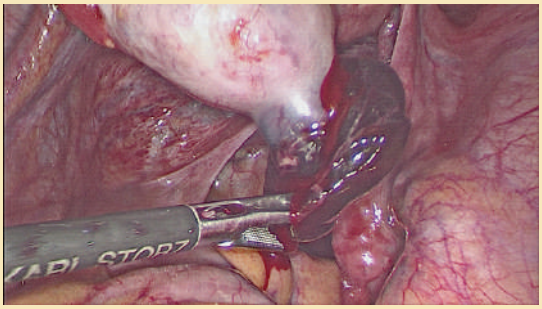
Dr Seetha

Case 1: 25 year old woman G5E2A2, conceived through IVF, had come for routine scan after confirming pregnancy. This was the patient's 4th attempt at IVF conception. She had a previous history of 2 ectopic pregnancy for which left salpingectomy was done. The other ectopic pregnancy was medically managed. Ultrasound scan done showed right adnexal lesion 1.3 x 1.2 cm with increased vascularity seen close to right ovary. Routine investigations were done and patient was taken up for Emergency Operative laparoscopy. Intraoperatively it was found to be a ruptured right ovarian ectopic pregnancy with hemoperitoneum which was excised. Histopathology revealed chorionic villi with ovarian follicles. Postoperative period was uneventful. Patient was then discharged on 2nd postoperative day.



Case 1 : Right ruptured ovarian ectopic

Case 2: 23 year old G3A2 at 5 weeks came for a routine scan for confirming pregnancy. Patient conceived spontaneously. Ultrasound scan done revealed a left adnexal mass of size 2 x 2 cm with hemoperitoneum. Routine investigations were done. Patient was taken up for Emergency Operative laparoscopy. Intraoperatively it was found to be an left ovarian ectopic pregnancy with hemoperitoneum. Ovarian ectopic was excised. Histopathology revealed chorionic villi with ovarian follicles. Postoperative period was uneventful. Patient was discharged on 2nd postoperative period.



Case 2 : Left ovarian ectopic

Discussion:

Ovarian pregnancy constitutes only around 1-3% of all ectopic pregnancies. However, it accounts for approximately 10% of deaths related to pregnancy, making it an important entity to recognise. The aetiology of ovarian ectopic remains largely idiopathic. Possible reasons include fertilisation of the ovum in the distal fallopian tube and secondary implantation within the ovary or pregnancy occurring in an unextruded follicle. The commonly associated risk factors are intrauterine device use and ovulation induction. Ovarian ectopic pregnancies are usually not related with aetiologies such as pelvic inflammatory disease, previous gynaecological surgery.

Usual presenting symptom is varying degree of abdominopelvic pain during the first trimester (usually 6-10 weeks gestational age). Per vaginal haemorrhage can also occur. Ovarian ectopic are also detected in asymptomatic women during routine obstetric ultrasound scans. First diagnostic modality is usually ultrasound scans. Trans vaginal ultrasound scan is done at the outset or once a suspicion is made in trans abdominal ultrasound scan. However, due to varying anatomical locations, ultrasound may not detect all cases of ovarian ectopic pregnancy.

Transvaginal ultrasound scan demonstrates an adnexal mass or cyst with a wide echogenic outer ring, either on or within the ovary. Pressure applied through probe will be unable to separatee mass from the ovary. A hyper vascular rim may be seen on colour doppler. Intraoperatively Spielberg criteria describes four criteria used to identify ovarian ectopic pregnancies. These include an intact fallopian tube on the affected side, a gestational sac occupying normal position of the ovary, ovary and gestational sac connected by the utero-ovarian ligament to the uterus and histological confirmation of ovarian tissue in the gestational sac wall.

The gold standard for both investigation and therapeutic intervention is laparoscopy. Laparoscopy is the treatment of choice for haemodynamically stable patients. Ovarian conservation should be attempted by an ovarian cystectomy or wedge resection. Early bleeding for small lesions can be managed by ovarian wedge resection while larger lesions Oophorectomy must be performed. Emergency laparotomy should be done in haemodynamically unstable patients. Methotrexate can be tried in asymptomatic patients with small, unruptured ovarian ectopic pregnancies however, it is mostly reserved for cases where there is persistent trophoblastic tissue. It has been recommended in cases in which the gestational sac is lower than 30mm, without fetal cardiac activity, less than 6 weeks old and without presence of hemoperitoneum.

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POST HYSTERECTOMY MASS ABDOMEN PARASITIC LEIOMYOMA AS A DIFFERNTIAL DIAGNOSIS

Dr Shilpa V

A 46 year old woman, with previous history of Total Abdominal Hysterectomy with Bilateral Salpingectomy performed 1.5 years prior for AUB with Multiple Fibroid Uterus, came to the OPD with complaints of a mass per abdomen. It was not associated with any history of abdominal pain, urinary or bowel complaints, early satiety or nausea.

On examination, vitals were found stable. Per abdomen examination revealed a mobile firm lesion with all borders palpable in the right lumbar and iliac region. Ultrasonography done showed a mixed echogenic mass of 9.4x10.2cm with no peripheral vascularisation towards the right side of the abdomen. Bilateral ovaries were obscured and could not be visualised. MRI scan done further revealed a large hyperintense mass with hypointense components with a thick hypointense capsule in the upper pelvis extending into the lower abdomen. The lesion was surrounded by a well defined smooth margin of fat. Both ovaries were visualised and found to be of normal size and morphology. The features were indicative of a parasitic leiomyoma or broad ligament fibroid but no definite attachment could be made out. Tumour marker Ca-125 was done and found negative.

Patient was thence posted for Operative Laparoscopy. Intraoperatively, pelvic adhesions were released. A mass seen attached to the posterior peritoneum of size 10 x 9 cm It was seen drawing vascular supply from the surrounding structures, found to be a parasitic fibroid on enucleation. The mass was enucleated and placed into a safety isolation bag and was retrieved after in-bag morcellation. Peritoneal washing done using normal saline. The morcelated mass was sent for HPR which revealed Leiomyoma without atypia. Postoperative period was uneventful and patient was discharged on the third postoperative day.

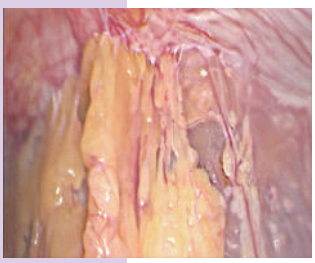
Discussion:

Uterine leiomyomas are the most common benign solid pelvic tumours in women. Risk factors primarily include- Nulliparity, Obesity, African-american race, Hormone replacement therapy. The most common site of fibroid is in the uterus; however, it can originate wherever smooth muscle cells exist. The extrauterine leiomyoma presentations include benign metastasizing leiomyoma, disseminated peritoneal leiomyomatosis, intravenous leiomyomatosis and parasitic leiomyoma.

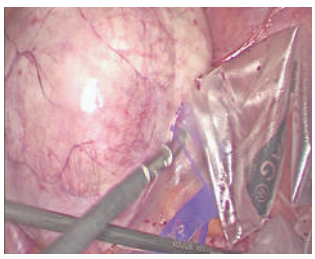
Spontaneous/ Primary Parasitic leiomyomas are rare pathologic structures of uncertain etiology. One theory suggests that a pedunculated subserosal leiomyoma becomes separated from the uterus and derives its nourishment by neovascularisation from adjacent structures such as the bowel, peritoneum, omentum or mesentery. Disseminated peritoneal leiomyomatosis is another theory in which there is development of multiple benign nodules on peritoneal surfaces. Different pathological mechanisms have been implicated including hormonally sensitive smooth muscle areas, genetic factors, pregnancy, oral contraceptive pills, and prior surgery. Estrogen exposure can stimulate metaplasia and differentiation of subperitonealmesenchymal stem cells to smooth muscle cells. Although considered as a benign condition- malignant transformation has also been noted in some cases. Secondary/ Iatrogenic parasitic leiomyoma is caused due to unintentional seeding of fragments during a previous laparoscopic myomectomy while using a morcellator. The duration between the procedure and the incidence of the parasitic leiomyoma is highly variable.

Parasitic Leiomyoma is usually found as an intra-abdominal tumour. The symptoms of parasitic fibroids are not specific and hence some patients may remain asymptomatic until found incidentally. However some parasitic fibroids may cause mass effect due to compression of adjacent organs.Treatment of this type of leiomyoma is usually by surgical resection of the mass either by laparotomy or laparoscopy. Meticulous examination of the blood supply to the parasitic fibroid is crucial for safe resection and good outcome of patient.

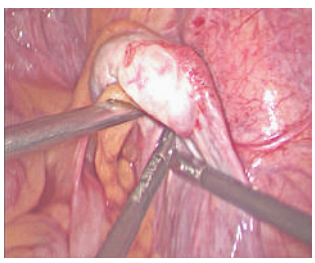
A - Parisitic leiomyoma of 10 x 9cm



B - Mesentric attachment to leiomyoma



C - Leiomyoma placed in the safety isolation bag



D - Bilateral ovaries normal

STATISTICS

Jan. - Aug. 2021

Total no of cases	**344**
Total Laparoscopy	111
Total Hysteroscopy	70
Open	2
Operative Hysteroscopy	23

Obstetrics

Vaginal deliveries	38
Total LSCS	84
Elective LSCS	36
Emergency LSCS	48

Minor Cases

PESA/TESA	10
Bartholin s cyst excision	1
Cu T insertion	1
Amniocentesis	1
Mirena insertion	2
ERA	2
PPS	1
SSG	1
S&E	5
Cervical Encerclage	10
Pipelle sampling	4

Lap Procedures

TLH +/- BSO	14
LAVH	1
Myomectomy	26
Endometriotic cystectomy	7
Adenomyomectomy	7
Salpingectomy for ectopic	14
Salpingostomy for ectopic	5
Dermoid cyst excision	2
Laparoscopic sterilisation	2
Paratubal cystectomy	2
PCO drilling	6
Fulgration of endometriotic deposits	16
Adnexectomy	1
Laparoscopic tubal recanalisation	1
Excision of ovarian ectopic	1
Diagnostic Laparoscopy	2
Laparoscopic encirclage	2

Other Major Cases

Vaginal Hysterectomy	2

Operative Hysteroscopy

Septum resection	1
Polypectomy	5
Sub mucous fibroid resection	3
Endometrial sampling	4
Adhesiolysis	4
Pre IVF Hysteroscopy	53
Tubal cannulation	6

Conception + IUI statistics

Total conceptions	151
Total IUI conceptions	37
IUI conception rate	10.05 %
Other Conceptions	114
Spontaneous	97
COH only	17

IVF/ICSI Statistics Jan to Aug. 2021

Total No of cases	145
Total Conception Rate	34.2 %
Frozen ET cycles	68
Conception rate after Frozen ET	44.2 %

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