Vol. 10 / May. 2020 - June 2020

NEWS LETTER

Email: kjkhospital@gmail.com | www.kjkhospital.com

KJK HOSPITAL

FERTILITY RESEARCH AND GYNAEC CENTRE
Shawallance Lane, Nalanchira, Trivandrum-15
Phone: 0471-2544080, 2544705, 2544706 Fax: 0471-2543926

Editorial

The Covid pandemic has swept through the whole world has plunged into a new crisis for the survival of human race and untold misery to many. In these circumstances we have taken a collective decision to cancel Advances 2020 this year which was postponed to August middle and we will hold it early next year in May 2021.

In between we will have webinars of short duration for monthly meetings if conditions are not ideal for large gatherings .

Be safe and secure. Happy viewing for June Newsletter!

Dr. K. Jayakrishnan

COVID-19 and Human Reproduction Joint Statement: ASRM, ESHRE, IFFS

May, 2020

The American Society of Reproductive Medicine, the European Society of Human Reproduction and Embryology, and the International Federation of Fertility Societies have affirmed in a joint statement that reproduction is an essential human right that transcends race, gender, sexual orientation, and country of origin; a human right to which the COVID-19 pandemic has posed unique threats and challenges. Reproductive health care professionals are in a special position to provide advocacy for this right and promote the health and well-being of their patients.

Declaration of principle

Reproduction is an essential human right that transcends race, gender, sexual orientation, or country of origin. Infertility is the impairment of reproductive capacity; it is a serious disease that affects 8-12% of couples of reproductive age and harms physical and mental well-being. Infertility is time-sensitive, and prognosis worsens with age. While there is no cure for most causes, the disease is most often treatable, and the majority of patients who seek treatment can ultimately become parents.

Final Thoughts

Reproductive care is essential and reproductive medicine professionals are in a unique position to promote health and wellbeing. In addition, ASRM, ESHRE and IFFS are collaborating to advocate for patients and to gather data and resources to enhance the understanding of COVID-19 as it pertains to reproduction, pregnancy, and the impact on the fetus and neonate. The lessons learned from these experiences will be useful as humanity deals with future pandemics.

1. BENZODIAZEPINE USE BEFORE CONCEPTION IS LINKED TO INCREASED RISK OF ECTOPIC PREGNANCY
2. CORD ANOMALIES - AN ANSWER TO SOME OF THE UNEXPLAINED INTRAUTERINE DEATHS IN THIRD TRIMESTER ?
3. HIGH HbA1C - DOES IT WARRANT TERMINATION
4. LAPAROSCOPIC MANAGEMENT OF HUGE OVARIAN CYST : A CASE REPORTS
5. OVARIAN PREGNANCY - DIAGNOSIS AND MANAGEMENT:
6. RECURRENT PREGNANCY LOSS – IMMUNOGLOBULIN A RESCUE THERAPY ?

BENZODIAZEPINE USE BEFORE CONCEPTION IS LINKED TO INCREASED RISK OF **ECTOPIC PREGNANCY**

Dr K Jayakrishnan

Review from Human Reproduction June 2020 -
Review article by Dr K Jayakrishnan

Women who use a class of tranquilisers called benzodiazepines (Benzodiazepines include alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam and triazolam) before becoming pregnant are at greater risk of ectopic pregnancies, according to a study of nearly 1.7 million women.

One of the world's leading reproductive medicine journals, Human Reproduction found that the risk of an ectopic pregnancy, where the embryo starts developing outside the womb, usually in a fallopian tube, was 50% higher in women who had filled out a prescription for benzodiazepines in the 90 days before conception.

Ectopic pregnancies occur in one to two percent of pregnancies each year and are a serious health emergency for women. They are responsible for 6-13% of pregnancy-related deaths, and deaths from haemorrhaging is the leading cause of pregnancy-related death in the first trimester of pregnancy. They can also lead to serious complications and infertility.

Although pelvic infections, use of reproductive technology, intrauterine devices, smoking and increased age are known to be risk factors for ectopic pregnancies, approximately half of women who have an ectopic pregnancy do not have a known risk factor.

A total of 30,046 (2%) pregnancies were ectopic and 17,990 (1%) were to women who had a benzodiazepine prescription before conception.

"This translates to 80 excess ectopic pregnancies per 10,000 pregnancies among women exposed to benzodiazepine compared to those not exposed to benzodiazepine before conception," said Dr Wall-Wieler.

In order to check whether it might be the benzodiazepine use or the medical condition being treated that could be involved in the risk of ectopic pregnancy, the researchers carried out two separate analyses into women diagnosed with anxiety or insomnia.

"For each of these analyses, we saw that the association was not as strong as that seen in the group as a whole. This could mean that either the underlying condition could also be a risk factor for ectopic pregnancies, or that there are other factors that women with anxiety or insomnia share that are also potential risk factors for ectopic pregnancy," she said.

The researchers stress that their findings show only that benzodiazepine use is associated with an increased risk of ectopic pregnancy, not that it causes the condition.

"For women with specific health conditions such as anxiety or insomnia, benzodiazepines can be an important part of their treatment; yet a lot is unknown about how safe it is to use these drugs for women who become pregnant. This study shows that women who use benzodiazepines when they become pregnant are at higher risk of having an ectopic pregnancy. When identifying treatment options, women and their care providers should understand the benefits and risks associated with treatment options, and more options should be available that have been demonstrated to be safe to use before and during pregnancy,"

"It is nearly always premature to draw firm conclusions from a single observational study and more research needs to be carried out. However, it is a relatively low risk intervention to recommend supervised, tapered cessation of benzodiazepine use prior to stopping one's contraception, as long as this can be safely and appropriately done under physician supervision. The potential for positive impact is high if even a small number of ectopic pregnancies can be avoided."

The researchers suggest that healthcare providers could consider carrying out early pelvic ultrasound for women who have used benzodiazepines before conception, particularly if they have other risk factors for the condition. However, many women do not know they have an ectopic pregnancy until they start experiencing pain or other complications.

From Stanford University School of Medicine, said: "For women using benzodiazepines, it is important that providers are aware of the potentially small increased risk of ectopic pregnancy, and women should be counselled about possible symptoms of ectopic pregnancy such as early blood spotting and lower abdominal pain. Early ultrasound and pregnancy hormone blood tests can help identify whether a pregnancy is ectopic or not."

Limitations of the study include the fact that the researchers relied on outpatient prescription data to identify benzodiazepine use before conception, which could result in over- or under-estimation of the actual consumption of the drug. They also relied on data from US health insurance claims to identify pregnancies and conception date, which could result in misclassification of pregnancy outcomes and the length of gestation.

CORD ANOMALIES - AN ANSWER TO SOME OF THE UNEXPLAINED INTRAUTERINE DEATHS IN THIRD TRIMESTER ?

Dr. SUMAM JOHN

26-year-old Mrs X, Primigravida presented at 34 weeks 1 day of gestation with decreased fetal movements since previous day afternoon. Her ultrasound examination revealed intrauterine fetal demise. She had no GDM or gestational HTN. NT scan, double marker and anomaly scan were normal. Growth scan which was done one week back showed corresponding growth, adequate liquor and normal doppler parameters. The present USG showed no evidence of growth restriction, oligamnios, anomalies or hydrops. She had no history of fever, recent infection, travel, urinary or vaginal infection. Maternal blood group was B positive; TORCH IgM was negative. Labour was induced with vaginal PGE1 and augmented with oxytocin. She delivered a dead female fetus of weight 2.15 kg with no evidence of external anomalies or IUGR. The umbilical cord showed an area of stricture near to placental insertion with deficient Wharton's jelly and two twists of cord at the site of stricture with congested cord distally. Placenta weighed 450 gm and histopathology showed no evidence of umbilical vein thrombosis, placental infarction or chorioamnionitis. Fetal autopsy was suggested but refused by patient and her relatives.

Discussion

A normal umbilical cord is 50-60 cm long and has single vein and two arteries. Abnormalities in umbilical cord characteristics - length, diameter, placental insertion, vessels, knots may contribute to fetal compromise. Long cord (more than 70 cm) is associated with cord accidents, fetal growth restriction and fetal demise. Short cord (less than 40cm) related to fetal inactivity is associated with malformations, myopathy and oligoamnios. Massive cord edema can cause acute changes in FHR pattern, often seen in trisomy 18, omphalocele. Diffuse edema is seen in HDN, gestational HTN and GDM. Cord stricture has been implicated in fetal compromise which may be the result of torsion or amniotic band. Marginal insertion of cord is usually benign but velamentous insertion is associated with fetal growth restriction and anomalies. When associated with vasa previa, it can lead to an acute fatal event. True knots occur in 1% of births, and is associated with 10% perinatal mortality. When the outcome in Single Umbilical Artery associated with anomalies depends on underlying abnormality, in isolated cases the course is benign. Umbilical cord thrombosis may result from compression, prolapse, fetal hypercoagulable states, marginal insertion which impedes the blood supply and may result in distress or demise of fetus.

Umbilical cord accidents (UCA) contributed to 10% of stillbirths according to a report by Stillbirth Collaborative Research Network. But this did not include pathologies like torsion, entanglement, abnormal placental insertion, under the presumption that these do not cause actual death or recurrent stillbirth. But recent studies and scrutiny into cause of stillbirth have deducted a role for UCA as a significant cause of fetal death and recommends that 18-20 weeks ultrasound review should include umbilical cord characteristics and description of its placental and fetal attachment. The American Association of Ultrasound Technologists has defined these parameters for umbilical cord abnormalities: 1. Abnormal insertion 2. vasa previa 3. abnormal composition 4. cyst, hematoma, masses 5. UC thrombosis 6.coiling, collapse, knotting, prolapse.

Fetal hyperactivity thought to be a fetal response associated with compression, and capable of repositioning to relieve the compression should prompt evaluation. Persistent decreased fetal movement especially in the third trimester warrants strict surveillance. Routine ultrasound screening for UCA and fetal vessel doppler in such situations, may avoid these unforeseen mishaps.

Dead fetus with no anomalies / IUGR

Umbilical cord stricture with deficient Wharton's Jelly.

Torsion of umbilical cord.

HIGH HbA1C - DOES IT WARRANT TERMINATION

Dr Reshma

Mrs X, 39 yrs reported to our OPD for antenatal regestration. She was G5P1L1A3 with previous 1 LSCS. She had 3 miscarriages including 1 second trimester miscarriage following which she under went Lap encerclage at KJK Hospital in 2009. She had a full term ceaserian delivery in 2010. Now after 9 yrs she presented with her fifth pregnancy. She was an overt diabetic with HbA1c -9.4, FBS-178 and PPBS- 306 and was on insulin. The patient was counselled regarding the sugar values and was clearly explained the kind of anomalies, chances according to HbA1c levels and the need for more scans and close follow up with tight sugar control in pregnancy if she wants to continue. Accepting the risk patient wants to continue the pregnancy. The patient continued with antenatal check up. Her diet was modified with the help of a dietitian. Sugar monitoring done with glucometer (self monitoring) thrice weekly and insulin levels were adjusted accordingly. Renal fuction tests were done. NT scan, Detailed anomaly scan, Fetal echo at 24 weeks done. Growth monitored serially by third trimester scans. InjBetenasol given at 36 weeks and she underwent elective LSCS at 37 weeks.

Discussion:

Overt diabetes is diagnosed when the woman meets any one of the criteria in the first prenatal visit.

1. Fasting plasma glucose > 126
2. HbA1C> 6.5
3. Random plasma glucose > 200 (Needs further conformation)

The most important adverse outcomes related to overt diabetes are Congenital anomalies of the fetus and spontaneous miscarriages.

HbA1C	Congenital anomalies	Miscarriage
< 8 %	5 %	8%
8-15 %	25%	15%
>15 %	40%	20%

Base line risk of anomalies in general population is 1-2 %.

Most common congenital anomaly associated with overt diabetes is cardiac defects - TGA, VSD, ASD, Coarctation of aorta.

The most specific defect associated is CNS defects especially Caudal regression syndrome.

Others are anotia, microtia, limb defects, hypospadias, orofacial clefts etc.

The precise etiology of these anomalies is unknown and thought tobe multifactorial. Hyperglysemia per se is believed to cause structural changes to embryo and yolksac. Hyperglycemia induced oxidative stress also thought to inhibit gene expression and neural crest migration.

How to manage a patient with overt diabetes?

Management should start preconceptionally. Preconceptional counselling regarding good glycemiccontrol, Regular glucose monitoring, diet andexercise, weight reduction if needed (if BMI > 27) and preconceptionafolic acid5mg/day. Retinal and renal assessment should be done. Referral to a nephrologist to be considered if serum creatine > 1.2 or estimated GFR < 45 ml / mnt/ 1.73 m2.

In first antenatal visit HbA1c to be checked and risk assessment and counselling to be done. In first trimester good glycemic control is needed as blood sugar levels at the time of organogenesis determines the chances of congenital anomalies. NT scan between 11-14 weeks to detect neural tube defects and detailed anomaly scan at 18-20 weeks should be done. Fetal echo to be performed at 24 weeks to look into the cardiac defects in detail. Fetal growth and amniotic fluid volume should be checked every 4 weeks from 28- 36 weeks. Patient can continue pregnancy till 38 weeks if blood sugar is controlled. If not controlled, termination of pregnancy is advised after attaining lung maturity. Careful use of IV fluids and Insulin is recommended for intrapartum management. In puerperium, Capillary blood glucose should be regularly monitored. Start with 1/2 to 2/3 of pre-delivery dose of insulin. Infections to be identified and treated. Counselling regarding contraception and need of regular blood sugar monitoring to be advised.

To conclude, if a patient with overt diabetes comes with a positive pregnancy test ,it is not necessary to terminate the pregnancy even though HbA1C is high. There is still 75 % chance to get a normal child and this option should be discussed.

LAPAROSCOPIC MANAGEMENT OF HUGE OVARIAN CYST : A CASE REPORTS

Dr Swati Shree

A 30 years old parous female presented with complaints of heaviness in abdomen. She had regular cycles with 1 previous normal vaginal delivery. She was hypothyroid with history of laporoscopic ovarian cystectomy for endometriotic cyst 3 years back. Onper abdominal examination a soft cystic mass felt arising from pelvis corresponding to 32 weeks size. On per vaginal examination soft cystic mass felt in right fornix. Ultrasound done revealed a huge right ovarian cyst 23x22 cm, unilocular with no septations and no increase in peripheral Vascularity .MRI done suggested large cystic space occupying lesion in pelvis and abdomen. Tumour markers (LDH, CA 125, B HCG, and AFP) doneand RMI score calculated (RMI = 0, as no feature in ultrasound) in view to rule out any chances of malignancy were found to be negative. The decision to go ahead with cystectomy or oophorectomy as per intra operative finding, was taken after consent for laparoscopy with need for conversion to laparotomy. During surgery veress needle was inserted at Palmer's point into cyst and 6 litres of straw coloured, with mild blood staining was drained. This was followed by placement of supraumblicaland 3 accessory ports, once the size of the cyst reduced. Abdomen inspected thoroughly to look for any suspicious lesion, no gross evidence of malignancy found. Right ovary could not be differentiated from cyst. Ovarian cyst was adherent posterior of the Uterus, adhesions released. Endobag introduced and cyst placed inside endobag. Right adnexectomy done. Further aspiration and morcellation was done in endobag and specimen sent for histopathology. Patient recovered well and was discharged on post operative day 3. Histopathology report of cyst revealed mucinous cystadenoma of ovary.

Discussion

Ovarian cyst are very common during reproductive age with 80% of women developing some of form of cyst during their lifetime. In premenopausal women almost all ovarian masses and cysts are benign with 1:1000 being malignant which increases to 3:1000 at the age of 50.1 Although histopathology is definitely diagnostic for any malignancy there are several pre operative tumor markers and screening tests which can successfully differentiate between benign and malignant masses.

WHO classifies Ovarian masses according to the most probable tissue of origin. Mucinous cystadenoma are benign ovarian cysts arising from surface epithelium of ovary by mucinous metaplasia of epithelial cells with chances of malignant transformation in 5-10 % cases. They account for 20-25% of all ovarian tumours, and are the largest ovarian tumour.

A thorough medical history with specific attention to risk factors or protective factors for ovarian malignancy and a family history of ovarian or breast cancer and a careful physical examination to include abdominal and vaginal examination and the presence or absence of local lymphadenopathy helps in clinical differentiation between benign and malignant cyst. RCOG guideline recommends measurement of serum Lactate dehydrogenase (LDH), ?-FP and B HCG in all women under age 40 with a complex ovarian mass.

The estimation of RMI score is essential to rule out malignancy in ovarian mass. There are specific ultrasound features derived from IOTA group which are highly specific and sensitive in differentiating benign from malignant lesions.

According to IOTA rules, ultrasound features of benign cysts (B rules) are unilocular cysts with solid components < 7 mm and of size < 10 cm, with acoustic shadowing, with no blood flow. Whereas features of malignant cyst (M rules) are irregular multiloculated solid tumours with size > 10 cm, having at least 4 papillary structures and very strong blood flow. 1

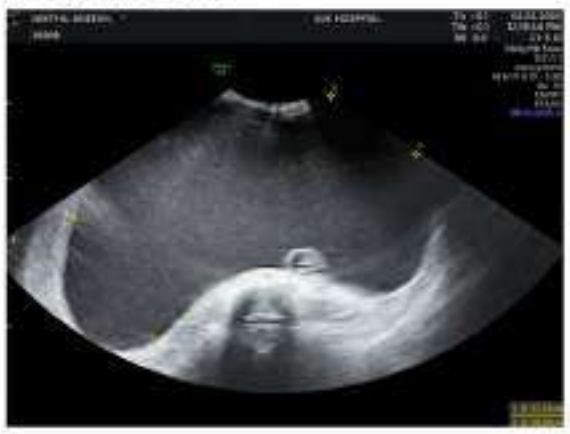
Women who undergo laparoscopy typically have shorter hospital stays, decreased pain, and decreased convalescence time compared with those who undergo laparotomy. Laparotomy and laparoscopy have equal rates of intraoperative cyst rupture, but laparoscopy results in significantly decreased operative time, perioperative morbidity, length of hospital stay, postoperative pain.2

There is no recommendation which defines large ovarian cyst and at what size laparotomy should be done. Some authors define large ovarian cyst as one more than 10 cm, and some as those reaching upto umblicus. There are several case reports of huge ovarian cysts being managed laparoscopically. Most important factor is proper case selection and expertise in laparoscopic surgery.

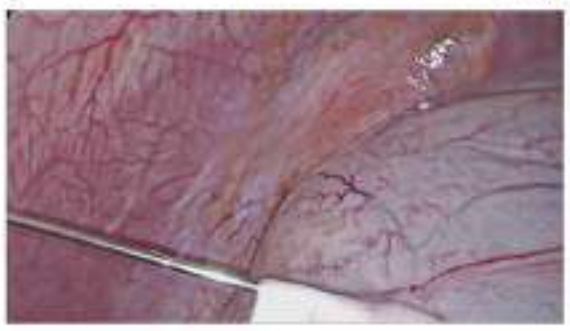
In our case with the proper investigations the chances of malignancy were ruled out to beminimal. With good clinical experience and laparoscopic expertise, thehuge ovarian cyst was successfully removed via laparoscope.

Conclusion: Even in huge ovarian cyst, laparoscopy can be an excellent choice if malignancy can be surely ruled out. And even if laparoscopy is done for benign lesion, all possible measures should be taken to prevent spillage and upstaging of malignancy in any rare instance. Even a slightest possible suspicion of malignancy should be an indication for laparotomy.

References: 1. RCOG. Management of suspected ovarian masses in premenopausal women. 2011; Green?top Guideline, No. 62. London: RCOG, 2011.
2. Graham L. ACOG releases guidelines on management of adnexal masses. Am Fam Physician 2008;77:1320-3.



Transabdominal scan showing unilocular Ovarian cyst



Aspiration of Ovarian Cyst

OVARIAN PREGNANCY - DIAGNOSIS AND MANAGEMENT:

Dr Srilekshmi

A 25yr old woman, G2E1, married for 5yrs with previous history of right salpingectomy for right tubal ectopic gestation, underwent PICSI for male factor infertility. Single embryo, culture day 5, was transferred and placement within the uterus was confirmed with ultrasound. Serum ß-hcgon the fourteenth day of embryo transfer (ET) was 104mIU/ml. Serumß-hcgfollow up done and it showed raising values and patient remained asymptomatic. Routine USG performed at 6wks 3days of gestation. Vaginal sonography showed empty uterine cavity, left adnexal mass of 2.1x2.3cm, with increased vascularity and the right adnexa was normal with Serum ß-hcg value of 14000mIU/ml. Emergency laparoscopy was performed with the diagnosis of ectopic pregnancy. Hemoperitoneum of 500cc with clots were seen in the peritoneal cavity. Left ovary was found ruptured and bleeding actively, and hence left sided wedge resection of ovary was performed and sutured.Right fallopian tube absent, Left fallopian tube and right ovary were normal. Postoperative recovery was uneventful. The pathologic examination con?rmed the clinical diagnosis. Patient ß-hcg level had decreased to 143mIU/ml postoperative.

A 25 yr old women, married for 4 years, underwent ICSI for male factor infertility. Two embryos, culture day 4, were transferred and placement with in the uterus was confirmed by ultrasound. Despite appropriate initial and rising hcg levels, she presented 22 days after transfer with abdominaldiscomfort. Ultrasound examination showed empty uterine cavity, right adnexal mass of 1.6x1.5 cm, a hemoperitoneum and normal endometrium. Emergency laparoscopy was performed with diagnosis of ectopic pregnancy. Hemoperitoneum of 250 cc was seen in peritoneal cavity. Uterus was bulky and right ovary was found ruptured with active bleeding and hence right sided resection of ovarian ectopic was performed, left ovary normal. Bilateral fallopian tubes were normal. Postoperative recovery was uneventful.

DISCUSSION:

The incidence of spontaneous primary ovarian pregnancy ranges from 1:7000 to 1:40,000 pregnancies, accounting for 3.6% of all ectopic pregnancies. With the development of assisted reproductive technologies the incidence of ovarian pregnancy has been increasing. The incidence of ovarian pregnancy after IVF-ET is reported to be 0.3% of all IVF pregnancies and 6% of all IVF ectopic pregnancies. There have been a few reported cases of primary ovarian pregnancy following assisted reproductive technologies such as IVF, ICSI, and GIFT. There are reports of occurrence with fresh, cryopreserved, and donor embryos

This case meets the diagnostic criteria for ovarian pregnancy as described by Spiegelberg: (i) the gestational sac was located in the region of the ovary, (ii) the ectopic pregnancy was attached to the uterus by the ovarian ligament, (iii) ovarian tissue in the wall of the gestational sac was proved histologically, and (iv) the tube on the involved side was intact.

General risk factors include pelvic inflammatory diseases, previous gynaecologic surgery, tubal pathology, and IUD use. The mechanisms behind ovarian pregnancy are not completely understood; however, two distinct mechanisms have been established: direct fertilization inside the ovary and ectopic implantation of a fertilized embryo with retrograde migration from the endometrial cavity to the ovarian surface. The latter would be the mechanism in cases occurring after ART. Possible explanations for the increased risk with IVF procedures include higher volume of the culture medium, a higher pressure of injection into the uterus, ovarian surface scars from oocyte retrieval, high estrogen levels, progesterone levels, ovarian hypervascularity after ovarian stimulation, a high number of transferred embryos, and transfer of blastocyst.

Diagnosis of primary ovarian pregnancy is very di?cult because of the rarity and the asymptomatic nature before rupture. A high index of suspicion is based upon a combination of ultrasound finding, (both grey scale and colour Doppler), as well as high levels of serum HCG and sonographic experience. Diagnosis is confirmedby laparoscopy or laparotomy and by histopathology.

Laparoscopic management with resection of ovarian gestation and preservation of ovarian tissue is considered the gold standard treatment; however medical management with methotrexate has been reported. It is important for clinicians and patients to appreciate the risk of primary ovarian pregnancy after ovarian suppression and donor embryo transfer. Even gestational carriers will have an increased risk of ectopic pregnancy due to the ART process, and appropriate counselling is paramount. Clinical suspicion, sonographic assessment, and close follow-up can help ensure early diagnosis and treatment and straight forward recovery.

Patient A. Ruptured left ovarian ectopic pregnancy.

Patient B. Right Ovarian pregnancy

RECURRENT PREGNANCY LOSS – IMMUNOGLOBULIN A RESCUE THERAPY ?

Dr Priya

Recurrent pregnancy loss (RPL) is a distinct disorder defined by two or more failed clinical pregnancies. Pregnancy is defined as a clinical pregnancy when it is documented by ultrasonography or histopathological examination. It is estimated that fewer than 5% of women will experience two consecutive miscarriages, and only 1% experience three or more.Studies that focus on RPL have examined factors related to genetics, age, antiphospholipid syndrome, uterine anomalies, thrombophilias, hormonal or metabolic disorders, infection, autoimmunity, sperm quality, and lifestyle issues. Several recommendations have been published regarding the evaluation and management of RPL. These publications do not support definitive conclusions about the causes of RPL because most studies of pregnancy loss have focused on sporadic miscarriage and not RPL. A putative diagnosis will be made and treated in approximately 50% of patients with RPL. Here lets discuss an interesting case of RPL where the patient emerged out in flying colours with a successfull live birth following 7 consecutive pregnancy losses

30 yr old Mrs X, G7A6, k/C/O pcod, hypothyroid, presented first to our antenatal opd at 6 weeks gestation with c/o bleeding p/v. She was on LMWH and Aspirin 150 mg od started from elsewhere. All her pregnancies were spontaneous conceptions, with h/o 2 blighted ovum, 3 missed abortion [out of which 2 times cardiac activity was recorded] – all of which were before 8 weeks. She had underwent 2 D & E for her previous pregnancy losses. In her last pregnancy and the present one she was on LMWH and aspirin. Her APLA screening was negative. Parental karyotyping was normal. Blood sugars were normal. She was admitted, TVS done confirmed a viable IU gestation and was started empirically on intramuscular immunoglobulin injection and injectable progestogens. LMWH and aspirin were continued. IM immunoglobulin was given once in 3 weeks. Bleeding P/v subsided. NT scan was normal and she was planned for elective cervical encirclage at 13 weeks when she developed PPROM prior to planned procedure. Hence the pregnancy had to be terminated.

She again presented to our antenatal opd as G8A7, after 10 months post 2nd trimester miscarriage, as spontaneous conception at 4 weeks+ gestation. In view of her past obstetric history with only the recent pregnancy going beyond 12 weeks and the only difference being administration of immunoglobulin, she was empirically started on it once in 3 weeks. LMWH and Aspirin 150 mg od and folic acid were continued. She had on and off bleeding p/v., Elective cervical encirclage was done at 12 weeks + 6 days by Modified shirodhkars technique. Recurrent vaginitis and UTI were treated with antibiotics during her hospital stay. IM immunoglobulin was continued once in 3 weeks throughout the pregnancy along with aspirin and LMWH. She underwent emergency CS at 36 weeks + gestation as breech in labour and successfully delivered a male baby of weight 2.79 kg on 31/12/2019 at KJK hospital.

Some cases of unexplained recurrent spontaneous pregnancy loss have been proposed to arise from an undefined immunological barrier to normal placentation. One proposed treatment, active immunization with allogeneic leukocytes, benefits only 8% to 10% of treated couples, who cannot be selected by means of diagnostic testing. Another treatment, passive immunization with intravenous immunoglobulin (IVIG), was promising in uncontrolled trials. IVIG, which is human IgG prepared from pooled plasma, has a diverse antibody profile because thousands of donors contribute to the pool. IVIG treatment has now been evaluated in five randomized controlled trials (RCTs).

The effectiveness of parenteral immunoglobulin as a treatment for recurrent spontaneous pregnancy loss remains unproven. IVIG does not prevent further losses among women with primary recurrent spontaneous pregnancy loss. A potential effect has been demonstrated in the less prevalent problem of secondary recurrent spontaneous pregnancy loss. The published data are insufficient, however, to exclude the possibility that the treatment also has no value in the latter condition. Severe side effects of IVIG are rare in well-selected patients. Mild side effects including fever, malaise, myalgia and headache occur in 4% of patients. Severe reactions are encountered in IgA deficient patients; the prevalence of IgA deficiency is 1 per 1000. Nephrotoxicity, alopecia, aseptic meningitis and retinal necrosis are rare but serious sideeffects. The potential for harm from immunotherapy during pregnancy cannot be excluded, and potential risk of using a preparation derived from pooled plasma cannot be assessed from currently available data. Immunoglobulin treatment is also expensive.

Parenteral immunoglobulin as a treatment for recurrent pregnancy loss should be evaluated in patients who are informed, consenting participants in an institutional review board approved randomized clinical trial. For the management of recurrent spontaneous pregnancy loss parenteral immunoglobulin is an experimental treatment. However more studies need to be done to be recommended as an evidence based treatment in RPL

STATISTICS

JAN. - APRIL 2020

TOTAL NO OF CASES	339
Laparoscopy	79
Hysteroscopy	57
Operative Hysteroscopy	15
OBSTETRICS	**120**
Vaginal deliveries	28
Total LSCS	91
Elective LSCS	53
Emergency LSCS	38
MINOR CASES	**72**
S&E	9
Cervical Encerclage	55
Pipelle sampling	5
Amniocentesis	2
Mirena insertion	1
EUA	1
PPS	2
PESA/TESA	9

OTHER MAJOR CASES

TAH	1

OPERATIVE LAP PROCEDURES

TLH +/- BSO	13
Cornual resection of ectopic	1
Myomectomy	18
Endometriotic cystectomy	4
Adenomyomectomy	4
Salpingectomy for ectopic	5
Salpingostomy for ectopic	1
Dermoid cyst excision	1
Sterilization	1
Paratubal cystectomy	3
PCO drilling	14
Adhesiolysis	1
Fulgration of endometriotic deposits	4
Adnexectomy	2
Sacrocolpopexy	1
Excision of ovarian ectopic	2
Ovarian cystectomy	1

OPERATIVE HYSTERO PROCEDURES

Septum resection	1
Polypectomy	10
Sub mucous fibroid resection	2
Endometrial sampling	2
Pre IVF Hysteroscopy	41

CONCEPTION + IUI STATISTICS

Total conceptions	70
Total IUI conceptions	31
IUI conception rate	12 %
Other Conceptions	29
Spontaneous	14
COH only	15

IVF/ICSI STATISTICS JAN TO APRIL 2020

Total No of cases	115
Total Conception Rate	38.5%
Frozen ET cycles	51
Conception rate after Frozen ET	37.2%

Our Team

REPRODUCTIVE MEDICINE, OBSTETRICS & GYNAECOLOGY
Dr. K.JAYAKRISHNAN MD, DGO, DNB
Chief Infertility Specialist & Laparoscopy Surgeon
Dr. ANITHA M. MBBS, DNB
IVF Co-ordinator
Dr. NIRANJANA JAYAKRISHNAN
MD, (OBG), DNB
Consultant in Reproductive Medicine
Dr. ASHWIN JAYAKRISHNAN MD (OBG) DNB
Consultant in Reproductive Medicine

SENIOR CONSULTANT OBS & GYN
Dr. BINDU BALAKRISHNAN MD, DGO
Dr. DEEPTI B. MS, DGO, MRCOG

CONSULTANT IN OBS & GYN
Dr. ABHILASH ANTONY V. MBBS, DGO
Dr. PRIYA S. RAJU MBBS, DNB
Dr. SUMAM JOHN MS, DNB
Dr. RESHMA R. MBBS, DGO

ANAESTHESIOLOGY
Dr. UNNIKRISHNAN S. MD (PGI), DA, FIMSA
Chief Anaesthesiologist
Dr. APARNA SUDARSAN MBBS, DA, DNB
Consultant Anaesthesiologist
Dr. RATEESH REGHUNATH MD
Consultant Anaesthesiologist

PAEDIATRICS
Dr. MADHU K.V. MD, DCH
Dr. SUNIL KUMAR K.B. MBBS, DCH

RADIOLOGY/SONOLOGY
Dr. R.N.RAMESH DMRD

EMBRYOLOGIST
Dr. JAYAPRAKASH D. Phd
Mr. ABDUL SALAM
Mr. SANAL KUMAR

PATHOLOGIST
Dr. JAYASREE P.V. MD

UROLOGIST
Dr.VINOD K.V. MS, MCH (URO)

CONSULTANT SURGEON
Dr. SUBHASH R. MS. MCH

FELLOWS
Dr. SRILAKSHMI KANKANALA
Dr. SWATHI SHREE

Published quarterly by KJK Hospital for private circulation only ■ Edited by Dr. K. Jayakrishnan Co- Editor Dr. Deepti B.