J&GS

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मीमांसा

JOGS BULLETIN

THEME

SAVE THE UTERUS

STANDING TOGETHER FOR ENCOMPASSING AND PROTECTING WOMEN'S HEALTH

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DOCUMENTATION & RECORD KEEPING

1. Meaning of document

Indian Evidence Act – 1872 and Indian Penal Code Section – 29 defines Document –

Document means any matter expressed or described upon any substance by means of letters, figures or marks, or by more than one of those means, intended to be used, or which may be used, for the purpose of recording that matter.

2. Importance of document

"Courts are not the courts of justice, they are the courts of evidences."

Courts are blind. Court decides the case only on the basis of evidences produced in front of it. The only evidences in case of medical professional are their documents. It is said that

Good documents	–	Good defence
Poor documents	–	Poor defence and
No documents	–	No defence

It is the most tedious job but still there is no excuse in the law for documentation and record keeping.

3. Why to keep documents

A doctor is bound to produce record when asked by the Court and if he does not produce the same, adverse inference might be drawn. Under some act it is punishable too.

Section - 1.3.2 of The Indian Medical Council (Professional conduct, Etiquette & Ethics) Regulations, 2002 – If any request is made for medical records either by the patient or authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours. Failure to issue the same will be regarded as misconduct as per Section 7.2.

Certain provisions of Clinical Establishment act and Different Nursing Home Registration Acts mandates to keep certain documents.

4. How long to preserve documents

Under different Acts there are different guidelines for the period of preservation of records.

Consumer Protection Act	-	A case can be filed within 2 years from the cause of action.
Civil Litigations	-	3 years.
Income Tax Act	-	3 years
Criminal Litigation	-	No limit
PNDT Act	-	2 years
MTP Act	-	5 years
ART Act	-	10 Years and then to be submitted to Registry.
FOGSI Guidelines	-	At least 5yrs
MCI Guideline	-	3 years (Section – 1.3.1 of Code)

5. What documents are to be maintained

Medical Record

- OPD Case Paper
- Indoor Case Paper
- Consents
- Prescriptions
- History & Examination Sheets, Requests for investigation

- Reports of Investigations – Pathological Testings, ECG, X Rays, CT Scans, MRI etc.
- Pre-op, Per-op & post-op orders with operative notes
- Discharge Card
- Refer Notes
- CDs or DVDs.
- Medical Certificate if given.
- Forms
- Registers

Registers

- O.P.D. Case Register (3-C Register)
- Indoor Case Register
- Operation Theatre Register
- Autoclaving Register
- Fumigation Register
- Biomedical Waste Register
- PNDT Register – (PC-PNDT Rule – Section – 9(1))
- MTP Register – (Admission Register – Form-III)
- Sterilization and IUCD Register
- Birth and Death Register
- Medical Certificate book – as per MCI Guidelines
- Drug Register
- Vaccination Register
- MLC Register
- Indoor Case as per MCI Guidelines
- Discharge Card as per MCI Guidelines
- DAMA Certificate
- Files – Gynecology and Obstetrics
- Death Certificate
- Registers under different Acts – Labour laws, NH Registration Acts etc.

Indoor Case Paper – Fully written up contemporaneous record with all details

- Registration Form
- Admission Consent
- Chief complaint
- Histories
- Clinical examinations
- Provisional Diagnosis
- Investigations (All reports of investigations)
- Diagnosis after investigation
- Plan of treatment
- Counselling (Medical, Financial, Psychological etc.)
- Consents
- Pre-op orders, pre-op medication and check-ups (Physician, Anaesthetic etc.)

- Per-op Anaestheic note
- Operative note (Detailed with reasoning of decisions)
- Post-operative examination and order
- Nursing medication chart
- Nursing TPR-B.P. Chart, I/O chart
- Discharge Card
- Check list
- Annexure
- Paginating the Indoor Case and send it to MRD department.

Records –

Record keeping is an art. There are more than 150 Acts which are applicable to one clinical establishment. Some of them known and some are not known to a common practitioner. It is advisable to keep one BOX File for each Act. All relevant papers of that particular Act are to be kept in one BOX File so that, whenever asked for can be easily retrieved. Day to day update of the files is necessary.

Few extra tips

- Keep the records of visiting doctors in their own hand writings or signed by them.
- Keep originals in your custody and give Xerox copy if demanded.
- Avoid over writing. Alteration should never be done.
- Altered notes can lead to loss of credibility.
- Additions with date & time are allowed.
- Every page should contain the name and registration number.
- Date and time should be mentioned at each step.

6. Where to keep documents

Every hospital should have a separate MRD room.

Efforts should be made to digitalize the records for quick retrieval. (Sec. 1.3.4 of IMC Code).

Agencies are there which keep records digitally by scanning.

7. How to destroy documents

After passage of depicted time under different laws one can destroy the documents after giving public notice of reasonable time in two local daily newspapers, one in English and one in local language.

8. Conclusion

Good documentation is a reflection of good patient care. Good documentation over all improves quality of medical establishment.

Good documentation saves the medical practitioner in the court of law most of the time.

So Documents should be Accurate, Complete , Legible, Free of extraneous information and in proper chronology.

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GUIDELINES TO PREVENT UNNECESSARY HYSTERECTOMIES

MINISTRY OF HEALTH & FAMILY WELFARE

JUDGMENT

The Guidelines indicate that while in developed countries hysterectomies are typically conducted amongst pre-menopausal women above the age of forty-five years

In India, community-based studies have consistently found rising **hysterectomy rates among young women, ranging from twenty-eight to thirty-six years of age.**

Field based studies have indicated that unnecessary hysterectomies are performed in cases where medical or non-invasive treatment would have been sufficient.

The evidence indicates a higher risk among poor, less educated women, particularly in the rural areas.

JUDGMENT

Guidelines provides guidance on prevention of unnecessary hysterectomies

It refers to the role of program me managers and refers to the role of different levels of public health facilities

Guidelines note that reporting of hysterectomies, cases conducted for women less than 40 years of age and the cause of the hysterectomy must be incorporated in the existing screening checklist.

To achieve this, the Guidelines propose the setting up of Hysterectomy Monitoring Committees at District, State and National levels

JUDGMENT

Issue necessary orders to both public and private sectors to submit a line list of all women who underwent hysterectomy every month

The line list must include information on parameters such as:

Age, Parity, Occupation, Indication of hysterectomy, Previous medical/surgical history

Hysterectomy route: • Abdominal • Vaginal • Laparoscopic

Any other surgery done along with hysterectomy: • Past treatment history: • HPE:

JUDGEMENT

Every quarter the district committee must audit cases with following indications and issue necessary instructions if required:

- Hysterectomy with/ without BSO in women
- Hysterectomy with BSO in women< 40 yrs. of age
- All cases where no indication for doing the procedure is mentioned in the records
- All cases where no records of treatment prior to hysterectomy (in papers or in history) are available
- Discrepancy between mentioned indication and HPE report: Any severe morbidity/mortality due to hysterectomy
- Arrange necessary trainings and sensitization sessions for both public and private sector professionals

- All the States and Union Territories must take stringent action for blacklisting hospitals once it is detected that any unnecessary hysterectomy was carried out or that the procedure was taken recourse to without the informed consent of the patient
- We direct that necessary action be taken in accordance with law

Thank you

NON-SURGICAL MINIMALLY INVASIVE ALTERNATIVE FERTILITY-PRESERVATION MODALITIES FOR UTERINE LEIOMYOMA: IT IS TIME TO SAVE THE UTERUS

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Because of the long experience with the mode of treatment, myomectomy remains the gold standard for treating uterine fibroids in reproductive-age women. However, in recent years, the wide evolution of less invasive approaches led to a change in the options used by the clinician to treat symptomatic fibroids.

Minimally invasive techniques like Uterine Artery Embolization (UAE) are increasingly used to treat symptomatic fibroids. Other alternative treatment modalities are becoming more common, such as magnetic resonance–guided high-frequency focused ultrasound (MRgFUS), cryomyolysis, vaginal occlusion and laparoscopic closure or clipping of the uterine arteries. Both advantages and limitations of these techniques under development must be taken into account but this wider range of choice is being increasingly considered for a tailored treatment.

This article aims to provide the latest evidence-based care in the non-surgical alternative fertility preservation modalities for the management of uterine leiomyomata in reproductive age group.

Uterine leiomyomas, also known as myomas or fibroids, are the most common benign uterine tumours in women of reproductive age, occurring in 20–25% of women. Depending on the localization, symptoms vary in frequency and severity, including anaemia caused by heavy bleeding, pressure symptoms, pelvic pain, dysmenorrhea, infertility and reduced quality of life.

During the 1970s, hysterectomy was the treatment of choice for symptoms caused by fibroids such as menorrhagia, anaemia, abdominal and pelvic pain. Hysterectomy represents still an important treatment modality of uterine myomas but is an unacceptable treatment for many women desiring uterine preservation. Depending on the underlying cause, maintaining the uterus is of main importance in patients with fibroids, not just for reproduction, but also to avoid a "radical" surgery.

Over the last 30 years, advances in technology have promoted different pathways of treatment, leading to less invasive techniques. The target of these treatments is to achieve good results in terms of fertility, bulk-related symptoms and menstrual disorders, without the great invasiveness of the previous procedures and without the

unattractive side effects of the medical therapy. Myomectomy, particularly hysteroscopic myomectomy, is the treatment of choice for submucous fibroids in reproductive age women and can increase the chance of pregnancy and live birth. Laparoscopic myomectomy is instead the treatment of choice in case of intramural or subserous fibroids. However, myomectomy is associated with risk and adverse outcomes such as haemorrhage, conversion to hysterectomy, uterine rupture and abnormal placentation in following pregnancies. Conversely, non-excisional alternative techniques cannot provide a histological confirmation of the disease, with the risk of missing an underlying malignancy. The possibility of inadvertent treatment of malignant disease, thus delayed diagnosis and worsened prognosis exists with all non-excisional therapies for uterine leiomyomas.

The following are the few alternative therapies that have come up in recent times:

Uterine Artery Embolization (UAE)

UAE has been developed in recent times in a variety of clinical settings including postpartum haemorrhage, bleeding after caesarean section, bleeding following gynaecological surgery, treatment of arterial venous malformations (AVM) of the genital tract as well as gestational trophoblastic disease.

Magnetic Resonance Imaging-guided High-frequency Ultrasound Therapy (MRgFUS)

MRgFUS is a thermal ablation technique approved by the Food and Drug Administration (FDA) in the United States in 2004. It is an emerging non-invasive technique for the management of symptomatic myomas and for other non-gynaecological conditions. The method uses MRI to visualize the anatomy, define the target to control and monitor the parameters of ablation of myomas. Ultrasonic energy is directed to a focal point within a fibroid, resulting in a coagulative tissue necrosis with minimal damage to the targeted fibroid.

Cryomyolysis

Cryomyolysis is a conservative surgical option for uterine fibroids, which involves a probe with a cooling agent that is applied directly to the myoma followed by vessel coagulation. Cryoablation is not yet approved by the United States FDA for fibroids; however, it is commonly used for treating renal tumours, liver tumours and atrial fibrillation. The ultrasound-assisted laparoscopic cryomyolysis is the most commonly published technique for cryosurgery; the whole procedure being done on an outpatient basis.

Vaginal occlusion of uterine arteries

Temporary transvaginal occlusion of the uterine arteries is an emerging technique in the non-invasive approach. The uterine arteries are closely associated with the lateral vaginal fornices; thus, by 6 weeks gestation, their pulsations can be palpated during vaginal examination and are thus used to diagnose pregnancy. Temporary occlusion of uterine vessels results in ischaemia of leiomyoma.

Laparoscopic occlusion of uterine arteries

Laparoscopic bilateral uterine artery occlusion essentially involves occlusion of the uterine arteries, at the level of the internal iliac artery with an endoclip and coagulation of the collateral arteries between the ovaries and uterus. This laparoscopic approach showed a 50% reduction in pictorial blood assessment score after 6 (in patients with heavy menstrual bleeding due to leiomyomas).

Thus, with the upcoming options of fertility preservation, women can now find it easy to preserve their uterus and feminity once diagnosed with leiomyomas. It is time to master our skills for the benefit of our population. The day is not far when India shall be at par with the Western counterpart in mastering the art of these newer treatment modalities.

A SURGICAL APPROACH TO PRESERVE FIBROID UTERUS

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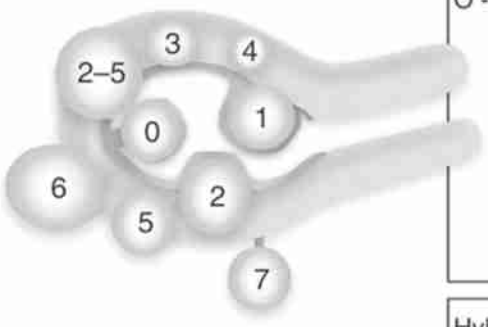
Women in any age presenting with fibroids are now a days one of the common indications of uterine surgeries, either myomectomy or Hysterectomy.Out of 70 to 80 % population presents in OPD with asymptomatic fibroids. Almost 30 % present with mere few symptoms like heavy menstrual flow, lower abdomen pain, pelvic pressure symptoms like urinary or bowel complains, and infertility.

Fibroids are mostly not seen before puberty,but its chances increase later in reproductive years, and again decrease in size after menopause.Aromatase in fibroid tissue allows for endogenous production of oestradiol, and fibroid stem cells express oestrogen and progesterone receptors that facilitate tumour growth in the presence of these hormones.

Diagnosing is important, Imaging helps a lot in this. Transvaginal ultrasonography is about 90% to 99% sensitive for detecting uterine fibroids, but it may miss subserosa or small fibroids. Adding son hysterography or hysteroscopy improves sensitivity for detecting submucosal myomas.There are no reliable means to differentiate benign from malignant tumours without pathologic evaluation.

Management

This article is dedicated on discussion of SURGICAL management of Fibroids.



SM - Submucosal	0	Pedunculated intracavitary
	1	>50% intramural
	2	≥50% intramural
O - Other	3	Contacts endometrium; 100% intramural
	4	Intramural
	5	Subserosal ≥50% intramural
	6	Subserosal <50% intramural
	7	Subserosal pedunculated
	8	Other (specify e.g., cervical, parasitic)
Hybrid leiomyomas	2-5	Submucosal and subserosal, each with less than half the diameter in the endometrial and peritoneal cavities, respectively.

Surgical Management

Myomectomy is the surgical removal of fibroids by hysteroscopic, laparoscopic, vaginal or abdominal routes.The excision steps decision is Established by the type (location), size, and quantity of fibroids.

Hysteroscopic Myomectomy

Hysteroscopic myomectomy (HSC-M) is a one of the minimally invasive route with high success rates the complications depends upon operating surgeons experience.and low risk for complications in the appropriately selected patient . HSC-M has shown to be most successful in resecting Type 0 and Type I fibroids. Complete resection rates of Type 0 and Type I fibroids range from 96 to 97% and 86 to 90%, respectively.

HSC-M can be used for type 2 fibroids; however, this often involves repeat procedures due to the lower complete resection rate of 61 to 83%. The amount of distension time ansd opersative time use dis important in management of such fiboids.The depth of fibroid invasion in myoma is directly proprtionate to volume absorbed during hysteroscopic resection (type 0: 450 ml, type I: 957 ml, type II: 1682ml).Patients with fibroids >3 cm and/or with two or more fibroids present have the highest risk of needing a repeat procedure.The overall rate of incomplete resection is approximately 5 to 17%.

Laparoscopic Myomectomy

Laparoscopic myomectomy (LSC-M) is another approach to remove symptomatic fibroids of type 2 through 8. The recurrence depends on location , size and number of fibroids.

LSC-M provides an 80% success rate in the relief of symptoms, similar to abdominal myomectomy.

Risk of complication during LSC-M is increased in patients with fibroids >5 cm, >3 total fibroids, and in those with intramural and intraligamentous fibroids.Complications include hemorrhage, fever/infection, bowel or bladder injury, conversion to laparotomy, and adhesive disease. A large multicenter study looking at over 2000 cases demonstrated a total complication rate of 11.1% (n=225), of which 9.1% were minor complications and 2.02% were major complications. The most common minor complications were fever of unexplained origin (5.1%) and urinary tract infections (3.4%). Among the major complications were hemorrhage (0.7%), hematoma (0.48%), bowel injury (0.04%), and post-op kidney failure (0.04%).

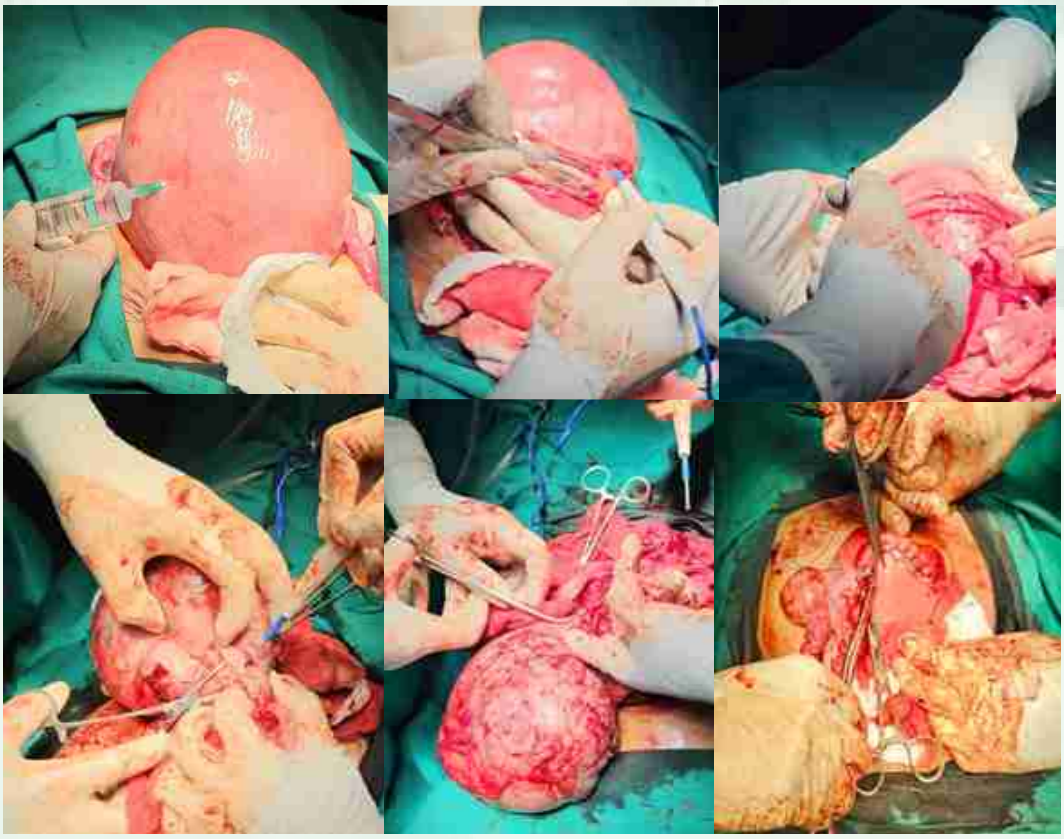
Robot assisted Myomectomy

Robot-assisted laparoscopic myomectomy (RLSC-M), is latest, not a different technique just a different appraoch. It is done by Robotic vinci SI systems, likein cases that involve ≥10 fibroids ≤ 7 cm or in patients with obesity due to improved visibility. The most significant difference between the two techniques is conversion to abdominal myomectomy.

Abdominal Myomectomy

Abdominal myomectomy (ABD-M) is a time tested major surgical procedure done by most of the gynecologists and best used for symptomatic intramural and subserosal fibroids.

With regards to fertility outcomes, a Cochrane review demonstrated no difference between LSC-M and ABD-M.When looking at the difference in operative time, Barakat et al. demonstrated that ABD-M is associated with a shorter operative time of 126 minutes, compared to 155 and 181 minutes with LSC-M and RLSC-M, respectively. Another benefit is the lower risk of recurrence with ABD-M eight years post-procedure (63.4% vs. 76.2%) compared with LSC-M. This is likely due to the ability to identify and remove sub-centimeter-sized fibroids more easily with an ABD-M approach.



Technique

Prophylactic Hemostasis-

Diluted vasopressin is commonly used.Use 1 ampule (20 international units) of pittressin diluted with 200 mL of normal saline. This is infused into the myometrium over the targeted fibroid using an 18-g PTC needle or a suction needle (Hakkou co.) after confirming no back flow in the syringe.The post injection time for quick incision and removal is 20 min.

Myometrial Incision Method

Both longitudinal and transverse are preferred as of size ,location and ease of suturing (in laproscopy).Oblique are also preffered if its posterior wall large fibroid.

Enucleation

Combination of sharp and blunt dissection is done to enucleate the fibroid with capsule.In case of laparoscopy thermal energy is used to remove and graspers and claw forceps to enucleate the tumor.

Suturing

Suturing is done by vicryl no 1.One need to be sure that the needle is introduced into the tissue at 90 degrees. A deeper myoma bed is more difficult for suturing repair . A thumb rule need to be follow is not to leave a dead space even if it requires 4-5 layers suturing.

The superficial layer by baseball suture or seromuscular reapproximationby this method, the edge of the wound becomes inverted in it and inhibits subserosal bleeding .It also lower down the risk of adhesion of the bowel to the wound.

If Endometrium is Perforated

If endometrium is perforated, then opening of the uterine cavity using 4.0 monofilament suture in a continuous fashion to prevent interuterine adhesion.

Does Myomectomy improves fertility?

It's a debatable topic every time.Fibroids that affect the uterine cavity countor, i.e., submucosal fibroids (FIGO Type 0-2), strongly affect reproductive outcomesa large number of studies suggests that even in asymptomatic patients with poor reproductive outcome ,cavity-distorting myomas should be surgically removed .Ithas shown women with intramural fibroids have a lower implantation rate, clinical pregnancy, and ongoing pregnancy/live birth.,A large prospective cohort studies explaining the in vitro fertilization (IVF) success found women with intramural fibroids ≤ 5 cm (mean size 2.3 cm), the clinical pregnancy rate per embryo transfer was 23.3% compared to 34.1% in women without fibroids. Looking into subserosal fibroids they do not play a role in infertility.5

Prognosis

Comparing Options For Management: Patient-centered results for Uterine Fibroids (COMPARE-UF), a prospective nationwide registry has shown that a short term post myomectomy ,all had improvement in short-term health-related quality of life ,return to activity and symptom severity score improvement. Which is better as compare to post Hysterectomy quality of life.

In short Risk of recurrence, re intervention,are there with myomectomy but still its give Chance of fertility preservation, quality of life and sexual life satisfaction by avoiding early age Hysterectomy.

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UTERINE SPARING APPROACH IN REPRODUCTIVE AGE WOMENFOR CERVICAL DYSPLASIA- A CASE REPORT FROM TERTIARY HEALTH CENTER

DR.VINEETA GHANGHORIYA

DR.NANDITA BHARTIYA

DR.SHRADDHA MEHTA

Introduction:

In recent times, there has been a shift in focus toward Conservative approach that spare the uterus and major surgeries for various gynecological conditions. Aim is to avoid complications and long term sequelae of hysterectomy. Saving the Uterus is pivotal not only as fertility preservation but also for the overall well-being of women and their physical, emotional, and sexual health. An alarming number of hysterectomies are done even in cases where conservative surgical or medical approach are possible. Data revealed that in India, 6 per cent of women in the age group of 30-49 years have undergone hysterectomy. In the age group 30-39 years 3.6 per cent prevalence of hysterectomy, according to the National Family Health Survey (2015-2016). More than 50% of Hysterectomies are carried out heavy menstrual bleeding (HMB). Women, mostly from poor socio-economic backgrounds, are often coaxed into hysterectomy with the fear of cancer, not able to afford cost of medical management or myth about hsterectomy as the only solution for their menstrual problems.

Common indications for hysterectomy in benign conditions are fibroids (45%), heavy menstrual bleeding (31%), cervical dysplasia (3%), Pelvic inflammatory Disease, and endometrial hyperplasia and uterine prolapse. In many instances, it is inappropriately recommended just for lower abdominal pain, back ache or white discharge which is totally unethical. Many hysterectomies are accompanied by bilateral oopherectomy to reduce the risk of ovarian cancer. Even if ovaries are spared, vascularity and function get affected leading to menopausal symptoms.

Case report:

We report a case of successful pregnancy outcome after thermal ablation for CIN-II lession. A 26 year old P1L1 reported to OPD at NCSB Medical College Jabalpur with thick foul smelling white discharge associated with itching and Lower abdominal pain & back ache since 2years. On per speculum examination Cervix was hypertrophied, ectropion was present, VIA & VILI were positive. Pap smear shows Acute inflammation and Negative for neoplasia. On colposcopy entire TZ was seen with Reid score-4, biopsy was taken from AW lesion and HPR revealed CIN 2. Thermal ablation was done in OPD and kept under follow up. She was advised abstinence for 6 weeks after which she conceived spontaneously 3 month later. During her ANC period ,her HPV test was negative and she delivered spontaneously at 38 week. Management and follow up is advised as per FOGSI GCPR guidelines for CIN lessions1 HPV and cytology / VIA to be repeated after 1 year and then every 3 years or more frequently as per the report. If left untreated, Persistence and Progression of CIN 2 to CIN 3 and invasive cervical cancer is 35 % 25% and 5% respectively over 5 years. So when lesion is entirely visible on ectocervix and no suspicion of invasive cancer ,it can be treated with ablative procedure allowing women to retain fertility . As Fertility and pregnancy outcome are important concern of women undergoing treatment for cervical intraepithelial neoplasia .

Fig:1 Colposcopic image after application of Lugol'siodine

Discussion:

Analysis of Hospital data to review the indications for the hysterectomy should be done regularly. Various research data are available were uterine conservation approach have been found to be associated with improved QOL as compared to hysterectomy. A retrospective cohort study conducted by Stepniewska AK et al in which Radiofrequency thermal ablation (RFA) treatment was done as an alternative to hysterectomy for adenomyosis. They compared the preoperative and followup symptoms using the ten-point visual analog scale (VAS) for pain assessment. Concluded that RFA allows for hysterectomy avoidance in most cases. It leads to marked improvements in pain symptoms, uterine bleeding and bulk symptoms. 2A prospective observational study conducted by Selvanathan S et al on Quality of life after hysterectomy and uterus-sparing hysteroscopic management of abnormal uterine bleeding or heavy menstrual bleeding total 354 having HMB were included in the study, of which 178 women had undergone hysteroscopic targeted therapy while 176 womenhadundergone abdominal hysterectomy as surgical treatment. Group I Hysteroscopic surgical procedure– polypectomy, endometrial resection, myomectomy. Group II– Hysterectomy– abdominal hysterectomy, vaginal hysterectomy, laparoscopic hysterectomy.). Health-related QOL assessed by Short Form 36 questionnaire response score was significantly better for women who underwent hysteroscopic targeted therapy at both short-term and long-term follow-up. This study helps to prove that hysteroscopic surgical procedures improve QOL earlier than hysterectomy, and QOL scores are better in both short and long term which is a primary concern of women suffering from AUB/HMB and helps them spare or conserve the uterus with its lifelong benefits.[3]

Conclusion:

Public health initiatives should create awareness regarding reproductive health especially in the rural India. Regular cervical cancer screening will also help reduce the incidence of hysterectomy. There is a dire need of counselling services for women regarding their reproductive health, the importance of uterus and the medical conditions that necessitate hysterectomy. with the advances in medical science, hysterectomy should be the last resort for a woman, not the first.

Reference :

fogsi GCPR screening and management of preinvasive lesions of cervix and hpv vaccination

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MIMANSA MONTHLY QUIZ 4

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RULES :

- Kindly share your answer on this email id editorkaveri@gmail.com
- First three entries with maximum scores will be the winners
- Name of winners will be announced

Q.1 A young girl with McCune-Albright syndrome is noted to have precocious menstruation. This condition is defined as the occurrence of menstruation?

A. <8 years B. <7 years
C. <10 years D. <11 years

Q.2 Irreversible side effect of danazol are all except ?

A. Acne B. Deepening of voice
C. Formation of ovarian cyst D. Increased facial hair

Q.3 All are absolute contraindications of uterine artery embolization except?

A. Cervical fibroid B. Concurrent use of GnRH analogue
C. Severe renal insufficieny D. Adenomyosis

Q.4 All are causes of anovulatory bleeding except?

A. Hyperprolactenemia B. Obesity
C. Anorexia nervosa D. Pelvic tuberculosis

Q.5 Mrs X PO+4 with history of recurrent abortions and curettage came with complaints of scanty menses and oligomenorrhea.Her LMP was 2 months back but her UPT was negative .On sequential treatment with estrogen and progesterone no bleeding occurred.What is the most probable diagnosis ?

A. PCOS B. Septate uterus
C. Asherman syndrome D. Secondary cervical stenosis

Q.6 The most common bleeding disorder in female presenting with heavy menstrual bleeding?

A. Factor 8 defeciency B. Bernard soulier syndrome
C. Von Willebrand factor deficiency D. Glanzmann syndrome

Q.7 All are second generation endometrial ablation techniques except?

A. Microwave endometrial ablation B. Thermal balloon ablation
C. Hydrothermal ablation D. Roller ball ablation

Q.8 Perimenopause transition is associated with ?

A. High FSH ,high LH B. Low FSH,high LH
C. High FSH,normal LH D. Normal FSH,normal LH

Q.9 All are true for post pill amenorrhea except?

A. Failure to resume menstruation within 6 months after discontinuation of ocp
B. Associated with low levels of gonadotrophins
C. Treatment is only required when pregnancy is desired
D. FSH and LH levels should always be done for establishing diagnosis

Q.10 All are incorrect about PALM-COEIN classification except?

A. A method of categorizing the results of investigations of women with AUB in reproductive years.
B. An algorithm designed to lead to a diagnosis of the cause of AUB
C. Appropriate for diagnosing women with postmenopausal bleeding
D. An acronym for a set of symptoms that may or may not contribute to the cause of AUB in reproductive years

"पाती एक अजन्मी की"

मैं बोझ नहीं हूँ माँ , मुझको यूँ कोख में न मारो तुम...
तुम्हीं तो हो ताकत मेरी
ऐसे हिम्मत न हारो तुम!

आने दो मुझे इस दुनिया में तुम्हारा नाम मैं रोशन कर दूंगी , तेरी हर तकलीफ को दूर कर मैं तेरा घर खुशियों से भर दूंगी , मैं भी तो तेरा खून ही हूँ इस बात को विचारो तुम

मैं बोझ नहीं हूँ माँ , मुझको यूँ कोख में न मारो तुम...

मुझ पर विश्वास भले न हो तुम खुद पर तो विश्वास करो
मुझे बचाने की खातिर तुम थोड़ा तो प्रयास करो ,
रूखी–सूखी खाकर मैं माँ संग तेरे ही रह जाउंगी
बेटी होने के फर्ज मैं सारे गर्व से पूरे निभाउंगी ,
इन लोगों के स्वार्थ की खातिर मेरी दुनिया न उजाड़ो तुम

मैं बोझ नहीं हूँ माँ , मुझको यूँ कोख में न मारो तुम...

मैं ही देवी , माता भी मैं ही , बाँधा है जिसने प्यार से सबको
असल में वो नाता भी मैं ही
बिन नारी न सृष्टि चलेगी इस बात का तुम ज्ञान करो
बोझ समझकर बेटी का ना अपमान करो ,
है सब का जीवन सुधारती तुम भी इसका सम्मान करो , वक्त आ गया आज है जो इसको अब संभालो तुम

मैं बोझ नहीं हूँ माँ , मुझको यूँ कोख में न मारो तुम
तुम्हीं तो हो ताकत मेरी
ऐसे हिम्मत न हारो तुम!

- अर्चना

HEALTH AWARENESS PROGRAMME

HEALTH CHECKUP PROGRAMME

VIOLENCE AGAINST WOMEN

TRAINING PROGRAMME

BREASTFEEDING WEEK ACTIVITIES

CONGRATULATIONS