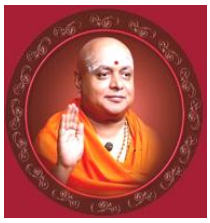
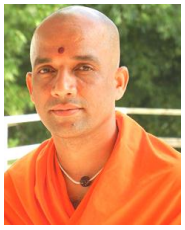


**JANANI**
**MOTHER IS LIVING**
**GOD**



**NEWS LETTER FROM DEPARTMENT OF OBG**



STATE LEVEL OBG CME-2016
On
**"Fetal Medicine Update"**
On March 30 th ,2016

Department of OBG
AIMS

## A RARE CASE REPORT OF GULLIAN BARRE SYNDROME IN PREGNANCY


**Dr Vijayalakshmi S, Dr Ravindra S Pukale, Dr Mahendra G**


**Introduction :** Guillain-Barré syndrome (GBS) represents a heterogeneous group of immune mediated peripheral neuropathies. GBS generally manifests as a symmetric motor paralysis with or without sensory and autonomic disturbances. Delayed diagnosis is common in pregnancy or immediate post partum period. GBS should be considered in any pregnant patient complaining of muscle weakness, general malaise, tingling of the fingers, and respiratory difficulty.

**Case report :** Mrs X aged 28 years ,$G_2P_1L_1$ with 35weeks of POG with cephalic presentation with previous LSCS presented to SAHRC to the department of OBG with complaints weakness of both upper and lower limbs and difficulty in walking since a day. Weakness more in both lower limbs compared to upper limbs and worsened the following day, unable to stand and walk and associated with slurring of speech. No bowel and bladder involvement On examination – patient was consious, co-operative, oriented. RS and CVS –WNL. On per abdomen examination –uterus term size, head at lower pole, FHS good. On neurological examination with intact higher mental function, slurred speech, all cranial nerves intact. With muscle power in upper limb 3/5 and lower limbs 2/5 .

With loss of deep tendon reflexes, fine touch, two point discrimination but intact crude touch, joint position sense and proprioception, a diagnosis of GBS made and referred to NIMHANS for further management. Patient got admitted in Bangalore private hospital, investigations revealed anemia (7 g% ), thrombocytopenia (0.65 lakhs/cumm) and nerve conduction study showed bilateral LL>UL mild sensory neuropathy and confirmed GBS . Patient was considered for large volume plasmapheresis . Patient went into labor , in view of previous LSCS and NST showing late decelerations , she was taken up for caserean section under GA and extracted a single live male baby. Patient could not come out of GA and was on ventilator, gradually weaned off after 2 days, in view of thrombocytopenia, urosepsis and LSCS next sitting of plasmapheresis was not done. Coagulation profile was within normal limits. Physiotherapy was started from day6 and she was discharged from hospital on day 14 of LSCS. Was advised physiotherapy on discharge. Patient readmitted at SAHRC on day 20 of LSCS with history of fever, with muscle tone in upper limb and lower limb 2/5, treated conservatively with IV antibiotics and discharged after 3 days . Referred to NIMHANS for further management .

**Discussion :** GBS is Immune mediated and has unclear pathogenesis . About two third of patients have an infection within the previous 4-6 weeks. Implicated infectious agent include Mycoplasma Pneumonia,Campylobacter Jejuni ,Cytomegalovirus, Epstin Barr virus. The preceding infection may cause an autoimmune response against the various components of the peripheral nerve myelin. GBS can ouccur in any trimester of pregnancy and postpartum period. Management of GBS in pregnancy is similar to that in the non pregnant population and includes IVIG, plasmapheresis and ventilator support when required.

**Conclusion :** High index of suspicion for early diagnosis and prompt intensive multidisciplinary supportive care in a GBS complicated pregnancy improve the prognosis for mother and fetus .

## INTERESTING RARE CASE OF HYDROMETROCOLPOS WITH HYDROSALPHINX WITH TRANSVERSE VAGINAL SEPTUM

**Dr.Gopal N, Dr. Bharathi K.R, Dr. Subbappa K, Dr. N.Divya Alamelu**

**Introduction :** Transverse vaginal septum is due to the failure of fusion of the vaginal plate and caudal end of fused Mullerian duct. Here we present a rare case of hydometrocolpos with hydrosalphinx with transverse vaginal septum in early adolescence.

**Case Report** : 11 year old girl presented with complaints of intermittent, crampy, severe lower abdominal pain since 6 months, each episode lasting for 1-2 days, more on the right side, not radiating . Was aggravated since past 3 days. There was no specific aggravating factors and was relieved by drugs. There was no other complaint of urinary disturbance, fever, mass per abdomen or abdominal distension. She had not yet attained menarche.

On examination, she was obese with weight of 52 kgs and height of 130 cms and BMI of 30.76 kg/m². Her vitals were normal and systemic examination was normal. Examination of thyroid gland normal. Breast was Tanner Stage II. Axillary and Pubic hair was absent. Per abdominal examination revealed a vague tender, cystic mass in the right para-umbilical region. On examination of the external genitalia Pubic hair absent. Labia Majora and Minora were normal. Hymen not intact (perforate). Bluish convex membrane was seen bulging through the vaginal introitus(fig 1).Urethral orifice normal. On per rectal examination, cystic bulge was felt anteriorly. A provisional diagnosis of hematometrocolpos with hematosalphinx was done. Routine blood and urine investigations were within normal limits. Ultrasound examination showed distended uterine cavity and vaginal canal suggestive of hydrometrocolpos measuring 8*4.8*4.2 cms fig(2). Hypo-echoic lesion was seen in right iliac fossa with relatively well defined margins suggestive of right ectopic kidney. MRI pelvis revealed hydrometrocolpos with linear transverse septum at the caudal end of the vaginal canal suggestive of low level transverse vaginal septum with maximum thickness of 2.8 mm with ectopic and cystic dysplasia of right kidney. Both ovaries and left kidney normal. Examination under general anesthesia was done which revealed bulging membrane through the introitus. Diagnostic laparoscopy revealed distended and enlarged uterus with thinned out uterine wall. Right tube was distended. Left tube and ovary were normal. Needle aspiration of the septum was done per vaginally and about 150 ml of clear serous fluid was drained(fig 3). Following the aspiration the uterus and right tube decompressed in size. Resection of vaginal septum was done and the edges were undermined. Post operative period was uneventful. Post operative ultrasound revealed a normal size uterus with no collection in uterus and vaginal canal. Patient was followed up after 2 weeks and 4 weeks, which revealed patent vaginal canal.

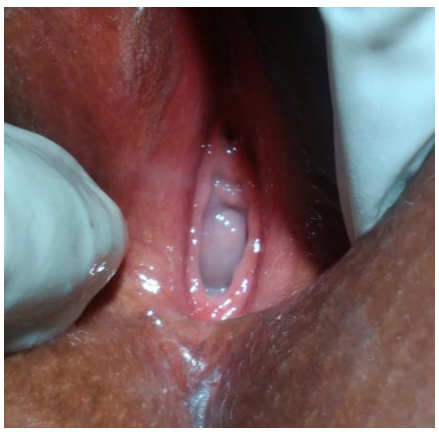


**Fig 1**

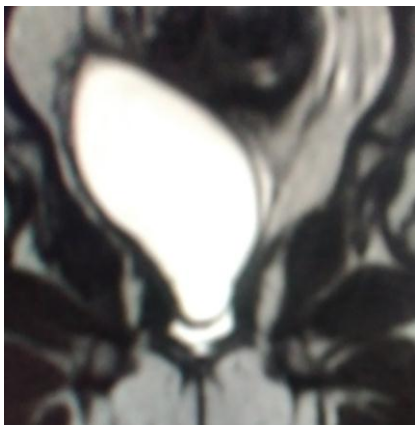


**Fig 2**

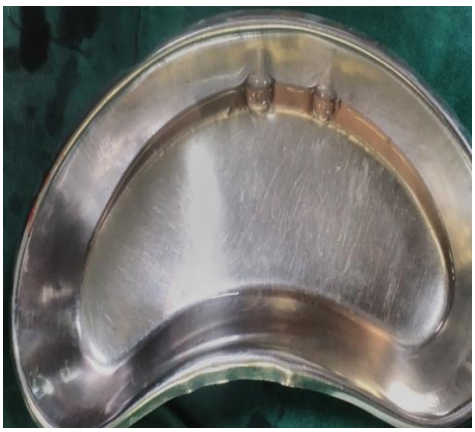


**Fig3**

**Discussion:** Transverse vaginal septum is due to the failure of fusion of the vaginal plate and caudal end of fused Mullerian duct. Reported incidence varies from 1 in 2,100 to 1 in 72,000. It occurs about 46% in the upper vagina, 40% in middle vagina and 14% in lower vagina. At puberty, transverse vaginal septum may present with primary amenorrhea with hematometrocolpos with hematosalphinx. This is one of the rarest cases which has presented with hydrometrocolpos with hydrosalphinx in the early adolescence. In literature no such cases has been reported till date.

**Conclusion:** Early detection and thorough comprehensive evaluation and prompt surgical correction of Mullerian anomalies is essential not only to treat the disorder but also to prevent possible hazardous sequelae on the patient's future reproductive health.

**GESTATIONAL GLUCOSE INTOLERANCE- DOES IT HAVE ANY ADVERSE MATERNAL AND FETAL OUTCOME?**

**Dr LokeshChandra. H.C , Dr Surakshith L Gowda**

**Introduction :** GDM is defined as carbohydrate intolerance of variable severity with onset or first recognized during the present pregnancy. Maternal and fetal complications associated with Gestational Diabetes Mellitus (GDM) are often reported from observational studies in which GDM is identified and treated in different ways.

**Objectives** : To evaluate whether there is an increased maternal or neonatal morbidity in association with Gestational Glucose Intolerance.

**Materials and Methods** : It was a prospective case control study between Jan 2015 to Dec 2015, where all pregnant women were screened for GDM with Diabetes In Pregnancy Study Group India (DIPSI) criteria, as and when the pregnant women enters the antenatal clinic, she was given 75gm oral glucose. Then two hours later, plasma glucose was estimated by Glucose Oxidase - Peroxidase method.

- 2hr post plasma glucose value of <120 mg/dl was taken as normal.
- Between 120-139 mg/ dl was considered as Gestational Glucose Intolerance.
- ≥140 mg/dl was diagnostic of GDM.

All women were screened at 12 – 16 weeks of gestation, but in a normal glucose tolerant woman the test was repeated again at 24 – 28 weeks & 32 – 34 weeks where as in GGI patients OGCT was done monthly and if she was found to be GDM at any stage, she was excluded from the study. Adverse maternal and fetal outcomes were looked for and compared between the case and the control groups.

**Results :** A total of 2221 women were screened during the study period and 2010 women were found to be NGT, 51 GGI and 160 GDM on initial screening. And on subsequent screening of the same patients 6 developed GGI & 11 developed GDM out of 2010 NGT women and out of 51 GGI cases, 14 developed GDM. Finally we were left with 1993 (89.8%) women with NGT, 43 (2%) women with GGI and 185 (8.2%) women with GDM. The mean age in the normal glucose tolerant group and GGI group was 22.7±2.7 years and 24.6±4.2 years respectively and the mean OGCT value was 93mg/dl and 129mg/dl respectively. There was an increased independent association between cesarean section rate, AFI, BMI, period of gestation and birth weight of neonates born to mothers with GGI (all p values < 0.05). The incidences of Preeclampsia, PROM, Preterm birth and hypothyroidism in the GGI group were 18.6%, 23.3%, 14% and 30.2% respectively, where as it was only 9.3%, 14%, 7% and 9.3% respectively in the normal glucose tolerant group. Association with GGI was found more in hypothyroidism with a Neonatal complications like hypoglycemia was 7% in NGT group and 18.6% in GGI group, also hyperbilirubinemia was 32.6% in GGI group and 20.9% in NGT group and GGI group had 16.3% NICU admissions with a significant p value of 0.03.

**Conclusion**: There was a significant association between cesarean section rate, AFI, BMI, period of gestation and birth weight and NICU admission of neonates born to mothers with GGI, also the prevalence of hypothyroidism was found to be more with GGI. Even though most of the children were healthy still there was increased maternal and neonatal morbidity. So this condition is worth monitoring and treating, since it has been demonstrated that good metabolic control maintained throughout gestation can reduce maternal and fetal complications

**CALENDER OF EVENTS:**

- International women's day celebrated on 8th March 2016.
- Jnana Vignana Mela was held in the month of February 2016 with active participation of Department of OBG in all days of the mela.

**CONFERENCES AND CME:**

**1**. 59th AICOG conference was held at Agra from 13th -17th January 2016 attended by Dr N Gopal, Dr. Bharathi K R and Dr. Surakshith L Gowda and postgraduates Dr.Divya K, Dr.Shashikala Narasappa Pujar, Dr Shika Agarwal, Dr Divya Alamelu N, Dr Joe Kaushik

**2.** State level OBG CME on FETAL MEDICINE UPDATE was conducted by dept of OBG, AIMS on 30th March 2016. Around 200 State and national delegates attended the CME.

1)Dr.Adinarayana Makam spoke on **"Down syndrome screening and current affairs" and "Fetal growth and Doppler in Obstetrics"**

2)Dr.Prathima Radhakrishnan gave lecture on **"Interventions in multiple pregnancy"**

3)Dr.Raja A Munireddy spoke on **"Anomaly Scan"**

4)Dr.Chandramouly M gave lecture on **"Role of 3D and 4D ultrasonography in Obstetrics and Gynaecology"**

**3.** 18th National Seminar on Hospital & Healthcare Management, Medicolegal Systems & Clinical Research held on 6th & 7th May 2016 by Symbiosis International University, Pune was attended by Dr Surakshith L Gowda.

**4.** BSOG PG CME held at Bengaluru in June 2016 was attended by all final year potgraduates. Dr.Divya K and Dr.Divya Alamelu N participated in case discussion .

**5.** Work shop on **vaginal hysterectomy** was held on 26thJune at JSS hospital Mysore in association with MOGS,was attended by Dr Vijaylakshmi.S, Dr Bharathi K R, Dr Mahendra G and postgraduates Dr Shika, Dr Joe Kaushik, Dr Vindhyashree, Dr.Himaja.

**6.** Workshop **ENDOVISION** in association with BSOG on 16th and 17th July at St Jhons medical college Bangalore was attended by Dr N. Gopal , Dr. Surakshith L Gowda.

**7. FOCUS- PG** Training Programme at Thrissur, August 2016 attended by postgraduates Dr.Divya K, Dr.Divya A, Dr.Joe Kaushik, Dr.Shashikala N, Dr.Shika Agarwal.

**Paper Presentations by Postgraduates**

- **"Second stage partogram A novel tool in obstetric practice"**by Dr.Divya K at AICOG 2016 .
- **"Study of induction of labor with vaginal PGE2 in relation with cervical ripening and fetomaternal monitoring"** by Dr.Shashikala Narasappa Pujar at AICOG 2016 .
- **"Mifepristone in preinduction cervical ripening in term pregnancy A novel discussion"** by Dr Divya Alamelu N at AICOG 2016.
- **"Role of Oral Misoprostol in Prevention of PPH"** – A Comparative study with 10 units IM Oxytocin – By Dr. Shikha Agrawal at AICOG 2016.

- Debate on Diabetes Endocrinology Basic science ,advances in therapy and education participated by Dr Ravindra S Pukale held at Bengaluru on 29th -31stJanuary 2016.
- Dr Vijaylakshmi. S Prof & HOD ,participated in the workshop on "**health care and environmental ethics"** organized by MEU in association with Asia pacific chair international network of the UNESCO chair in bioethics (Haifa ) on 12th February 2016 at AIMS Bellur .
- Dr Vijayalakshmi S , Prof & HOD chaired the session on "Medical Management in AUB" by Dr. Latha Venkataraman in Mysuru conducted by MOGS on 19th Mar 2016.
- Dr Vijayalakshmi S, Prof & HOD participated as a delegate in workshop on "Vaginal Hysterectomy"held on 26th June 2016 at JSS hospital Mysore in association with MOGS

## PUBLICATIONS BY STAFF :

| Sl no | Title of research paper | Name of the journal | Authors | Date | Page no |
|---|---|---|---|---|---|
| 1 | A cross sectional study of rate, trends and determinants of cesarean section among mothers attending a rural medical college in Karnataka | Indian Journal of Obstetrics and Gynecology Research. | DrRavindra S Pukale | 2016 Issue 1 | 13-17 |
| 2 | Fetomaternal Outcome in Cesarean Sections Done in Second Stage of Labor | Indian Journal of Obstetrics and Gynecology Research. | Dr.Mahendra.G, Dr.Vijayalakshmi.S | 2016 Issue 1 | 51-54 |
| 3 | Heterotopic Pregnancy in natural conception | Journal of Pharmaceutical and Bio Medical Science | Dr.Surakshith. L Gowda. | 2016; 06 (02) | 86-88 |
| 4 | Fallopian Tube Prolapse- A Rare Complication of Hysterectomy. | Indian Journal of Obstetrics and Gynecology Research. | Dr.Surakshith L Gowda. | 2016 Mar 3(1) | 78-79 |
| 5 | Central cervical fibroid with a typical Lantern on top of St. Paul's cathedral appearance | International Journal of Reproduction, Contraception, Obstetrics and Gynaecology. | Dr Surakshith L Gowda | 2016 Mar;5(3) | 924-926 |
| 6 | Impact of socio demographic factors on the severity of maternal anaemia | International Journal of Reproduction, Contraception, Obstetrics and Gynaecology | Dr Surakshith L Gowda | 2016 Mar;5(3) | 868-872 |
| 7 | Oxytocin versus methyl ergometrine in the management of third stage of labor: a comparative study from a South Indian tertiary care hospital. | International Journal of Reproduction, Contraception, Obstetrics and Gynaecology. | Dr Surakshith L Gowda. | 2016 May 5(5) | 1327- 1330 |
| 8 | Litigations in Obstetric and Gynecological Practice: Can it be prevented? A probability to possibility. | Journal of Obstetrics and Gynecology of India | Dr Surakshith L Gowda | 2016 March. | |

**DEPARTMENT OF OBG**