

DIAGNOSIS AND SUCCESSFUL LAPAROSCOPIC MANAGEMENT OF PREGNANCY IN A RUDIMENTARY HORN: AN INTERESTING CASE REPORT

INTRODUCTION

Mullerian duct anomalies have been reported to occur in 3.2% of women (Simon et al., 1991). They can be diagnosed at different stages of life. The presentation can vary from a mass resulting from an obstructed mullerian system in an infant (mucocolpos), primary amenorrhea, cyclical pain with mass per abdomen (hematocolpos), to infertility or bad obstetric history (Raga et al 1997., Golan et al., 1989 Johansen et al., 1983). A unicornuate uterus is one such anomaly which results from the failure of lateral fusion of the malformed duct with the contralateral duct. The malformed duct presents as a rudimentary horn which may or may not consist of a functional endometrial cavity. The presence of functional endometrium in a non-communicating rudimentary horn may further complicate the condition by causing cryptomenorrhea, hematocolpos or retrograde menstruation leading to pelvic endometriosis.

Pregnancy in a non- communicating rudimentary horn is a rare form of ectopic gestation and its incidence is between 1/100,000 to 1/140,000 pregnancies (Heinonen, 1997). The only possible explanation of this phenomenon is by transperitoneal migration of sperm, ovum or zygote. The rudimentary horn pregnancy (RHP) usually culminates in rupture of the pregnant horn. Unlike other ectopic gestations, rupture is usually seen in the second or third trimester because of the thick uterine horn musculature. It leads to life threatening intra-peritoneal bleeding and hemorrhagic shock. Therefore, early pre-rupture diagnosis is of utmost importance for the maternal well being. Here, we report a case of RHP diagnosed sonographically leading to successful laparoscopic management.

CASE REPORT

A 34 year old lady came to our hospital in January 2009 with a history of 35 days amenorrhea. Her urine pregnancy test was positive and she wanted the present pregnancy to be terminated. As per her obstetric history, she had previous two missed abortions at 60-65 days of pregnancy evacuated by dilatation and curettage. The third pregnancy resulted in a successful caesarean delivery at term. Per operative findings at that time confirmed the presence of a unicornuate uterus with a right rudimentary horn. She had no relevant medical history.

The transvaginal sonography (TVS) revealed a good endometrial reaction in the non communicating rudimentary horn while the uterus demonstrated a thin endometrium with a corresponding corpus luteum of the right ovary. Serum beta hCG was advised for the patient and the value was 7694.2mIU/ml. A provisional diagnosis of pregnancy in the right rudimentary horn was made. She was advised stringent follow up at 40 days to visualize a sac in the rudimentary horn or an ectopic pregnancy. But the patient was unwilling for any follow up and left the hospital. She subsequently came for review after 10 days at 45 days of amenorrhea when the TVS showed a gestational sac with yolk sac and cardiac activity in the right horn. A ring of myometrium was seen surrounding the gestation sac and there was no continuity observed between the endometrium lining the gestational sac with that of the unicornuate uterus. These two sonographic features further supported our pre operative diagnosis of rudimentary horn pregnancy (RHP). The patient was counseled and laparoscopy was done.

The per- operative findings confirmed the presence of an enlarged and congested right rudimentary horn with an ectopic gestation (Fig 1 & 2). The pregnant horn was attached to the uterus with a fibrotic band. Bilateral adnexae appeared normal with the presence of a corpus luteum in the right ovary (Fig 2). Laparoscopic excision of the pregnant horn with ipsilateral salpingo-oophorectomy was performed with the help of harmonic scalpel and bipolar electrocautery (Fig 3 & Fig 4). The excised specimen was sent for histopathological examination which confirmed the diagnosis of a RHP. The patient recovered well and post operative period was uneventful.



Unicornuate uterus with right non communicating rudimentary horn with pregnancy and normal left tube & ovary



Right non communicating horn with pregnancy



Right Laparoscopic Excision of rudimentary horn with ipsilateral salpingo-oophorectomy



Morcellation

Maldevelopment of the mullerian ducts occurs in a variety of forms and each category is distinct from the other. A unicornuate uterus can be present alone or with a rudimentary horn on the opposite side which can be communicating or non communicating. Most rudimentary horns are non-communicating connected only by a fibromuscular band or there may be no connection at all (O'Leary and O'Leary, 1963).

The condition is also often associated with urinary tract anomalies. On the side opposite the unicornuate uterus, there may be a horseshoe or a pelvic kidney or it may be hypoplastic or absent. The whole abdomen sonogram of our patient confirmed the presence of both the kidneys.

The anomaly may lead to several gynecologic and obstetric complications during different stages of reproductive life of a woman. Non-communicating RH with a functional endometrium is known to cause complications like hematometra and endometriosis. The fact that is unusual in our patient is that despite a functional endometrium she had no symptoms suggestive of the same. Pregnancy is the rarest and most life threatening complication of a rudimentary horn with functional endometrium. Rupture through the wall of the vascular RH leads to sudden and massive intraperitoneal hemorrhage and shock. However, the advent of advanced diagnostic, surgical and anesthetic facilities have decreased the mortality rate to around 0.5% (Nahum, 2002). Also, recently a case of late second trimester pregnancy in a RH has also been reported (Patra et al., 2007).

To decrease this serious complication, early diagnosis is of utmost importance. However, the sonographic diagnosis of a RHP has differential diagnosis like a tubal pregnancy and pregnancy in a bicornuate uterus. A RHP shows a ring of myometrium around the gestation sac which is not seen in a tubal pregnancy. The sonographic differences between pregnancy in a bicornuate uterus or a RH are subtle and require a meticulous examination as they can be easily missed (Kadan and Romano 2008, Tsafirir et al., 2005).

Continuity is seen between the endometrium lining the gestational sac and the other uterine horn which is characteristic of a bicornuate uterus. On the other hand, this feature is missing in a unicornuate uterus and the two horns are variable in myometrial thickness and the distance between the two is also marked. These sonographic criteria helped us to clinch the diagnosis pre-operatively in our patient.

The conventional route of excision of rudimentary horn was through laparotomy. Nezhat et al in 1994 first reported the laparoscopic removal of a non-pregnant rudimentary horn (Nezhat et al., 1994). The principles of surgery though remain the same either in the pregnant or non pregnant state. The excision can be effected through use of electro-surgical or stapling devices (Creighton et al., 2000). However, we believe that the use of harmonic scalpel affords a convenient and a relatively bloodless option. The removal of the

uterine horn with the help of a morcellator is quick and also eliminates the need of an extra colpotomy incision or extension of the suprapubic incision.

Rudimentary horn pregnancy is a rare and serious condition and every attempt should be made to diagnose the condition at the earliest. To the best of our knowledge, this case is one of the few where the preoperative sonographic diagnosis of the same was made before rupture and managed laparoscopically. The meticulous examination of a patient suspected with rudimentary horn pregnancy using the non invasive modality of ultrasound can go a long way in the early diagnosis and management.

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Dr. Priya Selvaraj MD MNAMS MCE
Dr. Gunjan Singh MD DNB MRCOG (I)
Dr. Megha Agrawal MS G G Hospital

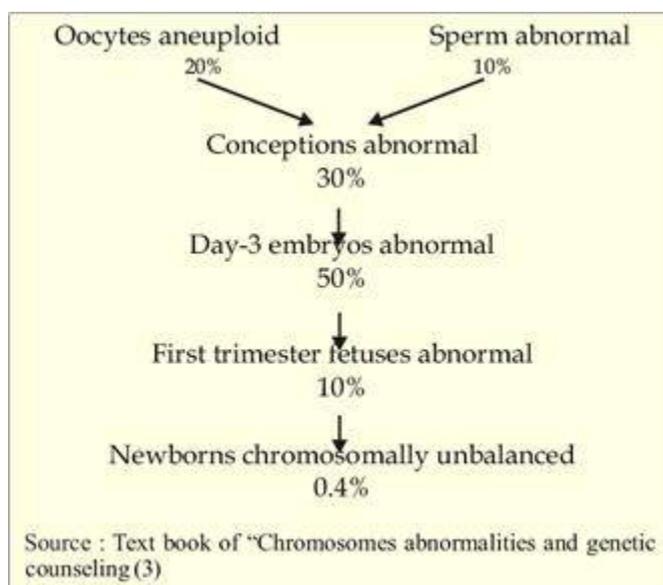
KARYOTYPE POLYMORPHISM AND SIGNIFICANCE IN INFERTILITY

There are certain influences which have been documented to have an effect on the genetic conduct of a conception be it natural or assisted. These are namely consanguinity, inheritable 30% disorders, sex linked disorders, hormonal imbalance and environmental factors. The end result of any of these could be repeated miscarriages, phenotypic abnormalities, metabolic syndromes or carcinogenesis. In an assisted conception unit we attempt to overcome these by adequate counseling for options like PGD and selective embryo transfers, donor programmes, weight loss and dietary rectification, removal of environmental hazards and adoption. Given all this, let us take the situation of idiopathic infertility where there are no known causes actually preventing conception, but requiring assistance of some form.

Can there be the existence of a chromosomal element either in the form of inversions, deletions and translocations in these otherwise normal couples with no other demonstrable causes of infertility? If so, what influence does it have on fertilization and conception? Can this be implicated as one of the reasons for not conceiving? Literature has revealed that in patients who have simple fertilization failure deemed as idiopathic, the proportion of women with chromosomal abnormalities was higher in comparison to their male counterparts, about 6.4%.

When a significant male factor was present, the incidence of chromosomal abnormalities in women was 2.5%. Stern et al noted the rate of balanced reciprocal and robertsonian carriers to be 3% in those who had failed more than 10 attempts at embryo transfers (1) . In yet another series, the incidence of non autosomal translocation carriers in women who failed IVF attempts more than 15 times was 8% (Raziel et al 2002) (2). While a fraction of cases of male infertility do have presence of Y chromosome microdeletions yet another group have normal karyotypes. However there is an increased sperm aneuploidy/diploidy rate with sex chromosomes being most affected.

There is also inherently a natural selection process whereby errors in gametes, preconception are rarely represented in newborns. This is evident in the flow chart given above where 30% of gametogenic errors result in 10% fetal abnormality rate in first trimester and 0.4% chromosomal errors in newborns.



In an IVF set up as is represented in literature and the chart above, almost 40 to 50% of day2/3 embryos even in the best grades may be chromosomally unbalanced which is why the success rates hover around the same range, at times reaching a higher end of 54 to 56%. Given all this, we shift the attention to significance of karyotypes in infertile couples and if it is something that should be done mandatorily in cases of idiopathic infertility and in the existence of either female or male factor or combined factors.

We are in the initial stages of our study in this regard, where 9 men of idiopathic infertility, demonstrated karyotype polymorphism namely interstitial deletions of long arm of Y chromosome (Yqh), translocations and increase in heterochromatin or satellite on either long or short arms of autosomes or Y chromosome. These men had normal semen parameters but whose wives had not conceived at all. It is known that translocations are associated with infertility, miscarriage and fetal abnormalities but how many of these men are prone to contribute to the above mishaps? What are the risks in conception and transmission? According to Vegetti et al (2000), men who fathered children with abnormal karyotypes through ICSI did not demonstrate a higher rate of aneuploidy when tested by FISH in comparison to men with similar male factor but showed a higher incidence when compared to normal population.

At our centre, the incidence of either partner demonstrating a karyotype deviation is 8.51% while both partners is 1.31%. A comment of normal variation needs to be ascertained as opposed to the suggestion for prenatal fetal Karyotyping. The outcomes for the above mentioned karyotypes are available for three couples where pregnancies are in the first trimester with no demonstrable anomalies thus far.

It remains to be seen as to how many of these couples would be influenced by a karyotype in achieving a normal conception. We have started to collect our data and are curious about polymorphisms involving one or both partners. According to literature those involving chromosome 9 are associated with infertility while it has been rarely reported for 21. We seem to be dealing with more cases involving the latter. This was written to spark off ideas and hopefully we should be able to publish good data. We also need to look at a control group to actually determine the significance-namely couples who have conceived with karyotypic polymorphism and their outcomes.

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***Dr. Priya Selvaraj MD MNAMS MCE
G G Hospital***

HEREDITY & CRYO TALK....

HEREDITY

Inescapably, this is me - the diagnosis is cause for anger at those who brightly say We choose our destinies. There is no store of courage, wit or will can save me from myself and I must face my children, feeling like that wicked fairy, uninvited at the christening, bestowing on my own, amidst murmurs of apprehension, a most unwanted gift - that of a blighted mind. No one could tell me of this curse when I was young and dreamt of children and the graces they would bear. Later, it seemed that a chill morning revealed deeper layers of truth. For my romancing there is a price to pay - perhaps my children's children will pass this tollgate after me. My grandmothers gaze down from their frames on my wall, sadly wondering.

- Meg Campbell

Where is the wisdom we have lost in Knowledge? Where is the knowledge we have lost in information?

- Meg Campbell

Source : Text book of "Chromosomes abnormalities and genetic counseling by R.J MvKinlay Gardner and Grant R.Sutherland. 3rd Edition 2004.

CRYO TALK....

This year has been another phenomenal journey thus far, what with another pregnancy from frozen thawed oocytes- twins this time around and by vitrification! Well as much it may seem as if we are doling out pregnancies there is no doubt about learning curves in ART with trials and errors. Then there is always a silver lining, and ofcourse ours was in the form of Dr.Patrick Quinn, who happened to visit our lab; or rather we stole him from a hectic schedule for some precious moments of learning and brain drain. We have been constantly updating our statistics on frozen oocytes and how dismal the final pregnancy rates can be in comparison to the conventional ART programmes. It is also something you don't get to do in daily practice and hence the long learning curve and understanding of processes. Well this time we were determined that being in association with SAGE media we were one of the lucky ones to try their vitrification media intended for oocytes, embryos and primarily blastocysts.

CASE PROFILE

It would not suffice, to just supply media but also ensure that the personnel are comfortable with use and do generate results. In that aspect the team has been absolutely cooperative and helpful. The details of this particular pregnancy generated from vitrified frozen thawed oocytes using Quinn's media and cryolock as loading device is given below. The Job did not end there for Dr.Quinn, who ensured we did it and also gave him a feedback of the progress of pregnancy. So we are grateful to him for his guidance and support and ever willing attitude to share knowledge and skill.

Mrs. S, aged 41 years had failed previous attempts at IUI and was a poor responder who had registered for the donor programme in November 2008. Earlier one treatment cycle had been cancelled owing to non availability of a suitable donor.

She otherwise had no known medical or surgical illnesses. Frozen-thawed oocytes in her case were used as a suitable donor was unavailable for a fresh transfer. Since her parameters were compatible with the oocytes frozen from a potential donor less than 36 hours previously we thawed the same for her use. Out of the 10 oocytes frozen by vitrification, 6 oocytes were thawed with 100% survival, 5 fertilized following ICSI with husband's pre- prepared sperms and 5 embryos were transferred 1(4cells)grade 1-2, 3(4cells) grade 2 and 1 (5- 6cells) grade 2. She was given a good luteal support using micronised progesterone and tested positive for

pregnancy on 31/03/09. It was a triplet gestation on scan which eventually underwent spontaneous reduction to twins. The first trimester progressed well with initial screening turning out to be normal. However she became a hypertensive and was treated with conventional antihypertensives used in pregnancy

Level II scan was also normal. But signs of early growth restriction prompted us to admit her for a more stringent follow up. On 21/9/09, owing to an abnormal doppler blood flow, India's first set of twins created from vitrified frozen thawed oocytes saw the light of the day. Twin male babies weighing 750 and 860 gms respectively were delivered by emergency LSCS. There were on ventilatory support and were stable. On 1/10/2009 one twin was extubated the other twin was extubated on 5/10/2009. Both babies are doing well till date. Nothing can be predicted in the field of ART and we are hopeful that the twin babies will go home well. In the same breath I must add that through all trials and tribulations we hit our third frozen oocyte pregnancy from slow freeze technique on 19/9/09.



CARE FOR A SPA RX?

Welcome to the year's first newsletter and this time we Well as much as we may all want to head to one ... the SPA (Single Port Access) that we are actually talking about is a boon in the field of laparoscopic surgery. What with robotics and minimal access taking over conventional skilled surgeons and multiport entries. Yes, we are talking about single port access surgery which has the following advantages.

How this works?

1. Lower blood loss
2. Less pain
3. Faster recovery time (3-4 days)
4. Less scarring
5. Lower infection rate
6. Lower rate of complications

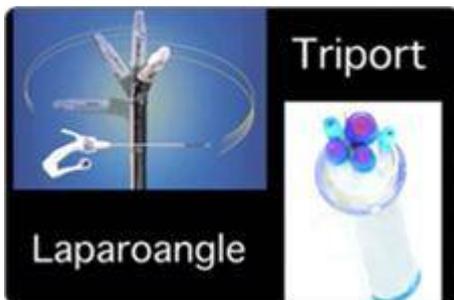
Conventional laparoscopic approach uses a main viewing port and 2-3 working access ports. In SPA the umbilical port is the lone entry through a single incision. Introduction of a triport or quadriport, allows the surgeon to perform standard laparoscopic procedures through multi instrument accesses fitted in the umbilical port.

South India's First SPA Surgery

Dr. Deepu Rajkamal Selvaraj - 2009 First SPA Hysterectomy - 21/8/2009 First SPA Varicocelelectomy - 11/9/2009

World First SPA Surgeries

First SPA Cholecystectomy - May 2007 - Dr. Paul Gurcillo - (USA) First Hysterectomy - July 2007 - Dr. Kate O Hanlan - (USA)



DIET AND PCOS & PARENT TALK

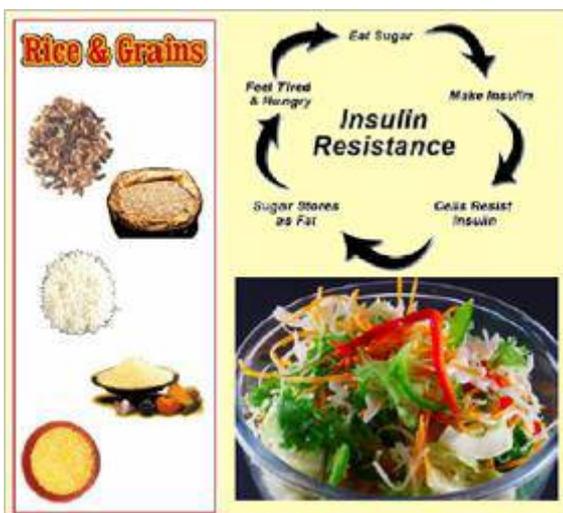
DIET AND PCOS

Until recently, diet was not thought of as an important adjunct in the treatment or management of PCOS. However, the recent discovery regarding the role of insulin resistance plays an important part in understanding the need for dietary intervention. Suggestive research also indicates that being overweight, and obese are associated mostly with this condition and hence the need for a nutritional recommendation to maintain a healthy lifestyle and improve the symptoms of this condition. A balanced diet is one that comprises all the five food groups (cereals, pulses and legumes, fruits and vegetables, milk and meat products and fats, oils and sugars) in required quantities based on age, activity and body composition. As an Indian one can easily balance his/her food by including all these groups in their daily food intake. In our day to day life we find that most often both lunch and dinner is usually balanced, hence one has to concentrate on the breakfast as this meal kick-starts the day and also provides one-third of an individual's metabolic and nutrient requirement. Since no single food group has all the nutrients that can nourish our body it is important to have variety of healthy options among the food groups to ensure the balance. A balanced diet coupled with moderate regular physical activity is the simple equation to a healthy life. A well balanced diet can actually show a marked difference in weight management but better still a deeper understanding about each nutrient would provide more insight into the diet required for PCOS. High intake of carbohydrates, especially the refined ones (i.e. Sugar, white flour and its products - semolina, sooji, white bread, white rice, etc.) will quickly convert to sugar and cause elevated levels of insulin. Since high levels of insulin is one of the causative factors in these women, it's better to avoid refined carbohydrates and instead include whole cereals like wheat, ragi, jowar, bajra etc. Sugar can be included in moderation depending on the sugar levels of the individual. Wise method of including carbohydrates would be by maintaining a combination method with protein, fat, vitamins, minerals, fibre and water. Moderate inclusion of protein in the form of pure proteins (Skimmed fat off) would be the ideal play as these foods have low glycemic index and also provide bulk in the diet which cuts on the carb percentage.

Care should be taken to include protein without fat as this combination is more prevalent among Indian foods (i.e. Milk, chicken, fish, egg etc) Either the food itself comes in the combination or the type of preparation (deep frying) adds to this effect. Hence vegetarian source of proteins such as legumes contribute more to managing PCOS.

A diet rich in saturated fats (ghee, butter, animal fat etc) can contribute to PCOS whereas unsaturated fats (vegetable oils, fish oils, almonds, and flaxseed) can help to modify the syndrome process. Since essential fatty acids play a major role in our metabolism embarking on a zero fat diet does not help. Right combination and balance of saturated and unsaturated will do the needful.

Vitamins like vitamin C helps in fat oxidation whereas certain other vitamins are essential to keep the metabolic fire burning hence going low on these can lead to weight gain contributing to PCOS. Certain minerals like calcium and iron are required during PCOS as it can also help in fertility. Vitamins also serve as antioxidants helping in efficient excretion of the metabolic wastes and toxins and in weight loss. The best source would be fruits (in moderation) and vegetables. Non nutrients like fibre and water also contribute to the satiety value of the system and hence indirectly help in PCOS, fibre especially the soluble fiber can help in relieving constipation which can occur due to reduced calorie intake.



Good water intake can contribute to proper metabolism in the body for utilization of sugars by the system contributing to insulin efficiency

This is also not a temporary diet it is one that you will need to follow long term! Therefore you will need to make it as healthy and tasty as possible. Remember any diet works best if coupled with some kind of physical activity especially the one that is in long run and enjoyable!

Number of studies indicates that physical activity is an essential factor in managing PCOS - and the resultant weight loss increases fertility as well as adds to a healthy lifestyle. Visceral fat, the fat that surrounds organs, is best lost through a program of diet and exercise. While weight loss is affected by diet alone, or by exercise alone, studies have shown that belly fat (visceral) is affected by the combination of both. Women with PCOS, as a rule, are unable to lose weight, and this very factor makes them targets of diabetes and heart disease, both of which are often accompanying diseases of PCOS. Exercise is very effective in improving the metabolic processes which in turn has a pronounced the effect on heart, chronic fatigue syndrome, and even in some forms of cancers. A moderate exercise program not only has physical benefits, but also improves mental outlook. Exercise promotes the propagation of endorphins, which in turn balance the mood and emotions. Since depression is also an accompanying feature of PCOS, exercise can benefit greatly in this regard as well. Starting an exercise program can sound like a difficult task, but just remember that your main goal is to meet the basic physical activity recommendations: 30 minutes of moderate-intensity physical activity at least five days per week, or vigorous-intensity activity at least three days per week, and strength training two to three times per week. Choose activities that appeal to you and will make exercise fun (cycling, swimming, aerobics, dancing etc). Walking is a great, easy way to do moderate-intensity physical activity.

In conclusion, we know that weight loss plays a key role in decreasing insulin resistance in obese women. It appears that a lower glycemic diet may play an important role in helping to control insulin levels as well as promoting weight loss. However if weight loss is not required in certain women, the concept of balanced diet is still essential for weight maintenance and general well being.

- Mrs. Veena Sekar
Nutritionist, G G Hospital

PARENT TALK

Respected Doctor,

I am writing this letter in enormous gratitude for bringing in my life boundless pleasure. I am Dr K a n i m o z h i m a r r i e d t o Dr Ashok Orthopaedician working in Withybush Hospital Haverfordwest South Wales UK.

After marriage I was issueless for 7 long years and even after a few trials clinically in the UK I was not able to conceive. Having heard about the great service rendered by you I came over to GG Hospital in September 2006. Immediately you and Dr Priya took me under your care.

Due to fantastic care and dedication to each and every case and bestowing great personal attention to the different circumstances of the individual cases and their needs I was able to conceive. Throughout my confinement I received excellent attention to each and every small setbacks and finally gave birth to a chubby little boy in May 2007.

I and my husband very gratefully remember you, Dr Priya, Dr Vijaya and all the dedicated staff of GG Hospital on the occasion of his 2nd birthday. I am enclosing one of his photos .

we hope and pray to God that your great service and pioneering work to continue and benefit many many families and bring everlasting joy and cheer unto them.

With highest regards

Dr Kanimozhi

Dr Ashok FRCS(Glasgow)



ART BABES...



- NAME : BRAMMI JEYAKUMARAN
- PROCEDURE : IVF - ET
- DOB : 01-10-1998 & 11 YEARS
- CLASS : 6th std
- HOBBIES: learning vocal / music /classical dance

• AMBITION :: To become a doctor Maintains a good academic record an proficiency in dance. Participated in state level “spell bee” nation level bright scholar”, international level ‘ma millan’ exams and won prizes.

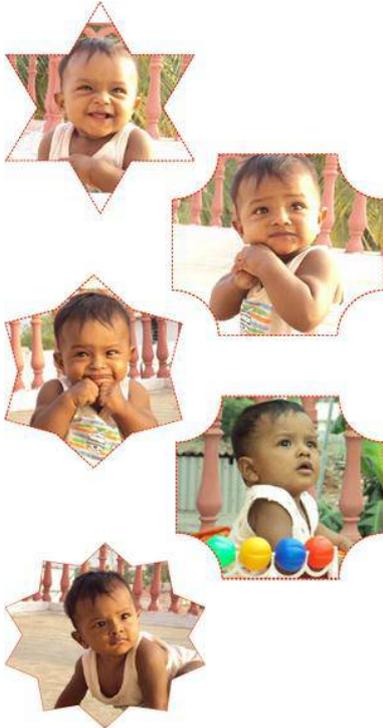
She has performed in jaya tv, ‘thakadimi tha ‘jackpot’ as also in programmes of kalaignar t chutti tv, and raj tv. She has joined the group of her guru to perform at ida, at the natyanjali, kumbakonam and oth temple programmes She has won many prizes in cometition

Hobbies are drawing, painting and singing



- NAME : Annapoorna
- PROCEDURE : IVF - ET
- DOB : 11.08.1998
- CLASS : 6th std
- HOBBIES : Reading books /cycling /Watching TV
- EXTRA ACTIVITIES : Learning vocal/Music/Classical dance
- AMBITION :: To Become an scientist

Our 1st frozen oocyte baby Turned One ...On 27/8/09



PRESS CLIPS....

PRESS CLIPS.....

Twin success from donor eggs

Special Correspondent

CHENNAI: Less than a year ago, in August 2008, a baby was born after eggs donated by a stranger was first frozen, then thawed. About 14 weeks ago, the procedure was repeated on a 41-year-old woman, with twice the measure of success - two foetuses formed in her womb after she received donor eggs.

New method

Doctors at the Fertility Research Centre in GG Hospital here claimed that the country's first twin pregnancy from frozen, thawed female eggs (oocytes) using a new method of freezing called vitrification, was well on its way. Vitrification is a rapid, more successful method of freezing the eggs, said Priya Selvaraj, who performed the procedure on Mrs.S. It has not yet outdone the more popular freezing method, but the risk of freezing within the cell comes down significantly, thereby rendering better recovery and fertilisation rates.

Mrs.S had failed previous attempts at conception, using the intra-uterine insertion technique called, 'a poor responder.' However, she had no other medical illnesses and was deemed fit for frozen egg transfer.

The eggs, from a donor, were fertilised with her husband's pre-prepared sperms using the intracytoplasmic sperm injection method. The embryos so formed were then transferred to the mother, five of them at a time, to increase the chances of a pregnancy.

She tested positive for pregnancy on March 31 this year and the twin foetuses are normal and doing well, Dr. Priya said.

1st frozen oocyte twins to be born

DC CORRESPONDENT

foetus healthy

First in India

On one of her visits to the hospital, we found that the eggs of a donor that had been frozen matched all her parameters and six oocytes were thawed and fertilised with her husband's sperm. Five of these embryos were transferred to her uterus.

called vitrification, that is not only less time consuming, but does not require a cryoprotector. "While therapy involving frozen embryos have good success rates, there has only been one successful pregnancy with frozen oocytes in India, and only a handful across the world," said Dr. Priya Selvaraj, assistant director of the hospital.

The patient, (name withheld) had failed previous attempts at intra-uterine insemination procedures, and registered for an egg donor, to help her conceive. "On one of her visits to the hospital, we found that the eggs of a donor that had been frozen through vitrification less than 36 hours previously, matched all her parameters. She decided to take a chance, and six oocytes were thawed and fertilised with her husband's sperm. Five of these embryos were transferred to her uterus," Dr. Priya Selvaraj said.

The patient tested positive for a twin pregnancy on March 31, and her foetuses are developing normally, the doctor said.

THE NEW INDIAN EXPRESS
TUESDAY, JUNE 16 | 2009 | CHENNAI 13

Twin pregnancy through frozen oocytes

Express News Service
Chennai, June 16

A MERE 20 hours after doctors at the GG Hospital and Fertility Centre here delivered twins that they had received, they found the perfect match for them: a 41-year-old woman who had been trying to conceive but failed cycles of an assisted reproductive technique known as intra-uterine insemination.

She is from an economically weak background and because of her age and the odds, she registered for her donor egg programme. "I had long since in pregnancy with twins and had completed her third trimester," said Dr. Priya Selvaraj, gynaecologist and fertility specialist at the hospital. "We are amazed about the pregnancy in that it has been achieved through a relatively new method, that is vitrification of oocytes (eggs), their subsequent thawing, fertilisation and implantation."

Conventionally, oocytes are frozen and thawed in a solution of cryoprotectant. The entire procedure of freezing and storage takes around two and a half hours. In vitrification, a more modern technique, the process involves freezing oocytes for a much shorter period of a few minutes in a much higher concentration of cryoprotectant.

"Vitrification also offers us a lot of other advantages and chances of low crystal formation on the other hand. In this case we far lower according to better survival rate, therefore, better fertilisation chances and it does not require special handling after the fertilisation," said Dr. Selvaraj. According to her, this is the first time in the country that twin pregnancy has been achieved through vitrification of oocytes.

For Mrs. S who wishes to remain anonymous, one out of the 10 frozen eggs was thawed. Of these, five were fertilised using her husband's sperm and, of these, five embryos were transferred to her uterus. She conceived and the pregnancy with twins is progressing well, Dr. Selvaraj said.

Yet another pregnancy from frozen egg in city

THIS IS NEWS NETWORK

Chennai: Nearly a year after they delivered the country's first baby born out of frozen oocytes, doctors at GG Hospital here have treated another mother-to-be, who has conceived a child conceiving through the procedure. And this time, it is a "sophisticated" rapid freeze technology used, which they used with a procedure called vitrification.

When the doctor used reports of 41-year-old Mrs. S who had long tried to get pregnant, she was advised to undergo vitrification. "Frozen eggs in a procedure that has been successful in 1,000 cases, we have been working on frozen oocytes for the last 11-12 months," said Dr. Priya Selvaraj, who is associated with the hospital's in vitro fertilisation programme, who referred to the doctor's suggestion. "When doctors would transfer eggs to be fused with her husband's sperm. But the day she conceived herself, the hospital had to fresh donors, who were suitable for her. However, just when 30 frozen eggs, they were frozen eggs of a single donor, who was able to conceive. Treatment for fertility, more sophisticated rapid freeze technology the successful time."

"While in the earlier instance, we did a simple freeze, where the cells were kept in a solution, and after several cryoprotector and passed into the rapid freeze method, in the rapid freeze method, the cells are passed through vitrification, in less than 12 minutes and placed into liquid nitrogen. The doctors are confident," said Dr. Selvaraj.

HOT CHOCOLATES !

A group of graduates, well established in their careers, were discussing their lives at a class reunion. They decided to go visit their old university professor, now retired, who was always an inspiration to them. During their visit, the conversation turned to complaints about stress in their work, lives and relationships. Offering his guests hot chocolate, the professor went into the kitchen and returned with a large pot of hot chocolate and an assortment of cups. Some cups were porcelain, glass, crystal, some plain looking, some expensive, some exquisite. He invited each to help themselves to the hot chocolate.

When they all had a cup of hot chocolate in hand, the professor shared his thoughts. "Notice that all the nice looking, expensive cups were taken, leaving behind the plain and cheap ones."

"While it is normal for you to want only the best for yourselves, that is the source of your problems and stress."

"The cup that you are drinking from adds nothing to the quality of the hot chocolate. In most cases it is just more expensive and in some cases even hides what we drink."

"What each of you really wanted was hot chocolate. You did not want the cup . . . but you consciously went for the best cups." "And soon, you began to eye one another's cups."

"Now friends, please consider this . . . "Life is the hot chocolate . . . your job, money and position in society are the cups."

"They are just tools to hold and contain life." "The cup you have does not define, nor does it change, the quality of life You are living."

"Sometimes, by concentrating only on the cup, we fail to enjoy the hot chocolate God has provided us."

Always remember this . . . God brews the hot chocolate, He does not choose the cup.

The happiest people don't have the best of everything.

*They just make the best of everything that they have!! Live simply . . . Love generously . . . Care deeply . . .
Speak kindly . . . Leave the rest to God.*

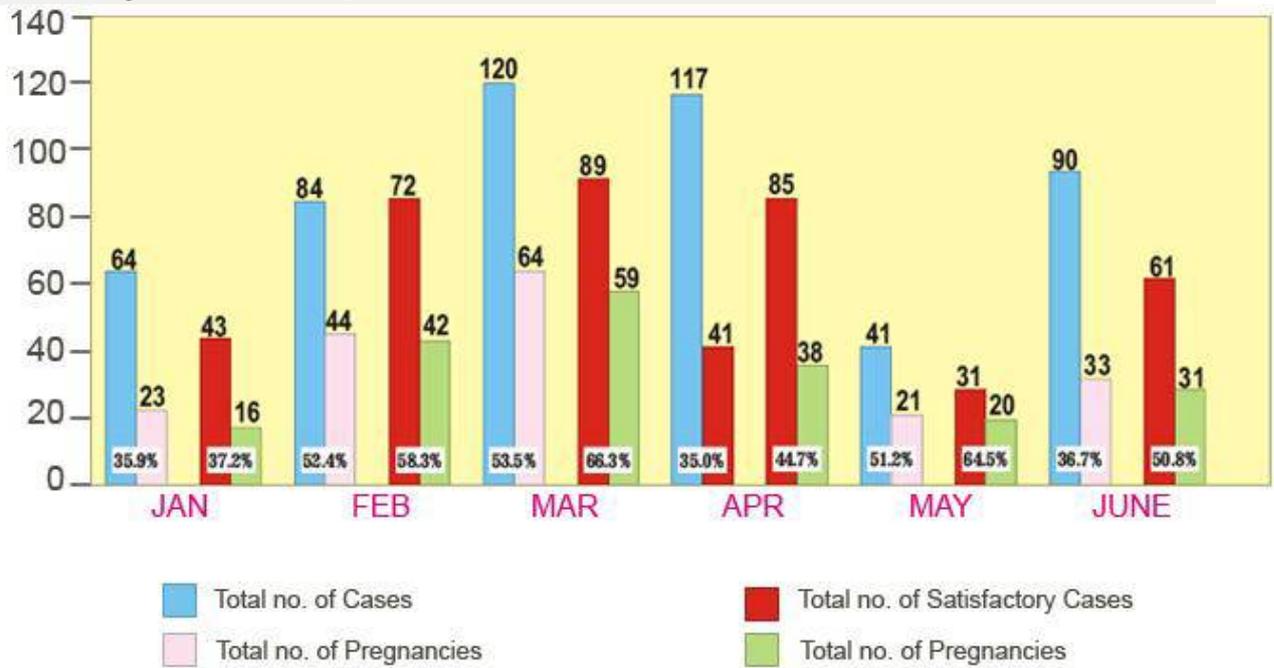
~ and remember ~

The richest person is not the one who has the most, but the one who needs the least.

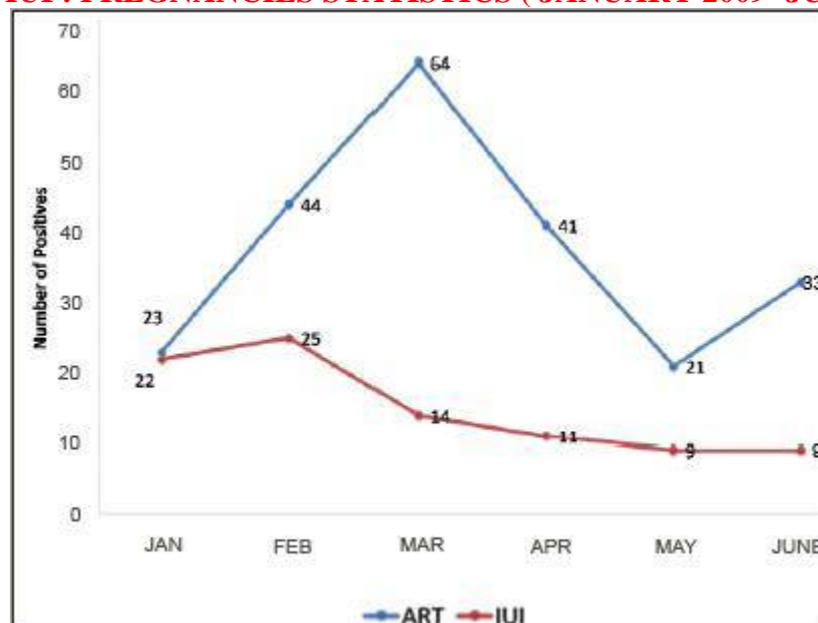
Enjoy your hot chocolate!!



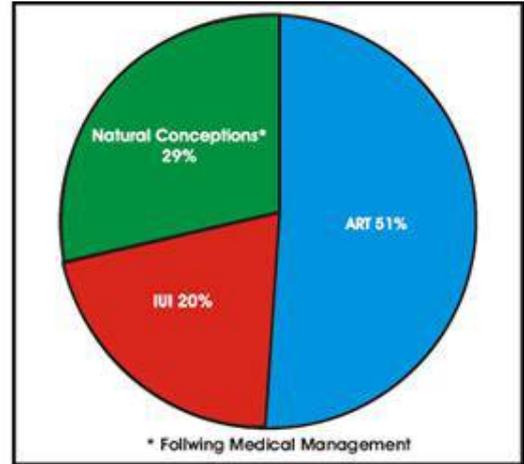
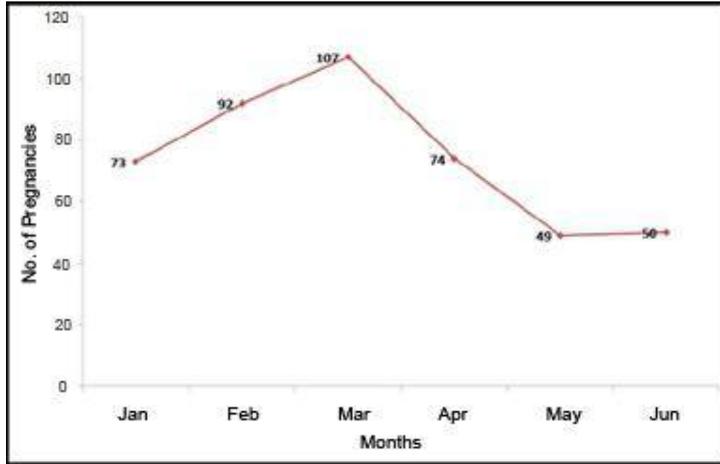
MONTHLY VARIATIONS IN ART PREGNANCIES -(JANUARY 2009 -JUNE 2009)



ART Vs IUI : PREGNANCIES STATISTICS (JANUARY 2009 -JUNE 2009)



TOTAL No. OF PREGNANCIES/ MONTHLY (JANUARY 2009 -JUNE 2009)



ART STATISTICS (JAN 2009 - DEC 2009)

ART STATISTICS (JAN 2009 – DEC 2009)

PROCEDURES	NO OF CASES	PREGNANCIES	PREG.RATE (%)
IUI (OWN / DONAR)	863	90	10.42
GENERAL			
IVF ET	3	1	33.33
ICSI ET	152	53	34.86
IVM ICSI ET	3	0	00.00
IVF & ICSI	4	3	75.00
RI ICSI	2	0	00.00
Bt	1	0	00.00
DUAL			
GIFT + ET	2	1	50.00
GIFT + ICSI	5	5	100.00

FROZEN EMBRYOS			
FROZEN CISI	32	8	25.00
FROZEN ICSI +IVF	10	3	30.00
FROZEN OOCYTE + ICSI	1	0	00.00
FROZEN PROST + ET	1	0	00.00
SEQUENTIAL TRANSFER (OWN / DONOR)			
DAY 2 AND DAY 5 TRANSFER	142	84	59.15
RUPTURE ET (OWN / DONAR)	32	13	40.62
DONOR OOCYTE PROGRAMME (DOP)			
IVF ET	8	3	37.50
ICSI ET	52	23	44.23
IVF & ICSI ET	3	2	66.66
FROZEN ET	1	0	00.00
OOCYTE THAWING – ICSI ET	3	1	33.33
BT	3	0	00.00
GIFT	2	0	00.00
DUAL			
GIFT + ET	1	0	00.00
GIFT + ICSI	4	2	50.00

DONOR EMBRYO PROGRAMME			
IVT ET	9	5	55.55
ICSI ET	1	1	100.00
FROZEN DET	20	8	40.00
BT	6	3	50.00
DUAL GIFT + ET	2	0	00.00
OWN + DOP			
IVF + ET	1	1	100.00
ICSI ET	6	4	66.6
OWN + DET	4	2	50.00

- Total Number of pregnancies achieved : 3265
- Total Number of patients delivered by ART : 1707
- Total Number of babies delivered by ART : 2187
- Total Number of ongoing pregnancies : 244
- Total Number of Fetal wastages :1299
- Lost in follow up : 15