OUR VISION
Pioneering in the field of fertility for over 36 years with an immaculate track record, we aim to provide an exceptional and unparalleled medical service in fertility care by delivering a comprehensive range of services aided by state-of-the-art equipments and revolutionary techniques.

OUR MISSION
Every woman has the right to attain motherhood, and we at GG believe in their dreams by providing affordable and comprehensive healthcare solutions to all their needs. Our team of highly skilled and experienced doctors along with support staff see them through with dedication, compassion and diligence.

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SUCCESSFUL SURGICAL MANAGEMENT OF HERLYN-WERNER- WUNDERLICH SYNDROME IN AN ADOLESCENT GIRL

INTRODUCTION

The Mullerian duct anomalies are a diverse group with varying degrees of anomalies and presentation. The Herlyn-Werner-Wunderlich (HWW) syndrome is one variety of the same which usually presents in adolescent girls with non specific symptoms. Awareness of such entity greatly facilitates accurate diagnosis and timely treatment.

We present a case of a 13 year old girl who came to us with hypomenorrhea and on evaluation was found to have the classical features of HWW syndrome and was successfully surgically treated. Here is a detailed case report with emphasis on classification and management.

The Herlyn-Werner-Wunderlich (HWW) syndrome is a rare congenital anomaly, which occurs as part of a larger spectrum of Mullerian ductal anomalies. It is characterized by uterus didelphys, unilateral obstructed hemivagina and ipsilateral renal agenesis [1].

The other name for it is obstructed hemivagina and ipsilateral renal anomaly (OHVIRA). The usual presentation is a young woman with dysmenorrhea, abdominal pain and pelvic mass. MRI is valuable in surgical planning which is the primary treatment.

CASE REPORT

An adolescent 13 year old girl presented to us with complaints of scanty periods. She had attained menarche 7 months ago followed by amenorrhea of four months with cyclical spotting for the subsequent three months.

She was a product of 3rd degree consanguineous marriage and her two siblings [one brother and one sister] were phenotypically normal. She also gave a history of recurrent urinary tract infections since past few months. Her karyotype was normal.

An MRI was done at a different centre which revealed uterine didelphys with haematocolpos of right vagina and left solitary kidney. She had normal secondary sexual characteristics [tanner staging 2].

Her pelvic ultrasound with us, showed uterus measuring 5.8*2.3cm with evidence of right haematocolpos of size 5.6*3.3cm. In view of diagnosis based on history, USG & MRI, she was posted for diagnostic laparoscopy and proceed on 01/08/2018.

SURGICAL PROCEDURE

Patient was positioned in lithotomy under GA. Parts were painted and draped. Bladder was catheterized. Per speculum findings revealed septate vagina with right hematocolpos, which appeared as a bulge in upper part of the right vagina.

Needle aspiration was performed. First, 50ml of collected old blood was removed. Once it reduced in size, a cruciate incision was made and septum was opened up, letting out the remaining blood. Excess septal tissue was trimmed, re-fashioned and sutured with 1-0 vicryl.

Now both right and left cervix was visualized and sounded. Two separate cavities were revealed. A betadine vaginal pack was kept in situ to be removed 4 hours later. Patient's vitals were stable post procedure.

DISCUSSION

Although Mullerian duct abnormalities cover a wide range of developmental anomalies, the incidence of HWW syndrome is relatively rare accounting for about 0.16-10% of all mullerian duct anomalies [2].
The exact etiopathogenesis of HWW syndrome is still not known. Classic theory of uterine anomalies as proposed by the AFS [American fertility society] is somehow inadequate to explain complex female urogenital anomalies like HWW syndrome, particularly their coexistence with renal anomalies. Studies of uterine organogenesis have implicated the HOX and WNT genes as regulators of uterine morphology.

A more recent theory proposed by Acein [3] is more explanatory for such anomalies. It postulates that appropriate development, fusion and resorption of the separating wall between the two Mullerian ducts seems to be induced by Wolffian duct which acts as a guide.

Any absence or distal injury to one of these ducts will give rise to renal agenesis, a blind or atretic ipsilateral hemivagina and uterine anomalies. This theory has been further reinforced by data published by Sánchez [4].

A newer classification has been proposed by Lan Zhu et al who reviewed 79 patients of HWW syndrome at Peking union medical college hospital. The subtypes are Classification 1 which has a completely obstructed hemivagina and Classification 2 which involves an incompletely obstructed hemivagina [5]. This simpler classification allows for earlier diagnosis and treatment.

Most patients present with non specific symptoms such as pelvic pain, a pelvic mass or as primary amenorrhea. They generally present at puberty with these symptoms. The palpable mass may be associated with hematocolpos or hematometra, which occurs with occlusion of vaginal canal due to the fusion of the septum with the vaginal wall [6].

Diagnosis is aided by ultrasonography and MRI. Although MRI is considered as a gold standard for diagnosis and pre-operative planning of HWW syndrome, transvaginal sonography has the advantage of low cost and easy availability.

The MRI not only defines the morphology of the uterus it also detects communication between vaginal and uterine lumen, and characterizes fluid contents. The associated renal agenesis and associated complications like endometriosis are also better delineated [7]. The single most effective treatment is surgery both in terms of alleviation of symptoms and retaining fertility.

Resection as much as possible of the obstructing vaginal septum is the optimal surgery. This is best done around the time of menstruation, as a large distended hematocolpos is easy to visualize and palpate, aiding resection. Although vaginal septotomy is usually done by hysteroscopic approach rather than laparoscopic technique [8].

Hur et al considered laparoscopic evaluation preferable in patients who have an obstructed vaginal septum for prevention of menstrual regurgitation, endometriosis and pelvic adhesions [9]. One aspect not easily amenable to surgery is the associated cervical agenesis which is why laparoscopic or transabdominal resection of the affected ipsilateral uterus is suggested.

Early diagnosis and treatment leads to good prognosis with preservation of fertility. Although as much as 80% patients can conceive, the rates of premature delivery (22%) and abortion (74%) are higher than in the general population leading to the necessity of Caesarean section in over 80% of patients with HWW syndrome [9].

CONCLUSION

The HWW syndrome is a rare component of the spectrum of Mullerian duct anomalies. Awareness of such an entity makes it possible to detect it earlier and offer the right treatment at the right time.
Although the exact etiopathogenesis is still being evaluated, the newer classification helps simplify the treatment which is primarily surgical.

REFERENCES


DR. PRIYA SELVARAJ MD MNAMS MCE
DR. SUGANTHI MBBS DGO

INDIA’S FIRST FROZEN OOCYTE
BABY BOY TURNS 11...

NAME : JEEVAN
DOB & AGE : 27/08/2008 & 11 YRS
CONCEPTION : IVF-ET
HE IS ALWAYS FIRST IN STUDIES & SPORTS
INTRODUCTION
Risk of developing cholelithiasis is elevated during pregnancy due to hormonal changes resulting in increased cholesterol levels (1). When biliary colic or acute cholecystitis occurs during pregnancy, medical treatment is indicated, often beginning with supportive care (2, 3). In cases where conservative management such as IV fluids, antibiotics, and pain control are insufficient in alleviating symptoms, providers generally consider further need for surgical intervention (4). Laparoscopic cholecystectomy is a good viable treatment for acute cholecystitis in the setting of pregnancy (5, 6). However, surgical intervention is not without risks.

Spontaneous miscarriage and congenital abnormalities are associated with cholecystectomy during the first trimester of pregnancy (7). During the third trimester, laparoscopic cholecystectomy is challenging because the size of the gravid uterus can obstruct the surgical field (8, 9). Laparoscopic cholecystectomy is usually not associated with pre-term labour (10-13) and current guidelines do not recommend prophylactic tocolysis in pregnant population with acute abdomen.

The timing of laparoscopic cholecystectomy in the context of pregnancy and acute cholecystitis is not well established (13). Furthermore, the increased dilemma and management of acute abdomen in a pregnancy, need for surgical interventions, with the rare occurrence of surgical acute abdomen especially in patients who have conceived by IVF, there are no clinical recommendations or guidelines for management.

Advantages of Laparoscopic cholecystectomy over laparotomy are
* Decreased blood loss
* Faster recovery
* Serving as a less invasive procedure, and
* Reduced post-operative pain.

However, higher the weeks, more difficult the approach, thereby warranting an open approach.

Here we present a case of acute cholecystitis with twin pregnancy and its successful management.

CASE REPORT:
A 27-year old woman with PCOS and in a non-consanguineous marriage for five years came to our hospital on 1/11/2016. She gave history of having undergone laparoscopic electrocauterisation of ovarian stroma (LEOS) at an outside hospital in May 2014.

Husband’s semen analysis and karyotyping of both partners were normal. USG pelvis revealed a normal uterus with polycystic ovaries. Blood investigations and hormone analysis (LH, FSH, AMH and serum prolactin) were within normal limits. Subsequent diagnostic hysteroscopy at our centre on 10/11/2016 was also normal.

She failed two cycles of IUI and following counseling, the couple elected to undergo IVF using long protocol with oral contraceptive pills and down regulation with GnRh analogue injection 3.6 mg (Goserelin acetate, Astrazeneca, UK) on day 20. Controlled ovarian stimulation was started on day 3 using recombinant FSH (Newmon, LG lifesciences, Korea) and gonadotropins (IVF M2, LG lifesciences, Korea). When maximum follicular size reached 1.8 X 1.8 cm, a hCG trigger was given (Inj. Amlife 10,000 IU/ml, American formulations, Gujarat).

Trans-vaginal aspiration of oocytes was performed on 20/3/2017, resulting in the retrieval of 15 oocytes, of which, 13 were fertilized. A subsequent frozen sequential transfer cycle was performed on 19/6/2017 (2 embryos) and 20/6/2017 (1 blastocyst). Her β-hCG values were 518 mIU/ml on day 28 and 2950 mIU/ml on day 30.
Her transvaginal scan on the 38th day showed twin gestational sacs. The patient experienced an uneventful first trimester with normal screening test. She developed gestational diabetes in second trimester and was started on insulin four units once a day and her subsequent blood glucose levels were within normal range. At 15th week, a prophylactic cervical cerclage was done for threatened miscarriage and twin pregnancy.

At 18 weeks she was admitted with severe upper abdominal pain, nausea and vomiting. Her blood investigations revealed elevated uric acid 7.9 mgs/dL, elevated triglycerides 213 mgs/dL, and LFTs with lowered albumin and globulin ratio. Ultrasonography of the gallbladder revealed multiple microlithiasis (1-3mm) and sludge with a normal size common bile duct. As conservative treatment with IV fluids and medications failed, the patient was counseled and consented for a laparoscopic cholecystectomy on 28/09/2017.

In the operating room, the patient was painted and draped in a lithotomy position as the surgeon prefers the French technique of performing a Laparoscopic Cholecystectomy. Abdominal entry was achieved using an optical trocar (5mm) as it offers the best method of a visualized entry, thereby eliminating the chance of any injury to the gravid uterus.

An additional 3, 5mm trocars were placed for instrumentation after insufflating the abdominal cavity with carbon dioxide. The maximum insufflation pressure was capped at 15 mm Hg. Laparoscopic cholecystectomy was performed in the usual manner, tracing the fundus of the gallbladder, dissecting calot's triangle, skeletonizing and clipping the cystic duct and artery before their division, and finally extracting the specimen after dissection from the liver bed.
The whole procedure was uneventful. After completion of the procedure, obstetric scan confirmed fetal wellbeing. Tocolysis was administered with IV Ritodrin for 48 hours post procedure. Patient commenced oral diet on day 1 of post-op and was discharged on the 5th day of post-op. The gall bladder specimen sent for histopathology revealed acute calculous cholecystitis.

Her antenatal period thereafter was uneventful until 33-34 weeks of pregnancy when she presented with preterm labour. An emergency LSCS was performed on 26/1/2018. She delivered twin babies (Boy weighing 2.18kgs / Girl 1.76kgs) and had an uneventful post natal period. Presently after 1.5 years, mother and children are well.

**DISCUSSION**

Biliary colic during pregnancy can most often be managed successfully with diet and analgesics. If acute cholecystitis is suspected, antibiotics can be added, and cholecystectomy can be postponed until after delivery. If these measures are not successful, cholecystectomy is indicated.

Managing conservatively during the first trimester and then delaying cholecystectomy until the second trimester is generally considered the ideal (5).

In 1998, Graham et al. published six case reports of laparoscopic cholecystectomy during pregnancy and performed a literature research of 105 similarly published cases. They concluded that, although the above procedure is technically feasible in all three pregnancy trimesters, the incidence of spontaneous miscarriage and preterm delivery is lower during the second trimester (14).

Since then, laparoscopic surgery, especially laparoscopic cholecystectomy is well documented as a safe procedure during pregnancy (3, 6, 15-18).

At the time of publication, the authors were only aware of one other case study demonstrating the use of laparoscopic cholecystectomy due to acute cholecystitis in a patient with IVF pregnancy (19).

**CONCLUSION**

Laparoscopic cholecystectomy during the second and early third trimester of pregnancy with perioperative fetal monitoring is safe for mother and foetus.

This rare case report gives assurance that surgical intervention should be attempted with caution to ensure successful outcome.

**REFERENCES:**


DR. DEEPU RAJKAMAL SELVARAJ MS Mch
DR. SUGANTHI MBBS DGO

FREE FERTILITY AWARENESS - CAMP III @ PONDICHERRY
Case Report

Baby P (one of twins) was delivered at 26 weeks gestation with birth weight 925g, by emergency Cesarean, following labor pains to a 25 year-old primigravida, conceived following ovarian stimulation with clomiphene citrate and embryo transfer. The pregnancy was complicated by preterm labor, premature rupture of membranes and chorioamnionitis. Maternal antibiotics and betamethasone were given prior to delivery. Baby received positive pressure ventilation by bag mask ventilation in the delivery room and APGAR scores assigned were 7 and 8 at 1 and 5 minutes of life.

In the NICU, Baby P was started on positive pressure ventilation in view of severe respiratory distress and cyanosis. Surfactant was administered, after which high ventilator settings could be weaned. Dobutamine was started for shock. ECHO at 48 hours of age showed 2mm patent ductus arteriosus (PDA) with left heart dilatation. PDA was closed with ibuprofen. He was started on empiric IV ampicillin and gentamicin after sending blood culture.

Minimal enteral nutrition with expressed breastmilk was started on day 4, after improvement in shock. Parenteral nutrition via central venous access was started on day 1. Feeds were given based on abdominal girth and nasogastric aspirates. Only expressed breastmilk (mother's own milk and donor milk) was used. Baby P exhibited intermittent feeding intolerance with aspirates or increased abdominal girth: but initially normal abdominal exams, stable vital signs and abdominal films showing nonspecific bowel gas pattern. On day 5-6, there were bilious nasogastric aspirates (>5ml volume per feed), increased abdominal girth by 3.0 centimeters and the abdomen appeared firm and tender. Abdominal film showed dilated bowel loops, pneumatosis intestinals and pneumoperitoneum. Enteral feeds were held, gastric decompression with continuous suctioning and a sepsis work up initiated. A complete blood count, metabolic profile, blood gas and blood culture were drawn, which revealed neutropenia (ANC 1134), anemia (hematocrit 28.9%) and thrombocytopenia (63,000). Feeds were held, gastric decompression with continuous suctioning and a sepsis work up initiated. A complete blood count, metabolic profile, blood gas and blood culture were drawn, which revealed neutropenia (ANC 1134), anemia (hematocrit 28.9%) and thrombocytopenia (63,000).

He was started on IV meropenem, vancomycin and fluconazole. Blood gas showed a moderate mixed metabolic and respiratory acidosis with a pH of 7.12. He was started on dopamine for hypotension. Paediatric surgical opinion was obtained from Dr Prasad. In view of the findings of pneumoperitoneum and the setback in general condition, a peritoneal drain was placed and serosanguinous fluid was drained (there was no fecal or gangrenous drainage). The possible need for laparotomy was explained to the parents. X-rays, serum electrolytes, blood gases and blood counts were monitored every 8 hours till stabilization (3 days). Within 24 hours of peritoneal drainage, general condition improved, and acidosis and pneumoperitoneum resolved. In 48 hours, shock and need for high ventilator support improved. Supportive care included parenteral nutrition, blood and blood products. After 10 days NPO, bowel gas pattern normalized, and abdomen was soft with bowel sounds heard. On day 12 of illness, baby passed healthy stools. Feeds were restarted on day 14 after detection of pneumoperitoneum. Gradual feed advance at 10 to 20 ml/kg/day was tolerated. Full feeds were reached on day 30 of life.

Baby was extubated on day 24, and oxygen was required till 6 weeks of age. There were no episodes of culture-positive sepsis despite few setbacks: hypoglycaemia, late-onset apnea. After weight gain to 1 kg, paladai feeds were started. Retinopathy resolved with conservative management. Cranial ultrasound was normal on day 4, 10 and 30. Hearing screen showed no deficits. Baby was discharged on day day 42 on full feeds, with weight 1.27kg.
Review of literature

Despite many advances in the field of neonatology, necrotizing enterocolitis (NEC) continues to be a cause of significant morbidity and mortality. It is the most common gastrointestinal emergency in preterm infants.

The incidence of NEC is inversely related to the gestational age at birth, highest in those whose birthweight is less than 1,500 g and varies from 2 to 7%. Mortality is as high as 15% to 30%. NEC has been broadly characterized as primary or secondary NEC. Primary NEC is the more common variety that occurs after the first week of life in a relatively stable preterm infant on enteral feeds, with no recognizable inciting event. Secondary NEC occurs in preterm or term infants who may or may not have been fed, usually having a recognizable trigger. The constellation of gastrointestinal and systemic signs are similar in primary and secondary NEC. Gastrointestinal signs include feeding intolerance with emesis, abdominal distention with tenderness, hematochezia and abdominal wall discoloration. Systemic signs include metabolic acidosis, hematologic abnormalities, temperature instability, lethargy, apnea/bradycardia, respiratory failure, and shock. Radiographic findings consistent with NEC are pneumatosis intestinalis (bubbles of gas in the small bowel wall), hepatic portal venous gas and free peritoneal air in the presence of progressive disease.

Baby P had predisposing factors such as shock, PDA and intra-uterine infection in addition to extreme prematurity, but no specific trigger. The presence of acidosis, thrombocytopenia and systemic setbacks strongly suggest the diagnosis of NEC and moderate-to-severe disease. However, the confirmatory diagnostic sign is pneumatosis intestinalis on X-ray.

Depending upon the severity and staging of disease, NEC is treated with medical therapy with or without surgical intervention. Medical therapy consists of bowel rest, gastric decompression, intravenous broad-spectrum antimicrobial therapy, parenteral nutrition, management of hematologic and metabolic abnormalities, serial abdominal exams and radiographic studies. The role of peritoneal drainage (paracentesis) in NEC is subject to debate. Paracentesis is an emergency treatment for pneumoperitoneum.

Diagnostic paracentesis is done in cases of progressive disease: worsening acidosis or thrombocytopenia or general condition. If stool, bile or fluid with positive gram stain is obtained on paracentesis, laparotomy may be needed. The severity of disease and/or the presence of intestinal perforation as evidenced by free peritoneal air in the abdomen on radiographic evaluation or a positive paracentesis determine the necessity for surgical intervention (resection of gangrenous gut and primary anastomosis or ostomy). In the absence of these findings, there is little consensus on the optimal timing of surgical intervention as well as the type of intervention performed. However, surgical consultation must be obtained early in NEC, and the neonatologist and surgeon work as a team to optimize outcomes.

Baby P received aggressive supportive care (antibiotics, inotropes, blood products, parenteral nutrition). Surgical opinion was obtained very early in the illness. The good
response to peritoneal drainage by the surgeon mitigated the need for surgery. However, the need for laparotomy was constantly assessed during the critical phase.

Preventive strategies for NEC is a widely researched area in neonatology. Since we can recognize predisposing events in secondary NEC, there are suggested recommendations for preventive strategies based on triggers such as late-onset sepsis, rapid feeds etc. However, primary NEC still eludes the exact mechanism of pathophysiology. The etiology and pathophysiology of primary NEC remains to be fully elucidated but it is likely multifactorial leading to intestinal mucosal injury. The immaturity of the preterm intestinal mucosa includes decreased immune function, impaired motility, carbohydrate malabsorption and abnormal bacterial colonization.

NEC may be an inflammatory process related to the presence of undigested carbohydrates in the distal ileum/proximal colon, which is acted upon by the abnormal bacterial flora producing short chain fatty acids at a faster rate than the premature intestine and liver can handle. This results in accumulation of organic acids which may be responsible for initiating injury to the preterm intestinal mucosa, compromising the mucosal barrier, translocation of bacteria and systemic acidosis. A pro-inflammatory response at the site of mucosal injury further propagates intestinal damage and systemic illness.

Based on these pathophysiologic processes, recommendations for preventative strategies have been evolved. Exclusive use of breastmilk is the most evidence-based parameter to prevent NEC. Probiotics have been studied to promote healthy flora in the gut and decrease inflammation. There are recommendations for early initiation of enteral feeds and advancement of enteral feeds in accordance with evidence based feeding protocols. Both primary and secondary NEC continue to be a significant cause of mortality and morbidity in NICU survivors; avoidance of predisposing factors, early recognition, aggressive treatment and further investigations into potential therapies and preventative measures are needed.

Baby P developed NEC despite use of breastmilk, slow feed advance and aggressive treatment of risk factors such as shock and PDA. However, aggressive multi-disciplinary treatment resulted in survival without sequelae.

References


DR. DEEPA HARIHARAN MBBS, A.B (PAEDS / NEO)(USA) FAAP
Dr Steven D Fleming is Director of Embryology at ORIGIO. He is the recipient of research grants from the National Health and Medical Research Council, the Rebecca L Cooper Medical Research Foundation, the Fertility Society of Australia and the University of Sydney. He has authored and edited several books, chapters and numerous articles in peer-reviewed journals. We were fortunate to interact with him and improvise our lab protocols and techniques. An intensive lab audit was conducted with Dr. Fleming to benefit our embryologists.

Dr. Fady.I. Sharara is the founder and Medical Director for the Virginia Center for Reproductive Medicine (VCRM), headquarted in Reston, VA. Dr Sharara has been named one of America’s Who’s Who in Medicine and Health Care every year from 2002 until present. He gave us valuable inputs on management of poor responders, use of double trigger in antagonist cycles and luteal support.
OUR ART BABIES

NAME : MR. ABHINAV
DOB & AGE : 22/04/2000 & 19 YRS
CONCEPTION : IVF- ET
STUDYING : B.TECH COMPUTER SCIENCE
AMBITION : TO BECOME AN ENTREPRENEUR
HOBBIES : PLAYING TENNIS & KEYBOARD

NAME : MS. M. RATHNA PRABHA
DOB & AGE : 31/03/94 & 25 YRS
CONCEPTION : IVF- ET
STUDYING : B.TECH CIVIL
AMBITION : KEEN INTEREST IN SOCIAL SERVICE
HOBBIES : READING

NAME : MR. KAVIN NARAYAN.B
DOB & AGE : 21/03/2005 & 14 YRS
CONCEPTION : ICSI - ET
CLASS : 8TH STD
AMBITION : TO BECOME A DOCTOR
HOBBIES : COIN COLLECTION, SWIMMING, WATCHING MOVIES
OUR ART BABIES

TWIN 1: MASTER K. SRIVISHAKAN  
TWIN 2: MS. K. SRIHARINI  
DOB & AGE: 03/10/2011 & 7 YRS  
CONCEPTION: IVF- ET  
CLASS: 3RD STD  
INDIA'S FIRST BLACK BELT HOLDER AT THE AGE OF 7

TWIN 1: MS. VARANA.N.DEV  
TWIN 2: MS. VASUNA.N.DEV  
DOB & AGE: 03/10/2008 & 10 YRS  
CONCEPTION: IVF- ET  
CLASS: 5TH STD  
HOBBIES: MUSIC, DANCE AND READING
CONFERENCES AND EVENTS - APRIL 2018 - JUNE 2019

DR. KAMALA SELVARAJ

**ISAR**
- Delivered a lecture on “When to refer IVF” and chaired a session on “PGS and PGD - Indian setting” under Tamilnadu and Pondicherry ISAR state chapter session on 20/04/2018 at ISAR 2018 held at Science City, Kolkata
- Moderated a panel discussion on “Management of infertility” on 04/08/2018 at ISAR Infertility Conclave held at Hotel Taj Oberoi Udaipur, Udaipur
- Delivered a lecture on “Role of Immunological testing in Recurrent implantation failure” at 4th Embryology ISAR held at Hotel Laft, Jaipur on 02/12/2018
- Video shoot on “Pre-IVF Management in Special Circumstances” for online CME on PG series in Gynaecology conducted by ISAR Digital on 09/01/2019 at GG hospital premises.
- Delivered a lecture on “Rejuvenation of the female reproductive system” on 03/03/2019 at ISAR 2019 held at Grand Hyatt, Mumbai

**TAPISAR**
- Delivered a lecture on “Ovarian Stimulation - A key to improve ART outcome” at EroFERT 2018 @ Erode at IMA hall on 24/06/2018 (Erode city chapter TAPISAR)
- Inaugurated Coimbatore Chapter of TAPISAR on the 29/09/2018 at Hotel Radisson Blu at Coimbatore
- Delivered a lecture on “Tackling ovarian endometrioma” at ISAR-IAGE Spotlight on Endometriosis workshop (Tapisar in association with Madurai OG Society (MOGS)) held at Hotel Star Residency, Madurai on 20/10/2018
- Delivered a lecture on “Tackling ovarian endometrioma” at ISAR-IAGE Spotlight on Endometriosis workshop (Tapisar in association with OGSSI) held at Hotel Radisson Blu, Egmore on 21/10/2018
- Inaugurated the Salem Chapter of Tapisar on 24/11/2018 and also presented a lecture on “Rejuvenation of the female reproductive system” at the Salem Tapisar 2018 held at Hotel Radisson Blu, Salem on 25/11/2018

**YUVAISAR**
- Delivered a lecture on “Management of Infertility in Indian Scenario” at Abbott CME in association with FOGSI, Pondicherry on 08/04/2018
- Delivered a lecture on “First line treatment in PCOS” and chaired a session on “Developing ART Practice in Low and Middle Income Countries and Management of hirsutism” and on 28/07/2018 at YUVAISAR 2018 held at Feathers hotel, Chennai
- Delivered a lecture by webinar on “Hydrosalphinx” conducted by Mylan company on 14/08/2018 at GG hospital.
- Delivered a lecture on “Endometriosis and ART” at Dr. S. Manorama Memorial CME-ART - LIVE Workshop The Inside story held at IMA Hall, Madurai on 30/09/2018
- Delivered a talk at “My personal journey in the IVF world, my challenges and how I overcame them” at Annai Velankanni IVF lab inauguration on 27/01/2019 at Tirunelveli
- Delivered a lecture on “Creation of life” on 08/03/2019 at Bharathi University, Selaiyur, Tambaram
- Delivered a lecture on “Creation of life” on 08/03/2019 at Vinayaka Mission’s Research Foundation, Aarupadai Veedu Institute of Technology, Pailanoor.
- Was the chief guest & delivered a lecture on “My personal journey in the IVF world, my challenges and how I overcame them” at Alma mater of Kasturba Medica college, Mangalore on 16/03/2019
INTERNATIONAL CONFERENCES (APRIL 2018-JUNE 2019)

- ESHRE - BARCELONA 2018
  Attended the 34th Annual Meeting of ESHRE held in Barcelona, Spain from 01/07/2018 - 04/07/2018 and also attended the First Edition of the Asia-Pacific STEP UP Program in IVF Excellence with IVI Valencia Educational Centre, held at Valencia from 05/07/2018 - 06/07/2018.

- ESHRE - VIENNA 2019
  Poster on “Endometrial receptivity analysis in recurrent implantation failure: A prospective study comparing benefits in own versus donor cycles” in the 35th Annual Meeting of ESHRE held in Vienna, Austria from 23/06/2019 to 26/06/2019.

- COGEN - RALEIGH 2018
  Presented a poster on “Preimplantation Genetic Testing For Aneuploidy (PCT-A) - should I be a universal or specifically indicated application?” at the 5th CoGEN Congress in Paris from 01/11/2018 - 03/11/2018.

- HUMAN REPRODUCTION - DUBLIN 2019
  Presented a oral presentation on “Effectiveness of Intrauterine infusion of granulocyte colony stimulating factor (G-CSF) on ART outcomes in infertile women with recurrent implantation failure” held at 10th International Academy of Human Reproduction World Congress, held in Convention centre Dublin from 03/04/2019 - 06/04/2019.

- NAPLES 2019
  Attended the 2nd World Conference on Luteinizing Hormone in ART: A Galaxy to Explore held at Hotel Royal Continental, Naples, Italy on 24/05/2019 & 25/05/2019.

NATIONAL CONFERENCES (APRIL 2018-JUNE 2019)

- ISAR 2018-2019
  Delivered lectures on “Genetics related to ART” and “Methods of Sperm selection during ICSI” and was a panelist for “PGS and PGT – Indian Setting” session on 20/04/2018 and 21/04/2018 at ISAR 2018 held at Science City, Kolkata.


- Moderated a session on “Selecting the best embryos - Tips and tricks” on 02/03/2019 at ISAR 2019 held at Grand Hyatt, Mumbai.

- YUVA ISAR 2018
  Chairied a session on 27/07/2018 at YUVA ISAR 2018 held at Sri Ramachandra Medical College, Chennai on “Setting Up Of An I Lab, Embryo Culture Techniques And Assessment Of Fertilization And Embryo Grading” and delivered an lecture on “PGS / PGD and SPERM SELECTION TECHNIQUES PRIOR TO ICSI”.

- Also organized the Embryology workshop.

- Chaired a session on 28/07/2018 at YUVA ISAR 2018 held at Feathers-A Radha Hotel(Hall C) on “Sperm Functional Assessment And Preparation In Art: An Overview, Role Of Sperm In Embryo Formation, DNA Fragmentation Testing – Value And Application, Advanced Methods For Sperm Selection, Application, Pros And Cons” and delivered a lecture on “Mitochondrial Replacement Application, Methodology And Ethics”.

- Panelist for panel discussion on the topic, “Clinical case Scenario” at IFS Fertility Preservation Navigator program held on 13/05/2018 in Hotel Savaer.

- Delivered a lecture on “When to refer for IVF” at IAGE 2018 workshop held at Taramani on 04/08/2018.

- Presented a poster on “Effect of sperm DNA integrity on reproductive outcomes after ICSI” at the 7th annual congress AGE Goa 2018, held at Holiday Inn Resort, Goa from 17/08/2018 - 19/08/2018.

- Delivered a lecture on “Advanced techniques in ART” at ICEEE 2018 conference held at Hotel Radisson Blu, Mahabalipuram on 08/09/2018.

- Oral presentation and second prize for “Surrogate pregnancy after percutaneous oocyte retrieval following modified radical Hysterectomy with left salpingo-oopherectomy and right ovarian Transposition to anterior abdominal wall” at FPSI 2018 conference held at Hotel Lalit, New Delhi on 22/09/2018.

- Delivered a lecture on “Fertility Preservation - Clinical, Surgical and lab perspectives” at the 35th Annual conference OGSICON held at Hotel Taj Connemara, Chennai on 11/11/2018.

- Delivered a lecture on “Trigger” at the Salem Tapisar 2018 held at Hotel Radisson Blu, Salem on 24/11/2018.

- Delivered a lecture on “PCOS and ART” at the 5 Day ‘Certificate course in ART, SMART’ held at Sri Ramachandra Medical Centre, Porur on 20/12/2018.

- Delivered a lecture on “Aromatase inhibitors in Ovulation Induction” on 06/01/2019 held at Hotel Sangam, Thiruvanthapuram conducted by Dr. Punitha Rajesh.

- Delivered a lecture on “Why, When and for Whom PGS and PGT - May be Beneficial” on 01/02/2019 held at 18th International Conference in MMM, Chennai.

- A Panelist for a session on “Oocytes & Embryo: Expert perspectives on Quality or Quantity?” in Fertility International Speaker Program (ISP) organized by Ferrin Pharmaceuticals, on 28/2/2019 at TBI, Chennai.

- Delivered a lecture on “Integration of recent technologies in ART practice” on 17/3/2019 at CME on Recent advances in ART organized by IFS held at Hotel Trident, Meenambakkam.

- Delivered a lecture on “Pre implantation genetic testing - PGT-A / M” at the Certificate course in ART, SMART held at Sri Ramachandra Medical Centre, Porur on 19/03/2019.

- Panelist for the session on “Self-regulation vs Government mandate” at the ET Health world Fertility Conclave held on 11/04/2019 at Chennai.

- Delivered a lecture on “Current consensus on PGS/PGD” during the CME on “Updates in ART” on 20/04/2019 held at SIMS hospital, Vadapalani.

- Attended OGSII midyear conference 2019 on 08/06/2019 and 09/06/2019 held at OGSII Auditorium, IOT campus, Egmore, Chennai.
FELICITATION OF DR. KAMALA SELVARAJ @ KASTURBA MEDICAL COLLEGE, MANIPAL - MARCH, 2019

My sister Revathi and I came from an orthodox family. So we led shuttered lives, protected and secure. One fine day when we left home to start a new life in Manipal where we were admitted to the MBBS course we were excited. We were going to be out in the world, free, like birds set free from a cage.

Right from Day One we knew we were going to enjoy ourselves thoroughly. We were full of adventure and spirit, unlike the other new students who were home sick and depressed. They would often telephone their homes and tell their parents how much they were being missed. Some parents would actually land up in Manipal, to inquire after their loved ones. We were never homesick. We never let our parents feel anxious about our well being. Manipal for us was a home away from home. We were comfortable and very happy.

Soon after we were admitted into the MBBS course at Manipal, our parents visited us. My father had driven from Madras to Manipal in a Standard car. They were staying at the guesthouse and in the morning, on reaching the parking lot my father found to his horror that the Standard car was missing. We later learnt that four students of the Engineering college had "stolen" it at night to go for a drive, and the boys unfortunately met with an accident. My mother was completely shaken. She decided this was not the right place for us. But my father was cool as ever. He not only found out if the boys were all right, he also persuaded the Principal not to take punitive action against them for, he felt it would affect their future both professionally and as human beings as a question of their entire career.

We began the course in 1983 and the pre-clinical courses were conducted at Manipal and clinical courses at Mangalore. So the first two and a half years we were in Manipal and for the rest of the course we were at Mangalore in the Smritiveda hostel. Both Revathi and I have treasured the lovely memories of the time in both Manipal and Mangalore. We often relive those wonderful days.

Every festival Diwali, Pongal or Vinayaka Chaturthi would be celebrated in grand fashion. We would spend all nights drawing rangolis (colored designs) on the floor, much like members of one big joint family. We would decorate the college premises for the next day’s celebrations being together, working together and thoroughly enjoying ourselves in the process. We would take part in all the cultural programs like dancing, singing and drama and also sporting activities like table tennis and throw ball. I cannot remember not having participated in a single celebration, festival or tournament. We won many prizes, too. We performed a dance-drama, Pedmatraju, taught by a dance master in Mangalore. It was appreciated by all. Dr. T.M.A. Pai wished us to perform it in the All India Surgeons Conference. We presented the same dance for them and won great applause. Revathi and I got the first prize in the inter-college dance festival. The award was given by Prabhavathy Kapor (the renowned sonn-father of Raj Kapor), for the best performance.

We enjoyed academic life as much as we enjoyed entertainment. We played a lot of pranks. I would mix (from) nucleated blood with non-nucleated human blood and show it to my demonstrator. I would ask innocently what sort of blood is it. We would laugh at his bewilderment.

We would smash black ants and place them under a microscope. It would look like a novel flower with petals. Then we would ask our botany demonstrator what flower it was. We would enjoy his puzzlement. It would be real funny seeing him scratching his head, fiddling with the slide. When at last, he would realize they were ants, he would shower disappointment on us. Then he would leave.

Even mark sheets became the subject of laments. But we never did compromise on the quality of our work. Both Revathi and I would score high marks.

Studying in Manipal did wonders for our all-round development: academic, sports and cultural. It gave me the foundation on which I could build a successful career. Manipal gave me the basic material with which I honed my professional skills. It is always a pleasant feeling to walk down the memory lane of our college days.

Today the University has undergone a lot of changes. There used to be those four buildings around Tiger Circle, the bank, anatomy museum, physiology block and the Hotel Le Shangri-la. Now the place has changed so much that we, the alumni, can identify it only with the Tiger Circle and the buildings around it. It is like seeing your old friend after a long time, trying to recognize all that has passed in the years between.

A university is the place where one gets an education not just knowledge but all that which goes to make one a complete individual. I look back with gratitude at all the good things and good times. I owe my achievements at least in part to the excellent education offered by Manipal and the care given to us by professors and other staff. I can see a lot of all their efforts in whatever I do. When my patient delivered South India’s first test baby, the first ICSI baby, the first frozen embryo, epidural, the PROST and GIFT twins, the first Indian surrogate baby first (in Asia) and when a Moyer-Koistinsky Kuster Hauser Syndrome affected women finally became a mother through surrogacy, I like to tell students, “Opportunity taps very softly, grab it. ‘Troubles, like a washing machine, twist and kink but are around, but in the end we come out brighter than before’. Always be someone and nor anyone and make a mark in this world before you leave your last footprint.
IVF WORKSHOP 2018

DATE : June 18th - 22nd 2018 VENUE : Fertility & Women’s Speciality Centre
LECTURES & DEMONSTRATION

- Introduction to program
- Evaluation of an infertile couple - Overview
- Cryopreservation of sperms / Oocytes / Embryos
- Role of cryobiology in IVF, including Vitrification techniques
- Fertility enhancing Endoscopic surgeries
- Journey of Gonadotrophins & Ovarian functional assessment and stimulation protocols in IVF
- Setting up of an IVF lab & maintenance
- Embryo grading & assessment
- PESA, TESA, Testicular biopsy, ICSI, IMSI, PICS – an overview
- IFetal reduction – screening & pitfalls
- Culture microenvironment – what we need to know
- PCOS – Recent trends and management for Clinicians
- Male infertility – recent trends in ART
- OHSS – Etiology & management
- Factors affecting success rates in ART
- Trouble shooting in ART
- Nuclear and cytoplasmic maturation of oocytes
- Genetics for ART clinicians
- Pre implantation Genetic Screening & Endometrial Receptivity Array

- Handling of oocytes, sperms and embryos
- Embryos loading & transfer, identification and grading
- Semen analysis preparation and handling of microscopes / manipulators orientation
- Setting of TV aspiration of oocytes / IVF / ICSI / IMSI / PGS
- Vitrification observation

FACULTIES

- Dr. S. Suresh, Mediscan systems, Chennai
- Dr. Gopinath, SRM institute for medical sciences, Chennai
- Dr. Palaniswamy, Madras Veterinary College, Chennai
- Dr. S.N.Sivaseelvam, Dept. of Animal Genetics & breeding, Agartala
- Dr. Priya Kannan, Garbarakshambigai Fertility Centre Pvt Ltd, Chennai
- Dr Kamala Selvaraj, Dr. Deepu Rajkamal Selvaraj & Dr Priya Selvaraj, GG Hospital, Chennai
- Ms. Swasti Bharti, National Institute of Design, Gandhinagar

PARTICIPANTS

- DR.A. Mythily MD(OBG), DRM
- Dr. S. Gowri Meena MBBS, MD, DNB, CIMP, MRCOG (UK), FICMCH
- Dr. Indhra Nedumaran MBBS, FEM, DNB
- Dr. J. Dhwaganja MBBS, DGO, MS
- Dr. Bharathi Ravi MBBS, MD
INDIA'S FIRST BABY BORN THROUGH A SURROGATE TO A WOMAN WITH UTERINE CANCER FOLLOWING MODIFIED RADICAL HYSTERECTOMY WITH LEFT SALPINGO-OPHERECTOMY AND RIGHT OVARIAN TRANSPOSITION

Press release

A bundle of joy from a hidden ovary

The baby was born through surgery after the egg was retrieved from a transposed ovarian follicle. The woman, who had undergone a radical hysterectomy due to uterine cancer, was able to conceive with the help of a surrogate mother. This rare medical procedure is a milestone in the field of reproductive medicine.
ISAR WALKATHON FOR FERTILITY HEALTH AWARENESS

First time in the city and all across the country a walkathon was organized on 16th February, 2019 under the auspices of ISAR. Comprising of 15 leading fertility centres, more than 150 participants inclusive of doctors and staff attended the event enthusiastically and made the meet a grand success. ISAR president Dr. Rishma Dhillon Pai commemorated ISAR founder’s day and flagged off this walkathon.

BEST ACTIVITY AWARD - RECEIVED FOR ISAR WALKATHON @ ISAR 2019, MUMBAI

FUN TIME @ ISAR 2019, MUMBAI

ISAR BEST DANCE AWARD 2019 FOR TAPISAR STATE CHAPTER
MY MOTHER

For those lucky to still be blessed with your Mom, this is beautiful. For those of us who aren't, this is even more beautiful. For those who are moms, you'll love this. The young Mother set her foot on the path of life. "Is this the long way?" she asked. And the Guide said: "Yes, and the way is hard. And you will be old before you reach the end of it. But the end will be better than the beginning." But the young Mother was happy, and she would not believe that anything could be better than these years.

So she played with her children, and gathered flowers for them along the way, and bathed them in the clear streams; and the sun shone on them, and the young Mother cried, "Nothing will ever be lovelier than this." Then the night came, and the storm, and the path was dark, and the children shook with fear and cold, and the mother drew them close and covered them with her mantle, and the children said, "Mother, we are not afraid, for you are near, and nothing can harm us." And the morning came, and there was a hill ahead, and the children climbed and grew weary, and the mother was weary.

But at all times she said to the children, "A little patience and we are there." So the children climbed, and when they reached the top they said, "Mother, we would not have made it without you." And the Mother, when she lay down at night looked up at the stars and said, "This is a better day than the last, for my children have learned fortitude in the face of hardship. Yesterday I gave them courage.

Today, I've given them strength." And the next day came strange clouds, which darkened the earth, clouds of war and hate and evil, and the children groped and stumbled, and the mother said: "Look up. Lift your eyes to the light.

And the children looked and saw above the clouds an everlasting glory, and it guided them beyond the darkness. And that night the Mother said, "This is the best day of all, for I have shown my children God." And the days went on, and the weeks and the months and the years, and the mother grew old and she was little and bent.

But her children were tall and strong, and walked with courage. And when the way was rough, they lifted her, for she was as light as a feather; and at last they came to a hill, and beyond they could see a shining road and golden gates flung wide.

And Mother said, "I have reached the end of my journey. And now I know the end is better than the beginning, for my children can walk alone, and their children after them." And the children said, "You will always walk with us, Mother, even when you have gone through the gates." And they stood and watched her as she went on alone, and the gates closed after her. And they said: "We cannot see her but she is with us still.

A Mother like ours is more than a memory. She is a living presence......" Your Mother is always with you.... She's the whisper of the leaves as you walk down the street; she's the smell of bleach in your freshly laundered socks; she's the cool hand on your brow when you're not well. Your Mother lives inside your laughter.

And she's crystallized in every teardrop. She's the place you came from, your first home; and she's the map you follow with every step you take. She's your first love and your first heartbreak, and nothing on earth can separate you...Not time, not space...not even death!

MAY WE NEVER TAKE OUR MOTHERS FOR GRANTED NO MATTER WHAT...
MONTHLY PREGNANCIES (JAN 2018 - MAY 2019)

MONTHLY ART PREGNANCIES (JAN 2018 - MAY 2019)

AS OF 15TH JUN 2019

+ Total No. of babies delivered : > 26000
+ Couples delivered by ART : > 20000
+ Total No. of patients conceived Naturally* : > 4000

* - Following Medical and Surgical Management

Note: The above statistics may vary between different ART clinics, especially referral centres, based on patient population characteristics like high risk individuals, previous failures and donor programs. Figures cited are actuals and comparable to any tertiary care referral centre (no tall claims).
ASSISTED REPRODUCTION - OUR SERVICES

- IUI - Intra Uterine Insemination
- Sequential Embryo transfer
- Intracytoplasmic Sperm Injection (ICSI)
- Intracytoplasmic Morphologically Selected Sperm Injection (IMSI)
- Sperm Chromatin Structure Assay (SCSA)
- Cryopreservation of sperms, oocytes, embryos and blastocyst (Vitrification)
- Blastocyst culture
- Laser Hatching
- Pre Implantation Genetic testing for Monogenic (PGT- M)
- Pre Implantation Genetic testing for Aneuploidies (PGT- A)
- Endometrial Receptivity Array (ERA)
- Non invasive test for Chromosomal examination (NACE)
- Non invasive Prenatal test (NIPT)
- Product of Conception (POC) Chromosome Analysis
- Donor programmes
- Surrogacy

Advanced laparoscopic surgery

- Laparoscopic Cholecystectomy
- Laparoscopic Incisional Hernia Repair
- Laparoscopic Hysterectomy (LAVH & TLH)
- Laparoscopic Adhesiolysis
- Laparoscopic Myomectomy
- Single port access (SPA) surgery

Other facilities

- High Risk Obstetrics Unit
- Medical and cardiac care with Comprehensive MHC
- General surgery
- Pediatric surgery
- Neonatal and pediatric care with neonatal intensive care unit (NICU)
- Sonology / Radiology / Clinical laboratory

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