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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.
ATRAUMATIC RUPTURE OF NON GRAVID UTERUS IN A 28 YEAR OLD FEMALE

CASE REPORT:

A 28 year old lady married for 11 years came to us with complaints of five months amenorrhea and white discharge per vaginum. She had no other significant complaints. Her first natural conception resulted in a full term caesarean section and the boy is 10 years and healthy. Her second natural conception however resulted in an intrauterine fetal demise at 16 weeks of pregnancy which was surgically terminated at another centre.

Her third natural conception resulted in a pre-term caesarean section due to PPROM. The female baby died after a month. Her fourth natural conception ended in an intra uterine fetal demise at four months with placenta previa. She was taken for an elective hysterotomy with sterilization at our hospital in November 2016. She had no other significant medical history.

At another centre, a trans abdominal ultrasound done on 27th January 2018 showed a 5.9x4.2x4.3cm mixed echoic lesion with peripheral cystic component near the anterior uterine scar region, extending exophytically with no evidence of vascularity. Wide gaping of anterior uterine scar was documented.

A differential diagnosis of
A) Scar endometrioma or
B) Ectopic gestation or
C) Dehiscence was made.

A pelvic MRI done on 29/1/18 showed scar dehiscence with significant peri uterine haematoma. Her serum beta HCG was 0.17 mIU/ml.

Transvaginal scan at our centre showed a lesion of mixed echogenicity [possibly a haematoma] measuring 5.4x3.5x3.8 cm seen near the cervico uterine junction.

We made a working diagnosis of scar dehiscence and planned for diagnostic hystero-laparoscopy and proceed to confirm findings. The laparoscopy was done on 3/2/2018, where we observed dense adhesions between the abdominal wall and the anterior wall of the uterus.

The adhesions were released and the anterior uterine wall and the uterine scar were found to be intact on further exploration. The haematoma was noted on the posterior uterine wall extending from the cervico uterine junction up to the lateral pelvic wall towards the left adnexa.

It was decided to convert the laparoscopy into laparotomy. The haematoma was evacuated and a rent of about 3 cm was noted in the posterior uterine wall which was repaired surgically using vicryl-1 and 2.
The third reported patient was a 30 year old female admitted with bronchiectasis and pneumonia who developed abdominal distension and vaginal bleeding and went into shock. An emergency laparotomy showed a large bleeding rent in the posterior uterus which was closed and the patient recovered [6].

While rare, atraumatic spontaneous rupture of the non-gravid uterus should be included in the differential diagnosis of an acute abdomen and shock in a non-pregnant female of child-bearing age. Although our patient was stable, spontaneous uterine rupture is often a life-threatening emergency that requires immediate resuscitation, identification, and surgical intervention with either primary repair or hysterectomy.

REFERENCES

DR. DEEPU RAJKAMAL SELVARAJ MS MCH
DR. SUGANTHI MBBS DGO
MANAGEMENT OF EXTREMELY PREMATURE INFANT WITH CHRONIC LUNG DISEASE

CASE REPORT:

Baby A was born at 25 weeks gestation to a 22 year old primigravida mother. Conception was by assisted reproduction using frozen embryos. The mother had gestational diabetes mellitus requiring insulin therapy. The female infant was born by vaginal delivery following rapidly progressive preterm labor not responsive to tocolysis. Antenatal steroids could not be administered. Birth weight was 1.02 kg, and the infant was classified as ‘large-for-dates’, due to mother’s diabetic condition. Apgars were 7 and 8 at 1 and 5 minutes.

At birth, the infant had severe respiratory distress and required intubation in the delivery room. Chest X-ray showed features of respiratory distress syndrome (RDS) with low-volume white-out lungs. Ventilation was started with patient-triggered mode. Three doses of surfactant was given due to inability to wean FiO2 below 40% at 24 hours of age. ECHO at 48 hours of age showed left ventricular dysfunction and 2 mm patent ductus arteriosus (PDA), hemodynamically significant with left-to-right shunting. Three doses of ibuprofen were given, after which PDA closed. Heart function improved with inotropes. Ventilator settings were weaned to some extent, but lungs showed features of evolving chronic lung disease by end of first week. Antibiotics, parenteral nutrition, trophic enteral feeds and fluid therapy with electrolyte monitoring were given. Cranial ultrasound was normal. Infant developed seizures treated with phenobarbite and midazolam. Expressed breastmilk was given by nasogastric infusion and feeds were slowly advanced. Hemoglobin was maintained above 11gm% by packed red cell transfusion as needed.

Managing Chronic lung disease was the main challenge in this infant. The infant continued to have ventilator requirement for several weeks. Physical exam revealed tachypnea on ventilator, crepitations, wheezing and barrel-shaped chest in addition to growth failure.

X-ray showed hyperinflation, patchy recurrent atelectasis, cystic changes and streakiness in lungs characteristic of bronchopulmonary dysplasia (BPD). By the new National Institute of Health criteria (US), this infant was classified to have severe BPD: need for >30% oxygen, with or without positive pressures at 56 days postnatal age (<30% oxygen at this age need defines moderate BPD, breathing room air at this age defines mild BPD).

Pathologically, classic BPD is characterized by necrotizing bronchiolitis, alveolar septal injury, inflammation and scarring in the lung. In modern days, post-surfactant and with gentle ventilation, BPD is characterized by dilated acini in lung with thin septa and minimal fibrosis. The paucity of normally functioning alveoli causes respiratory failure.

Prematurity is the most important risk factor for BPD; mechanical ventilation and oxygen administration are iatrogenic etiologies, despite being life-saving therapies in such infants. Infection and malnutrition are aggravated by BPD and these factors aggravate BPD in a vicious cycle. Male gender and Caucasian race are also risk factors. With growth the lungs recover, although airway abnormalities may persist in early childhood.

Baby A’s clinical course consisted of prolonged need for ventilation and frequent episodes of cyanosis. Ventilator settings were adjusted as needed, including moderate PEEP, and titration of FiO2 to maintain SpO2 92% to 96%. Increased bronchial secretions were managed by physiotherapy and suctioning as needed. ECHO was repeated every 10 days to rule out pulmonary hypertension and cor pulmonale, complications of BPD.

Two episodes of pneumonia (elevated CRP, increased ventilator settings, and infiltrates on chest X-ray) were treated with meropenem and azithromycin.
Other medications to treat BPD include furosemide and caffeine. Furosemide to decrease lung water content was started at 1 mg/kg/day. Electrolytes and calcium status were monitored. Caffeine was started early at 20mg/kg loading dose, followed by 5 mg/kg/day. In addition to improving the central drive for breathing, caffeine is also a diuretic and bronchodilator. Salbutamol nebulizations were added when wheezing was significant. As nutrition is crucial for lung growth, aggressive nutritional support was given using parenteral nutrition and human milk fortification to ensure caloric intake of 125kcal/kg/day, and protein intake of 3.5g/kg/day.

As the role of supplementing specific micronutrients or antioxidants like vitamins E or A are not proven, these were not given. Osteopenia was treated aggressively with calcium/phosphorus supplements, as it is aggravated by ventilator dependence. As gastro-esophageal reflux worsens BPD, domperidone and ranitidine were given. The role of steroids in treating BPD is highly controversial. The risks (especially neurodevelopmental deficits) outweigh benefits.

On discussion with the parents, their preference was to avoid steroids. Early intervention including physiotherapy, occupational therapy, speech therapy were started in the NICU, due to risk of neurodevelopmental deficits in premature infants with BPD. Psychologic support was simultaneously offered to the parents.

With careful monitoring of ventilator support, asepsis and early treatment of infections, aggressive nutritional therapy, and judicious use of medications and blood products, Baby A gradually recovered. Ventilator support was weaned at 13 weeks, and oxygen after 105 days. Infant was discharged on direct breastfeeds and room air, with a weight of 2 kg. The need for higher nutritional support in infancy, close developmental follow-up, vaccinations (including pneumococcal and flu vaccines) and avoiding risk factors for reactive airway disease were explained prior to discharge.

On follow up at 13th months of age, baby A was thriving well (weight 7kg), crawling, babbling and had normal hearing and vision. There were no significant respiratory infections or wheeze. This case illustrates the multifactorial risk factors for BPD and the need for perseverance and aggressive management.
ONCO - FERTILITY

There are 14 million cases of cancer worldwide and it is expected to rise over 24 million by the year 2035.

In India alone, there are around 2.5 million people living with the disease and every year over 7 lakh individuals are newly diagnosed with cancer.

It accounts for 71% of all deaths between the ages of 30-70 years.

The commonest cancers are tabulated below:

<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIP / ORAL CAVITY</td>
<td>BREAST</td>
</tr>
<tr>
<td>LUNG</td>
<td>CERVIX</td>
</tr>
<tr>
<td>STOMACH</td>
<td>ENDOMETRIUM</td>
</tr>
<tr>
<td>COLORECTUM</td>
<td>COLORECTUM</td>
</tr>
<tr>
<td>PHARYNX</td>
<td>OVARY</td>
</tr>
<tr>
<td>TESTICULAR</td>
<td>LIP / ORAL CAVITY</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Lymphoma</td>
</tr>
</tbody>
</table>

*Source: National Cancer Registry Programme (NCRP) report 2009 - 2011.*

What about the young pubertal adults? It happens to be the 9th common cause of death among children aged between 5-14 years (Boys:0.8-5.8%, Girls:0.5-3.4%). Leukemia, Lymphoma and CNS tumors remain the commonest cancers in this age group.

Hence, fertility preservation options and counseling should become a serious discussion within the referral physician, oncologist, oncosurgeon and fertility specialist who will eventually play an equal role.

Yet, there is a general neglect or rather a choice of treatment / cure over future fertility as it becomes an option. As much as preserving life is important it becomes a basic right of the individual to be counselled about what their options are if they wished to have their own offspring in the future.

Finally, based on clinical presentation, gravity and stage of disease, intensity of treatment and prognosis will help make a decision if it’s possible or not.

A strategic approach would be:

- Detailed discussion of disease process and the choice or order of therapeutic approach
- Treatment protocol: R/C/Surgery + R/C
- What key effects the chosen mode of treatment will have on the reproductive organs, sexual functions or gametogenesis
- What options of fertility preservation are available and best suited for the individual
- Long term prognosis
- Any future or current fertility treatments like IVF that need to be initiated right away or post treatment schedule
- Radiation and chemotherapy

**EFFECTS OF CHEMOTHERAPY ON FEMALE FERTILITY**

- Ovarian atrophy / Primordial follicle loss
- The maximum rate of depletion occurs around the age of 38 years when the reserve is just about 10%
- The cytotoxic effects depend
  - Types of cytotoxic drugs
  - The dosage & Age of the women
- Histology
  - Pre-granulosa cell swelling
  - Primordial follicle architecture disruption with disappearance of its lumen
  - Oocyte positive apoptotic staining
  - Eg: Cisplatin and Doxorubicin

**EFFECTS OF RADIATION ON FEMALE FERTILITY**

Ionizing radiation has detrimental effect on gonadal functions in all age groups and non-ionizing has no sufficient data for associated risk. The key factors of ovarian dysfunction are age, radiation dose and duration of treatment.
An ionizing radiation has direct DNA damage to ovarian follicles, follicular atrophy and reduces reserves which leads to impaired ovarian hormone levels. A dose of <2 Gy is enough to destroy 50% of immature oocytes

<table>
<thead>
<tr>
<th>Types of Malignancies</th>
<th>Radiation Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hodgkins</td>
<td>Pelvis</td>
</tr>
<tr>
<td>Rectal</td>
<td>Abdominal</td>
</tr>
<tr>
<td>CNS</td>
<td>Cranio-spinal</td>
</tr>
<tr>
<td>Bone Marrow transplantation</td>
<td>Total body irradiation</td>
</tr>
</tbody>
</table>

**CANCER IN MALE**

- 4% - < 35 years of age
- 75% - 5 year survival rate for patients < 15 years of age
- 66% - 5 year survival rate for patients 15 - 44 years of age
- 50-95% - Suffer from persistent infertility
- 30% of men with testicular cancer have semen abnormalities at the time of diagnosis
- Semen abnormalities are also common among young men at the time of diagnosis with other cancers
- In 158 untreated men (aged 16–52 years) recently diagnosed with Hodgkin’s lymphoma, 111 (70%) had semen abnormalities prior to treatment

**EFFECTS OF RADIATION ON MALE FERTILITY**

- Immature Spermatogonia are highly sensitive to radiation whereas Leydig cells are more resilient
- Damage to spermatogenesis may result from direct radiation or scatter radiation (eg. Rectal cancer; 18.7% radiation exposure in pelvic cancers)
- Increase in DNA fragmentation has been reported in cases of testicular cancer 2 years post radiation.
- Average return of near normal semen parameters: 10-24 months

<table>
<thead>
<tr>
<th>Dose of radiation (Gy)</th>
<th>Effect on the Testis</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.8</td>
<td>Oligospermia</td>
</tr>
<tr>
<td>0.8-2</td>
<td>Transient azoospermia</td>
</tr>
<tr>
<td>2-3</td>
<td>Irreversible azoospermia</td>
</tr>
</tbody>
</table>

**EFFECTS OF CHEMOTHERAPY ON MALE**

Spermatogenesis declines during the 3–6 months following chemotherapy or radiotherapy for testicular cancer, but steadily recovers thereafter. Two years after treatment, 97% and 94% of men treated with chemo - therapy or radiotherapy (with shielding of the contralateral testicle), respectively, show good recovery of spermatogenesis.

In contrast, the prevalence of azoospermia among men treated for lymphoma is reported to be as high as 59% and a long recovery period (45 months) is needed to achieve the highest sperm concentration (Bahadur et al., 2005).

**FERTILITY PRESERVATION OPTIONS FOR MEN**

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sperm cryopreservation</td>
<td>Cryopreservation of ejaculated sperm</td>
<td>Must be post-pubertal; can be used for IUI or IVF</td>
</tr>
<tr>
<td>Surgical sperm extraction</td>
<td>Percutaneous puncture and aspiration of sperm from the testis or epididymis</td>
<td>Outpatient surgical procedure; can be used for IVF with ICSI</td>
</tr>
<tr>
<td>Immature testicular tissue cryopreservation</td>
<td>Surgical biopsy of testicular tissue from prepubertal boys</td>
<td>Experimental; only option for prepubertal boys</td>
</tr>
</tbody>
</table>

It is very important for oncologists / onco surgeons to create awareness about the ill effects of treatment in future fertility. Counseling for fertility preservation should be an integral part of any cancer screening or diagnostic programs. At present, the commonest techniques available are semen and oocyte cryopreservation.

However, ovarian tissue cryopreservation has been successful resulting in live births after re-implantation and treatment. The first step towards successful outcome in these groups is creating awareness and helping them to make a choice. Sometimes surgical intervention may be made, displacing gonads outside of radiation field or anchors them in a subcutaneous plane in the anterior abdominal wall.
FERTILITY PRESERVATION OPTIONS FOR WOMEN

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embryo cryopreservation</td>
<td>Hormonal stimulation of ovaries and collection of oocytes to create embryos using IVF methods; resulting embryos are cryopreserved</td>
<td>Must be postpubertal; need partner or donor sperm; established technique with thousands of live births</td>
</tr>
<tr>
<td>Oocyte cryopreservation</td>
<td>Hormonal stimulation of ovaries and collection of oocytes with cryopreservation of unfertilized oocytes; can be fertilized in future to create embryos for transfer</td>
<td>Must be postpubertal; do not need sperm source; IVF required upon thawing; several studies demonstrating live birth rates similar to procedures using fresh embryos</td>
</tr>
<tr>
<td>Ovarian tissue cryopreservation</td>
<td>Removal and cryopreservation of outer layer of the ovary (cortex), which contains immature oocytes</td>
<td>Experimental, can be pre- or postpubertal; outpatient surgical procedure; future uses include transplantation of thawed tissue or in vitro maturation of follicles and fertilization of oocytes; currently only option for prepubertal girls</td>
</tr>
<tr>
<td>In vitro maturation</td>
<td>Collection of immature oocytes without hormonal stimulation</td>
<td>Must be postpubertal; case reports demonstrating viable embryos; Must be postpubertal; case reports demonstrating viable embryos;</td>
</tr>
</tbody>
</table>

Again, let the choice of methodology is an integrated decision taken by the involved gynecologist, oncologist and oncosurgeon.

**POINTS TO PONDER**

- Radiation and chemotherapy induced insult to HPO axis and gonads are dependent on age of exposure, type of treatment protocol and duration of therapy
- Cranial irradiation poses a significant risk for disorders of HPO axis
- Women exposed to pelvic irradiation are at an increased risk of pregnancy related complications- spontaneous miscarriages, preterm births and placental abnormalities
- Whenever possible, direct irradiation to the ovaries should be avoided.
- It is imperative to offer fertility preservation options as outlined earlier especially ovarian transposition and semen cryopreservation to maximize chances for fertility
- Newer protocols in chemotherapy such as adjuvant and anti-apoptotic therapy may mitigate damage to fertility
- Newer radiation techniques, including IMRT and proton radiotherapy, may alleviate effects, but require further investigation.

**REFERENCES:**

3. Malgorzata et al., Fertility Preservation Options for Men and Women With Cancer. 218 Vol. 17 No. 4 201. Reviews in Urology

**DR. PRIYA SELVARAJ MD MNAMS MCE**
AWARDS 2017-18

GG HOSPITAL WON THE BEST HEALTHCARE PROVIDER - THE RECENTLY CONCLUDED PROVOKE AWARDS HELD ON - 20th DECEMBER 2017, CHENNAI

DR. KAMALA SELVARAJ WAS HONOURED WITH LIFE TIME ACHIEVEMENT AWARD BY ACADEMY OF CLINICAL EMBRYOLOGISTS (ACE) ON 15th SEPTEMBER 2017 AT HYDERABAD

DR. KAMALA SELVARAJ WAS HONOURED WITH YET ANOTHER LIFE TIME ACHIEVEMENT AWARD BY PUTHIVA THALAIMURAI TELEVISION ON 3rd MARCH 2018 AT CHENNAI
FERTILITY AWARENESS CAMP - I

We conducted a Fertility and Women’s health awareness camp at Kanchipuram on 9th December 2017. Around 150 couples attended and really benefitted. These couples were offered consultation, sonology and general health check free of cost.

Our next camp was conducted at Thiruvallur on 24th March 2018. Around 50 couples were benefitted through this camp.

Being a centre for excellence for fertility, laparoscopy and women’s health from puberty to menopause, we will indulge in more such endeavours.
GG BABE AT MARINA RUNNERZ - A MARATHON HELD ON FEB 25TH 2018

Chennai is a fast progressing hub for fitness and wellness in all arenas, especially marathons. Under the auspices of its founder member Dr. Velmurugan (our Neonatalogist and Pediatrician), yet another Marathon (MRM 2018) was held on February 25th at East Coast Road, Chennai. The categories were 5k, 10k and 21k.

There is nothing more inspiring or gratifying when a fellow runner happens to be a baby that you helped deliver almost 11 years ago. And yes she beat me to it!!! Running a 10k marathon for creating awareness and that too at a young age deserves applause. Proud of our GG babe!
OUR ART BABIES

TWIN 1 : NIDAL
TWIN 2 : NADAL
CONCEPTION : IVF - ET
CLASS : 5TH STD
AMBITIION : NADAL - TO BECOME A TEACHER
NIDAL - TO BECOME AN ENGINEER

NAME : MS. AMUKTHA PTHAMSETTI
DOB & AGE : 24/09/2007 & 10 YRS
CONCEPTION : IVF ICSI
EDUCATION : 5TH STD
HOBBIES : READING BOOKS, BADMINTON, SWIMMING.
EXTRA CURRICULAR ACTIVITIES : PARTICIPATED IN SPELL BEE COMPETITION, BHARATANATYAM, CARNATIC MUSIC

NAME : MAHALAKSHMI
DOB & AGE : 23/07/2001 & 16 YEARS
CONCEPTION : IVF - ET
CLASS : 12TH STD
AMBITIION : TO BECOME A BANK MANAGER
OUR ART BABIES

NAME : PULENDRAH THITUVATUTAN (ARURAN)
DOB & AGE : 30/01/2009 & 8 YRS
CONCEPTION : IVF- ET
CLASS : 4TH STD
HOBBIES : PLAYING GAMES, DRAWING AND HE IS VERY GOOD IN STUDIES

NAME : B. MRUDHULA
DOB & AGE : 27/04/2007 & 10 YRS
CONCEPTION : IVF- ET
CLASS : 5TH STD
HOBBIES : SINGING AND DANCING AND ALWAYS AN OUTSTANDING STUDENT IN SCHOOL

TWIN 1 : LAKSHIKHA SRI
TWIN 2 : LAKSHITHA SRI
DOB & AGE : 23/02/2015 & 2 YRS
CONCEPTION : IVF- ET

VERY INTERACTIVE AND BRIGHT KIDS
We Deepa and Vijay are extremely happy to share our bundle of joy Mithran Vijayakumar who has arrived today 20th March 2018 @ 11:23 AM CT USA time.

This wonder couldn’t have been possible without Dr Geetha, Dr Kamala and Dr Priya, Dr Vijaya and all other GG staffs.

We are grateful for your great service and please do pass on our regards to all the wonderful staff there.

I have known GG hospital since I was a child. My cousins were born in 1993 and 1996. They were precious babies. So when I moved to Chennai, people recommended me to consult at GG.

I got my laparoscopy, cervical cerclage and C-section done at GG. Each procedure was taken care very well. Kamala Mam and Priya Mam were extremely kind and patient. I would highly recommend this hospital for those who want to become parents soon.

Although they guarantee great success rates you have to follow whatever they say. You should not expect instant or overnight results.

Also, treatments can appear a tad bit expensive, if you don’t have insurance coverage; they are definitely value for money! Also one cannot put a price over joy of motherhood.

To,

Our dearest Dr Priya.
We can never thank you enough for what you have done for us.

Lots of love

Shradha, Sarita & Reinaa
CONFERENCE ROUNDS

DR. KAMALA SELVARAJ

- Delivered a lecture at ACE 2017 on “My personal journey in the IVF world, my challenges and how I overcame them” on September 16th 2017 held at Hotel Novotel, Hyderabad
- Delivered a lecture at Travelling Seminar on Ovulation Induction and Luteal Support & TAPISAR Chapter on “Step wise approach to different situations in Ovulation Induction” on October 5th 2017 held at Hotel Residency towers, T.Nagar, Chennai
- Panelist for “An integrated approach to Diabesity” held on 25th January 2018 at The Raintree Hotel, Anna Salai conducted by Ethicon Surgical care, Johnson & Johnson

DR. PRIYA SELVARAJ

- Delivered a lecture on “PGD and PGS in infertility” at Sri Ramachandra University, Porur on 22nd September 2017 at the Certificate course in ART
- Attended the workshop on “Cryopreservation of Ovarian Tissue-On Lab and Clinics” held at the 5th world congress of the International Society for Fertility Preservation on November 16th, 2017 at Vienna, Austria
- Participated in debate on “PGS not for all” at Yuva ISAR 2017 held at Gujarat University Convention & Exhibition Centre, Ahmedabad on 16th December 2017
- Delivered a lecture on “PGD and PGS in infertility” at Sri Ramachandra University, Porur on 2nd February 2018 at the Certificate course in ART
- Delivered a lecture on “Diagnostic hysteroscopy Vs HSG – differences” at Hotel Taj Coromandel, Chennai on 31st March 2018 at the GET ENDO conference 2018

LOST & FOUND!

On my way, I found a piece of paper pinned to a tree, with a small note on it.

I was curious to know what was written, so I went closer and read it. It read “I lost Rs. 50 somewhere on the road. If any of you find it, please give it to me at this address……. My vision isn’t great so please help.”

I was urged to follow that address and found an old hut with an older woman sitting outside. She was frail and asked who is it, following my footsteps.

I said I came by this way, found Rs. 50 on the road so wanted to handover to you.

She began crying on hearing this. She said “my dear I have had more than 30 people come over and give me Rs. 50 saying they found it on the road. I didn’t write that note; I cannot even see properly nor do I know to read and write”

I said it’s Ok Amma you keep it. She asked me to tear that small note on the tree on my way back.

I walked back with a million thoughts as to who could have written that note? The old lady would have asked everyone to tear that note, but none did. I mentally thanked that person and realised that we just have to feel the need to help, there are so many ways to do it. He/She just wanted to help this old woman who lives alone……

While walking back, someone stopped me and asked, “Brother, can you help me with this address…… I found a 50 rupee note, want to handover.”
36TH HOSPITAL ANNIVERSARY DAY CELEBRATIONS
31ST JANUARY 2018

DISTINGUISHED VISITOR - 12/12/2017

Dr. James Catt PhD. has been the Scientific Director at Sydney IVF and then with Monash IVF in Australia, and was also in charge of conducting training at both these institutes.

He has more than 25 years of experience as a clinical embryologist and is currently an independent consultant.

An interactive lab audit was conducted with Dr. James Catt at our fertility research lab, much to be benefit of our embryologists and clinicians.

Dr. James Catt with the Intermedics team
MONTHLY IUI PREGNANCIES (JAN - DEC 2017)

MONTHLY PREGNANCY STATISTICS (JAN - DEC 2017)

GGH STATISTICS (TILL FEB 2018)

шая No. of babies delivered : 25,579
 Couple who underwent ART     : 17,880
 Total No. of patients conceived Naturally* : 3,079

* - 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 false claims).
ASSISTED REPRODUCTION - OUR SERVICES

- IU1 - Intra Uterine Insemination
- Sequential Embryo transfers
- Intra Cytoplasmic 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 Screening (PGS)
- Pre Implantation Genetic Diagnosis (PGD)
- 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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twitter.com/gghospital, facebook.com/gghospital
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Ms. Sugunaa D.C.Tech
Ms. Srimathi B.Sc
The Complete Solution for Fertility Management

For controlled ovarian hyperstimulation
Recombinant FSH Inj. 75 IU, 150 IU
**NEWMON-Rx**
The RIGHT STEP for ART

The ideal treatment in women with LH deficiency
**IVF-M™**
human menopausal gonadotropins 75 IU, 150 IU

The preferred medication in endometriosis
**Leuprogon™**
Leuprolide Acetate 3.75 mg

Optimal triggering of ovulation after follicular maturation
**IVF-C™**
human chorionic gonadotropin 5000 IU

Prevent premature LH surge in ART
**Cetide™**
Cetrorelix Acetate 0.25mg Inj.

**LG Life Sciences**
<table>
<thead>
<tr>
<th>Product</th>
<th>Composition</th>
<th>Indication</th>
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<tbody>
<tr>
<td><strong>NEWMON-Rx</strong></td>
<td>Recombinant FSH 75 IU, 150 IU</td>
<td>COH to induce the development of multiple follicles in ART, e.g. in vitro fertilization (IVF),</td>
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<td>gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT), intracytoplasmic</td>
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<td>sperm injection (ICSI)</td>
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<tr>
<td><strong>NEWMON-R</strong></td>
<td>Recombinant FSH 75 IU, 150 IU, 225 IU, 300 IU</td>
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<td>In Prefilled syringe</td>
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<tr>
<td>IVF-M ™ Inj.</td>
<td>Menotropin 75 IU, 150 IU</td>
<td>• Female: For stimulation of the development of multiple follicles (superovulation) in women</td>
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<td>undergoing ART.</td>
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<td>• Male: Hypogonadotrop hypogonadism, Cryptorchidism</td>
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<tr>
<td>IVF-C ™ Inj.</td>
<td>Human chorionic gonadotropin 5000 IU</td>
<td>• Female: Ovulation induction in women undergoing ART, anovulatory infertility, corpus luteum</td>
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<td>insufficiency, habitual abortion</td>
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<td>• Male: Cryptorchidism, hypogonadotrop hypogonadism, oligospermia &amp; asthenospermia</td>
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<tr>
<td>Cetide ™ Inj.</td>
<td>Cetorelix Acetate 0.25 mg</td>
<td>Prevention of premature ovulation in patients undergoing a controlled ovarian stimulation followed</td>
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<td>by oocyte pick-up and assisted reproductive techniques</td>
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<tr>
<td>Leuprogon ™ Inj.</td>
<td>Leuprolide Acetate 3.75 mg</td>
<td>Endometriosis, Uterine leiomyomatata (fibroids)</td>
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