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NEWS LETTER

KJK HOSPITAL PVT. LTD.

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Editorial

Dear Colleagues,

Becoming parents is a dream for many couples, but it can be challenging for some. Fortunately, IVF has provided hope for millions of couples worldwide by helping them achieve their dream of starting a family.

With its high success rate in recent years, experts are looking to incorporate new technological advances in IVF and other fertility treatments.

Fertility treatment has come a long way in recent years, with numerous advances and trends helping to improve the success rate and treatment experience for those seeking to start a family.

In vitro fertilization (IVF), in particular, has undergone significant changes and innovations in recent years, leading to better outcomes and expanded treatment options for patients.

We are pleased to welcome you to be 23rd Annual Workshop of KJK Hospital. Much has changed in the field of Genetics over the last few years, With significant implications for clinicians. The interest in infertility and assisted reproduction has grown. Keeping this mind, the theme for this one day workshop is on Essential Genetics in Reproductive Medicine which would benefit Clinicians and Fellow post graduates. The “workshop will be held on December 10th, 2023 at Hotel Residency Towers, Trivandrum. The special update on Reproductive Medicine by leading master clinicians ensures that by discussing and presenting the latest scientific improvements, you are current with these changes. The educational focus is recommendations, setting standards, training and educating doctors in the field of Reproductive medicine. See you all in December at Trivandrum

Dr K Jayakrishnan
Managing Director &
Chief Consultant
KJK Hospital



ANNUAL WORKSHOP OF KJK

THEME: ESSENTIAL GENETICS IN REPRODUCTIVE MEDICINE

DATE

10TH DEC 2023, SUNDAY

TIME

8.30 AM TO 3.00 PM

VENUE

THE RESIDENCY TOWERS
GOVT. PRESS ROAD,
THIRUVANANTHAPURAM

ORGANIZED BY

KJK HOSPITAL
CHAIRPERSON
DR K JAYAKRISHNAN

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UPDATES IN
MONOCHORIONIC TWIN
PREGNANCIES

Borderline ovarian tumor in women of childbearing age - challenges in the management



DR MEENAKSHILA

MBBS, DNB

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Twenty-eight years old unmarried Ms X came with complaints of abdominal distension for the past six months. She attained menarche at 12 years of age and had regular menstrual cycles associated with passage of clots and severe dysmenorrhea. She had an insidious onset of heaviness and abdominal distension for the past six months, not associated with bowel or bladder symptoms. She did not have a loss of weight or appetite, no medical comorbidities and no previous abdominal surgeries. There is no history of malignancies in family members. On abdominal examination, a mass felt occupying the midline corresponding to 26 weeks size with cystic consistency with smooth borders, mobile and non-tender arising from the pelvis. A transabdominal ultrasound scan showed a 21 x 19cm multiloculated cyst arising from the right ovary with low-level internal echoes and a papillary nodule of 2.2cm in size. The uterus was normal, and the left ovary could not be visualised. On haematological workup, there was borderline elevation of CA 19-9 (35.6 U/mL). Other tumor markers

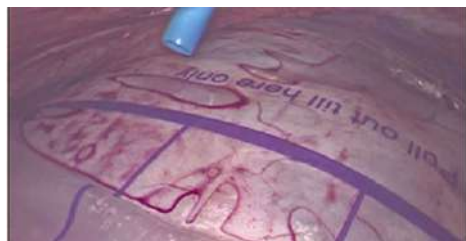


Figure 1: Ovarian tumor placed into the endobag



Figure 2: In-bag decompression and retrieval of contents

were within normal limits. Pre-operative MRI of the abdomen and pelvis showed findings favouring cystic neoplasm of right ovarian origin (O-RADS 4) with a possibility of mucinous cystic neoplasm of borderline type. It was decided to proceed with the right salpingo-oophorectomy. The patient and her parents provided their consent for the procedure, understanding that a staging laparotomy may be required in the future if malignancy is confirmed. During laparoscopy, a 20 cm cyst was found in the right ovary without capsular involvement, surface excrescences, and ascitis. The left ovary was normal. Peritoneal fluid was sent for cytology. Right salpingo-oophorectomy was done, and in-bag decompression and retrieval were done. The histopathology report came as benign mucinous cystadenoma. She was advised to follow up after 6 months with tumor markers and ultrasound.

The Ovarian-Adnexal Reporting and Data System (O-RADS) ultrasound risk stratification and management system provides consistent interpretations and decreases ambiguity in ultrasound reports in assigning risk of malignancy. These recommendations function as guidance in the management of patients who demonstrate adnexal lesions. These include O-RADS 0 to 5. O-RADS 4, as in our case, refers to the intermediate-risk category (10% to <50% risk of malignancy) that includes descriptors that predict a higher risk of malignancy. The lesions include multilocular cysts that are greater than or

equal to 10 cm or have an irregular inner wall or septal irregularity (<3 mm in height), unilocular and multilocular cysts of any size with a solid component or color score up to 4, and smooth solid lesions (>80% solid) with color score of 2-3.

Borderline ovarian tumors (BOTs) account for approximately 15% to 20% of all epithelial ovarian cancers. More than 96% of BOTs are serous or mucinous type. Historically, standard management of BOT is peritoneal washing cytology, hysterectomy, bilateral salpingo-oophorectomy, omentectomy, and complete peritoneal resection of macroscopic lesions.

Because BOTs are often diagnosed at an earlier stage, in younger age women and have a better prognosis and higher survival rate than IOC, fertility-sparing surgery is one of the options to preserve childbearing capacity. When only cystectomy is performed, relapse rates can be as high as 31%. In addition, some authors have suggested that more conservative bilateral cystectomy may be favoured in bilateral serous BOT for patients who want to preserve childbearing capacity because no significant difference is seen in the recurrence rate compared to unilateral salpingo-oophorectomy with contralateral cystectomy. It is important to perform thorough pathological tests on the margins around the resected tumor, and efforts should be taken not to rupture the tumor during surgery. The diagnostic accuracy rate for frozen sections remains high for benign and malignant ovarian tumors but is relatively low for BOTs. The use of minimally invasive or traditional open techniques has been evaluated in the literature, and it has been reported that there is no difference in recurrence rates, and similar survival curves were observed across these surgical approaches. The choice of surgical approach for BOTs should consider the size of ovarian masses, the presence and localization of peritoneal implants, the presence of bulky nodes, the surgeon's skills and the patient's individual characteristics.

The need for systematic lymphadenectomy represents another topic for debate on the surgical management of early-stage BOTs. Positive lymph nodes do not affect the global recurrence rate and the patient's overall survival. For this reason, the vast majority of investigators do not recommend routine pelvic and para-aortic lymphadenectomy for managing these tumours; otherwise, the removal of bulky suspicious nodes is suggested. In patients undergoing fertility-sparing surgery, a routine follow-up evaluation should be done, including clinical examination, ultrasound and dosage of serum tumour markers to help early diagnosis of relapse. When BOT recurs in the spared ovary and the patient desires to preserve fertility, a second fertility-sparing surgery, identical to the first, can be considered. If the patient does not desire to preserve fertility, bilateral salpingo-oophorectomy can be performed.

In conclusion, fertility-sparing surgery for BOTs is feasible and does not seem to negatively influence patients' long-term survival. Treatment decision-making should be based on the patient's overall clinical picture, symptoms, preferences, previous medical and surgical history, tumor markers and clinical and radiological findings. Thorough pre-operative patient counselling and informed consent are mandatory for every case so that the attending surgeon can proceed as per different intra-operative findings.

Use of native tissue for laparoscopic pelvic floor repair: McCall's Moschowitz repair

DR MAYANK JAIN
MD, OBG

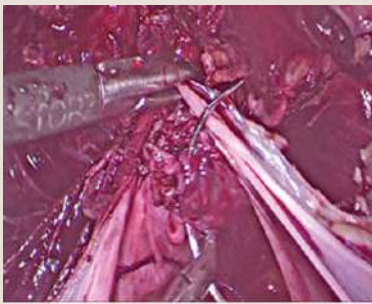
Fellow in Reproductive Medicine



INTRODUCTION

Hysterectomy is one of the most frequently performed gynecological procedures.(1). After hysterectomy the vault suspension is a major intervention to prevent vault prolapse in future. Several suspension procedures at the time of hysterectomy have been suggested to prevent subsequent prolapse occurrence. McCall culdoplasty and sacrospinous ligament fixation have been suggested as preventive surgical procedures at the time of vaginal hysterectomy. Suturing the cardinal and uterosacral ligaments to the vaginal cuff has been suggested as a preventive procedure at the time of abdominal or laparoscopic hysterectomy. (2) In Moschowitz-McCall repair, the principles of 2 procedure are combined. The uterosacral and cardinal ligaments of both sides to the vaginal apex are brought in midline and sutured to the vaginal vault(Mc-calls culdoplasty). In addition, purse string sutures connecting the peritoneum and the anterior wall of the rectum are applied before the sutures were passed through the peritoneum anteriorly that brings the supportive structures in the midline to prevent enterocele (Moschowitz repair)

Case presentation: A 58yr, P2L2, with Previous 2 Term vaginal deliveries with her last child birth 33 years back, presented to our out patient department with complaints of something coming out pervaginum since 6 months on and off. It was also associated with back ache on and off. There was no history of heavy weight lifting or chronic cough. Patient was a known case of hypercholesterolemia, on rosuvastatin 5 mg OD since last 3 years. No history of any other chronic medical illness



or surgery in the past. There were no urinary or bowel complaints. On Valsalva manoeuvre, an apical prolapse was noted reaching upto the level of hymen. On per speculum examination the vaginal mucosa was hypoestrogenised. 2nd degree UV prolapse was noted involving the apical and posterior compartment. No stress urinary incontinence was elicited. On Bimanual examination, the uterus was atrophic, mobile and non tender. Bilateral fornices were free. A transvaginal ultrasound was done. The uterine size was of 4.9 x 2.7 x 4.6 cm. A Fundal intramural fibroid measuring 1.9 x 1.8 cm was noted with normal vascularity seen around the fibroid. Endometrium was 3.7 mm. Bilateral adnexa appeared normal. Owing to the second degree nature of prolapse, laparoscopic route for hysterectomy was decided over vaginal route and hence patient was planned for Laparoscopy assisted vaginal hysterectomy. Pre anesthesia investigations were normal. An informed consent for the procedure was taken prior to surgery. Patient was positioned in the dorsal low-lithotomy position. Laparoscopic ports were placed in baseball

Triplet Pregnancy After Fetal Reduction. Risk of PPRM

DR S GAYATHRI
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Fellow in Reproductive Medicine



Mrs X, 30 years old, primigravida with FET conception, GDM on OHA, Rh negative pregnancy. Triplets pregnancy, was normal till 12 weeks. At 12 weeks 4 days patient was admitted and posted for fetal reduction on maternal request with KCL 15% 10 ml under ultrasound guidance used for fetal reduction. Anti D was given after procedure. Post procedure 2 FHR was noted. Triplets reduced to DCDA twins. Anomaly scan and other repeated scans were normal. At 31 weeks 4 days patient came to hospital with complaints of PV leaking. Admission CTG, fetal bradycardia in first twin and followed by USG showed oligohydramnios. Patient taken for Emergency Preterm



LSCS with PPRM delivered live pre term twins, 1.5 and 1.7 kg. Anti D taken as baby blood group positive(o+).

CONCLUSION:

There is higher incidence of adverse maternal and perinatal outcomes among multiple pregnancies than singleton pregnancies. High risk units in the obstetric ward and a well-developed neonatal intensive care set up would help to reduce the maternal, perinatal morbidity and mortality. Antenatal counselling and education for regular checkups could be ensured. Maternal and fetal morbidity and mortality can be decreased by providing optimum antepartum, intrapartum and postpartum care.

diamond method. Bilateral cornual structures were coagulated and cut using harmonic ace scalpel. UV fold was dissected and bladder was pushed down. Uterine artery was skeletonized and coagulated and cut using ligasure. The remaining steps of hysterectomy were done vaginally. Curvilinear incision was placed over the cervicovaginal junction. Vaginal mucosa was pushed back and anterior and posterior peritoneum was opened. Mackenrodt and uterosacral ligament complex was clamped, cut and transfixed with vicryl No 1 suture. Specimen was retrieved vaginally. Redundant vaginal mucosa was cut and vault closure was done vaginally and a corrugated drain was placed through the vaginal vault. Vaginal packing was done. Then pelvic floor repair procedure were done laparoscopically. Uterosacral ligaments were plicated to the vaginal vault and for Moschowitz repair, a purse string stitch was taken. All ports were closed. Patient was stable in postoperative period and discharged after 2 days in stable condition.

An incidental finding of STUMP in case of myomectomy for large fibroid uterus



DR SHARDA SHARMA

MBBS, DNB

Fellow in Reproductive Medicine

Introduction - Uterine fibroids are one of the most common types of pelvic tumors in women. Uterine smooth muscle tumors have, historically, been classified into benign leiomyomas and malignant leiomyosarcomas according to the degree of cytological atypia, mitotic activity, and other molecular tissue markers. However, there is a spectrum of borderline tumors, including variants of mitotically active, cellular, and atypical leiomyomas, as well as Smooth Muscle Tumours of Uncertain Malignant Potential (STUMP). STUMP encompasses a broad group of uterine neoplasms that do not meet the current histologic criteria for a diagnosis of either benign or a malignant tumor. Among women undergoing hysterectomy or myomectomy for a presumed diagnosis of leiomyoma, 0.01% receive a diagnosis of STUMP. Due to the rarity of this disease and inconsistency in diagnostic criteria, the true prevalence of STUMP is difficult to determine. STUMP often presents with symptoms consistent with a benign leiomyoma—include a combination of abnormal uterine bleeding, pelvic mass, or symptoms due to secondary compression and anemia. Various treatments are available for the management of uterine fibroids, such as having a hysterectomy or a myomectomy.



TVS -Uterus 14.5 x 8.9 cm. Anterior IMF towards right 9.5 x 7.9 cm, Anterior IMF towards left 5.1 x 4.9 cm increased peripheral vascularity. ET 11.6 mm, 3D showed endometrial cavity pushed posteriorly by large fibroid. Bilateral ovaries normal.

Case report -43year-old P2L2, previous 2 LSCS came with complaints of heavy menstrual bleeding x 8 months, periods lasting 8-10 days with clots. In view of breathlessness she was admitted in hospital 2 months back, Hb dropped down to 4.5 gms %, managed with 2 units of PRBC, currently on iron supplements, otherwise had no significant past medical history. On physical examination—built—average, BMI-22.7 kg/m². Her vitals were stable and no pallor. Her general, CVS and CNS examination were within normal limits. On PA examination, a large firm mass was palpable corresponding to 18-20 weeks gravid uterus with its lower pole not palpable. The mobility of the mass was restricted due to its huge size, the margins of the mass were ill defined and it was non-tender. There was no evidence of ascites clinically. On PS examination, cervix and vagina was healthy. On PV examination Uterus 18-20 weeks, could not be felt separately from the mass, pouch of Douglas was free. Her blood investigations were within normal limits. Cytology was negative.

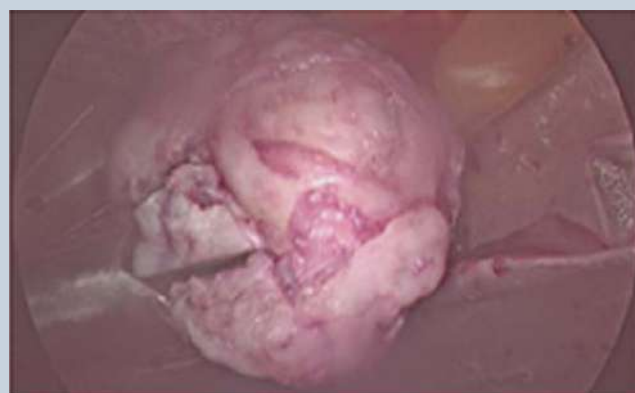
Postoperative recovery was uneventful and the patient was discharged on day 3. The postoperative histology of the specimen was reported as a STUMP cannot be ruled out, proliferative endometrium without atypia. Tumor had a low mitotic index with <10 MF/10 HPFs and no coagulative tumor necrosis. She has referred to the RCC for immunohistochemistry.

A provisional diagnosis of AUB-L was made. The results were discussed with the patient, counselling regarding hysterectomy was done, she was not willing for same, wants to go for lap myomectomy.

Laparoscopic myomectomy (In bag Morcellation) + diagnostic hysteroscopy + endometrial biopsy was done



Uterus enlarge with multiple fibroid



In bag Morcellation

Conclusions

STUMPs are a rare and heterogeneous group of tumors with difficult-to-predict clinical behaviour. The pathologic criteria for STUMP diagnoses are not defined and it is necessary to create a consensus to resolve this problem. In most cases, its histological diagnosis is achieved after surgery for a suspected leiomyoma. The challenge is to find diagnostic tests that help us to suspect these tumors before surgery. Although IHC studies may help in differentiating these tumors, more research is required to improve their diagnosis. A total hysterectomy is the standard and most accepted surgical treatment, although a myomectomy may be considered for women who wish to preserve their fertility. To date, neither IHC characteristics nor serological markers seem to be useful in identifying worse prognoses and a higher risk of recurring tumors. Due to STUMP's potential for recurrence and metastasis, long-term follow-ups seem necessary.

Successful use of Laparoscopic Myomectomy to remove large Cervical Fibroid



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Uterine leiomyomas are the most common benign smooth muscle tumours with prevalence of 20-50% in women of reproductive age. Depending on its location in the uterus, fibroids are classified as uterine, cervical and ligamentary of which the cervical fibroids are the rarest which makes up around 2-2.5% of the total incidence of fibroids. They arise from infravaginal or supravaginal part of cervix - infravaginal cervical fibroids present as polyps and supravaginal ones can be either interstitial, subserous or submucous fibroid. Depending on the position, they are anterior, posterior, lateral or central. Huge central fibroids give the classically described appearance of “**Lantern on St. Paul’s Cathedral**”.

Cervical fibroids are commonly sessile and may grow into broad ligament causing pressure effects over the ureter and can press upon bladder anteriorly and rectum posteriorly. The most important thing is the relation with ureter. Uterine artery and ureter lie in close proximity with fibroid and with each other in cases of cervical fibroid. Narrow operative field, possible injuries to surrounding pelvic structures such as ureters, urinary bladder and rectum, significant haemorrhage and a difficult repair of the big cavity renders the procedure technically very challenging.

Case Report

A 37-year-old nulligravida woman with primary infertility presented to our hospital with a four-month history of lower abdominal pain, frequent urination and dyspareunia with regular menstrual cycle. Her medical and surgical history was non-eventful. On local examination, there was a firm non-tender pelvic-abdominal mass about the size of 12-14 weeks pregnancy with restricted mobility. **USG revealed a large posterior cervical fibroid measuring 8 x 7 cm.** No additional pathology was noted in the remainder of her pelvis or abdomen. The results of the routine laboratory testing, including complete blood count, serum electrolyte levels and biochemical tests, were within normal limits. On the basis of these findings, patient was counselled for laparoscopic myomectomy.

Operative Steps

After obtaining pre-anesthesia clearance and written informed consent, patient was scheduled for laparoscopic myomectomy. Pneumoperitoneum was achieved using a supraumbilical Veress with midline supraumbilical 10 mm port for the telescope, and then two 5 mm accessory trocars were positioned in the left lateral quadrants. Intra-operatively uterus was found to be enlarged to 12-14 weeks size with large posterior cervical fibroid measuring 7x8 cm. Bilateral ureters were traced at the beginning of procedure. Intraoperative USG was done for fibroid mapping. After injecting dilute vasopressin over uterine serosa overlying the myoma, oblique incision was given using harmonic scalpel. Intracapsular myomectomy was performed. Myoma was enucleated by traction and counter traction technique. The myometrial defect and edges were closed with a continuous suture using a V-loc unidirectional barbed suture. The operative time was 120 min. The weight of the excised myoma

was 380 grams. The postoperative course was uneventful. On next post-operative day Foley’s catheter was removed and the patient was discharged on post-operative day 3. Cervical leiomyoma without atypia was confirmed histopathologically.



We propose the mnemonic “**MUSIC**” as a helpful guide for a consistent surgical strategy:

M-Preoperative USG/ MRI for diagnosis
U- Prophylactic ureteric catheterization
S-Shell out the myoma and stay intracapsular
I-Immediate suction to clarify deadspace
C-Close the cavity by spiraling stitch

A. Uterus bulky and enlarged to 12-14 weeks size. B. Myoma enucleated

Conclusion

This case confirms the efficiency, reliability, and safety of a minimally invasive surgical approach for removing cervical leiomyoma. Although a laparoscopic approach for large myomas has several challenges, it does represent a convenient option for the minimally invasive removal of very large myomas in the hands of an expert surgeon with appropriate surgical equipments and team work.

Updates in Monochorionic Twin Pregnancies



DR. DEVI RESHMA
MBBS, DNB (OBG)
Consultant

Mrs. P 38 years, primigravida, LMP-21/07/2023, EDD-26/04/2024, OI conception, k/c/o PCOS. Dating scan confirmed live MCDA gestation at 9 weeks. Aneuploidy screening was done around 11-14 weeks. NT scan showed MCDA twin gestation corresponding to 12 weeks 6 days. Admitted at 13 weeks in view of threatened miscarriage. USS showed MCDA twins corresponding to 13 weeks 2 days, with small SCH of 1x0.9 cm and low-lying placenta. The patient was managed conservatively with progesterone supplements. Early anomaly Scan at 15 weeks -No gross anomalies detected, Concordant for growth, bladder was visualized for both fetuses with normal study and normal AFI. Anomaly scan at 18 weeks- MCDA twins corresponding to 18 weeks 1 day, discordant for anomaly, concordant for growth, liquor, bladder, and Doppler. Fetus A-shows features s/o non communicating Hydrocephalus- possibly Aqueductal Stenosis. Fetus B- Normal growth with no soft markers of aneuploidy, Weight discordancy- Fetus A-10%. Counselling patient regarding the poor prognosis and implication of other apparently normal fetus explained. The option of Selective termination by Cord coagulation or Radiofrequency ablation of affected twin's cord to reduce one twin explained.



T Sign in Monochorionic Pregnancy



Moderate to severe ventriculomegaly with dilation of third ventricle

INTRODUCTION

MCDA twins are monozygotic, resulting from the fertilization of a single egg that splits into two natural clones. After the first trimester, amnion, and chorion fuse to form the intertwin septum, making it difficult to ascertain if same-sex

twins are mono- or dichorionic. The incidence of monozygotic twins remains mostly constant worldwide and accounts for 3–5 per thousand births. The incidence of monochorionic twins is 1 in 300 pregnancies.

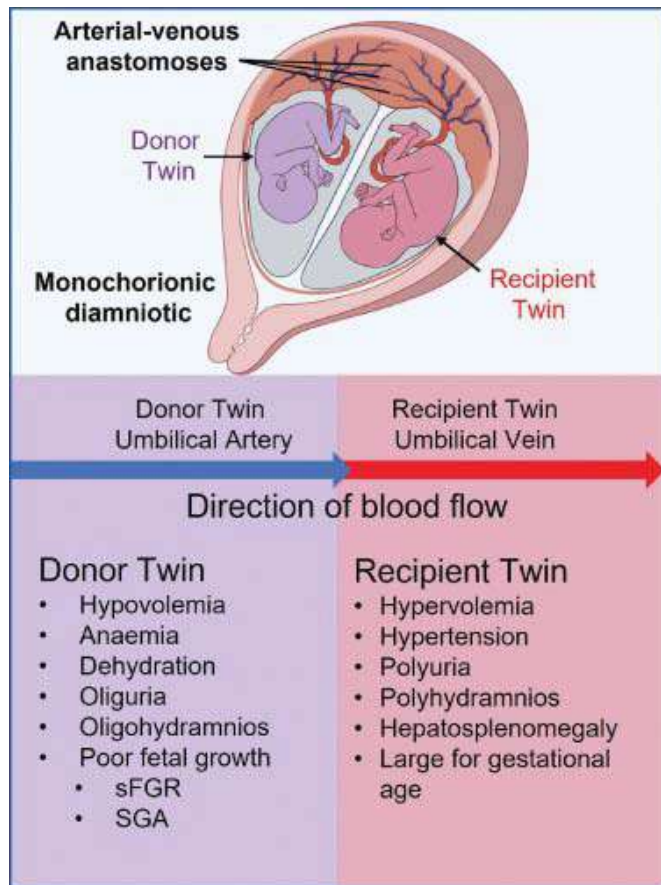
ROLE OF ULTRASOUND IN DETERMINING CHORIONICITY AND AMNIONICITY

- All women with twin pregnancies should be offered ultrasound examination between 11 and 13 +6 weeks of gestations (CRL- 45-84 mm) to assess fetal viability, gestational age and chorionicity. In MCDA pregnancies, the inter twin membrane becomes progressively thin after 9 weeks. A characteristic T sign is seen in ultrasound with a 100 % sensitivity and greater than 98% specificity for detecting MCDA gestation.
- In uncomplicated monochorionic twins, following first trimester scan, further scans should be performed at least every 2 weeks from 16 weeks to detect TTTS.
- Timely intervention for twin-twin transfusion syndrome results in the survival of at least one twin in about 85% of pregnancies. In 15%, an imbalance in blood exchange occurs.

Monochorionic Twin Pregnancy	
11–14 week	• Dating, labeling, chorionicity • Screening for trisomy 21
16 week	• Fetal growth, DVP
18 week	• Fetal growth, DVP
20 week	• Detailed anatomy • Biometry, DVP • UA PI, MCA PSV • Cervical length
22 week	• Fetal growth, DVP • UA PI, MCA PSV
24 week	• Fetal growth, DVP • UA PI, MCA PSV
26 week	• Fetal growth, DVP • UA PI, MCA PSV
28 week	• Fetal growth, DVP • UA PI, MCA PSV
30 week	• Fetal growth, DVP • UA PI, MCA PSV
32 week	• Fetal growth, DVP • UA PI, MCA PSV
34 week	• Fetal growth, DVP • UA PI, MCA PSV
36 week	• Fetal growth, DVP • UA PI, MCA PSV

In the first trimester, we use the crown-rump length (CRL) of the larger twin to determine the due date in spontaneously conceived pregnancies. Structural anomalies are twice as common in MCDA twins (5%) as in singletons and although they are monozygotic, in 90% only one twin is affected.

TTTS: Unique to monochorionic pregnancies. It occurs in approximately 10%, usually between 16 and 26 weeks.



- **TAPS:** A discordance in hemoglobin is its hallmark. TAPS is diagnosed on ultrasound scan if there is a significant difference (more than 1MoM) in the PSV-MCA between the twins.

• DISCORDANT ANOMALIES IN MC TWIN-

Discordant anomalies in MC twins are not an uncommon event. Discordant congenital anomalies in monochorionic twin pregnancies are not exceptional and related to genetic and epigenetic mechanisms. Among these, discordant fetal anencephaly, is among the most ethical controversies in prenatal management.

MANAGEMENT

- These pregnancies can be managed expectantly or by selective fetocide of the abnormal twin
- In cases where the abnormality is non-lethal but may result in serious handicap the parents need to decide whether the potential burden of a handicapped child is enough to risk the loss of the normal twin from fetocide-related complications.
- In cases where the abnormality is lethal it may be best to avoid the risks associated with selective fetocide, unless

Techniques	Success rate (technical/ clinical)	Remarks
Sclerosing substances (i.e., ethanol) and embolization (i.e., coil)	33%	Recanalization or migration of coils
US or fetoscopic guided cord ligation	62%	PPROM 30%, technical difficulties, multiple ports
Monopolar thermocoagulation	?	
Laser cord transection		Higher failure with more advanced gestational age (>20 wks')
Bipolar diathermy	80%	Higher failure with more advanced gestational age (>20 wks')
Radiofrequency ablation	90%	Low chance of terminating the wrong fetus
Harmonic scalpel	?	Require laparotomy

the condition itself threatens the survival of the normal twin. For example, in anencephaly or trisomy 18 (with associated esophageal atresia or diaphragmatic hernia), there is >50% risk of development of polyhydramnios at 24-26 weeks' gestation placing the normal twin at high risk of preterm birth and associated mortality and morbidity.

Selective fetocide in monochorionic twins

- Fetocide can be carried out by occlusion of the umbilical cord vessels through endoscopic laser, ultrasound-guided bipolar forceps, or radiofrequency.
- Fetocide at e"16 weeks: risk of miscarriage 20% and risk of birth at <32 weeks 20%.

Various techniques of cord occlusion have been described. In utero bipolar diathermy and radiofrequency ablation of the umbilical cord seem to be the most effective method, whereas injection of absolute alcohol and coil occlusion are associated with higher failure rate

CONCLUSION

MCDA twins are associated with several well-known complications. Twinning increases the chances of structural anomaly in the fetus. Discordance in the physical development of the fetuses raises both ethical and management dilemma. Chorionicity plays an important role when selective fetocide is an option. Certain anomalies are unique to monochorionic twin gestations. These anomalies may require utero intervention to salvage its normal co-twin. Parents should be informed that usually a planned birth is recommended at 36 completed weeks, and this does not increase the risk of any neonatal morbidity.

STATISTICS

Jan to Nov 2023

TOTAL CASES	913	Lap sacrocolpopexy	2	Colposcopy directed biopsy	1
Laparoscopy	265	Lap isthmocele repair	2	Fetal reduction	2
Hysteroscopy	217	LAVH	1	MALE CASES	29
Minor cases	150	HYSTEROSCOPY	217	TESA	22
Male cases	29	Pre IVF	49	TESE	3
Obstetric cases	245	Diagnostic	68	NAB	4
Others	7	Operative	67	OBSTETRIC CASES	245
LAPAROSCOPY CASES	265	SMF resection	13	FTND	83
TLH	59	Endometrial biopsy	39	LSCS	162
TLH+sentinal node biopsy	1	Septal resection	8	Elective LSCS	85
Myomectomy	71	Therapeeptic curetage	2	Emergency LSCS	77
Adenomyomectomy	9	Tubal cannulation	8	Vaccum delivery	14
Cystectomy	27	Hysteroscopic polypectomy	30	OTHER CASES	7
Salpingectomy	13	MINOR CASES	150	Vaginal hysterectomy	5
Salpingostomy	5	Suction evacuation	42	Laparotomy-myomectomy	2
Oophorectomy	1	Fractional curettage	14	TOTAL CONCEPTION	371
Adnexectomy	6	SSG	28	Spontaneous conception	148
PCO puncturing	9	Cervical encirclage	23	COH + Natural conception	34
Fulguration of endometriotic deposits	26	Bartholin cyst excision	3	IUI conception	62
Ovarian ectopic resection	1	Endometriosis excision	1	IUI conception rate	16.71%
Lap abdominal encirclage	6	Pipelle sampling	14	ART : IVF/ICSI STATISTICS	
Lap abdominal encirclage removal	2	EUA	1	Total no of cases	241
Diagnostic laparoscopy	1	ERA	3	Total conception	127
Ovarian PRP instillation	7	CuT insertion	1	Total conception rate	41.47%
Gonadectomy	1	Mirena insertion	7	Total conception in FET cycles	81
Lap ovarian detorsion and oophoropexy	1	Amniocentesis	7	Conception rate after FET cycles	44.51%
Paraovarian cystectomy	1	Vaginal tightening	1	Total conception in fresh cycle	19
Lap sterilization	7	Vaginal botox injection	1	Conception rate after fresh cycles	38.00%
Lap detorsion of tube	1	Incision and drainage	1		

POSTDOCTORAL TRAINING IN REPRODUCTIVE MEDICINE (GYNAE ENDOSCOPY & ASSISTED REPRODUCTION)

**For Postgraduates
planning to pursue a career in
Reproductive Medicine**

**Course duration - 12 months
Jan, May, Sep, Two candidates each**

**Qualification Post Graduate - M.D, or
DNB in Obstetrics & Gynaecology**

**Details can be website
www.kjkhospital.com**

**Obtained from
Email: kikhospital@gmail.com**

**FOR DETAILS CONTACT
Dr. K. JAYAKRISHNAN**

**FNB - REPRODUCTIVE MEDICINE
BY NATIONAL BOARD STARTED**

Own Team

REPRODUCTIVE MEDICINE & LAPAROSCOPY

DR K JAYAKRISHNAN MBBS, MD (OBG), DGO, DNB

DR NIRANJANA J MBBS, MD (OBG), DNB

DR ASHWIN JAYAKRISHNAN MBBS, MS (OB), DN

IVF COORDINATOR

DR ANITHA M MBBS

OBSTETRICS & GYNAECOLOGY

DR DEEPTI B MBBS, MD (OBG), DGO, MRCOG

CONSULTANTS IN OBSTETRICS & GYNAECOLOGY

DR MEENAKSHI A. MBBS, DNB

DR DEVI RESHMA R.N. MBBS, DNB (OBG)

PAEDIATRICS & NEONATOLOGY

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