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BHATIA GLOBAL HOSPITAL AND ENDOSURGERY INSTITUTE NEWSLETTER

VOL. 05

NO. 2

FEB 2005

ANNUAL SUBSCRIPTION: RS. 25/-

EDITORIAL

INSIGHT: Are we giving our best?

If you give your best to the world, world's best will come back to you.

A frail old man went to live with his son, daughter-in-law, and four-year grandson. The old man's hands trembled, his eyesight was blurred and his step faltered. The family ate together at the table. But the elderly grandfather's shaky hands and failing sight made eating difficult. Peas rolled off his spoon onto the floor. When he grasped the glass, milk spilled on the tablecloth.

The son and daughter-in-law became irritated with the mess. "We must do something about Grandfather," said the son. "I've had enough of his spilled milk, noisy eating, and food on the floor". So the husband and wife set a small table in the corner. There, Grandfather ate alone while the rest of the family enjoyed their dinners together.

Since Grandfather had broken a dish or two, his food was served in a wooden bowl. When the family glanced in Grandfather's direction, sometimes he had a tear in his eye as he sat alone. Still, the only words the couple had for him were sharp admonitions when he dropped a fork or spilled food.

The four-year-old watched it all in silence.

One evening before supper, the father noticed his son playing with wood scraps on the floor. He asked the child sweetly, "What are you making?" Just as sweetly, the boy responded, "Oh, I am making a little bowl for you and mamma to eat your food in when you get old." The four year old smiled and went back to work.

The words so struck the parents that they were speechless. Then tears started to stream down their cheeks. Though no word was spoken, both knew what must be done. That evening the husband took Grandfather's hand and gently led him back to the family table. For the remainder of his days, he ate every meal with the family. And for some reason, neither husband nor wife seemed to care any longer when a fork was dropped, milk spilled, or tablecloth soiled.

Life sometimes gives you a second chance.

If you pursue happiness, it will elude you. But, if you focus on your family, your friends, the needs of others, your work and doing the very best you can, happiness will find you.

I've learned that children's eyes observe more than their ears ever hear and the example we set for them determines their actions.

I've learned that every day, you should reach out and touch someone. People love that human touch — holding hands, a warm hug, or just a friendly pat on the back. People will forget what you said.... People will forget what you did.... But people will never forget how you made them feel.

I've learned that life is about people and making a positive difference.

R. S. Bhatia Minakshi Ahuja

The title "doctor" is derived from the Latin word docere-to teach, and the physician should share information and medical knowledge with others and be willing to teach, what he or she has learnt, to colleagues as well as to students of medicine and related professions. The practice of medicine is dependent on the sum total of medical knowledge, which in turn is based on an unending chain of scientific discovery, clinical observation, analysis, and interpretation. Advances in medicine depend on the acquisition of new information, that is, on research, which must often involve patients; improved medical care requires the transmission of this information.

It is better to understand a little than to misunderstand a lot. Anatole France

In this issue...

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- 2 Article** Scope of Laparoscope in Sub-Fertility
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Our team of experts

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2004-2005/512
dt. 16-04-2002

Approval of hospital
u/s 17(2)(ii)(b) of I.T. Act
1961, F. No: Addl. CIT
(Coord.)/ Hospital/2002-
03/3563

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Links 'n' Grafix
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BOOKS



Laparoscopic Hernia Repair
(a step by STEP approach)

Forewords by

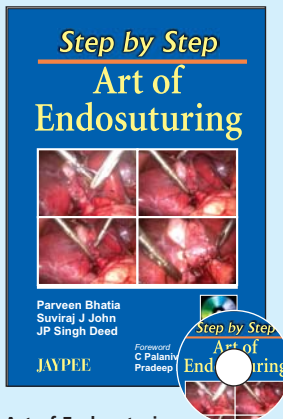
Dr. J. Barry Mckernan
Dr. Adarsh Chaudhary

Contents

200 pages with 16 chapters,
300 coloured photographs &
diagrams

Authors

Dr. Parveen Bhatia
Dr. Suviraj J John



Art of Endosuturing
(a step by STEP approach)

with **Mini Interactive CD**

Authors

Dr. Parveen Bhatia
Dr. Suviraj J John
Dr. J. P. Singh Deed

Forewords by

Dr. C. Palanivelu
Dr. Pradeep Chowbey

Contents

183 pages, 121 coloured photo-
graphs, 70 illustrations

SCOPE OF THE SCOPE IN SUBFERTILITY

Global Fertility services



Dr. Archana Dhawan Bajaj

*DNB. MNAMS,
M.Med Sci in Assisted Reproductive Technology,
University of Nottingham. U. K.*

Dr. Bajaj is a Gynaecologist who has super specialized in Infertility, IVF and Reproductive medicine. She has obtained her degree in Assisted Reproduction from **NURTURE IVF**

Centre at the Queen's Medical Centre, Nottingham U.K. Her training and experience at Farah IVF center under Dr. Zard Kilani in Jordan has further enhanced her expertise in this field.

She has joined Global Hospital and Endosurgery Institute as full time consultant in Infertility and Reproductive Medicine.

Endoscopy is the gold standard for diagnosis of Tubal pathology, uterine and other intra-abdominal causes of subfertility. Advances in IVF and Endoscopy have changed Infertility to Subfertility implying that now we have treatment options for most if not all causes of subfertility. The current section provides an over view of role Laparoscopy in subfertility, role of hysteroscopy will be discussed in a subsequent edition.

In general, semen analysis, HSG and documentation of ovulation should be done prior to Laparoscopy. It is our practice to start an infertility (female) work up with a semen analysis, HSG and documentation of ovulation. We proceed to Diagnostic Laparoscopy in cases with abnormal HSG or those who don't conceive despite 3-6 months of regular treatment with a normal HSG (all other causes of infertility having been evaluated). In subfertile patients Laparoscopy reveals abnormality in 21-68 % cases after normal hysterosalpingogram (HSG). Depending on the severity of Laparoscopic findings, the initial treatment decision e.g. IUI, can be changed into direct laparoscopic correction of the abnormality followed by IUI, fertility-improving surgery by laparotomy or referral to IVF.

Indications of Laparoscopy in Subfertility can be diagnostic alone, to evaluate the cause, or therapeutic where the surgery is curative for the disorder.

- Polycystic Ovaries diagnosis and drilling
- Diagnosis and fulguration of endometriosis
- Diagnosis of chlamydial or tubercular infections
- Lysis of adhesions
- Evaluation and treatment of ovarian cysts
- Fallopian tube occlusion. A diagnostic Laparoscopy may clarify the diagnosis and treatment prior to reconstructive surgery.
- Tubal reconstruction

- Structural abnormalities of the uterus, including congenital developmental abnormalities (such as a bicornuate or unicornuate uterus)
- Removal of uterine fibroids
- Diagnosis and management of ectopic pregnancy

DIAGNOSTIC LAPAROSCOPY

It is important to approach the evaluation of the pelvis in a systematic and thorough manner. The Upper abdomen, intestinal tract, uterus, fallopian tubes, ovaries, pouch of Douglas and uterosacrals should be carefully examined. Chromopertubation should form a part of all diagnostic work ups

OPERATIVE LAPAROSCOPY IN INFERTILITY

Polycystic Ovaries Ovarian drilling is done for women with PCOD who have not responded to life style management and medical ovulation induction. Electrocautery or laser can be used to drill holes in the ovaries. 4 holes at 40W, 4 mm depth for 4 sec are optimum and it is reported that ovarian drilling results in an 80% ovulation rate and a 50% CPR.



Ovarian drilling for polycystic ovaries

Endometriosis Laparoscopy remains the gold standard for the diagnosis and management of endometriosis. Laparoscopic appearance of endometriosis may include any of the following

- The classical "powder-burn" or blueberry lesion
- White lesions that mimic scar tissue
- Clear or slightly brown-colored papillary lesions
- Strawberry or flame-like lesions which are hor-

Start doing the necessary, you will then start to do the possible and suddenly you would be doing the impossible.
St. Francis of Assisi

monally active

- Peritoneal pockets which contain endometrial implants
- Ovarian endometriomas or chocolate cysts



Endometrial implants

Studies ascertain that Laparoscopic ablation of minimal-mild endometriosis relieves pain and improves fertility rates. The aim of the surgery is complete excision of Endometrial implants along with restoration of pelvic anatomy. Chocolate cysts can be excised with preservation of normal ovarian tissue and function, and should be attempted only by an expert. Excision, fulguration by electrocautery or laser and aqua dissection can be utilized judiciously to attain removal of all visible implants.

Evaluation and excision of ovarian cysts (including chocolate cysts) can be excised with preservation of normal ovarian tissue and function, and should be attempted only by an expert.

Fallopian tube occlusion refinements of instrumentation and techniques allow laparotomy to be avoided for tubal reconstructive surgery in most instances. The advent of salpingoscopy, a new endoscopic technique, has allowed improved patient selection for tubal surgery. Procedures like fimbrioplasty for fimbrial blocks and phimosis, tubal anastomosis for isthmic and ampullary blocks can be dealt with laparoscopically with pregnancy rates similar to microsurgery in expert hands.

Hydrosalpinx Laparoscopic reconstructive surgery (salpingostomy) for mild or moderate (Stage I or II) hydrosalpinges is an effective approach in distal tubal occlusion. Extent and nature of adhesions, thickness



Hydrosalpinx

of tubal wall and diameter of the hydrosalpinx diameter are useful parameters for predicting the pregnancy outcome in cases with hydrosalpinx. Patients with Stage III and IV disease are best referred for IVF. It has been shown that IVF implantation rate is markedly reduced (about 50%) and the miscarriage rate increased with hydrosalpinx. Hydrosalpinx fluid retained in the tube is embryo toxic and impairs endometrial receptivity. Enlarged tubes may compromise the blood flow to the ovary causing a poorer response to gonadotropins. Studies have shown that salpingectomy removing the hydrosalpinx improves the subsequent success of IVF. It is now generally recommended to remove or ligate these tubes laparoscopically before IVF.

Removal of uterine fibroids Pedunculated subserous, small and single leiomyomas are managed more easily laparoscopically than multiple and larger tumors. Uterine size < 14 weeks; no individual myoma larger than 7 cm; no myoma near the uterine artery or tubal cornua and at least 50% of the leiomyoma subserosal are criteria for adequate repair of the myometrium laparoscopically. Most studies have found no significant difference in pregnancy rate after surgery between laparoscopic and abdominal myomectomy, though decreased hospital stay, postoperative recovery time and blood loss; reduced postoperative pain, smaller incisions, better cosmetic results are significant advantages.



Sub serous fibroid

Adhesions cause infertility by distorting pelvic anatomy with or without causing tubal blockage. Peritubal adhesions affect ovum pick-up by fimbriae. Periovarian adhesions may also interfere with the normal ovulatory function.

Laparoscopic adhesiolysis is performed as a day care procedure along with the diagnostic laparoscopy. It is associated with shorter hospitalisation and recovery times. There are fewer de novo adhesions associated with laparoscopic surgery compared to laparotomy. Therefore although the overall pregnancy rates after laparoscopic adhesiolysis are similar to those after adhesiolysis at open surgery, laparoscopic adhesiolysis remains an effective procedure for infertile patients with adhesions.

(Next Issue Scope of Hysteroscopy in subfertility)

NEWS FLASH

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Dr. Neeraj Jain

Consultant Incharge,
Global Pain Clinic
Senior Anaesthesiologist
& Interventional Pain
Specialist.

Trained at

AIIMS and Chronic Pain
Clinic, John Hopkins,
Baltimore, USA.

on being awarded 1st
prize at International
Conference of
International Association
for Study of Pain
ISSPCON 2005, Pune
Jan 28 – 30, 2005
for his paper
"Vertebroplasty in
Traumatic Vertebral Body
Fractures"

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at FICCI Auditorium
on

March 1, 2005

4.00pm – 7.00pm

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**If you give a man more than he can do, he will do it.
If you only give him what he can do, he will do nothing.**

Kipling R.

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VOL: 05 NO: 02

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- April 2,3, 2005 (Saturday, Sunday)
- July 2,3, 2005 (Saturday, Sunday)
- September 24, 25, 2005 (Saturday, Sunday)
- November 25, 26, 2005 (Friday, Saturday)

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Registered with Registrar of News Paper Vide Registration No.: RNI-DELENG/2001/6114

and Postal Deptt Vide: **DL-17014/2003-05**

Printed, published and owned by Dr. Parveen Bhatia and printed at Hindustan Offset Press: A-26, Naraina Industrial Area, Phase-II, New Delhi - 110028. Phone: 2-5705629 and published at 307 & 308, Ambika Vihar, New Delhi - 110087. Editor: R. S. Bhatia.