



**BHATIA GLOBAL HOSPITAL  
& ENDOSURGERY INSTITUTE**

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BHATIA GLOBAL HOSPITAL AND ENDOSURGERY INSTITUTE NEWSLETTER

VOL. 05

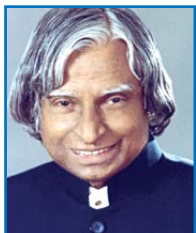
NO. 3

MAR 2005

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## EDITORIAL

### SONG OF YOUTH



#### ME AND MY NATION – INDIA

Ignited Minds by **Dr. A.P.J. Abdul Kalam**

As a young citizen of India, armed with technology, knowledge and love for my nation, I realize, **small aim is a crime.** I will work and sweat for a great vision, the vision of transforming India into a developed nation powered by economic strength with value system. I am one of the citizens of a billion, only the vision will ignite the billion souls. It has entered into me, the ignited soul compared to any resource, is the most powerful resource on the earth, above the earth and under the earth. I will keep the lamp of knowledge burning to achieve the vision — **Developed India.**

Our life is what we make it by our own thoughts and deeds. It is our own state and attitude of mind which determine whether we are happy or unhappy, strong or weak, sinful or holy, foolish or wise. If one is unhappy, that state of mind belongs to himself, and is originated within himself; it is a state which responds to certain outward happenings, but its cause lies within, and not in those outward occurrences. If one is weak in will, he has brought himself to, and remains in, that condition by the course of thought and action which he has chosen and is still choosing.

We are further humbled by the encouraging words of our worthy scientist president. All this compassionate care for the rich and poor alike has been possible because of the constant encouragement by you all. **R. S. Bhatia**

### Thanks for the encouragement

A.P.J. Abdul Kalam

Rashtrapati Bhavan  
New Delhi - 110004

February 22, 2005

Dear Dr. Parveen Bhatia,

I am delighted to receive your letter and your book/CD on "Art of Endosuturing - a step by step approach" co authored by Dr. Suviraj John and Dr. J.P. Deed. It is indeed an excellent work in the area of Endosurgery for the Medical Community.

My best wishes to you, Dr. Suviraj John and Dr. J.P. Deed.

May God bless you all.

Yours sincerely,

(A P J Abdul Kalam)

Dr. Parveen Bhatia  
Medical Director & Laparoscopic Surgeon  
Bhatia Global Hospital and Endosurgery Institute  
307-308, Ambika Vihar,  
Near Central School, Paschim Vihar,  
New Delhi - 110 087

**You have still a surer way than this of rising, and which is wholly in your own power. Make yourself necessary.**

Lord Chesterfield, Letter to his son, 9 February 1748

#### In this issue...

- 1 Editorial** Song of the youth: Dr. A.P.J. Abdul Kalam
- 2 Article** Scope of Hysteroscope in Sub-Fertility  
**Available Books and CDs**
- 3 Article** (Contd.)
- 4 Event Calander**, Upcoming conferences, Global Laparoscopic Learning Courses,  
**Our team of experts**

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u/s 17(2)(ii)(b) of I.T. Act  
1961, F. No: Addl. CIT  
(Coord.)/ Hospital/2002-  
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Mrs. Shalini Bhatia

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MAR - 05  
VOL: 05 NO: 03

## BOOKS

Laparoscopic Hernia Repair  
(a step by STEP approach)

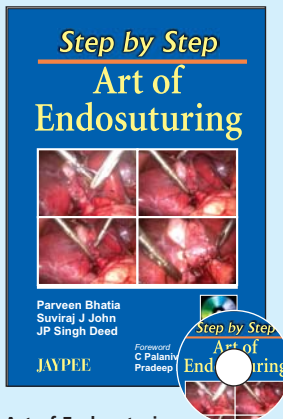
## Forewords by

Dr. J. Barry Mckernan  
Dr. Adarsh Chaudhary

## Contents

200 pages with 16 chapters,  
300 coloured photographs &  
diagrams

## Authors

Dr. Parveen Bhatia  
Dr. Suviraj J JohnArt 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 illustrationsSCOPE OF THE HYSTEROSCOPE 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.

**H**ysteroscopy is a valuable diagnostic and therapeutic modality in the management of infertility. For management of subfertility Hysteroscopy is best performed in the postmenstrual proliferative phase. Different media include CO<sub>2</sub> gas, Sorbitol, glycine, Mannitol/Sorbitol mixture, 5% dextrose in water, or 32% Dextran-70. Endoscopes can range from 2 mm in size to 6.5 mm in size.

Absolute contraindications to hysteroscopy include a pelvic infection or endometrial cancer, and relative contraindications are pregnancy, excessive bleeding, cardiovascular diseases or severe vaginitis.

Complications (1–3%) include cervical laceration, uterine perforation, bleeding, reactions to the distension media, or anesthesia. Potential long-term complications include intrauterine scarring or tubal obstruction, as well as injury to contiguous organs.

Hysteroscopy should be performed after careful history and physical examination. We prefer to perform a diagnostic laparoscopy at the same sitting as hysteroscopy. The initial step at hysteroscopy is to identify the uterine cavity and ostia and to evaluate the right and left cornua, fundus, anterior/posterior walls, and lateral walls for specific lesions, as well as to evaluate the overall contour of the uterine cavity. The endocervical canal is also carefully evaluated on withdrawing the instrument. Uterine sounding is performed at the end of the hysteroscopy to mini-

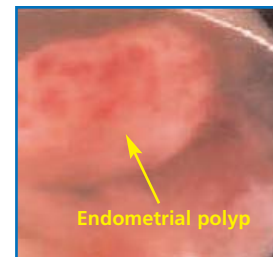


Normal uterine cavity on hysteroscopy

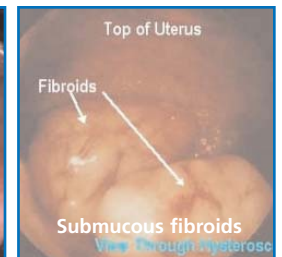
mize the creation of intrauterine artifactual lesions. Conditions that can be identified include adenomyosis, polyps, adhesions, fibroids, synechiae, congenital abnormalities and foreign intrauterine objects (e.g. IUD).

## ENDOMETRIAL BIOPSY AND POLYPECTOMY

Endometrial biopsy and polypectomy are usually performed at the time of hysteroscopy. Biopsy is easily carried out with use of a biopsy instrument or grasper, or curettage of the cavity. This will identify polyps as well as luteal phase dysfunction, endometritis, or rarely an infertile patient's malignancy.



Hysteroscopic view of polyp.



Viewed on hysteroscopy

## UTERINE MYOMAS

Sub mucous myomas can be identified at hysteroscopy. Myomas that have more than 50% of their volume inside the contour of the uterine cavity can be removed effectively with a resectoscope. Treatment of intrauterine myomas with GnRH agonists prior to hysteroscopy will reduce the myoma volume by approximately 50% in most cases. After treatment with GnRH agonists the uterine volume is reduced, the uterus will be hypoestrogenic and therefore more susceptible to perforation, even in the premenopausal woman. Resectoscopic myomectomy is a highly effective procedure, but fraught with potential hazards like uterine injury from the electrosurgical energy, perforation of the uterus, bleeding, infection, and most importantly, serious complication as a result of fluid overload. The upper range

If A is a success in life, the A equals x plus y plus z. Work is x; y is play; and z is keeping your mouth shut.  
Albert Einstein, in Observer (British newspaper), 15 January 1950

of uterine size when performing myomectomy should be approximately 8–12 cm of depth and only experienced surgeons should attempt a myomectomy larger than 5 cm. The advantages of hysteroscopic resection include the avoidance of laparotomy, uterine incision and creation of tubo-ovarian adhesions as well as the avoidance of a need for cesarean section in subsequent pregnancy. Overall, this is an excellent procedure if performed by skilled surgeons.

#### ASHERMAN'S SYNDROME

Intrauterine adhesions have been reported in 7% to 25% of infertile women. The pathophysiology involves damage to the stratum basalis and bridging of denuded uterine walls with variable cavity obliteration. Symptoms of intrauterine adhesions include hypomenorrhea or amenorrhea, cyclic pain, infertility and recurrent abortions possibly as a result of sperm migration disruption, tubal ostia obstruction, or impairment of blastocyst implantation.

Predisposing factors include an antecedent pregnancy; uterine trauma from curettage and endometritis (tubercular and others). Treatment involves removal or division of the adhesions with an endoscope, curettes, scissors, cautery, resectoscope, or nd-YAG laser. Prophylactic antibiotics, postop estrogen, or use of an IUD or Foley catheter is often used though their role remains controversial. We give antibiotics the night prior to surgery and for 3 days postop, along with estrogen for 4 weeks postop along with progesterone for the last week. Objectives of treatment are removal of adhesions and restoration of normal anatomy, with prevention of recurrence of adhesions, the restoration of menstruation and fertility. To achieve this, a gentle lysis of adhesions should be performed as is possible. In case of extensive adhesions, concomitant laparoscopic observation helps to reduce the risk of perforation.

#### CONGENITAL UTERINE ABNORMALITIES

Congenital uterine abnormalities occur in about 1 to 2 per 1,000 women. As high as 5–10% of infertile women who are evaluated hysteroscopically are found



Hysteroscopic resection of uterine septum

to have congenital uterine abnormalities. The association of uterine anomalies with infertility is unclear. A comprehensive infertility evaluation is necessary prior to label a congenital uterine anomaly as a cause of infertility. Intravenous pyelogram should be performed to rule out associated renal anomalies. The American Fertility Society Classification of congenital uterine anomalies has grouped the anomalies as hypoplastic/agenic, unicornuate, didelphis, bicornuate, or septate. Laparoscopy at the time of hysteroscopy can be useful to delineate the external uterine contour for uterine anomalies. Hysteroscopic treatment of the uterine septum has the objective of creating a uniform triangular cavity. Electrosurgery at 30 watts can be used for septum resection. No treatment is needed for uterus didelphis or unicornuate uterus. The Strassman procedure may be indicated for a bicornuate uterus associated with pregnancy loss. Postoperative hysterosalpingogram at two months can evaluate the results prior to patients attempting pregnancy.

#### PROXIMAL TUBAL OCCLUSION

Proximal tubal occlusion can be diagnosed by HSG and confirmed at laparoscopy. Current technology also allows for hysteroscopic tubal catheterization and fallopscopy to help evaluate the fallopian tubes.

Conditions associated with proximal tubal obstruction include muscle spasm or stromal edema, mucus plugs, intraluminal lesions such as adhesions or polyps, infectious lesions such as salpingitis or fibrosis, endometriosis and leiomyomas. Tubal catheterization will help confirm tubal occlusion, create tubal patency, and avoid major surgery for tubal repair and IVF if successful. It is a difficult and highly operator dependent procedure. Technical failures occur in at least 10% of the cases. The outcome of Hysteroscopic recanalisation / catheterization depends on the type of lesion. Thin non obstructive lesions have higher success rates and thick non obstructive lesions, dilated tubal stenosis and severe fibrotic processes have poor success rates.

The falloposcope is utilized through the hysteroscope and increases the ability to determine tubal status and diagnose pelvic disease. It is a system, using guidewires and coaxial catheters to cannulate the tube and requires hysteroscopy or fluoroscopy for placement.

The above highlights the vast uses of hysteroscopy in management of subfertility.

#### NEWS FLASH

Visit IAGES website renewed version at:  
[www.iages.org.in](http://www.iages.org.in)

#### Congratulations!



#### 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"

#### BUDGET TALK

at FICCI Auditorium  
on

March 1, 2005



[www.IndiaTaxLaw.com](http://www.IndiaTaxLaw.com)

**Success means only doing what you do well (and) letting someone else do the rest.**

Goldstein's Truism, in John Peers. comp., 1,001 Logical Laws, p. 15, 1979

**MAR - 05**  
VOL: 05 NO: 03

**OUR EXPERTS**

**Laparoscopic Surgeon**

Dr. Parveen Bhatia, M.S.

**G.I. Surgeon**

Dr. Adarsh Choudhary, M.S., FRCS

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**Infertility Expert**

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Dr. Neeraj Jain, M.D.

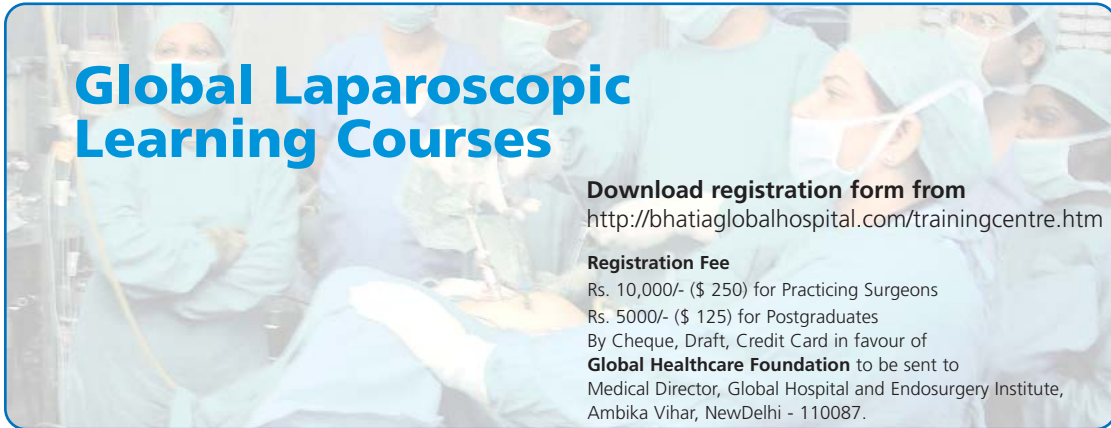
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- April 2,3, 2005 (Saturday, Sunday)
- July 2,3, 2005 (Saturday, Sunday)
- September 24, 25, 2005 (Saturday, Sunday)
- November 25, 26, 2005 (Friday, Saturday)

**EXPERIENCE THE EXPERTISE**

- |                     |                    |
|---------------------|--------------------|
| Dr. Parveen Bhatia  | Dr. S. P. Dembla   |
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**Venue** Ethicon Institute of Surgical Education, Kirti Nagar, New Delhi.



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A symbol of excellence, commitment and dedicated patient care, established in July, 2001. The vision is borne out of a single-minded focus on providing world class minimally invasive surgery to patients in many super-speciality areas. All under one roof. No matter whether it's medical equipment, care facilities, or international associations... the perspective is global.

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