Womb & Wellness

The POGS Chronicle ♦ Issue 10, January 2026

POGS App

On the auspicious occasion of Gudi Padwa, we are thrilled to announce the launch of the brand-new POGS App, set to debut at our 40th POGS Installation CME!
For the very first time, POGS is bringing you a state-of-the-art mobile application available on both Android and iOS. This app is designed to centralize all POGS-related information, making it easier than ever to stay connected and engaged.
Overview:
• Seamless New Member Registration: Join our community with just a few taps.
• Easy Conference Registration: Book your spots for upcoming events right at your fingertips.
• Monthly Quiz: Test your knowledge and win exciting prizes!
• Digital Library: Access monthly newsletters, a video library, and recordings of past conference lectures

Get ready to experience the convenience and innovation of the POGS App. Stay tuned and be prepared to take your POGS experience to the next level!

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Dr Nilesh Balkawade
General Secretary
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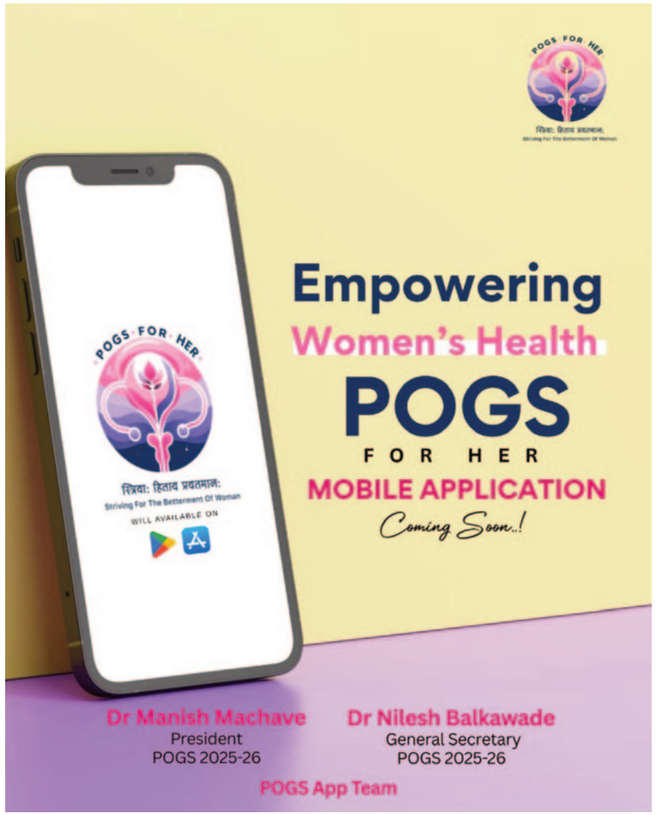

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Presidential Address

Dr Manish Machave
President, POGS

Happy new year and Greetings from the team,

This is our TENTH, theme based, dedicated and all-encompassing newsletter of POGS.
I begin with enriching words,
"The answers are all out there, we need to ask the right questions" - Oscar Wilde.

Every day in our clinics and hospitals, patients come to us not only with illnesses, but with questions—simple, sincere, and often filled with anxiety. "Doctor, is this serious?" "Will I need surgery?" "How long will it take to recover?" "Is this medicine safe?" These questions reflect more than curiosity; they reflect trust, fear, hope, and the need to be understood.
In today's age of instant information and online searches, patients are often overwhelmed by conflicting advice. While access to information has increased, clarity has not. This makes the doctor–patient conversation more important than ever. Addressing common patient questions with empathy and honesty helps bridge the gap between medical knowledge and patient understanding.
This newsletter aims to highlight the most frequently asked questions patients bring to their doctors and provide clear, evidence-based answers in simple language. By doing so, we hope to empower patients, reduce unnecessary anxiety, and encourage informed decision-making. For doctors, understanding these recurring concerns can improve communication, strengthen trust, and enhance the quality of care we provide.
Medicine is not just about diagnosing and treating disease—it is about listening, explaining, and reassuring. When patients feel heard and informed, healing begins even before treatment does.

Do take out time and post us your feedback.
Happy reading.
Looking forward to see you all soon.
TILL THEN "DO SVIDANIA"
NAMASKAR…..

Dr Manish Machave
President, POGS

Dr Nilesh Balkawade
Secretary, POGS

Secretary's Address

"New year — a new chapter, new verse, or just the same old story? Ultimately, we write it."

With this inspiring thought, I extend my warm wishes to all our members and readers for a very Happy and Purposeful New Year.

The year 2025 did end on a high note for POGS. I am delighted to share the successful achievement of the SIMS Black Travelling Fellowship, a matter of pride that reflects the academic commitment and global outlook of our society. It was in association with RCOG, Deenanath Mangeshkar Hospital. Prof Amar Bhide was the main faculty!

The 34th POGS Annual Conference – WOW: Womb of Wisdom was truly a landmark academic and cultural extravaganza. It was conducted at Hotel Sheraton Grand on 13 th and 14 th December 2025. The conference featured two outstanding masterclasses — the Code Blue Masterclass and the Fetal Medicine Masterclass, both of which were immensely appreciated for their hands-on learning and clinical relevance, respectively.

The prestigious Prof. Anjaneyulu Oration was delivered by Dr Jaydeep Tank,Past President FOGSI. The POGS Past President Oration, given by Dr Arati Nimkar, deeply resonated with the audience. The POGS Annual Conference Oration by Prof. S. Suresh left the audience truly spellbound with its depth and vision.

The conference inauguration was graced by Prof. Chittaranjan Yagnik, who delivered a thought-provoking address on healthy eating and the importance of fat index in Indians, reminding us of the crucial link between lifestyle, nutrition, and long-term health.

The POGS Awards Night was a superlative celebration, beautifully themed " Maa Tuze Salaam ", paying tribute to motherhood and values. A moment of great pride was the conferment of the POGS Lifetime Achievement Award to Dr Sanjay Gupte , honoring his immense contribution to obstetrics, gynecology, academics, and professional leadership.

As we step into the new year, exciting activities await us. We begin with a Heritage Walk and History Meet at Bharat Itihas Sanshodhak Mandal, Pune, on 4th January, reconnecting with our rich cultural roots. This is followed by the IIAL Masterclass on 11th January, in collaboration with AFMC, featuring a hands-on cadaveric session, a rare and valuable learning opportunity.

Several impactful public awareness initiatives are lined up, including the POGS–AMOGS Suraksha Kawach Campaign and the AMOGS "Mi Manasvi" Program, reaffirming our commitment to women's health, safety, and empowerment beyond conference halls.

Let us move ahead into this new year with renewed zeal, unity, and enthusiasm, continuing to learn, serve, and lead.

"नव्या उषेचा प्रकाश घेऊन,
नवे स्वप्न, नवी दिशा घडवूया;
ज्ञान, करुणा आणि सेवाभावाने,
समाजासाठी उज्वल भविष्य घडवूया."

Let's rock this year together — stronger, wiser, and more compassionate than ever.

Warm regards
Dr Nilesh Balkawade
General Secretary POGS

Warm regards,
Dr. Nilesh Balkawade
General Secretary, POGS

Editorial

Dr Kalyani Ingale
Editor

Seasons greetings!
Team POGS wish a very happy winter to all the respected readers. January is the month of new beginnings & global awareness.
Our country is known for the cultural diversity promoting peace & family unity worldwide. This month is filled with national festivals like Makar Sankranti, Lohari, Pongal & international celebrations like World Braille Day & International day of Education.
In our culture, we have festivals to promote the people get together & share the informations, updates on various topics which is beneficial for the betterment of the society through dissemination of such knowledge.
Since, January is recognized for its significance in promoting education, youth empowerment & public health which encourages people's participation & action on various social, cultural & environmental issues Team POGS has chosen the theme of this month chronicle to be "Public Awareness"

The Public awareness committee of POGS brings to you all an issue which discusses the topic wise FAQs (frequently asked questions) by our clients, friends or patients on day to day basis with their answers. This will definitely make many of us also aware about other subjects in OBGYn which we may not be dealing otherwise. The contributions by all the faculties who are proven to be the great counsellors are available in this issue.
We are proud to present you this newsletter to satisfy your hunger for knowledge & we are sure it will be an informative guide for your centers, clinics, hospitals.
Wish you all a very happy festive reading!!!!

Dr Kalyani Ingale
Editor

Co-Editorial

Dr Vaishali Biniwale
MD, DGO, FICOG

Dr. Shilpa Kshirsagar
Professor, Obgyn,
Dr. D. Y. Patil Medical College, Pimpri, Pune

Public awareness, in its simplest form, is the understanding and consciousness that a community holds about a particular issue. It helps us recognise our strengths, weaknesses, biases, and surroundings, leading to clearer choices, reduced stress, and more authentic interactions.

What is communication?
Communication is clear, empathetic dialogue (verbal & non-verbal) where doctors listens, explains and encourage questions. This helps patient feel heard and not just treated for the disease. These days, there seems to be a communication gap between health care professionals & patient or relatives . This is adversely affecting doctor- patient relationship based on the trust. To help our doctor community to have better communication with patients and to help them in counselling, Public awareness committee of Pune Obstetric & Gynaecological Society is presenting some important topics related to women's health in question & answer format.

The committee has roped in experts from various fields like psychiatry , anesthesiology apart from obstetrics & gynecology giving relevant information about various phases of women's life from youth to menopause and from infertility to issues related to birthing and postpartum . These Q&A s will help our members to counsel patients in various subjects.

We thank the office bearers President Dr Manish Machave , General Secretary Dr Nilesh Balkawade & Clinical Secretary Dr Kalyani Ingale for giving us an opportunity to compile this issue of "Womb & Wellness ". We sincerely hope that the Q&As given on the newsletter will help clinicians when they are counselling patients at various phases of their life.

Dr Vaishali Biniwale , Chair
Dr Shilpa Kshirsagar , Co Chair
Public awareness committee
Pune Obstetric & Gynaecological Society

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8th December 2025 — SIMS BLACK TRAVELLING PROFESSORSHIP

SIMS BLACK Travelling Professorship event was organised by Dr Jyoti Unni on behalf of RCOG & Dr Vaishali Korde Nayak on behalf of POGS at Deenanath Mangeshkar Hospital Pune on 8th Dec 2025. This symposium was conducted on the topic of 'Fetal growth restriction'.President POGS, Dr. Manish Machave welcomed the august gathering & the eminent speaker of the evening, Dr. Amar Bhide, Professor Fetal Medicine Unit, St. George's Hospital, London. Dr Bhide gave an excellent overview on recent updates on the topic of 'Fetal growth restriction.'

Dr. Aparna Kulkarni conducted a very informative & interactive panel discussion on FGR with case based scenarios. The event was attended by a gathering of 105 delegates which included POGS past presidents, senior consultants & resident doctors from various institutions from Pune.

POGS 34th Annual Conference

POGS 34th Annual Conference Womb of Wisdom WOW was organised on 13th and 14th December 2025 in Hotel Sheraton, Pune. It was a perfect amalgamation of excellent academics and picturesque cultural programme. The theme of the conference was Medical Disorders in Pregnancy. There were 200 registrations that materialised for the conference.

Day 1 Highlights

1. Free paper poster presentations
It received an overwhelming response with 23 entries. The judges for the competition were

a. Dr Uma Wankhede
b. Dr Kedar Marathe
c. Dr Shraddha Shastri
d. Col Sirisha Anne
e. Dr Deepak Kolte
f. Dr Surekha Gawade.

2. Key note addresses by Dr Manish Machave, Dr Uma Wankhede, Dr Charuchandra Joshi and Dr Nilesh Balakawade were very well appreciated.

3. Dr Anjaneylu oration by Dr Jaydeep Tank and Past Presidents oration by Dr Aarti Nimkar resonated very well with the audience.

4. Interesting debates on various controversies in OBGY garnered huge audience response.

Inauguration and Awards night

The conference inauguration was a spectacular event which was blessed by the presence of Dr Chittaranjan Yajnik as Chief Guest and Dr Savita Mehendale and Mr Om Bhutkar as Guests of honour. The inauguration ceremony was conducted by Dr Sandhya Meshram and Dr Charuta Joglekar.

The POGS awards night, with the theme of motherhood , struck an emotional chord with the audience . Various named awards in different categories like Infertility, Research ,Lactation , Adolescent health, Gynec onco were given to the well deserved recipients. The POGS Lifetime achievement award was conferred upon Dr Sanjay Gupte for his dedication in the field of OBGYN for last 40 years. It was conducted by Dr Anagha Pai Raiturkar and Dr Mahima Lalwani.

Day 2 highlights

1.Key note addresses by Dr Parag Biniwale, Dr Girija Wagh and Dr Kalpana Rawal were deeply admired.

2. Fetal medicine masterclass

Dr S Suresh delivered the prestigious Annual Conference oration on Fetal infections –Decoded which received a thunderous applause.

He also demystified the tale of twins in his talk on Twin pregnancy.

3. Code Blue masterclass

Dr Rajendra Patil and his team conducted an interactive session on basic and advanced life support in obstetrics for code blue in obstetrics. It was an extremely well organised and well conducted certificate course with didactic lectures and hands on training which was very well appreciated.

The conference was highly successful due to rich academic content and participation of expert faculties.

Effect of advanced age on infertility

Dr Kalyani Ingale
Editor 'Womb & Wellness'
Clinical Secretary POGS 2025-26
Director, Nirmiti clinic, a centre for assisted reproduction, Chinchwad, Pune
Director Roslina clinic, Boutique clinic, Aesthetic Gynaecology & Menopause clinic, Wakad, Pune

1. At what age is it called "Advanced Age of the woman" for fertility? - Above 35 yrs of age at the time of conception is termed as advanced age of the woman for conception.

2. How do we define infertility & what is the effect of advanced age of the woman on fertility? - Infertility is generally defined as the inability to conceive after one year of unprotected intercourse if the woman's age is younger than 35 years or six months if the woman is above 35 years of age. Factors contributing to infertility among older women can include: Decreased egg quality and quantity, Hormonal fluctuations, Increased risk of health conditions such as fibroids, endometriosis, adenomyosis, Chronic health issues like diabetes and hypertension, etc.

3. What are the risks associated with advanced age of the woman? – women over 35 yrs of age may face the increased risk of miscarriages, chromosomal abnormalities, foetal malformations, fertility treatment induced multifetal gestation, preterm labour, gestational diabetes, preeclampsia

4. What are the available fertility treatments for women with advanced age? – ovulation induction, intra-uterine insemination of sperms (IUI), In-vitro fertilization (IVF), pre-implantation genetic testing (PGT), Donor oocyte IVF treatment.

5. What is the impact of woman's age above 35 years on the success rates of ART treatments? – the success rates of ART treatment with own oocytes for women over 35 yrs of age decline as the age advances & it's statistically significant in case of woman's age over & above 40 yrs of age due to diminished ovarian reserve & declining genetic quality of oocytes. However, IVF treatment with oocytes procured from younger donor woman can reduce the risk of chromosomal abnormalities or miscarriages & one can have a healthy baby.

6. Is it safe to get pregnant for a woman after the age of 35 yrs? – Yes, it is possible & often safe to get pregnant after the age of 35 yrs. However, they may take a little longer to get pregnant & may require more medical attention during pregnancy. Additionally, the chances of certain health conditions like high blood pressure, gestational diabetes during pregnancy can increase with age. Fertility treatment related multiple gestation can further increase this risk.

7. Is PGT-A compulsory in ART treatments in advanced age women? PGT-A helps us to identify the chromosomally normal embryo for embryo transfer. However, as per literature PGT-A is not necessary in all advanced age women.

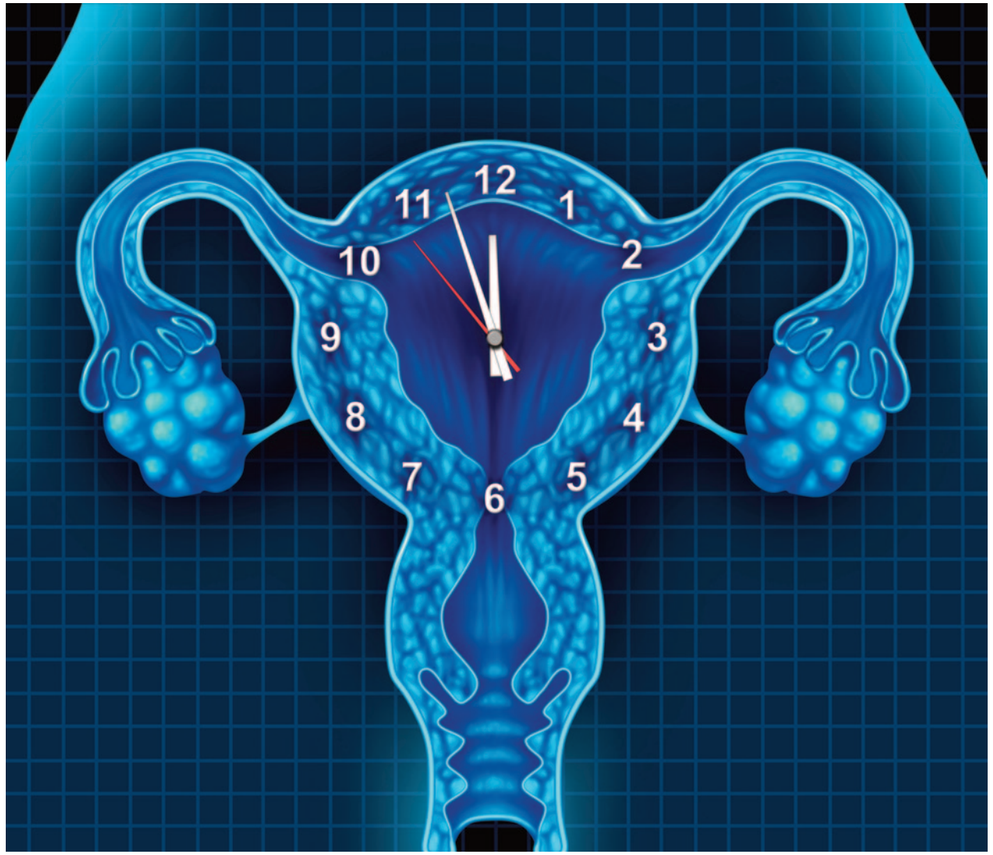
8. Is Surrogacy treatment suggested for advanced aged woman for infertility? No, surrogacy treatment is not suggested for infertility treatment of women with advanced age. It's indicated for the women having thin endometrium, repeated implantation failure or uterine abnormalities.

9. When is the donor oocyte treatment suggested for the advanced aged women? Donor oocyte treatment is indicated in case of severely diminished ovarian reserve (antral follicular count <3, AMH levels <0.5). As the age advances, the ovarian reserve starts declining & there is an increased risk of genetically abnormal embryo development. Thus, the risk of miscarriage is higher with the advanced age of the woman at the time of conception with her own oocytes.

10. Which preventive strategy can be applied in case of adverse outcomes associated with advanced age of the woman? In anticipated late marriages or pregnancy, one can preserve own fertility by oocyte or embryo vitrification at an younger age.

11. What is the cut off age after which the implantation failure increases & live birth rate decreases significantly? Live birth rate significantly decreases after the age of 40 years whereas implantation failure & pregnancy loss rates rose after the ages of 39 yrs & 43 yrs, respectively.

12. Which is the most important investigation to be done prior to the infertility treatment? The ovarian reserve testing in the form of antral follicular count by transvaginal sonography & AMH (anti Mullerial Hormone) assessment is must before any ART treatment for the



woman of advanced age.

13. Is there any treatment available to improve the egg quality & pregnancy rates? Medications like DHEA, growth hormone & Coenzyme Q can be given for 75 days prior to the fertility treatments.

14. Is there any possibility of improving or increasing ovarian reserve in the women with advanced age undergoing treatment for the conception? Intra-ovarian injection of PRP or autologous stem cells through transvaginal route under sonographic guidance or laparoscopic route can be promising to improve the ovarian reserve & fertility outcomes. But this treatment strategy is in the experimental phase at present.

15. Is the collections of eggs (after multiple ovarian stimulation cycles) for the development of embryos, a good strategy for the fertility outcome at the advance age of the woman? It can help the woman have more number of eggs available for fertilization but this strategy can not improve the quality of eggs & in turn the embryos. It is an expensive treatment strategy.

References : -

Adjuvant treatment strategies in ovarian stimulation for poor responders undergoing IVF : a systemic review & network meta – analysis, Yu Zhang et al. Human Reprod Update. 2020

Ovarian reserve markers to identify poor responders in the context of Poseidon Classification, Valentina Grisendi et al. Front Endocrinol (Lausanne) 2019

Dr Neelima Gandhe
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EPIDURAL ANALGESIA: MYTHS AND FACTS -

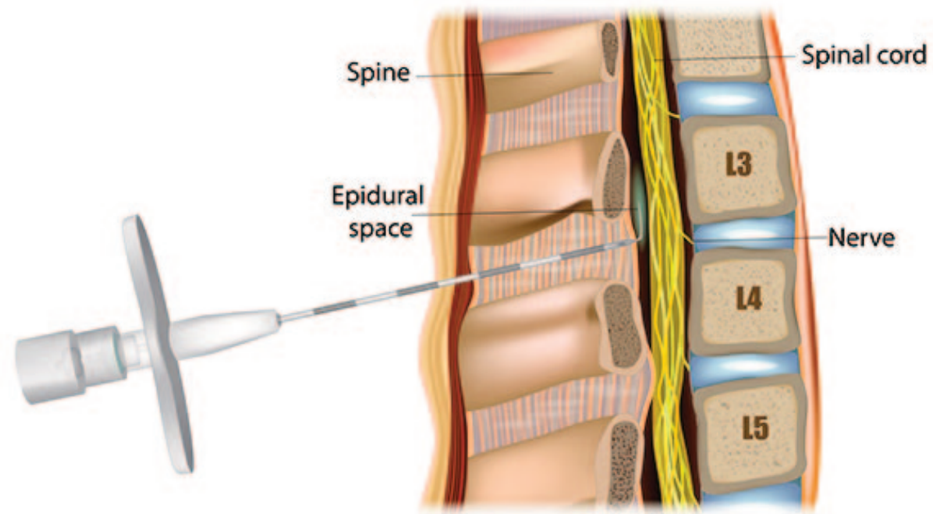
Till date not a single benefit of pain on the parturient mother and the fetus is documented. There is no other circumstance where it is considered acceptable for a woman to experience untreated severe pain amenable to safe intervention while under a physician's care.
Parturient women have a right to have an option of painless labour & according to A.C.O.G., maternal request should be sufficient justification for pain relief during labour.
Epidural analgesia is the most effective and least depressant method of intra-partum pain relief in current practice. It offers great versatility in extent and duration of effect as it can be tailored for the first and the second stage of labour.
But it is misunderstood modality of pain management. It is necessary to share science-based facts in the face of Epidural Myths.

Myth: HUMAN INTERVENTION IN THE NATURAL PROCESS OF BIRTH IS UNINDICATED.
Human intervention in the miracle of birth was against the will of the GOD. If GOD had wished labour to be painless, he would have created it so. So childbirth must be painful and any attempt to abolish pain is against the will of GOD. This is a pure superstition.
Many cultures consider childbirth to symbolize the sacrificial moment for newborn's good life. Medicalization of childbirth is denied.
For years together women have been tolerating this pain probably because there was no safe alternative to get rid of this pain. But now because of advances in the science of anaesthesia, it is quite possible to achieve labour analgesia without any adverse effect on mother, baby, or progress of labour. So the scenario is totally changed and we have pleasant, pain free birthing plan in majority of the hospitals.

Myth: LUMBER EPIDURAL GIVES 100 % PAIN RELIEF.
Promise of a totally painless labour is probably unrealistic and may even be unwanted.
Maternal attitude to pain in labour and its relation to satisfactory experience of child birth is obviously important. Epidural provides excellent analgesia preserving pressure sensation and motor power.
Majority of the times this pressure of the presenting part on the perineum is perceived as pain and leads to maternal discomfort. But proper counselling improves the acceptance.

Myth: ANY LABOURING WOMAN CAN HAVE EPIDURAL.
Epidural eligibility needs to be assessed based on medical and personal history.
Coagulation abnormality can be a complication of pregnancy and epidural cannot be given. Even in septicaemia, epidural is avoided.
Women taking anticoagulants or blood thinners must stop these medications within an appropriate time frame before labour to be eligible to receive an epidural. Women with other conditions such as spina bifida or previous back surgery may not be eligible to receive an epidural.
We highly recommend that women have anaesthesia consultation so as to create a care plan for their individual needs.

Myth: THERE IS A LIMITED WINDOW OF TIME WHEN EPIDURAL CAN BE GIVEN
Epidural can be given to the parturient any time during the labour.
There is no specific cervical dilatation range for epidural placement. The only requirement is the parturient needs to co-operate by remaining still during the procedure.
When labour is established and uterine contractions are spaced at five to seven minutes interval, in between the contractions, parturient can co-operate for placement of epidural.
When the labour progresses, the frequency and severity of labour pains increase and it becomes difficult for the parturient to remain still and co-operate.
Sometimes, while labours are induced, even the initial contractions are very painful and epidural can be given early.



There is no difference between early and late epidurals on progress of labour and mode of delivery.

Myth: EPIDURALS HAVE SEVERE CONSEQUENCES.
Epidurals are very safe for majority of parturients but complications do occur and range from short term and bothersome to long lasting and life threatening. Minimal blood pressure changes, itching and urinary retention are common adverse effects which can be easily tackled. Mother is advised to empty the bladder before top up epidural dose to avoid catheterization.
The severe complications are exceedingly rare. Nerve injuries and paralysis are extremely rare.
Sometimes while placing the epidural, there is injury to the outer covering of spinal cord that is Duramater and parturient will have headache on the third day of the delivery. This headache is temporary, lasts for one or two days and any pain killer will relieve it. The incidence of this complication is rare as epidurals to labouring women are always given by trained expert anaesthesiologists.

Myth: LUMBER EPIDURAL ANALGESIA CAUSES LONG TERM BACKACHE.
Incidence of self-reported low back pain during or after pregnancy and delivery is very high, and has been attributed to altered posture due to weight gain of pregnancy, increased laxity of ligaments of back due to pregnancy hormones and Hypocalcaemia. Chronic low backache is very common in women even if they have not received any injection in the back.
More recent long term follow-up studies found no link between epidural analgesia during labour and low back pain.

Myth: EPIDURALS HAVE HARMFUL EFFECTS ON THE BABY.
Almost every medication during pregnancy passes to your baby to some degree. This is the case for epidural medication as well. But, low dose and low concentration of local anaesthetics and opioids are safe for the baby. On the contrary, adequate pain relief improves foetal wellbeing.

Myth: LUMBER EPIDURAL PROLONGS TOTAL DURATION OF LABOUR.
In practice, epidural analgesia appears to enhance the progress of labour. This is because dysfunctional labour appears to normalize after labour analgesia and early aggressive use of oxytocin which is more common in these women reduces the likelihood of prolonged labour and operative delivery.
When labour progresses slowly, the psychology of prolonged labour dominates management strategies, as patient and families get exhausted. With use of epidural analgesia, there is less psychological pressure on obstetrician as patient is very comfortable and cooperative.

Myth: LABOURING WOMAN CANNOT PUSH WITH

AN EPIDURAL.
After an epidural, mother is in less pains which means she has less sensation to que to start pushing. The numbness caused by epidural also may make it difficult to get the hang of pushing. But now a days, with lower concentration of local anaesthetic narcotic mixture there is selective blockade of pain, keeping pressure sensation and motor power intact. Majority of the women can push effectively.

Myth: EPIDURALS INCREASE THE INCIDENCE OF INSTRUMENTAL DELIVERY.
Mode of delivery depends upon parturients ability to bear down, position of foetus and obstetrician's labour management plan.
Women who demand epidural may have severe pain due to difficult labour and dystocia and has been recognized as a risk for instrumental deliveries and Caesarean Section. Women who self-select epidural already represent a population with an increased risk of unfavourable course of labour.
Patients judged to be at high risk for operative vaginal or caesarean delivery may be encouraged to receive epidural analgesia so that epidural catheter is in place and tested for anticipated surgery.
Obstetricians are more likely to perform a forceps or vacuum assisted delivery in a patient with effective epidural analgesia.
Randomized trials are usually done in teaching institutions where trainees are taught how to perform instrumental vaginal deliveries.
Factors totally unrelated to analgesia may significantly affect parturients course including obstetrician's practice pattern and obstetric complications. Policy of delayed pushing compared to early pushing resulted in reduction in instrumental deliveries at the cost of prolonged second stage. All these factors interplay for the final outcome.
In short, epidural analgesia offers excellent pain relief but do increase the incidence of instrumental delivery due to reduced pushing strength and longer second stage of labour which necessitates intervention.
Modern low dose techniques significantly reduced instrumentation which is not harmful to new born.

Myth: EPIDURALS LEAD TO C-SECTIONS.
There is no credible evidence that epidurals increase likelihood of Cesarean Section. The decision of C-section is typically based on medical necessity such as Fetal distress or baby's position.
Some studies including our experience show reduced incidence of caesarean section in epidural group. The possible reasons may be:
Labour analgesia reduces maternal exhaustion thus reducing foetal distress and it allows prolonged trials.

Myth: A WOMAN CAN WALK THROUGHOUT LABOUR IF SHE HAS WALKING EPIDURAL
By using low concentrations of local anaesthetic narcotic mixture, there is selective blockade of pain keeping all other sensations intact. So woman can actually walk with good working epidural.
Adopting Upright posture may increase pelvic dimensions , reduce aorto-caval compression and improve uterine contractions. But ambulation does not improve labour outcome.
Uncomplicated and less painful labour permits ambulation rather than vice a versa.
Although parturients are capable of walking, they have no desire to do so once they receive adequate analgesia. In our experience after epidural, exhausted parturients prefer to sleep and conserve their energy for bearing down.
Many doctors do not encourage women with lumber epidural to walk as continuous foetal monitoring & intravenous line are always there.
Prior to allowing ambulation, the clinician must assess the clinical parameters. Women should not walk unattended.

Myth: YOU CANNOT GET AN EPIDURAL IF YOU HAVE LOWER BACK TATTOO.
Previously, tattoo on lower back was considered as a contraindication for epidural placement. But only a newer tattoo on lower back which has not healed is a relative contraindication.

Myth: YOU CANNOT BREAST FEED AFTER EPIDURAL.
Whether or not neuraxial analgesia may impact breast feeding initiation and duration is controversial and has been the subject of debate. Neither epidural analgesia alone or epidural analgesia with Fentanyl have any adverse effect on initiation or duration of breast feeding.

Ultimately the goal of epidural analgesia service is to have a safe and pain free labour. Potential benefits of epidural far overweigh the risks. So a scientific discussion about the MYTHS is necessary to highlight the FACTS .

Dr Mangala Wani.
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Obstetrician, Gynaecologist & Lactation Consultant.
Director- Hirkani Gynaecology & Breastfeeding medicine Clinic, Pune
Past President- Breastfeeding Promotion network of India, Maharashtra.(BPNI, Mah,2015-2023)

Breastfeeding: Frequently Asked Questions

1. What are the recommendations for breastfeeding?
Government of India, WHO and UNICEF recommend:
Initiation of breastfeeding within one hour of birth, Exclusive breastfeeding for the first six months of life and continued breastfeeding till 2 years of age or beyond along with appropriate complementary feeding after six months

2. Why is it recommended that baby should be given only mother's milk and not any other milk?
Mother's milk is a natural complete food for the baby. Mother's milk is for the baby while cow's milk is for the calf. Breastfeeding offers many advantages to mother-infant pair. These are listed below. Baby and mother will not get these benefits if cow, buffalo or formula milk is used for feeding.
Advantages offered by Breastmilk and Breastfeeding
For the baby:
1. All the nutrients are in proper proportion for optimal growth and development
2. Easily digestible
3. Germ free as it is transferred directly from the mother to the baby
4. Provides immune factors which provide protection against infections e.g. pneumonia, diarrhoea etc.
5. At right temperature
6. Makes child more intelligent
7. Protection against asthma and allergies
8. Protection against obesity, hypertension, heart disease and diabetes in later life
9. Decreased risk of some cancers
10. Stronger Mother - Infant bonding
For the mother:
1. Looses fat through breast-milk. Helps her to get back in shape (to be complemented with exercises and avoidance of excessive fat intake)
2. Decreased risk of breast, ovarian and uterine cancers
3. Helps to delay next pregnancy; but the mother should not depend on this as the sole method of contraception. (To consult doctor six weeks post-delivery)
4. Early expulsion of placenta
5. Uterus contracts faster to pre-pregnancy state
6. Decreased post-delivery bleeding
7. Convenient and requires no preparation
8. Protects from post-menopausal osteoporosis.
9. Free of cost. Breastfed babies fall less sick. Hence family saves on medical expenses.
10. Declining breastfeeding rates would increase the need for animal milk. This can damage the environment. Hence breastfeeding is environment friendly
Breastfeeding is advantageous not only for the mother and baby but also for the overall development of the society and the nation.

3. How should mother prepare for breastfeeding during pregnancy? Should she take some special care of breasts and nipples?
Baby needs to be exclusively breastfed till the end of 6 months. Both mother and family need to get psychologically geared up for this task. The family routine changes after child's birth. Extra effort and extra hands are required to meet the increased workload. All family members should provide encouragement, adequate time and supportive environment for breastfeeding.
Everybody should get to know scientifically correct information on advantages of breastfeeding, IYCN recommendations, positions, attachment and commonly encountered problems.
A pregnant mother can immensely benefit by observing another mother breastfeed and sharing experiences.
No nipple preparation is necessary during pregnancy. Breasts and nipples undergo natural changes as the pregnancy advances. The nipples which initially appear smaller become optimally fit for feeding by the time of delivery. The mother should not worry about the size of the breasts because milk production does not

depend on it. The breast size varies due to differences in amount of fat. Amount of milk producing glandular tissue is almost same in all the mothers.
Proper clothes that facilitate breastfeeding need to be kept ready. Sari-Blouse, shirt or gown (full front opening) is best suited for this purpose. Breastfeeding is not like a bottle feeding and use of the gowns or tops with zips on either side is not appropriate.

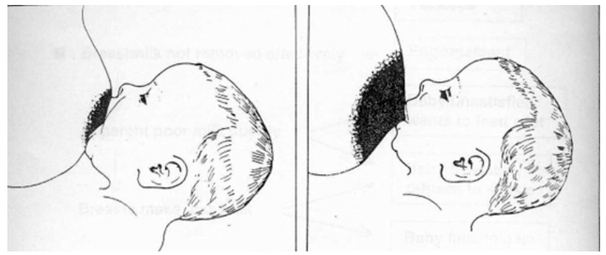
4. When should breastfeeding begin after delivery and how?
Soon after delivery the baby should be shown to the mother. Mother should be promoted to kiss and cuddle the baby and hold the baby in close skin to skin contact. This helps the baby to initiate breastfeeding within one hour after birth. After putting on mother's stomach the baby can move forward by kicking on mother's abdomen and can reach the breast.This is called breast crawl .Even after caesarean section,it is possible to initiate breastfeeding sooner in operation theatre only.
Following are the benefits of early initiation.
1. Baby is very alert and eager to breastfeed in the first hour after delivery.
2. The baby's temperature is maintained.
3. Risk of infections is reduced
4. Early initiation increases short term and long term breastfeeding success .
5. There is reduction in post-partum hemorrhage .
6. A strong emotional bond begins to develop between the mother and the baby.

5. Mother does not produce milk for first few days after delivery. What should be fed to quench baby's thirst and hunger during this period?
Even though the mother does not produce milk during the first two or three days post delivery, she produces a yellow fluid known as colostrum. Though less in quantity, it is sufficient enough to meet baby's needs. Following are the benefits of colostrum:
1. Rich in antibodies (immunity) and protects the baby against infections. Hence it is the first vaccine for the baby.
2. Helps the baby to pass the meconium. This helps to reduce the severity of physiological (normal) jaundice.
3. Helps to complete the maturation of the intestines.
One should avoid the temptation of giving any top milk or fluids (water, glucose, honey etc.) because this increases the risk of infection. This pre-lacteal feed may decrease the baby's eagerness to suckle at the breast. Thus the first and the subsequent breastfeeds may get delayed. This may lead to breastfeeding failure. Instead, the mother should focus on frequent skin to skin contact and breastfeeding (at least 8-10 times in 24 hours).

6) Where should the child be kept after delivery?
The child should be kept close to the mother (bedding in). It is not advisable to keep the baby in a cradle , on a separate bed or with someone else. The word 'rooming in' means that the mother and the baby are kept in the same room.The benefits of 'bedding in' are as follows:
1. It promotes demand feeding
2. The baby remains warm
3. Risk of infection is reduced
4. Helps let-down of milk
5. Helps to develop a stronger emotional bond between the mother and the baby.

7) How frequently and how long should the child be breastfed?
It is necessary to feed the baby more frequently during the first seven days (atleast 8-10 times in 24 hours). In this period baby should be promoted to breastfeed every 1.5 - 2 hrs by giving close skin-to-skin contact and recognizing the early feeding cues. Once baby starts gaining weight ,the baby can be fed on demand i.e. whenever the baby wants and as long as she wants. Very few babies demand feeds with a regularity of 2-3 hours.
Mother should feed on one side as long as possible because the milk which comes initially is rich in water & sugar (foremilk), while the milk which comes in the later part of the breastfeed is rich in fats (hind milk). It is necessary to feed the child frequently at night too.

8) How should the mother hold the child while breastfeeding?



correct attachment wrong attachment

Baby's Attachment
1. Max possible areola in baby's mouth (Lower portion more).
2. Mouth wide open.
3. Lower lip turned outward.
4. Chin touches the breast.

Baby's Position
1. Turned towards the mother.
2. Good skin to skin contact.
3. Head & body in one line.
4. Neck, back & buttocks well supported.

Mother's Position
1. Sitting comfortably with good back support
2. Holding breast in big 'C' grip of hand
3. Touches nipple to upper lip by bringing nipple in front of nose & gives mouthful of breast as soon as the baby opens the mouth widely
4. Interacting with baby while feeding
Different ways to hold the baby-
Cradle hold
Cross Cradle hold
Football hold
Lying down position
Laid back position

9. What is the cause of sore nipples? What is the remedy?
The main reason for cracked\sore nipples is improper attachment. The prevention and remedy is learning correct attachment . Mother should apply hind-milk to the cracked/sore nipple and leave it open to the air for some time. Frequent washing of nipple and areola with soap and water can cause drying and cracks by removing the natural oily substance which normally covers this area. Routine once a day cleaning of the breasts during bath is sufficient. Nipple may get cracked at the base if the child is taken away abruptly from the breast while feeding. Hence if the baby has to be removed from the breast, the mother should insert her little finger in baby's mouth and detach the baby slowly.

10. What should a mother do if breasts get hard and lumpy (engorgement)? What causes this?
The mother starts producing milk (i.e. mature milk) from three to five days after the delivery. Incomplete emptying of breast (Infrequent breastfeeding or poor attachment) will cause heaviness, hardening and pain (engorgement). Engorgement of the breast tissue which is normally present in the armpit will produce a lump there.
Engorgement can be prevented by frequent breastfeeding or by expression of milk. It is essential that every mother knows this technique of expression Unattended engorgement can lead to reduced milk supply and also increasing pain, redness over a part of the breast and fever (Mastitis). If neglected, this may progress to pus formation (Breast Abscess).

11. How long should the baby be breastfed?
Exclusive Breastfeeding is recommended for the first six months of life. Even water is not necessary during this period. Breastmilk contains enough water to take care of baby's needs even in summer.
Proper complementary foods should be started at the end of six months. However breastfeeding should continue along with complementary foods at least till second birthday.

12. How to know that the baby is getting enough breastmilk?
There are two gold standards to know if the baby is getting enough breastmilk; of this, one can be easily observed at home. If an exclusively breastfed baby is passing urine at least 6-7 times in a day and if the child gains at least 600 grams every month. These two tests cannot be used for about a week or two after birth when breastfeeding is getting established. During the first 3-5 days the baby passes urine infrequently and a full term newborn loses 7-8 % weight. Increasing urine output and weight after 3-5 days of birth indicate that

the mature milk has come in and baby is getting it in good quantities. Baby's stool patterns are also very important in initial days. Every day baby should pass stools more than 3-4 times and the colour of the stool should change from black to green by day 3 and yellow by day 5.Baby regains birth weight by 15th day of life. Baby doubles her birth weight in about 5 months and triples in one year.
Many mothers complaining about less breastmilk would in fact report that the baby has frequent urination and a good weight gain. Mother of such a baby may feel that her milk is inadequate due to following reasons:
1. If a child cries excessively it is always taken to mean that the mother is not getting enough milk. A baby may cry for many reasons other than hunger. A baby can express any discomfort only by crying out.
2. Milk comes in between 3-5 days after delivery. This can sometimes cause heaviness and mild engorgement of the breasts. However after a few days this heaviness passes off and breasts again become soft. Hence mother may feel that she is not getting enough milk.
3. The child often sucks at fingers (mouthing); but this is quite common and does not necessarily imply that the baby is hungry.
4. After breastfeeding is established in about a week, spontaneous dribbling of milk may occur for a few weeks from the other breast while the mother breastfeeds. This stops later on.
5. Babies grow faster during some periods (Growth Spurts). Babies feed frequently for longer periods during growth spurts.

13. Should breastfeeding be stopped during mother's illnesses?
It is not necessary for a mother to stop breastfeeding even if she is suffering from common infections and illnesses. Since the mother and the child live in the same environment and are in close contact, the child is usually infected by the time mother shows the symptoms. The child may have a shorter illness because it gets the antibodies (immunity) produced in the mother's body through breastmilk.

14. Is it correct to enforce dietary restrictions on mother with the fear that some food substances can affect baby's health?
Breastmilk is produced from blood. Composition of blood remains unchanged irrespective of what mother eats and so does composition of breastmilk. However it is necessary that the mother takes a balanced diet and also eats some extra food to support lactation. Routine tradition of giving ghee enriched sweet preparations to breastfeeding mother would stand to reason only if she is undernourished, or else this would only contribute to making mother more obese. The mother should avoid eating outside food due to the risk of getting the infection.

15. Is it all right to use a bottle for feeding the milk to baby ?
It is always unsafe to use the bottle. The risk of vomiting and loose motions (acute gastroenteritis) and other infectious diseases is much higher in bottle fed babies. Since it is easier to feed from a bottle, the baby may subsequently refuse to breastfeed (nipple confusion). While bottle feeding, child can accidentally aspirate milk. It is always safe to use cup, wati-spoon or a glass to feed the baby.

16. How should a working woman combine work with breastfeeding?
Mother should try to take maximum possible maternity leave after delivery.
She should express and store her milk every 3 hourly at workplace. There has to be a separate room and privacy for the mother to do this. If these facilities are not available then mothers should express milk 3 hourly and discard it to keep her milk supply intact and also to prevent engorgement.
This stored milk can then be transported back home to be used next day for the baby.
The mother should try to come home to breastfeed the child in between working hours or mother can carry the baby to workplace if crèche facilities are available. If a mother breastfeeds her baby more frequently at night, the child will demand less during the day.

17) Can a mother who is not pregnant or birthed the child, breastfeed the baby ?
Certainly yes. Women who were not pregnant and not delievered the baby but got the baby via surrogacy or via adoption, such women can also breastfeed their baby after inducing the lactation in them.There are different protocols for induction of lactation and it is done regularly at Hirkani Clinic, Pune. Health professionals need to be aware of this.

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FAQs on Prevention of Eclampsia – ZERO ECLAMPSIA

1. What is eclampsia ?
Eclampsia is a serious pregnancy condition that causes seizures (fits) in a pregnant or recently delivered person. It usually develops from preeclampsia, a condition marked by high blood pressure and organ stress during pregnancy.

2. Is prevention important? If yes..why?
Prevention is very important because:
• Eclampsia can be life-threatening
• It can harm both the mother and baby
• Many cases can be prevented with early care
• Simple steps like regular checkups can save lives
Preventing eclampsia mainly means preventing or controlling preeclampsia.

3. Can eclampsia be prevented?
Yes, many cases of eclampsia can be prevented. While eclampsia cannot always be predicted, regular medical care during pregnancy helps doctors:
• Detect high blood pressure early
• Monitor warning signs
• Start treatment before seizures occur
Most people who attend regular antenatal (prenatal) visits do not develop eclampsia.

4. What is the most important step in preventing eclampsia?
The most important step is:
Regular antenatal (prenatal) checkups
These visits allow healthcare providers to:
• Check blood pressure
• Test urine for protein
• Monitor weight gain and swelling
• Ask about symptoms like headaches or vision changes
• Assess baby's growth and health
Skipping checkups increases the risk of missing early warning signs.

5.Can anything be done before pregnancy?
Yes. Reducing weight before conception.
Controlling blood pressure if someone already has problem of high BP.
Other medical conditions which may be associated can be controlled.

6. When should antenatal care begin? Why ?
Antenatal care should begin:
• As soon as pregnancy is confirmed
• Ideally in the first trimester (before 12 weeks)
Early care helps identify:
• Pre-existing high blood pressure
• Medical conditions that increase risk
• Lifestyle factors that may need attention
The earlier care starts, the better the chance of prevention.

7. How often should antenatal visits be done?
General guidance:
• Once a month until 28 weeks
• Every 2 weeks from 28 to 36 weeks
• Weekly after 36 weeks
Your healthcare provider may recommend more frequent visits if you are at higher risk.

8. How does blood pressure monitoring help prevent eclampsia?
High blood pressure is the main warning sign of preeclampsia.
Regular monitoring helps:
• Detect rising blood pressure early
• Start treatment before complications develop
• Decide when closer monitoring or hospital care is needed
Even if you feel well, high blood pressure can still be dangerous—this is why regular checks are essential.

9. Should blood pressure be checked at home?
In some cases, yes.
Home blood pressure monitoring may help if:
• You have a history of high blood pressure
• Your doctor recommends it
• You are at higher risk of preeclampsia
If checking at home:
• Use a reliable device (preferably calibrate it

with doctor's device)
• Check BP in sitting position.
• Measure at the same time each day
• Sit calmly for a few minutes before measuring
• Report high readings to your healthcare provider
Do not self-medicate based on readings.

10. Why are urine tests important in prevention?
Urine tests check for protein in the urine, which is a sign that the kidneys may be under stress.
Protein in urine can indicate:
• Developing preeclampsia
• Increased risk of eclampsia
Regular urine testing helps doctors detect problems early, even before symptoms appear.

11. Can lifestyle changes help prevent eclampsia?
Healthy lifestyle habits support overall pregnancy health and may reduce risks.
Helpful habits include:
• Attending all prenatal appointments
• Eating balanced meals
• Getting enough rest
• Avoiding stress as much as possible
Lifestyle changes do not replace medical care, but they support prevention efforts.

12. Does diet play a role in prevention?
A healthy diet supports blood pressure control and overall well-being.
General dietary advice:
• Eat fruits and vegetables daily
• Include whole grains and protein
• Avoid very salty or processed foods
• Do not skip meals
• Follow medical advice on supplements
Do not follow extreme diets or restrict food without medical guidance.

13. Can reducing salt prevent eclampsia?
Moderate salt intake is healthy, but completely avoiding salt does not prevent eclampsia.
Current medical advice:
• Avoid excessive salty foods
• Eat a balanced diet
• Follow your healthcare provider's recommendations
Sudden or extreme salt restriction is not advised during pregnancy unless directed by a doctor.

14. Is drinking enough water important?
Yes. Staying hydrated:
• Supports kidney function
• Helps circulation
• Supports overall pregnancy health
Drink water regularly unless advised otherwise by your healthcare provider.

15. Does rest help in prevention?
Adequate rest is important during pregnancy.
Rest helps:
• Reduce physical stress
• Support healthy blood pressure levels
• Improve overall well-being
• Improves blood supply to the fetus
However, bed rest alone does not prevent eclampsia and should only be done if advised by a healthcare provider.

16. Can stress increase the risk of eclampsia?
Long-term stress can affect overall health and blood pressure, but definite association can not be stated
Helpful stress-reducing steps:
• Adequate rest
• Emotional support from family or friends
• Gentle activities approved by your doctor
• Talking to a healthcare provider about concerns
Stress management supports health but does not replace medical monitoring.

17. Can medications help prevent eclampsia?
In some high-risk pregnancies, doctors may prescribe:
• Medicines to control blood pressure
• Preventive treatments to reduce complications (e.g. blood thinners)
These medicines must:
• Be prescribed by a healthcare provider
• Be taken exactly as directed
• Never be started or stopped without medical advice
Self-medication is dangerous during pregnancy.

18. Should supplements be taken to prevent eclampsia?
Only take supplements recommended by your healthcare provider.
Low dose aspirin (blood thinner) msy be prescribed by the doctor
Common pregnancy supplements may include:
• Iron
• Folic acid
• Calcium (in some cases)
Do not take herbal or over-the-counter products without medical advice, as some may be harmful.

19. Who is at higher risk of eclampsia?
People at higher risk include those who:
• Are pregnant for the first time
• Are under 18 or over 35
• Have high blood pressure
• Have diabetes or kidney disease
• Are carrying twins or more
• Had preeclampsia or eclampsia before
High-risk individuals need closer monitoring.

20. Can previous pregnancy problems affect prevention?
Yes. A history of preeclampsia or eclampsia increases risk in future pregnancies.
Prevention steps include:
• Early prenatal care
• Informing your doctor about past pregnancy complications
• Regular monitoring throughout pregnancy
Early planning improves outcomes.

21. Can eclampsia be prevented after delivery?
Yes. Eclampsia can occur after childbirth, usually within a few days.
Prevention after delivery includes:
• Monitoring blood pressure
• Taking prescribed medications
• Attending postnatal follow-up visits
• Reporting warning signs immediately
Do not ignore symptoms after delivery.

22. What warning signs should never be ignored?
Seek immediate medical care if you experience:
• Severe headache
• Vision problems
• Swelling of face or hands
• Severe upper abdominal pain
• Nausea or vomiting

• Sudden weight gain
• Seizures
Early action can prevent serious complications.

23. Why is early reporting of symptoms important?
Many people delay seeking care because they think symptoms are "normal" in pregnancy.
Early reporting helps:
• Prevent seizures by administration og specific medications
• Prevent organ damage
• Protect the baby
• Reduce emergency situations
No symptom is too small to mention.

24. Can family members help in prevention?
Yes. Family support is very important.
Family members can:
• Encourage clinic visits
• Help recognize warning signs
• Support rest and nutrition
• Arrange transport for medical care
• Seek help quickly in emergencies
Awareness saves lives.

25. Can community awareness reduce eclampsia?
Yes. Education in communities helps:
• Increase early antenatal registration
• Reduce delays in seeking care
• Encourage hospital delivery
• Improve maternal health outcomes
Community awareness is a key prevention tool.

26. Is hospital delivery important for prevention?
Yes. Delivering in a healthcare facility allows:
• Blood pressure monitoring
• Immediate treatment if complications arise
• Safer care for mother and baby
Hospital delivery reduces risks linked to eclampsia.

27. What is the key message for preventing eclampsia?
Key prevention messages:
• Start antenatal care early
• Attend all prenatal visits
• Monitor blood pressure regularly
• Report warning signs immediately
• Follow medical advice
• Do not self-medicate
• Seek care even after delivery

28. Can preeclampsia be predicted ?
Yes.
There are various tests blood tests as well as USG (sonography parameters) which may help predict development of high BP and administration of certain drugs can prevent development of severe preeclampsia.

29. Can we dream to achieve zero or no eclampsia in registered patients?
YES….!
Prevention of preeclamsia (high BP)
Prevention of severe preeclampsia
Early diagnosis of severe eclampsia and its timely treatment with medication to prevent seizures .
Training of staff at peripheral healthcare level to administer Injections before shifting.
All these measures can reduce the occurrence of seizures to zero…
ZERO ECLAMSIA

Conclusion
Eclampsia is serious but often preventable.
With regular medical care, early detection, and timely treatment, most people can have a safe pregnancy and healthy baby.
Prevention begins with awareness—and awareness saves lives.

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Menopause

What is Menopause?
Women stop having periods when the ovaries stop producing hormones. When a woman does not have periods for a year, she has attained menopause.

At what age does this happen?
This usually happens between the ages of 45 and 55. Most women in India attain natural menopause at about 46-47 years of age.

What is peri-menopause?
Women may start having irregular periods a few years before the periods stop completely. Periods may come every 45 to 90 days or there may even be longer intervals. At this time, the estrogen levels are gradually reducing. This is also the time when women may develop symptoms due to low estrogen levels.

What is premature menopause?
If periods stop before the age of 40 years, it is said to be premature menopause. The importance lies in the fact that these women have to live without estrogen for ten or more years longer than their counterparts who attain menopause at the usual age.

Do all women experience menopausal symptoms?
Not all women have severe symptoms, though some women do. Many women have mild symptoms for a few years before and after the final menstrual period.

What are the symptoms of menopause?
Some of the common early symptoms are :
Hot flushes : This is one of the commonest symptoms. There is a sensation of intense warmth, which usually occurs in the face, neck and chest. It may be accompanied by redness and sweating and may be followed by a sensation of feeling cold.
Night sweats : Women may be woken up at night, bathed in sweat.
Sleep Disturbance or Insomnia : Sleep is often disturbed. Some women may have difficulty falling asleep, others wake up after a few hours and some others have very restless nights.
Joint pains : Joint pains and backache are common symptoms.
Fatigue : Low energy levels and feeling tired is reported by some women.
Memory loss : Women may feel that they are not able to remember things like before such as where the house keys are or that they are unable to concentrate on simple tasks which they could easily perform earlier.
Mood changes : Some women feel anxious, others feel low or depressed and some women feel uncertain and experience a lack of confidence.
Vaginal dryness : Due to lack of estrogen, the vagina feels dry and this may cause a feeling of soreness or irritation.
Loss of libido : Some women experience a loss of libido. Others avoid sex due to painful intercourse which may be related to the dryness of the vagina.
Urinary symptoms : There may be frequent urination, burning while passing urine, a feeling of urgency or occasionally leakage of urine before reaching the toilet.
Long term Consequences : There are some long term health issues which occur due to the lack of estrogen
Osteoporosis : Also called 'brittle bones', osteoporosis occurs due to the bones becoming more fragile after the menopause. Bones are built up during the first 30 years of life. From then on, bone strength reduces. Estrogen helps to maintain bone and so after the menopause, bones become 'brittle' and this is called Osteoporosis after there is loss of a certain proportion of bone. It can occur silently without any symptoms. However, if there is significant osteoporosis, fractures may occur with very small injuries.
It is thus important to maintain bone strength by a diet rich in Calcium, get enough sunlight for Vit D and perform resistance exercises to build muscle and maintain bone strength.
Heart Health : Cardiovascular disease is a common cause of problems in women, particularly

after the menopause. This is because estrogen has a protective action on the heart, causing the coronary arteries which are the blood vessels supplying the heart to remain open. It also helps to reduce the bad cholesterol and increase the good cholesterol, thus reducing the chances of heart attacks and strokes. Smoking, high blood pressure, high cholesterol, diabetes mellitus and obesity are modifiable risk factors for heart disease. Other factors such as family history are not modifiable.
Maintaining a healthy body weight by a nutritious diet and regular aerobic exercise helps to maintain heart health. Cessation of smoking, controlling blood pressure and blood sugar by diet, exercise and medication reduces the risk of both heart attacks and strokes.

Cognition : Mental abilities reduce with age. Memory loss coupled with difficulty in concentrating, makes women fear that they may be getting dementia or Alzheimer's disease. More often than not, it is not dementia, but reduction in cognition ie mental abilities. It is important to see a doctor if there is family history of dementia or symptoms seems to be rapidly progressive.
Socialising, learning new tasks, playing word games or Sudoku, developing a hobby or re- starting an old hobby which fell by the wayside due to a busy work or family life, help to maintain cognitive abilities.
Cancer : Though menopause does not increase cancer risk, increasing age is a risk factor for certain cancers. The incidence of cancers is on the rise. This is thought to be due to various factors, including increasing obesity, smoking, alcohol consumption and other environmental factors.
Fortunately, most cancers are being diagnosed earlier due to increased awareness and availability of investigations, which helps to ensure better treatment and reduces the risk of death due to cancer.
Breast cancer is becoming increasingly common, particularly in urban Indian women. Doing a regular breast self examination once a month, seeing a doctor for a clinical breast examination annually or earlier if there are problems will help to diagnose any issue early. A Mammography or an ultrasound of the breasts may be prescribed by the doctor for either screening or diagnosis.
Uterine Cancer may develop in the lining of the womb. This usually presents with abnormal vaginal bleeding. You should see your doctor who will perform some tests which will usually include an ultrasound and an endometrial biopsy.
Cervical Cancer is a cancer of the neck or mouth of the womb. Getting a Pap smear done or Human Papilloma Virus (HPV) testing as advised by your doctor will help to identify problems early. HPV vaccination is now widely available in India and should be given to teenagers and young women preferably before they become sexually active to get the maximum benefit.
Ovarian Cancer unfortunately is often diagnosed in late stages. Women with a family history of breast or ovarian cancer are at high risk. There is no good screening method, but any unusual symptoms such as bloating or flatulence should prompt a visit to a doctor.
Is there any treatment for menopausal symptoms?
First and foremost, women should start adopting lifestyle changes in their thirties, so that they enter menopause is a good state of health.
This will include a healthy diet, with plenty of vegetables, salads, fruits and low fat dairy products. Salt, sugar, refined flour, refined rice and other grains should be kept to a minimum.
Exercise should include both aerobic exercise and weight training exercise as the former is important for heart and lung health and the latter for bone and muscle strength.
Hobbies and friends should be nurtured, so that there is adequate socializing and activities that are enjoyable.
Calcium and Vit D supplements as well as other Vitamins may need to be supplemented as absorption of nutrients from the diet reduces with age.
Hormone therapy may be required in some women. It is very useful in women who are struggling with hot flushes, night sweats, sleep disturbance or mood changes. Estrogen can be given orally or as a spray or gel to be applied on the skin. In women who have a uterus, another hormone called Progesterone is also required to reduce the adverse effects of estrogen.
When symptoms are due to vaginal dryness or urinary problems, a vaginal estrogen is a good treatment option.
Do see your doctor and share all your concerns as they can tailor the treatment for your individual needs based on your complaints, medical history, family history and investigation reports.
Most importantly, stay positive as Menopause is not a disease, it is a normal physiological process.

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Peripartum mental health: FAQs

1) What is peripartum mental health?
Peripartum mental health is the focus in perinatal psychiatry which is a subspecialty of psychiatry that focuses on the mental health of women during pregnancy, childbirth, and the postpartum period, ie. from conception up to one year after delivery. Preconceptual mental health care is also addressed in Perinatal psychiatry.

2) Why is peripartum mental health important?
Untreated perinatal mental illness can lead to-
Poor antenatal care and nutrition
Preterm birth and low birth weight
Impaired mother–infant bonding
Impaired bonding can lead to neglect, attachment issues, developmental delays in the child
Increased risk of suicide and infanticide
Long-term emotional and cognitive problems in the child
Maternal suicide is a leading cause of indirect maternal mortality
In many cases, untreated illness is more harmful than medication exposure.

3)What are the psychiatric disorders seen in the perinatal/peripartum period?
Peripartum depression
Peripartum anxiety
Obsessive compulsive disorder
Phobic anxiety disorder
Panic disorder
Posttraumatic stress disorders especially after traumatic pregnancy
Bipolar mood disorders
Peripartum psychosis
Substance use disorders
Some women experience mental health conditions for the first time during the perinatal period, while others endure relapse, continuation, or worsening of a pre-existing condition

4) What is the prevalence of peripartum mental illness?
Globally perinatal depression is 10 to 25%. In low income countries higher 25 to 30%.1 in 5 women experience some form of perinatal mental illness.Only 50% are diagnosed 10–25% for perinatal depression and 25–45% for perinatal anxiety.Suicide is a serious consequence of perinatal depression and perinatal psychosis. 50 to 85% will have baby blues.2 to 3% will have Bipolar disorder (cycling depression with mania). Postpartum psychosis can be 1 to 2 in 1000.

5) What is the difference between baby blues and postpartum depression?
Onset of baby blues is with a week or two of delivery ,mild in symptoms and remit in a few weeks with reassurance and supportive measures. Postpartum depression onset could be within 4 to 6 weeks and symptoms are significant enough to merit medication with psychotherapy. Risk of self harm or harm to the child could also require a brief inpatient stay for treatment.

6) What is postpartum psychosis?
A psychiatric emergency characterized by an acute onset ie. within 1 to 2 weeks postpartum,characterised by delusions, hallucinations, mood swings, lability,disorganised behaviour, confusion and there is high risk of suicide and infanticide. Often associated with later presentation of a bipolar disorder ie. the patient may have non pregnancy episodes of bipolar disorder.

7) How can detection of peripartum mental health issues be done in the out patient visits?
Common screening tools for depression and anxiety in pregnancy can be Edinburgh Postnatal Depression Scale (EPDS), PHQ-9, GAD-7 (for anxiety).
Screening is recommended atleast once during pregnancy and once postpartum maybe at 6 weeks postpartum and during infant immunization visits.
WHO recommends use of PHQ9 with EPDS for the same, with EPDS cut off of 10 necessitating further evaluation and treatment.

8) What are major considerations in treatment of peripartum psychiatric disorders?
The four major considerations of risks and benefits to the mother and fetus/infant that need to be considered are risks of untreated maternal psychiatric illness
benefits of avoiding medication exposure
benefits of adequate control of maternal illness
risks of medications

9) Are antidepressants safe during pregnancy?
Many antidepressants are relatively safe when clinically indicated. Preferred ones usually are Sertraline ,Escitalopram ,Fluoxetine.
Avoid polypharmacy. Risk–benefit analysis is of course essential.
Documentation of counselling process for initiating treatment is essential. Document who was with patient with all details. Doctor handling interview. Document information given, decision made and individual making it. Detailed care plan discussed with the multidisciplinary team of healthcare professionals should be noted.

10) Is ECT safe in pregnancy?
ECT is safe and effective in pregnancy and postpartum, especially for severe depression with suicidality, catatonia and severe cases of postpartum psychosis not responding to oral or parenteral psychotropic medication.
Modified ECT ie ECT under short general anaesthesia is given with all risks and benefits explained and informed consent taken. Multidisciplinary monitoring is essential.

11) How is Bipolar disorder in pregnancy managed?
High relapse risk if ongoing medications are stopped hence avoid abrupt discontinuation of medication if already on treatment.
If on Lithium it may be continued with monitoring.
Valproate is not advised in the child bearing group but if patient is already on it, a care plan before conception to taper the same and introduce alternative medication needs to be done.
New onset of Bipolar disorder needs to be treated during pregnancy and postpartum period.
Regular obstetric and psychiatric antenatal care with fetal medicine inputs are desirable.
All mothers on psychotropic medications are advised to undergo anomaly scans in early trimester (10–12 weeks) as well as at 16–18 weeks when fetal echocardiography can also be done especially for mothers who are on medications that may be associated with a risk of congenital cardiac defects (e.g., lithium)
Individualized planning is essential.

12) Other circumstances needing psychological care in peripartum period?
Pregnancy loss grief. Distress because gender of child.
Medical illness in the infant and separation of mother and infant due to NICU admission may also lead to psychological distress including anxiety, anticipatory grief which requires psychological care.

13) When should a pregnant woman be referred to psychiatry?
EPDS ≥10
Suicidal ideation
Severe anxiety or OCD symptoms
History of depression, bipolar disorder , substance use disorder or psychosis
On psychiatric treatment
Poor functioning or bonding difficulties

14) How can perinatal/peripartum mental illness be mitigated/ prevented?
Antenatal screening
Psychoeducation
Strengthening social support
Early treatment of symptoms
Continuity of care postpartum

15) What is the scope of peripartum mental health care in an integrated perinatal care team involving multidisciplinary teams?
The psychiatrist can do
Risk assessment
Treatment planning for the peripartum psychiatric disorder mitigating risk to mother and child
Psychoeducation
Medication management
Early psychiatric intervention improves outcomes.
Paternal mental health is often ignored and also needs to be addressed.

Preconceptional care- FAQs

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Q: Do I need to meet a doctor before I plan to get pregnant, or is it okay if I meet them after a positive pregnancy test?
A: It is essential that you meet a doctor in the preconception period. The goal of pre pregnancy care is to reduce the risk of adverse health effects for you, the fetus, and neonate by optimizing your health, addressing modifiable risk factors, and providing education about healthy pregnancy.

Q: What can I expect in my preconceptional visit?
A: The doctor would ask for a detailed history, including your menstrual history, previous obstetric history, any medical or surgical history, significant family history, sexual history. They would then perform a thorough physical examination including your vitals, your weight and a vaginal examination. They may prescribe certain tests and start you on prenatal vitamins. They may also advise you regarding any pre-existing health conditions or lifestyle changes if necessary. A pap smear/ HPV screening may also be taken if not done previously, and certain vaccines may be advised.

Q: What are the basic tests that a doctor would prescribe to me before getting pregnant?
A: It would be prudent to get a routine health checkup, wherein your hemogram, thyroid hormones, blood sugars (HbA1C), screening for conditions like thalassemia through a hemoglobin electrophoresis, Rubella antibodies, HIV would be done. In addition to these, other tests may be advised if indicated by findings in your history and examination.

Q: What are prenatal vitamins and why do I need to take them?
A: The most essential component among prenatal vitamins is Folic acid, that is Vitamin B9. 400 mcg of folic acid per day is essential for women in the preconceptional period to prevent neural tube defects in the fetus. In women with previous history of NTDs, or women with seizure disorder, a higher dose of 4 mg/ day is needed. In addition to this, it may be prudent to test, and if needed, correct any deficiency of iron, vitamin B12, vitamin D before pregnancy. Prenatal vitamin use is associated with a lower risk of miscarriage.

Q: What are the vaccines I would need to take before pregnancy?
A: The CDC's Advisory Committee on immunization practice states that all patients should receive an annual influenza vaccination. Adult women who have never received a dose of Tdap or whose Tdap vaccination status is unknown should receive a single dose, as recommended for nonpregnant adults, in addition to 27–36 weeks regardless of prepregnancy immunization history. Human papillomavirus vaccination (HPV) and cervical cancer screening should be performed in accordance with current guidelines. The HPV vaccination currently is not recommended during pregnancy. If the HPV vaccine series is started and you then become pregnant, completion of the vaccine series is delayed until that pregnancy is completed. Vaccinations for rubella and varicella, whenever indicated, are given at least a month before planning pregnancy.

Q: If I am on any medications before pregnancy, do I need to stop them?
A: Speak to your doctor about the medical condition for which you are on the medication. Not all medications may be safe to take during pregnancy, but it may be unwise, or even potentially dangerous to stop them if they may worsen your pre-existing disease, or lead to exacerbations in conditions such as hypertension, seizure disorders, psychiatric illnesses, rheumatoid arthritis and so on. Multi-disciplinary care is the key in such instances. Your obstetrician may request a review with your primary physician to change the medication in such cases instead of stopping it entirely.

Q: If I am overweight, would that be a concern?
A: Being overweight may be associated with maternal or fetal complications, including but

not limited to infertility, miscarriage, birth defects, preterm delivery, gestational diabetes, gestational hypertension, fetal growth restriction,cesarean delivery, and thromboembolic events. Ideally, weight should be optimised before planning a pregnancy, but the health benefits of postponing pregnancy need to be balanced against reduced fecundity associated with aging.

Q: Can I continue my workouts if I am planning a pregnancy?
A: Regular physical exercise improves cardiovascular health, reduces obesity and associated medical comorbidities, and improves longevity. ACOG guidelines say that women should exercise moderately at least 30 minutes a day, 5 days a week, for a minimum of 150 minutes of moderate exercise per week. These levels of exercise are recommended prepregnancy, during pregnancy, and in postpartum women.
Yes, you can continue your workouts even while planning a pregnancy.

Q: Can I occasionally have alcohol/ smoke?
A: The WHO Fact Sheet of 2024 states that there is NO SAFE LIMIT of alcohol consumption, and even low levels may pose health risks. Alcohol can affect a fetus at any stage of pregnancy, and the cognitive defects and behavioral problems that result from prenatal alcohol exposure are lifelong. Adverse effects associated with smoking during pregnancy include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function, preterm prelabour rupture of membranes, low birth weight, perinatal mortality, and ectopic pregnancy. Children born to women who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity.
No, we do not recommend smoking, alcohol or drug use before or during pregnancy.

Q: What precautions does my husband need to take before?
A: Adopting a healthy lifestyle is recommended for your husband, to improve his overall health as well as improvement in his semen parameters. He must focus on a healthy lifestyle including a well- balanced nutritious diet, regular exercise, limit alcohol, smoking or drugs, manage stress, maintain a healthy weight. You should also make it a point to discuss his medical conditions/ prescription medications that can potentially affect fertility with your doctor.

Reference:
ACOG Committee Opinion No.762, Jan 2019 (Reaffirmed 2024)

FAQs for youth reproductive health cover understanding physical changes, puberty, contraception, and sexually transmitted infections (STIs)

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Sexual and reproductive health (SRH) education is a lifelong journey. Every year, the onset of adolescence changes the bodies of millions of girls and boys. Access to quality sexual and reproductive health information and services plays a crucial role in safeguarding the well-being of each adolescent, preparing them for a safe, productive and satisfying life, and also in protecting them from diseases, unwanted pregnancies, and human rights abuses, including gender-based violence and discrimination. This is particularly important for those who are on the move or living in a situation of forced displacement.
Key questions include what sexual and reproductive health education is, the types of birth control available, how to access services, and common health issues like STIs, which can include chlamydia, gonorrhea, HPV, herpes, and HIV.

What is reproductive health ?
• Sexual and reproductive health (SRH) encompasses having a satisfying and safe sex life, the ability to reproduce, and the freedom to decide if, when, and how often to have children.
• It includes understanding your body, sexual health, and access to information and services to prevent unintended pregnancies and STIs.
What are the most common reproductive health issues for young people?
• **Sexually Transmitted Infections (STIs):** Due to factors like lack of knowledge and inconsistent condom use, young people are at a higher risk for infections such as chlamydia, gonorrhea, HPV, herpes, syphilis, and HIV/AIDS.
• **Early and unintended pregnancies:** These are a major health concern that can lead to complications and impact a young person's education and future.
• **Menstrual health:** Young people need age-appropriate information about menstrual hygiene and can face stigma related to menstruation.
Schools and colleges do have lectures on this subject by Gynecologists ,Familly physicians where age appropriate talks are given .We have been doing YOUTH Melas for creating awareness about reproductive health and self defence .
• **Mental health:** This is an important part of overall SRH and includes issues like substance abuse and the psychological impacts of early sexual activity.

How can I protect my reproductive health?
• **Contraception:** Its important to discuss about this with doctors, Reproductive health counsellors before taking the step of intimacy Various methods can prevent pregnancy, including condoms, birth control pills, vaginal rings, shots, and Intrauterine devices called IUDs.
• **Safer sex:** Using condoms can help prevent both unintended pregnancies and STIs. Even if a girl is using birth control pills it is advisable to also use a condom for dual protection but remember condoms can tear so never to be reused.
• **Testing and screening:** Regular checkups, STI testing, and getting the HPV vaccine for both genders are crucial for maintaining sexual health.
• Getting vaccinated for prevention of HPV infection by taking the required dosages .Both boys and girls can avail these vaccinations from their doctors. Usually parents look after this till 18 years but after that the young adults ,if not yet vaccinated can request for it.
• But remember avoiding casual sex, safe sex practises , screening for precancerous changes in the cervix always help. If any infection ,vagi-

nal discharge ,painful urination, ulcers or soreness in the genital area occurs seek immediate help from a doctor preferably a gynecologist or a dermatologist.

Where can I get reproductive health services?
• School-based health centers: Some schools offer on-site services like birth control, Testing for sexually transmitted diseases , and counseling.In India schools do not offer advice on most of the above aspects so consulting a doctor helps.
• Clinics: Local hospitals, health departments, and clinics like Planned Parenthood , Family Planning clinics provide sexual health care.
• Online resources: Many online tools and apps can help you find local sexual health services.
How can I talk to my parents about reproductive health?
• It can be helpful to start with a calm and open conversation. If you're uncomfortable discussing it, you can start with a written note or a letter. In fact parents are adviced to bring up the conversation themselves
• There are many sites which provide you with correct information like the CDC to help start the conversation. UNICEF and UNFPA have a joint brochure which aims to equip adolescents with knowledge, attitudes and values that will give them the means to express themselves - respecting their health, well-being and dignity - to develop respectful social and sexual relationships.

• [1] https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/adolescent-and-sexual-and-reproductive-health-and-rights ; https://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health-programs-humanitarian-settings-0 ; https://www.unfpa.org/news/refugees'-and-migrants'-reproductive-health-needs-overlooked

Frequently asked questions (FAQs) for young people to discuss about their mental health:

What is mental health?
• Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act, and also helps determine how we handle stress, relate to others, and make choices. Half of all mental disorders begin by age 14, and 75% by the mid-20s. Early detection and intervention during this period can prevent escalation.
• Mental health challenges not only affect individuals but also lead to macroeconomic losses, with estimates showing a 6.5 x return on investment in implementing the Mental Health Care Act (2017).
• Community-based and peer-led approaches have proven effective in reducing stigma, improving help-seeking behaviour, and lowering costs.

What are some common mental health challenges for young people?
• Many young people experience stress, anxiety, and mood swings. Other common challenges include depression, anxiety , eating disorders like anorexia or bulimia, and conditions like conduct disorder.
• It's important to remember that variations in experiences can make some issues, like depression and anxiety, hard to identify.

What are some signs that I or a friend might need to talk to someone?
• Feeling stressed out and not sleeping well
• Feeling rebellious toward parents or guardians and wanting to run away
• Losing interest in activities you once enjoyed
• Having low energy or difficulty sleeping or eating
• Withdrawing from friends and social activities
• Using substances like alcohol or tobacco to cope
• Engaging in risky or destructive behavior
• Having thoughts of self-harm or suicide

Why do some people fear talking about mental health?
• The fear of being judged or misunderstood is a major barrier. Many young people worry about being seen as "weak" for struggling with anxiety or depression, which can delay getting help.

How can I help a friend who is struggling?
• Listen without judgment and let them know you care. Encourage him/her to open up and tell you their problems.
• Suggest they talk to a trusted adult, such as a parent, teacher, or counselor.
• Encourage them to take breaks from things that cause them stress, like schoolwork, and do things they enjoy. Sometimes it is difficult if they are in a busy routine but still help them to find little time
• If you are worried about their immediate safety, help them access emergency resources. You can call or text the emergency services Suicide and Crisis Lifeline at any time. 103,112, 1091,MANAS hepline 14416. There are many other crisis helpline numbers

What are some ways to support one's mental health?
• Stay connected: Maintain regular contact with family and friends specially if you are staying in a hostel. If staying at home make sure you have your dinner with family .
• Take breaks: Schedule time to relax and do things you enjoy. City life is busy with tuitions and classes but have a little break and if you are not getting it speak to your parents about it.
• Prioritize sleep and nutrition: Aim for regular sleep patterns and eat balanced meals. It's fun eating out once in away but not as a regular routine .
• Incorporate physical activity into your routine. Indulging in a physical sport or outdoor games as you also get fresh air and company of friends.
• Limit social media: Be mindful of the time you spend online and how it makes you feel. Limit your screen-time on your phone
• Unplug : Take intentional breaks from technology to engage in real-world activities.

Where can I find professional help?
• School resources: Every school/college has a counselor, psychologist, or nurse. One can always approach them and talk . If you are unable to approach them speak to your class teacher/parent /elder sibling or a friend who can speak on your behalf if you are too scared .It is very important to discuss with a professional person .
• Health care providers : Talk to your parent or guardian and tell them how you feel .They can take you to a doctor or other health professional. They can provide guidance and referrals.
• Mental health organizations: National or local mental health organizations can provide support and information.
• Crisis support: If you're in a crisis, call or text the emergency services Suicide and Crisis Lifeline to be connected
• UNICEF supported YuWaah recognizes that supporting young people's mental well-being is central to their learning-to-earning journey and to enabling them to thrive as individuals.

Dr Mahima Lalwani
Obstetrician Gynecologist, Fertility consultant, Director at Lalwani mother and child care hospital Pune

The Digital Pulse of Women's Health: Boon or Bane?

The New Waiting Room
As Obstetricians Gynaecologists, fertility specialists and laparoscopic surgeons in Pune, we are witnessing a fundamental shift in how our patients approach their health. The traditional, exclusive trust and reliance on a doctor's advice has been shared (not replaced) by a "first search on Google, then look on Instagram, and finally, consult the doctor" approach.
Does this mean that social media has transformed from a tool for social connection into a massive, unregulated health repository?
With over 68% of internet users seeking health information online, particularly in areas regarding menstrual health, PCOS, endometriosis, and fertility, the impact is undeniable. For women, this is a double-edged sword—offering unprecedented access to information while simultaneously spreading misinformation that can lead to unnecessary fear, delayed care, or harmful self-treatment.
This month, Pune obstetrics and Gynaecology society addresses this digital FAQ landscape from three perspectives: the doctor, the patient, and the influencer.

Part 1: The Doctor's Perspective
Q1: Is social media making my job as a doctor easier or harder?
It is a mix of both. On one hand, it is a boon for reaching a massive audience quickly—ideal for awareness campaigns like cervical/ breast cancer screening, menopause education, delayed fertility or prenatal care tips. However, it is primarily a curse due to the sheer volume of misinformation we have to debunk in every consultation. Solving myths is a bigger task to troubleshoot than treating.

Q2: What are the biggest "myths" you encounter?
• Contraception Infertility Myth: The belief that long-term oral contraceptives cause permanent infertility.
• Natural "Cleanses": The promotion of vaginal detox pearls or "uterine cleanses" by influencers.
• PCOS "Cures": Influencers selling unregulated supplements to "fix" hormones.
• Fertility: It is a women only problem. Semen analysis is not required for fertility treatment.
• Avoidance of Mammograms: Misinformation that radiation from mammograms causes cancer.

Q3: How should patients use social media regarding health?
Use it to increase awareness, not to diagnose or treat. If a post promotes a specific brand of supplement, a "detox," or suggests skipping medical screening, it is likely misinformation. Always cross-check with a registered medical professional. Remember the doctor has acquired this massive accurate information over a span of multiple years and experience viz-s viz an influencer who tries to cover the subject in 30 seconds.

Part 2: The Patient's Perspective
Q4: I feel overwhelmed by contradictory health advice online. What should I do?
This is known as the "paradox of choice" in women's health. It is common to feel stressed trying to figure out which expert to trust. The best approach is to verify the credentials of the person giving advice—are they a licensed medical professional, or just an "influencer"?

Q5: Are social media support groups safe?
They can be a boon for emotional support and finding others with similar conditions like endometriosis or PCOD. However, they are a curse when they promote anecdotal "miracle cures" over scientific evidence. Treat them as a space for emotional solidarity, not medical guidance.

Q6: What is the impact of filters and curated images?
It is significant. Constant exposure to "perfected" bodies and faces leads to lower self-esteem, anxiety, and body dysmorphia, commonly termed "Snapchat dysmorphia". Remember your imperfections is what defines you.

Part 3: The Influencer's Perspective
Q7: Is the role of a health influencer a curse?
It has the potential to be a boon if done responsibly. Influencers can make complex medical jargon easy to understand, break stigmas around topics like vaginal health or menopause, and build communities for women in remote areas who have limited access to information.

Q8: What are the ethical responsibilities of an influencer?
The biggest pitfall is promoting products without scientific backing, often for financial gain. A responsible influencer must disclose sponsored content, avoid making definitive health claims, and always advise followers to consult a doctor for diagnosis.

POGS Verdict: How to Navigate the Digital Age
Social media is neither a pure boon nor a curse; it is a tool. As women, our health is our most valuable asset.
• Check Credentials: Look for MBBS, MD, or recognized specialty certifications.
• Trust Your Doctor: Use online information as a starting point, but trust your doctor for the final diagnosis.
• Digital Detox: Limit exposure to content that makes you anxious or dissatisfied with your body.
In conclusion, use social media to empower, not to replace, your health decisions.

Disclaimer from the POGS team: Always consult your gynaecologist.

POGS Upcoming Events

Jan 4 Heritage walk

Jan 11- Cadaveric Workshop IIAL - AFMC

Jan 25 Webinar with SOVSI

Feb 8 FOGSI Hysterectomy CME

Feb 15 Alembic CME with Colposcopy Masterclass

March 1-FOGSI Endometriosis CME

March 8- POGS Cultural programme.

March 15 -AI Masterclass

In Male Infertility

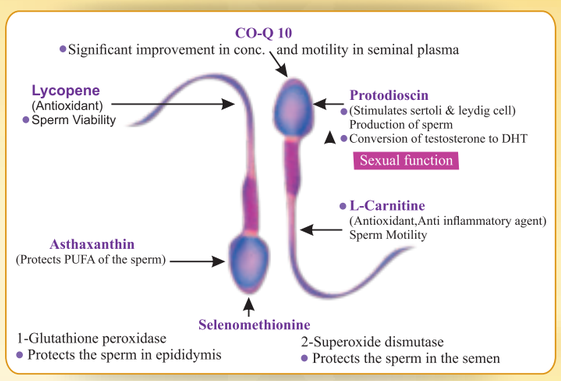
Zoafrag

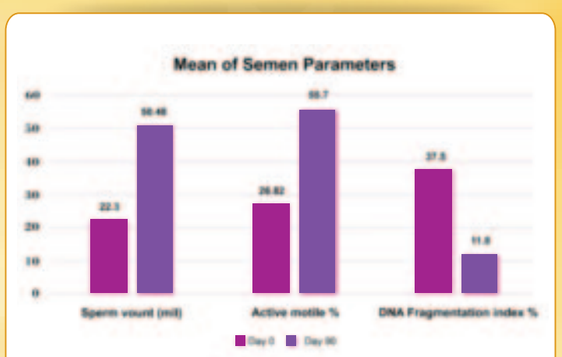
L-Carnitine 500mg + COQ10 100mg, Protodioscin 40mg + Astaxanthin 10mg + Lycopene 1250mcg + Selenomethionine 40mcg Tablets

Role of adjuvants (Zoafrag) in male infertility

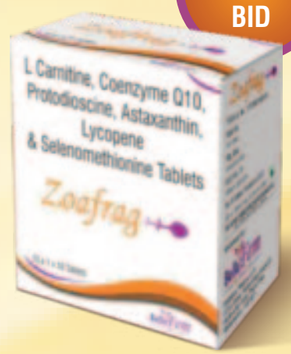
Original Research

Clinical Trial





Dose: 1 Tablet BID



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The Fem Era

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