

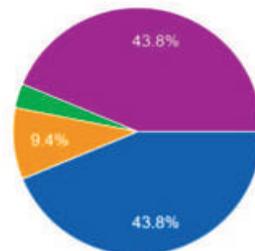
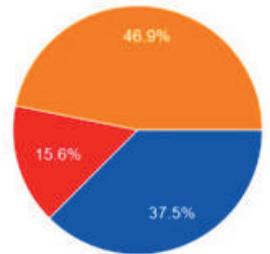
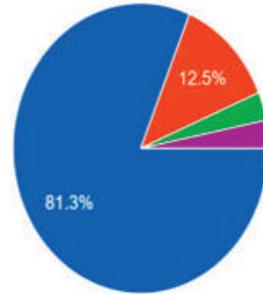


Womb & Wellness



स्त्रियाः हिताय प्रयतमानः
Striving For The Betterment Of Woman

The POGS Chronicle ♦ Issue 6, September 2025



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!

Dr Manish Machave

President POGS 2025-26

Dr Nilesh Balkawade

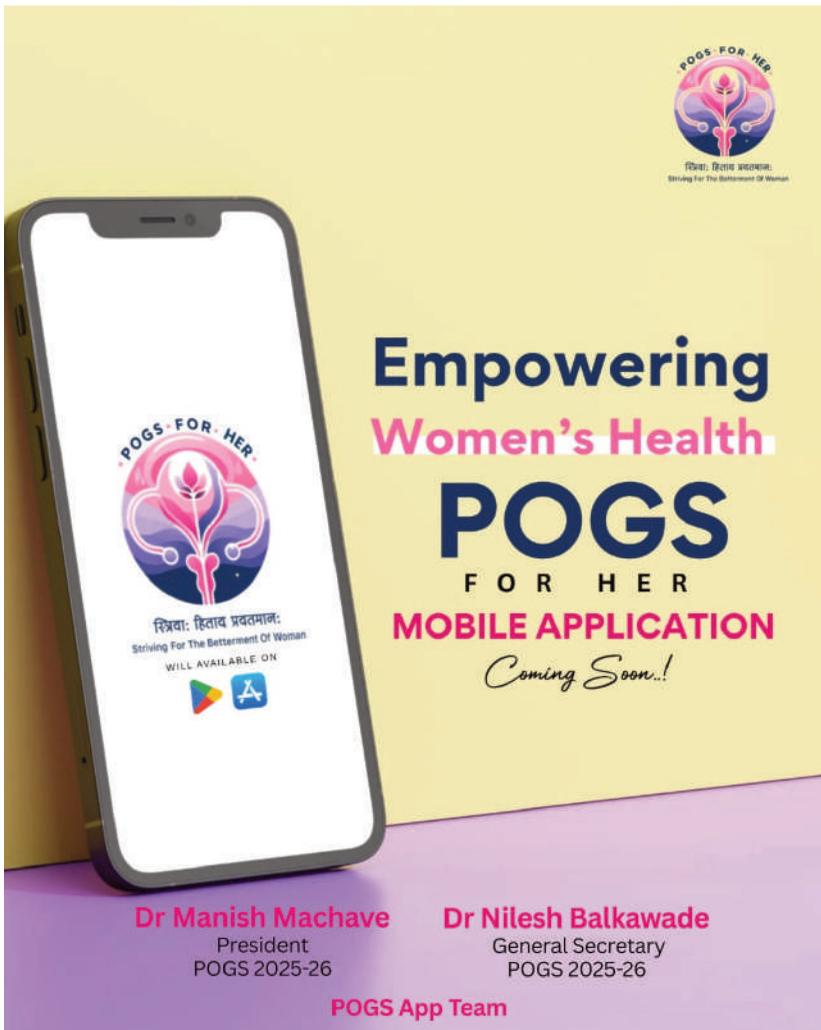
General Secretary

POGS 2025-26

POGS App Team

Dr Mahima Lalwani

Dr Mrinmayee Dharmadhikari



The graphic features a smartphone displaying the POGS app interface. The app screen shows the POGS logo, the motto 'नित्रया: हिताय प्रयतमानः' (Striving For The Betterment Of Woman), and the text 'WILL AVAILABLE ON' with Google Play and App Store icons. To the right of the phone, the text reads 'Empowering Women's Health POGS FOR HER MOBILE APPLICATION Coming Soon..!'. At the bottom, the names and titles of Dr Manish Machave (President POGS 2025-26) and Dr Nilesh Balkawade (General Secretary POGS 2025-26) are listed, along with the 'POGS App Team'.



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Presidential Address

Dear esteemed member of POGS,
Greetings from the team,

This our sixth , theme based, dedicated and all encompassing newsletter of POGS.

I begin with enriching words,

Knowledge will give you power, but character respect. Bruce Lee

I pray to the Almighty for the health, happiness and peace for all my POGS members

I pray that the spirit of festivities, the joy, cheer, mirth and merriment of this divine being, surrounds you forever.

We're pleased to bring you the latest edition of our medical newsletter, where we highlight key developments in healthcare, share insights from our experts, and keep you informed about the innovations shaping patient care today all through the medium of quiz.

This shall be a quick test of your clinical knowledge and decision-making skills. It shall also sharpen your expertise with this focused medical knowledge check.

Whether you're a clinician, novice, student, consultant or teacher, we hope you find the information in this edition valuable and thought-provoking.

Do take out time and post us a feedback.

Happy reading.

Looking forward to see you all soon.

Till Then, Wilujeng angkat, NAMASKAR.....

Dr Manish Machave
President, POGS



Dr Manish Machave
President, POGS



Dr Nilesh Balkawade
Secretary, POGS

Secretary's Address

*Each month we grow, each step we rise,
With knowledge deep and vision wise.
Together we serve, together we care,
For women's health, beyond compare*

Dear Esteemed Members,

August has been a month of remarkable academic and social accomplishments for POGS. With every event, we are moving closer to our shared goal of blending clinical excellence with meaningful connections.

🌸 **Highlights of August**

The month began with the Breastfeeding CME – Amrutpan at MIMER Medical College, beautifully organized by Dr. Vaishali Korde Nayak, spreading awareness on the importance of breastfeeding and newborn nutrition.

The ART Masterclass proved to be a milestone academic event—India's first Masterclass with the unique "one day, one hall, one theme" concept with none other than the Legend of Dr Jatin Shah. Dr Amey Purandare was the Invited Guest speaker. With a focused audience of over 200 delegates, excellent arrangements, and highly positive feedback, the event set new benchmarks in academic learning. POGS applauds the efforts of Infertility Committee POGS for immense efforts in arranging this CME.

Our POGS Outreach CME in Hadapsar was extremely well attended, coordinated seamlessly by Dr. Kalyani Ingale, Dr. Vaibhav Dangat, and Dr. Mrinmayee Dharmadhikari, ensuring academic updates reached the community at large.

The POGS Pink Conclave with AMOGS on 13th August stood out as a wonderful event, highlighting key aspects of women's health in partnership with Abbott.

The POGS-AMOGS Meeting on 22nd August furthered our academic collaboration and also reviewed preparatory arrangements for the much-awaited Fertility Carnival Conference, Goa.

Finally, Breastcon 2025 (23rd–24th August, Lonavala) was an immensely successful and well-

attended program. Dr. Charulata Bapaye and Dr. Mangala Wani deserve special appreciation for their dedicated efforts in making it a grand academic success.

🌟 **Looking Ahead**

I warmly invite you all to the Fertility Carnival Conference, Goa .

The stage is set, with a world-class scientific programme, enriching workshops, and the promise of unforgettable camaraderie and fun. Let us participate in full strength and make this celebration of science and togetherness truly memorable.

*Alone we can do so little, Together we can do so much.
With teamwork, passion, and vision bright,
POGS continues to shine its light .*

Warm regards,

Dr. Nilesh Balkawade
General Secretary, POGS

Editorial

Warm greetings from Team POGS !

This holy month of September has started with the blessings of our beloved Lord Ganesha, who is the God of Wisdom & will continue through with the blessings of Goddess - Navdurga (Navratri) who will shower us with all the powers & strengths.

With this flow of immense energy the POGS Quiz committee has stepped ahead to bring this newsletter of methods of polishing our knowledge & gather the wisdom.

The team has been engaged over the past few months to generate the data from all our members by utilising the quizzes & surveys. It's a very healthy, engaging & informative activity to be conducted. This helps any fraternity to reinforce knowledge, assess own learning progress & provide a valuable

feedback in a functional & engaging way. Quizzes help us improve communication skills, enhance critical thinking, boost confidence, help problem solving & promote a deeper connection to real world applications of learned material.

This method helps educators to identify knowledge gaps & inform future teaching strategies.

Hence, POGS has come up with this issue of the chronicle which is eminently compiled by our Quiz committee. We are sure this will provide a lot of information which is necessary for assessment & improvement of different aspects of our routine practices, work pattern & SOPs.

Happy reading & learning!

Dr Kalyani Ingale,
Clinical Secretary,
POGS 2025 – 26



Dr Kalyani Ingale
Editor

Co-Editorial

Warm greetings from the team POGS from this Festive month of September. September brings a beautiful transition—from bidding farewell to Lord Ganpati with gratitude, to preparing for the arrival of Mata Rani during Navratri with devotion. May this month bless us with wisdom, strength, and joy, as we celebrate both divine energies with faith and togetherness. This month focuses on QUIZ. Our vision for this year is to create a platform where learning and participation go hand in hand. Quizzes are not merely a test of memory, but a lively exercise in problem-solving, quick thinking, and applying clinical knowledge to practical scenarios. Through well-structured, interactive

sessions, we aim to cover a wide spectrum of topics—from basic principles to recent advances—ensuring that each participant gains both confidence and clarity. Our goal is to make quizzes more inclusive, encouraging young postgraduates and consultants alike to join in the spirit of healthy competition. By weaving together evidence-based medicine with clinical pearls and day-to-day practice, we hope to make every session both enriching and enjoyable. We invite all members to actively participate, share their insights, and make this year's quiz series a memorable journey of collective academic growth.



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Dr Vaishali Biniwale



Dr Sanjay Sharma

01/08/2025: Amrutpan CME with MIMER

The Department of Obstetrics and Gynaecology, MIMER Medical College, in association with POGS, organized the annual CME Amrutpan – 2025 on 1st August to promote breastfeeding and lactation. This year's focus was on sensitizing medical and nursing students, labour room and PNC nursing staff, ASHA workers, and Anganwadi staff. The event saw participation from around 200 delegates. Expert speakers, including obstetricians, pediatricians, and lactation consultants such as Dr. Mangala Wani, Dr.

Pramila Menon, Dr. Charulata Bapaye, Dr. Uma Wankhede, Dr. Shilpa Kshirsagar, Dr Renuka Parve, and Ms. Amrita Desai, addressed a wide range of topics from antenatal counselling to challenges in Breast Feeding. They also gave guidance regarding special situations like a mother having TB, HIV, cancer etc. This CME also highlighted interdisciplinary integration in Undergraduate teaching between dept of OBGY, Pediatrics, and Community Medicine to foster a unified approach toward breastfeeding advocacy.



03/08/2025: ART Masterclass

The Infertility Masterclass (3rd August) was a stellar event coordinated by Dr. Manjiri Valsangkar, with contributions from Dr. Sandhya Meshram, Dr. Nilesh Balkawade, and Dr. Samidha Dalvi, bringing clinical depth to daily fertility practice.

- India's first Masterclass with One Day, One Hall, One Theme----Concept
- Excellent Focused crowd of more than 200 delegates
- Talk of the town

- Similar programs being organized all over India now
- Received excellent feedbacks from the delegates
- Received touching feedbacks from AMOGS President Dr Kiran Kurtkoti and President Elect Dr Amey Purandare.

Dr Jatin Shah was extremely happy and conveyed his heartfelt letter of thanks and gave his comments that it was one of its kind program which he has ever attended!!



07/08/2025: Outreach CME at Hadapsar

On 7th of August 2025, POGS outreach programme CME, was conducted in hotel Kokitta at Hadapsar. This time's theme was "warkari" attire. More than 60 gynaecologist in and around Hadapsar attended this outreach program.

MOU of the CME, Dr Mrinmayi Dharmadhikari welcomed the president POGS Dr Manish Machave, general secretary; Dr Nilesh Balkawade and Clinical secretary; Dr Kalyani Ingle.

Outreach CME began with Ganesh Vandana by Dr Shweta Karlapudi, followed by lamp lightening and welcome speech by Dr Nilesh Balkawade.

In the academic session, first lecture was on shoulder

dystocia by Dr Vaibhav Dangat.

Dr Kundan Ingle and Dr Nilesh Balkawade conducted an interactive panel on: male infertility.

This panel discussion was followed by a micro skit on ethical practises in Ivf, which really pointed out the entry of unethical practises in Ivf. Everybody appreciated the performance of all actors in the skit.

Skit was followed by a panel discussion on PCOS. This was moderated by Dr Sandhya Meshram and Dr Anuradha Pai-Raiturkar.

Vote of thanks was given by Dr Vaibhav Dangat; convener of the outreach, CME.



13/08/2025: Pink Conclave

Pink Conclave, an academic event was successfully conducted on 13th Aug 2025. The topics covered in the CME were GERD in Pregnancy - an Gastroenterologist perspective, Augmentation of labour, Demystifying role of Camylofin in abdominal pain management. The lectures were deliberated by invited faculties, Dr Vinay

Thorat - renowned Gastroenterologist from Pune, Dr Parag Biniwale - Chairperson, ICOG, Dr Kalyani Ingale - Clinical secretary, POGS, Editor - Womb & Wellness newsletter of POGS. This Event was made interesting by interactions with the attending delegates & faculties.



23rd & 24th August: Breastcon Conference

BREASTCON360

A destination conference on Breastfeeding, breast health, Aesthetic Gynecology .. and much more

Organising Chairperson – Dr Charulata Bapaye
Org. Co-chair – Dr Mangala Wani

Dr Manish Machave, Dr Nilesh Balkawade, Dr Kalyani Ingale, Dr Samidha Dalvi gave their whole-hearted support to the event which made it a grand success.

POGS, Breast and Puerperal Health Committee, FOGSI and AMOGS joined hands to present BREASTCON360. **Dates – 23rd and 24th Aug 2025**

Venue – Hotel Rhythm, Lonavala

Highlights of the Conference-

Saturday – 23rd Aug – 2 workshops – Aesthetic Gynecology and Preventive Oncology were conducted with Dr Parul Saoji and Dr Charulata Bapaye as Conveners. A Journal Club with landmark paper discussions and packed halls were the highlights of these workshops.

This was followed by a plenary session with interesting discussions on Breast health, Breast-feeding, Invited talks and debates.

The Conference was blessed to have none other than Dr Madhuri Patel, FOGSI President Elect 2027 as Chief Guest along with Dr Parag Biniwale, Chairperson ICOG and Dr Kiran Kurtkoti, President AMOGS as the Guests of honour. The inauguration witnessed the felicitation of the Breast & Puerperal health Committee members, release of the POGS monthly Newsletter and prize distribution of the Poem slogan competition.

We had Gynecologists, Oncosurgeons, Paediatricians and Lactation consultants as Faculty and delegates.

There were 9 panel discussions, 7 Key note address, 2 invited talks, 1 special talk on sexual health by Dr Deepak Juman and 1 oration by Dr Madhuri Patel. We were fortunate to have Faculty from all across the country- right from Imphal upto Jaipur and Delhi upto Tumkur. Dr Sanjay Gupte, Dr Girija Wagh, Uma Wankhede, Vaishali Chavan, Geetha Balsarkar, Vidya Thobbi, Sarita Bhalerao, Prashant Gangal were some of the stalwarts who enriched the Scientific content of the Conference. Dr Kamlesh Bokil and Dr Shekhar Kulkarni, Dr Shilpi Verma- Breast surgeons-

clarified the doubts of all. The presence of Seniors like Dr Sanjeev Khurd and Dr Ramesh Bhosale added immense value to the conference.

The launch of MISSION PINK PALMS- conceptualised by AMOGS PAC Chairperson - Dr Revati Rane and Dr Charulata Bapaye witnessed the beginning of Breast aware-



ness PAN Maharashtra.

233 registrations – Faculty plus delegates, 17 stalls, 9 table spaces made the conference a lively affair. The Banquet with a live orchestra made the delegates groove till midnight. The early morning trek to Tungarli lake provided a refreshing view of beautiful Lonavala. The weather was picture perfect and the gynecologists returned home with happy memories.





Dr. Himadri Bal
Professor Emeritus,
Department of Obstetrics & Gynaecology, Dr D Y Patil Vidyapeeth, Pune

Scientific Writing: An Overview

In today's era of the medical profession, research and its publication has become an integral part. Till now we were only concerned with the clinical part, that is, healing of the patient. Academics generally take a back seat after passing out. But if we want to stay relevant in our professional environment, we cannot distance ourselves from academia. My target reader for this brief communication is the fresh entrant to the profession, the Postgraduate Resident.

Research has become an important parameter for evaluating the worth of a doctor in addition to his professional capabilities. If we believe in this we should take it seriously. We must understand the old adage "the taste of the pudding is in eating it". Similarly the value of a research lies not only in its validity but also how attractively we present it to draw more and more professionals to read it. This is where Scientific Writing stands tall in the field of research. At the onset we must remember that scientific writing should not be boring. This can be best achieved by presenting it as a story. Scientific article can be an original article, a case report, a short communication or even a letter to the editor. I will delve into an original article.

The structure of a scientific paper generally follows the IMRaD form, i.e, Introduction, Methods, Results, and Discussion. Before embarking on the journey of writing the main body of the manuscript, one must highlight the final destination. This is done by a suitable Title and an Abstract, both of which gives an idea of the research question. The Title should be interesting and eye catching like "Vicarious Menstruation: an Enigma". The title should be allied to the research question or hypothesis. The Abstract is nothing but a summary of the manuscript. The abstract of an original article should be structured into Background/Introduction, Methods, Results, Discussion and Conclusion highlighting the main features of the study. Abstract should be of 250 – 300 words.

Introduction

Introduction outlines the direction of your study by citing the background information supported by existing literature on the topic. The controversies or lacunae in the previous studies should be brought out along with the gaps in the knowledge of the subject and how are you going to address them in your study. This information will lead to the research question. Thus you can now pin point the hypothesis and thereby objective of your study.

Methods

The entire research, its reliability and validity depends on the methodology. It is written under 4 sub-headings.

1. Design: the type of study, which may be cross-sectional, case-control, cohort, before-after or a clinical trial and whether prospective or retrospective.
2. Subject: whom or what you will study.
3. Measurement: what and how will you evaluate. Calculating the sample size is very important as it has a bearing on the power of your study and its validity.
4. Analysis: how will you sieve through the data obtained and organize them to help you draw inference aligned to your objective

The details of ethical approval obtained from a recognized body must be explicitly mentioned.

Results

In the entire study and the manuscript, the fulcrum is the results, the outcome of your study. Hence it is important to devote attention to this section. Relevant data which can generate information to facilitate a judicious inference aligned to the hypothesis are to be segregated. This sieving and segregating will constitute the analysis of the data. Ultimately one should focus on the main findings, irrespective of p-value or statistical significance. The findings need to be tabulated and presented. Figures also help in presentation of findings. Figures may be photographs, diagrams, or data presentation in the form of graphs, bar charts.

**Discussion**

Discussion is basically critically evaluating your results. What you found, what do they mean in a clinical context, can there be an alternate interpretation. Then you analyze your findings based on the findings of other studies, have you bridged the knowledge gaps, if any, in the subject of your research. Any limitations of your study should be mentioned. Limitation means the problem faced in designing or its execution which may compromise the validity of your findings. One example is the sample size. Finally round off with the conclusion, that is your recommendations or what next.

References

Following are some of the guidelines for Reference:

- All information stated in the manuscript as facts, barring your own findings, should be backed by a reference.
- Do not cite a reference which you have not read yourself to confirm its authenticity.
- Cross check the reference list for any typographical errors.
- References, except for historical facts should be up to date
- A standard reference format known as the Vancouver style is followed by most journals

This is just an overview. For a detailed information, the reader may refer to a handbook on this:
Warren S Browner Publishing and Presenting Clinical Research



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ART & SCIENCE OF QUIZZING IN MEDICAL EDUCATION



INTRODUCTION

The word "quiz" first appeared in print in 1782, referring to an "odd-looking person." A popular but unverified anecdote credits Irish theatre manager Richard Daly with inventing the term in the 1790s as part of a wager to spread a nonsense word across Dublin. By the early 1800s, it evolved to denote practical jokes or eccentric objects. The meaning evolved over time, possibly influenced by words like "inquisitive," to mean "to observe, study intently" and then, by the mid-19th century, to its current meaning of a "test" or "exam". Today, "quiz" is primarily used to denote a test of knowledge, either as a noun (the test itself) or a verb (to test someone).

EVOLUTION OF QUIZ AS A TOOL

During the Han Dynasty (206 BCE–220 CE), civil service candidates underwent rigorous exams testing memorization of 9,000 characters, establishing one of the earliest formal assessment systems. Socrates used dialogic questioning ("Socratic method") to probe students' critical thinking, emphasizing oral defence over written tests. After Gutenberg's

press (1440), pamphlets with educational puzzles circulated, democratizing access to knowledge tests beyond elite academia. By 1867, "quiz" formally entered academic lexicon, describing short, unannounced knowledge tests in schools. This contrasted with high stakes "examinations".

Radio shows like "Information Please" (1938) and "Quiz Kids" (1940) turned quizzes into public entertainment, featuring experts answering audience questions. College Bowl (1950s–70s), a radio-turned-TV show, pitted university teams in knowledge battles, spawning international versions like University Challenge (UK). The BBC's Mastermind (1972) intensified quizzing with its iconic "spotlight" interrogation style, inspired by WWII POW interrogations. Trivial Pursuit (1981) revolutionized social gaming, selling over 100 million copies. Its success proved quizzes could be commercially viable leisure activities. Who Wants to Be a Millionaire? (1999) and Jeopardy! (1964–present) repopularized televised quizzes with high stakes and interactive formats (e.g., "phone a friend"). Online Platforms

Sites like Sporcle (founded 2007) and Quizlet enabled user-generated quizzes, creating global communities around niche topics (e.g., "Forgotten Civilizations"). Real-Time Analytics and Tools like Kahoot! (2013) gamified quizzes with live leaderboards, while ProProfs offered LMS-compatible assessments with instant feedback. Adaptive quizzing (e.g., via AI algorithms) tailors questions to individual skill levels, optimizing learning efficiency. Platforms like Quiz-Maker.com integrate exam prep with multimedia resources (e.g., fossil databases for evolution quizzes).

Evolution of quizzing in India

British colonial education introduced formal examinations, but structured quizzing remained absent. India's oral traditions—like Shloka recitations and folk storytelling—informally preserved knowledge but lacked competitive formats. Radio emerged as the first mass medium for quizzes. Shows like "Dr. IQ" (1939) inspired Indian adaptations, though localized versions only gained traction post-independence.

Neil O'Brien's Revolution: In 1967, Irish-origin Neil O'Brien conducted India's first formal quiz at a Kolkata church hall, earning the title "Father of Indian Quizzing." His events sparked "Quiz Wars" among Kolkata's schools and colleges, creating a competitive circuit.

Bournvita Quiz Contest (BQC): Launched in 1972 on All India Radio's Vividh Bharati, hosted by Hamid Sayani. Its blend of GK and entertainment made Sunday afternoons iconic, igniting a national passion for quizzing.

The North Star Quiz (1978), sponsored by Bata, started in Kolkata and went national by 1982.

Karnataka Quiz Association (KQA) was founded in Bangalore (1980s), standardizing rules and coordinating quizzes across South India.

Quiz Time (1980s): Hosted by Siddhartha Basu on Doordarshan, this inter-collegiate competition became India's first TV quiz sensation. Teams like RV College of Engineering gained national fame, boosting institutional prestige.

India Quiz: Basu's follow-up show broadened appeal with themes linking history and pop culture.

Mastermind India (1998): Adapted from the BBC format, it featured specialist subjects and rigorous written tests. India was only the second country (after the UK) to host this elite show.

Chennai's Rise: The city eclipsed Kolkata as India's quizzing capital, hosting events like the Landmark Quiz (1994–2020), an annual Independence Day tradition attracting multi-generational teams.

Kaun Banega Crorepati (KBC) (2000): Amitabh Bachchan's hosting transformed quizzing into prime-time entertainment.

PLACE OF QUIZZING IN MEDICAL EDUCATION
In Medical education, traditionally quiz was used as

feedback tool but is now regularly used to deliver curriculum. Quiz can be conducted using various question types, i.e., multiple-choice, true/false, short answers, multiple responses, fill in the blanks, matching, sequence, etc.

Few key benefits include.

- Interactive student-centric and engaging tool to deliver the medical curriculum.
- case-based or image-based approach. Such an approach helps bridge the gap between traditional classroom teaching and clinical application.
- acceptable tool that complements didactic lectures and improves students' learning and comprehension.
- enhances active student participation and encourages regular feedback mechanisms.
- promotes healthy competition and peer-assisted learning by encouraging active discussion among students.
- improving student performance in standard examination techniques, along with teacher satisfaction.
- Student-organized quizzing events promote leadership qualities, innovation, teamwork, time management, and organizational skills among medical students.

• application of quizzes in medical education aligns with the competency-based medical education (CBME) framework,

TOOLS AND APPS

Conventional/ traditional/ physical quizzes which are often conducted in multiple rounds using printed questionnaires and other multimedia tools like Power-Point presentation.

Online platforms

Forms (google forms/ SurveyMonkey)- Real-time collaboration, unlimited free forms, No branching logic; basic analytics, good for non-time bound feedback/ surveys.

Quilgo- google form with time management, auto close and submit features.

Freeonlinesurveys- offers over 20 question types, customizable themes and designs, multichannel distribution, real time data analysis, mobile optimised surveys, multi-language support, duplicate response prevention, quiz time and window of quiz access can both be set.

Slido- Simple meeting controls, Zoom/Teams integration, Q&A moderation, few question types; minimal gamification, \$17.5/month, often used for Webinars; corporate meetings.

Mentimeter- Polished business templates, sentiment analysis, Free plan: 50 participants/month, paid starts at \$11.99/month, often used for corporate training;

workshops.

Following table shows comparison of few more platforms.

Name	Key features	Pros	Cons	Remarks
ProProfs Quiz Maker	AI-driven quiz creation and access to 100,000+ pre-made templates. - Supports multiple question types (MCQ, fill-in-the-blanks, matching) with multimedia integration (images, videos, audio). - Detailed analytics on scores, completion rates, and question difficulty .	Integrates with LMS platforms (e.g., Google Classroom, WordPress). - Robust reporting tools for tracking learner progress.	No offline quiz creation or dark mode support.	Free plan available; paid plans start at \$20/month. Best For: Corporate training and K-12 education needing scalable, template-based solutions.
. Kahoot!	Gamified quizzes with timers, music, and leaderboards. - Supports multimedia-rich questions (images, videos) and live interaction	Fosters engagement through competition; integrates with Zoom and Microsoft Teams. - Popular for classroom and remote learning	Free plan limits users to 10/quiz and 20 questions/quiz. - Limited feedback mechanisms.	Starts at \$17/month (annual billing). Best For: Interactive, game-based learning in schools and team-building exercises.
Quizlet	Flashcard-based learning with 500+ million user-generated study sets. - Includes AI tools for quick quiz creation and interactive modes (matching, live games) .	Mobile app for on-the-go study; supports multilingual audio features. - Large community for resource sharing.	- Advanced features (analytics, collaboration) require paid plans.	Starts at \$17/month (annual billing). Best For: Self-paced study and language learning. Popular for competitive exam prep in India

Socrative	Real-time quiz delivery with instant feedback and basic analytics. - Integrates with Google Classroom	- Simple interface; ideal for quick formative assessments. - Free plan allows unlimited quizzes (up to 50 students/room).	- No multimedia support (images/videos).	Teacher plans start at \$9.99/month. Best For: Classroom teachers prioritizing real-time
	and LMS platforms .			interaction and low-cost solutions.
Flexiquiz	- Customizable branding (logos, fonts) and professional reports. - Supports timers, certificates, and randomization .	- Free plan includes unlimited quizzes (10 respondents/quiz). - Detailed question-level analytics.	- Advanced features (automation, certificates) require premium plans.	Starts at \$17/month (annual billing). Best For: Compliance training and certification programs needing branding flexibility. Supports Indian languages for quizzes.
Formative	- Live quiz delivery with instant feedback and asynchronous options. - Library of pre-made content aligned with educational standards .	- Real-time response tracking; integrates with Canvas and Schoology. - Free plan offers unlimited quizzes.	- Lacks gamification elements (badges, leaderboards).	Starts at \$15/month (annual billing). Best For: Educators focusing on formative assessments and real-time progress monitoring.

FUTURE AND RECOMMENDATIONS

One of the critical factors to assess the acceptability of the Quiz was to take into consideration the attendance rate after prior notification. More research and development are needed for user friendly platforms integrating multiple teaching learning needs and budget friendly options.

CONCLUSION

Quiz is an excellent teaching learning tool which can and should be integrated at various levels of formal education as well.

Suggested reading.

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<https://doi.org/10.55184/ijpas.v73i1.28>



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Evolving Paradigms in Gynaecological Practices: From Clinical Judgment to Technological Precision

Keywords: Ancient time, Empathy, Gynaecology, Investigations, Touch

Dear Editor,

Over the past few decades, the landscape of gynaecological practice has undergone significant changes, reflecting advances in medical technology, shifting societal views, and evolving patient demographics^[1]. Historically, gynaecology largely relied on subjective evaluations and clinical judgment. With limited means of investigations, diagnoses and treatments were frequently made only on the basis of personal experience and physical examinations. In contrast, advances in technology are driving gynaecological practice today. Modern diagnostic tools such as high-resolution ultrasound (for assessing ovulatory disorders, structural anomalies, endometrial conditions, ovarian reserve, and other contributing factors), advanced hormonal assays (for in vitro fertilisation, implantation, and growth of embryos), and genetic testing (for prenatal and postnatal diagnosis of inherited disorders)^[2-4] have shifted the focus from subjective judgments to objective data. This shift has enabled the early detection of conditions such as obesity, Polycystic Ovarian

Syndrome (PCOS), menstrual disorders, hypothyroidism, and genital herpes, which are now prevalent in the foetal, and obstetric outcomes) are standard practices, reflecting a more proactive approach to reproductive health. One notable shift is in the perception and management of Medical Termination of Pregnancy (MTP). Once a taboo subject, with MTP wards being discreetly hidden, the practice is now widely accepted due to changing societal norms, including the rise of modern relationships and evolving cultural attitudes. Although the preference for a 'female' gynaecologist was mostly seen in younger women, nowadays, education levels have been shown to impact the gender of a gynaecologist^[9].

In conclusion, the evolution of gynaecological practice from a subjective to an objective, technology-driven approach reflects significant advancements in medical science and shifts in societal attitudes. While these changes have un-

doubtedly improved patient care and outcomes, they also highlight the need for a balanced approach that integrates clinical expertise with technological innovation.

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FERTILITY IN FORTIES

Like at every stage of life, deciding to try to get pregnant after 40 is a personal decision that has its own set of advantages and drawbacks: women may feel more ready and financially secure, but at the same time, chances of miscarriage, gestational diabetes, preterm birth and other complications increase. About 1 in 10 women will conceive naturally after 40, while many other women in their 40s can achieve pregnancy with the help of assisted reproductive technology (ART), mainly because of poor ovarian reserve. Poor ovarian responders (PORs) embody 9–24% of patients undergoing ovarian stimulation for in vitro fertilization (IVF), meaning that up to one in four patients conceals a poor reproductive prognosis. Women have a finite number of germ cells whose number peaks at 6–7 million by gestation week 20. From mid-gestation onward and throughout reproductive life, an irreversible attrition progressively diminishes the germ cell pool of the gonad (Peters, 1976), mainly through follicular atresia. Various modern techniques that can be used for ovarian rejuvenation and strategies that can be used in patients in their 40s, with poor ovarian reserve:

- 1) Ovarian PRP
- 2) Ovarian Fragmentation for Follicular Activation Surgery
- 3) Minimal ovarian stimulation
- 4) Natural cycle
- 5) PGTA
- 6) Donor oocyte adoption

1) Ovarian Rejuvenation Through Platelet-Rich Autologous Plasma (PRP)—provides chance to have a child Without Donor Eggs, Improving the Life Quality of Women Suffering from Early Menopause Without Synthetic Hormonal Treatment. Platelet-rich plasma was produced in the amount of 2 ml; 0.7 ml of PRP was injected into each ovary with a concentration of 1,000,000 platelets per microliter (μ l). This corresponds to 700,000,000 platelets per ovary. PRP injections into the ovaries were performed by a gynecologist with a special 25G needle, 20

cm in length, as an ultrasound-guided procedure. In difficult cases, when it was impossible to reach the ovaries vaginally, or the goal was to check the tubal patency test, a laparoscopic-

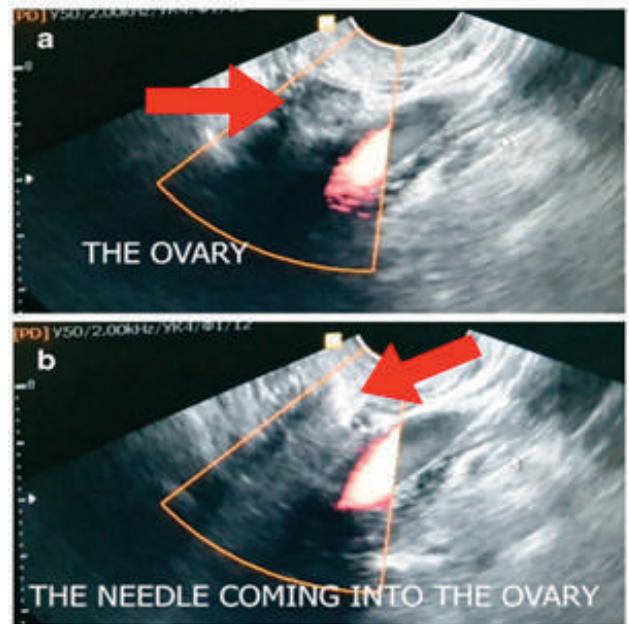


Fig. 1 Ultrasound-guided ovarian rejuvenation procedure. **a** The needle is going through the vaginal wall, puncturing the ovarian cortex, and **b** enriched plasma is coming into the ovary.

assisted approach was used.

There are numerous studies describing that the alpha granules of platelets contain more than 30 mitogenic and chemotactic growth factors (GFs). These GFs play an essential role in paracrine-mediated wound healing. The alpha granules of platelets contain platelet-derived growth factor (PDGF); transforming growth factors β 1, β 2, and β 3 (TGF- β 1, TGF- β 2, TGF- β 3); platelet-derived angiogenesis factor (PDAF); insulin-like growth factor 1 (IGF-1); platelet factor 4 (PF-4); epidermal growth factor (EGF); epithelial cell growth factor (ECGF); vascular endothelial cell growth factor (VEGF); primary fibroblast growth factor (bFGF); bone morphogenetic proteins BMP-2, BMP-4, BMP-6, and BMP-7; and other cytokines [9, 10]. There are several platelet-derived cytokines that are involved in wound healing.

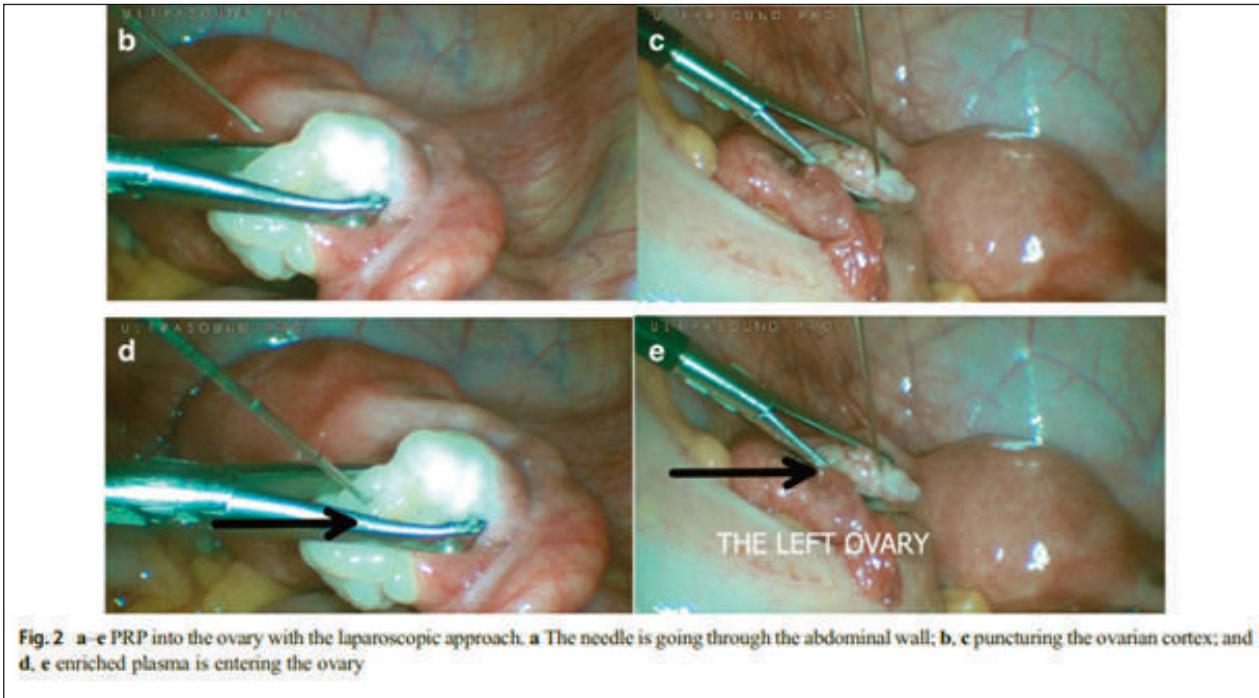
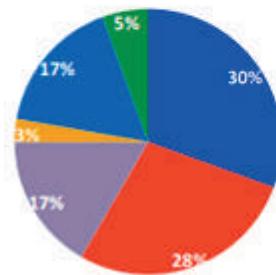


Fig. 8 The pie chart shows the proportion of pregnancy outcomes after PRP injection into the ovaries

PREGNANCY RESULTS IN WOMEN AFTER OVARIAN REJUVENATION

- Early US, embryo with heartbeat
- Pregnancy progress after 14 weeks
- Deliver a baby
- Miscarriage
- No implantation
- Genetic abnormalities of the embryo



2) Ovarian Fragmentation for Follicular Activation Surgery (OFFA)

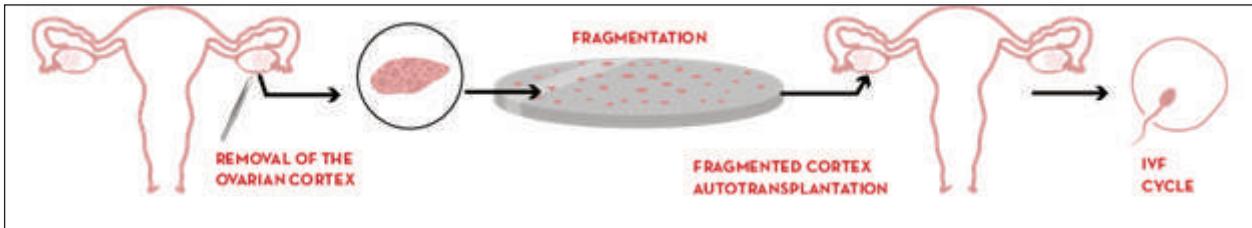
OFFA of primordial follicles with or without stimulators has been developed to treat patients with primary ovarian insufficiency (POI) successfully. However, the efficiency of the procedure is still very low. There is a requirement to optimize the protocol with increased efficiency for clinical application.

Procedure: Patients allocated to the OFFA group underwent laparoscopy to retrieve a 1- to 2-cm² ovarian cor-

tical biopsy specimen from the posterior side of the intervention ovary, using cold scissors and avoiding the use of electrocautery to achieve hemostasis. After retrieval, the ovarian medulla is removed with the use of the cold scalpel friction method (21) in M199 media (Sigma, St. Louis, MI) at 4C, and the ovarian cortex is fragmented into small pieces of approximately 1 mm³. The tissue fragments are then placed in a Gynetics Probet endometrial catheter (Gynetics, Lommel, Belgium) and handed to the surgeon. Subcortical pockets are

developed for tissue reimplantation by blunt dissection on the anterior side of the same ovary by creating a tunnel between the remaining cortex and the medulla. Each pocket was filled with tissue fragments

using the plunge of the Probet catheter. The tunnel is closed with a single suture, using Monosyn 4-0 (Braun Surgical SA, Rubi, Spain) by intracorporeal knot tying.



Inhibition of the Hippo Pathway:

Assessment of Hippo pathway inhibition by determining phosphorylated YAP levels showed that the phospho-YAP/ YAP ratio was reduced by 18.8% between samples at the time of tissue retrieval and 1 hour after fragmentation (1.0 - 0.2 vs 0.8- 0.5). When patients were individually examined, all but 1 showed increased phosphorylation levels at t ¼ 1 hour and therefore a successful Hippo pathway inhibition.

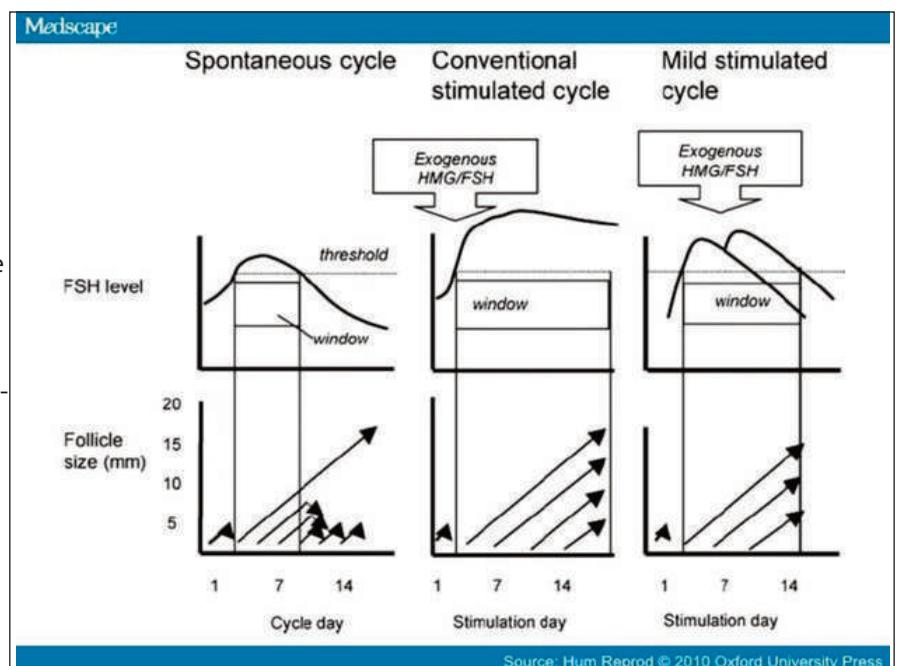
The relative gene expression of downstream Hippo factors showed up-regulation of BIRC1, BIRC7, and CCN2 1 hour after fragmentation when compared with basal levels (0 hours) .

Interestingly, an overall increased expression of BIRC1 was found in women with POR compared with reference ovarian tissues from healthy women (fold change t0h ¼ 7.9 -4.5, P¼-.004, and t1h ¼ 12.9 -7.7; P¼-.003) , which may have been induced by the procedure of tissue retrieval and decortication.

- Women in the OFFA group experienced an increase in total AFC compared with its baseline level due to a specific increase in the ovary that underwent surgery.
 - AMH levels and IVF outcomes showed no statistically significant differences between the control and the OFFA groups.
 - Assessment of Hippo pathway inhibition at the molecular level confirmed the efficacy of the fragmentation procedure,
 - It seems very unlikely that OFFA could have any impact on the reproductive outcomes of patients with POR, given that it could not demonstrate any difference in the number of retrieved MII oocytes (4.0 [1.0– 8.0] vs 2.0 [1.0–3.0] in the control and OFFA groups, respectively).
- Summary: OFFA can be offered in patients with POR, but definitive benefits needs further wide spread study & data analysis.

3) Minimal ovarian stimulation is an alternative to conventional protocols for older women:

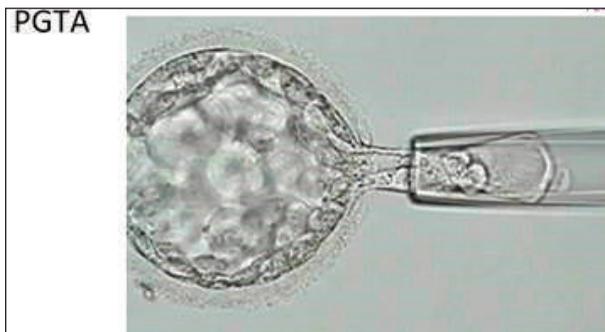
In a scenario where the overall oocyte yield is low (e.g. expected POR), the possibility of using mild stimulation regimens in PORs has been recommended by the American Society for Reproductive Medicine (ASRM), underlying the fact that clinical pregnancy rates after conventional IVF gonadotropin protocols are similar to those obtained after mild ovarian stimulation protocols using low-dose gonadotropins. Mild ovarian stimulation approach in POR offers some advantages such as patient friendliness, reduced duration and do gonadotropins, as well as reduced overall cost per ovarian stimulation cycle. Although number of oocyte retrieved and embryos formed are significantly lower with mild stimulation, clinical pregnancy rate and live birth rate are comparable to conventional stimulation.



4) Natural cycles

In poor responder patients with a diminished ovarian reserve, only very few follicles can be recruited and very few oocytes, if any, can be retrieved after ovarian stimulation. For this reason, some authors have suggested the use of the patient's own natural cycle oocyte(s), reporting good clinical pregnancy rates per embryo transfer despite high cancellation rates mainly due to untimely LH surge. Indeed, a managed natural cycle might be a patient friendly alternative in BC PORs of more than 40 years. However, its potential is very limited irrespective of patient's age, as the live birth rate per cycle was estimated to be 2.6%.

5) PGT-A: Preimplantation genetic testing for aneuploidies : formerly known as preimplantation genetic screening (PGS), method to select embryos for transfer in elder womens with age >40 on optional basis considering increased rate of aneuploidy with age . In PGT-A, trophoctoderm cells of the embryo are obtained by biopsy and tested. Embryos that show a normal number of chromosomes(euploid) are transferred.The benefit of next-generation sequencing (NGS)-based preimplantation genetic testing for aneuploidy (PGT-A) for embryo is studied. There was a significant increase in OPR(ongoing pregnancy rate) per embryo transfer with the use of PGT-A in the subgroup of women aged 35-40 years who had two or more embryos that could be biopsied.



6) Donor oocyte adoption

Oocyte and embryo donation is an established standard of practice for the treatment of age-related infertility and is associated with high rates of pregnancy success. Adverse obstetrical events and outcomes are associated with advanced reproductive age (ARA), particularly related to operative delivery, hypertensive disorders, gestational diabetes, and perinatal mortality. Women of ARA considering oocyte or embryo donation should undergo comprehensive medical testing focused on ascertaining cardiovascular and metabolic

fitness, as well as a psychosocial evaluation to determine if adequate supports are in place to raise a child to adulthood.

Conclusions: One of the most important problems in the management of elderly patients is the difficulty in predicting poor ovarian response to ovarian stimulation in order to tailor the correct stimulation regimen. But with advent of ovarian rejuvenation techniques and ovarian stimulation strategies better pregnancy outcome and live birth can be achieved in elderly women.

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Dr. Google: A Boon or Bane for Modern Healthcare?

There were 751.5 million internet users in India as of January 2024. [1] The World Wide Web, or Internet, has become a significant global source of information, including medical information. An emerging trend is the use of the internet for health-related queries, commonly referred to as consulting 'Dr. Google'. [2] With advancements in technology, the concept of 'eHealth' has evolved, creating new opportunities for individuals to access and exchange health information, manage their health through electronic platforms, and participate in "peer-to-peer healthcare." [3]

Patients often search for information about diseases, symptoms, treatments, and general health queries. [4] It has become increasingly common for individuals to correlate their symptoms with online information and self-diagnose before consulting a doctor. However, medical professionals, including general practitioners (GPs), often find it challenging to navigate consultations with patients who rely on 'Dr. Google'. [5] This reliance on online information can lead to doctors dismissing or contradicting the e-information patients bring to consultations.

The internet functions as an encyclopaedia, offering vast amounts of data accessible with a single click, provided the search terms are appropriate. Regarding health-related issues, individuals can obtain information on diseases, symptoms, latest drugs, and available treatment modalities. However, this information is often generalized and not tailored to individual needs. Applying the same treatment strategies to everyone can complicate medical conditions. Moreover, seeking low-cost treatment options online might prevent individuals from receiving the most suitable and effective care. Doctors provide personalized advice based on patients' symptoms while considering factors such as age, weight, cultural beliefs, psychological state, and socio-economic status. This holistic approach ensures comprehensive management of the patient's condition rather than focusing solely on isolated aspects. Ad-

ditionally, the empathy, emotional connection, and motivation offered by healthcare providers—including doctors, nurses, and therapists—play a crucial role in faster recovery compared to solely relying on eHealth solutions. Nonetheless, there is evidence suggesting that 'Dr. Google' is not always seen as a threat by GPs and can facilitate better mutual understanding of symptoms and diagnoses. [2] [6-8]

In conclusion, the role of 'Dr. Google' in healthcare should be limited to providing supplementary information, enhancing patient knowledge, and supporting effective communication between patients and doctors. It should not replace professional expertise in diagnosing or treating medical conditions.

The POGS Quiz committee did 2 surveys recently



Dr. Chugh Amey



Dr. Nilesh Balkawade



Dr. Kanchan Durugkar

1) Current Trends in Contraception

The first survey analyzing responses from 166 participants highlights evolving patterns in contraception use. The findings reveal a significant rise in emergency contraceptive (EC) use, largely driven by unprotected intercourse and lack of regular preventive methods. While Levonorgestrel pills remain the most common EC option, many providers still hesitate to recommend them routinely.

Social media plays a dual role—helping spread awareness but also contributing to misinformation and confusion. Concerns were raised about over-the-counter misuse, with menstrual irregularities and hormonal side effects being the most observed health issues.

Cultural stigma continues to be the biggest barrier for unmarried youth, outweighing financial or legal concerns. The majority of respondents agreed that pre-marital counselling is the most effective time to introduce contraception education, though counselling is often delayed until postnatal stages.

Overall, the study emphasizes the urgent need for early, stigma-free, and evidence-based counselling, along with reliable educational resources to counter misinformation and promote safe contraceptive practices.

REPORTS ON SURVEY FINDINGS: Current Trends in Contraception Total Responses Analyzed: 166

1. Trends in Emergency Contraceptive Use

- Majority (~81%) observed a significant increase in EC use.
 - A few (~3%) reported decreased or rare use.
- Interpretation: Emergency contraceptive use has increased substantially in recent years, indicating greater awareness and acceptance.

2. Reasons for Seeking Emergency Contraception

- Nearly 4 out of 5 participants (~79%) cited unprotected intercourse.
 - ~9% mentioned contraceptive failure.
 - ~12% pointed to lack of access/awareness of regular methods.
- Interpretation: Most women rely on EC due to absence of preventive contraception, rather than failure of an existing method.

3. Preferred Emergency Contraceptive Methods

- ~44% recommend Levonorgestrel (1.5 mg pill).
 - ~44% reported they do not routinely recommend EC.
 - ~9% suggested Copper IUD.
- Interpretation: There is still hesitation among providers in routinely counselling patients on EC, despite its ef-

fectiveness.

4. Impact of Social Media on Contraception Awareness

- Over half (~52%) felt social media increases awareness but spreads misinformation.
- ~15%: Improved accurate knowledge.
- ~15%: Led to confusion & misconceptions.

Interpretation: Social media is a powerful but unreliable source of contraception information.

5. Perceptions of Over-the-Counter EC Use

- Half (50%): Occasional use is safe, but misuse is rising.
- ~41%: Consider it a significant risk due to repeated/unsupervised use.

Interpretation: There is growing concern about over-use, highlighting the need for stronger counselling.

6. Observed Health Concerns

- Menstrual irregularities (~56%) most commonly reported.
- Hormonal side effects (~22%) also noted.
- A small fraction reported psychological stress or delayed adoption of regular methods.

Interpretation: EC misuse most visibly affects menstrual cycles and hormone balance.

7. Barriers for Unmarried Youth

- ~59% said cultural stigma is the biggest barrier.
- ~13% cited provider/pharmacist hesitation.
- ~22%: Depends on setting.

Interpretation: Stigma is the strongest obstacle restricting contraceptive access for young unmarried individuals.

8. Most Common Barrier Identified

- Fear of judgment/stigma (~47%)
- Inadequate sex education (~38%)
- Lack of privacy (~16%)

Interpretation: Psychological and educational barriers

outweigh financial or legal concerns.

9. Timing of Contraception Counselling

- Half (50%): During postpartum/postnatal period.
- ~28%: At first antenatal visit.
- ~9%: During pre-marital counselling.

Interpretation: Counselling often comes too late, instead of proactively.

10. Best Time for Newly Married Couples

- Nearly 2 in 3 (64%) said pre-marital counselling.
- ~21% said at first visit after marriage.

Interpretation: Strong consensus that contraception counselling should start early.

11. Approach to Patients Using Google

- ~41%: Provide trusted printed/digital materials.
- ~28%: Gently correct misinformation.
- ~25%: Clarify with evidence.

Interpretation: Providers prefer evidence-based and supportive approaches rather than confrontation.

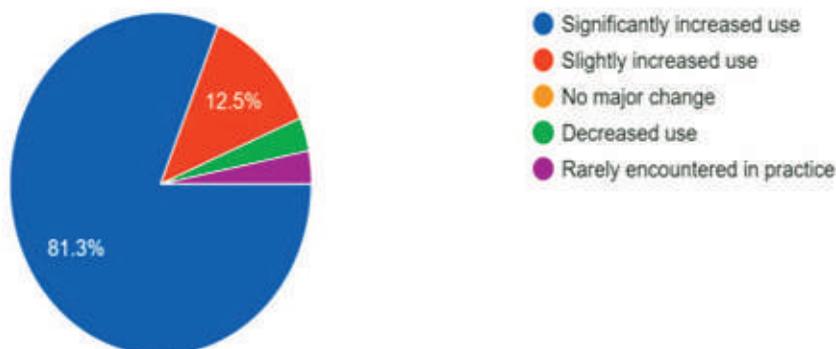
12. Recommended Resources

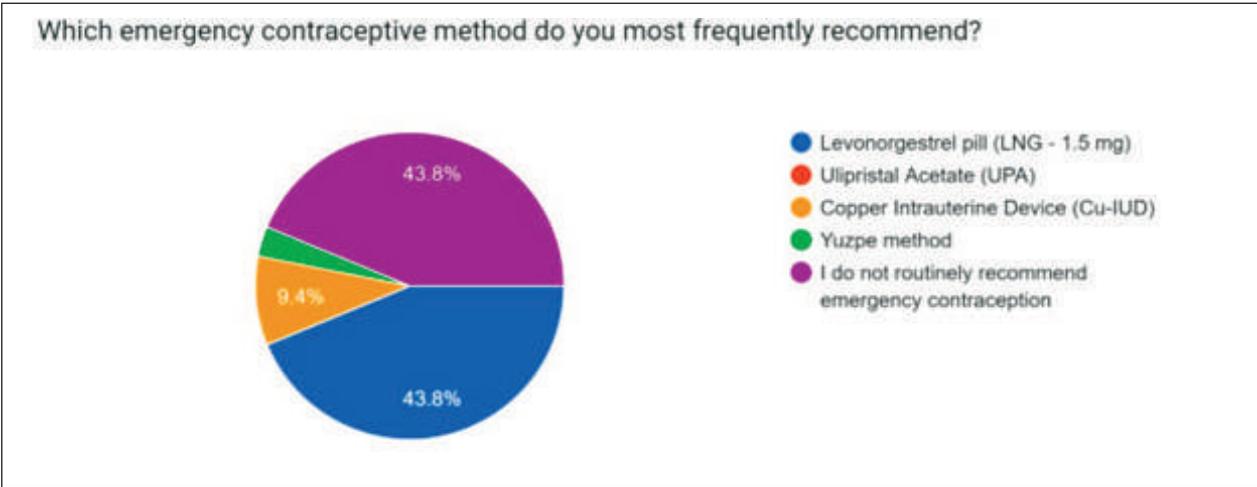
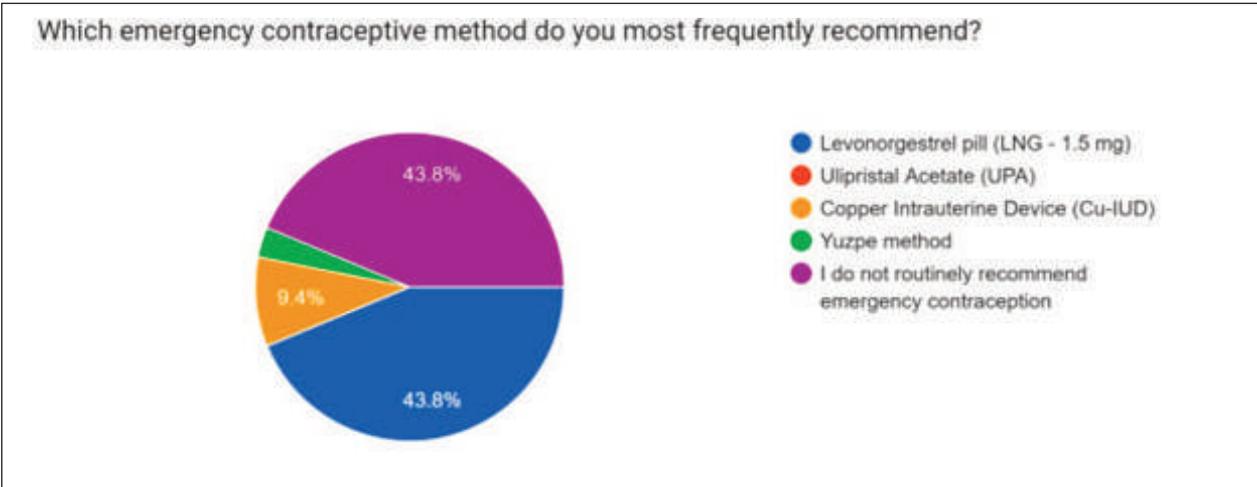
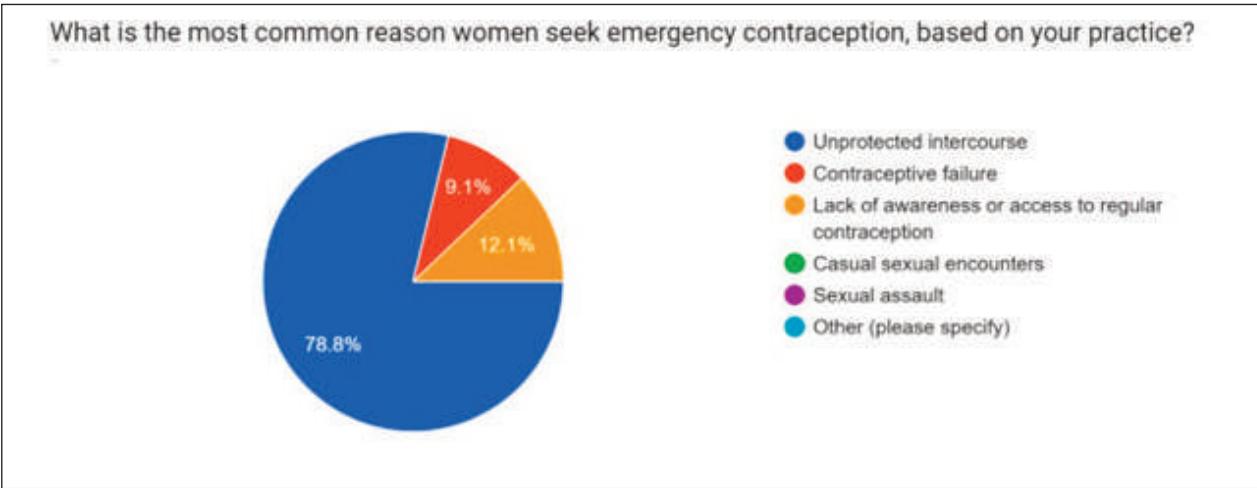
- Most common: WHO/MOH websites, FOGSI/national guidelines, clinic brochures, mobile apps.
- Interpretation: Doctors rely heavily on official and professional resources over social media.

Key Insights

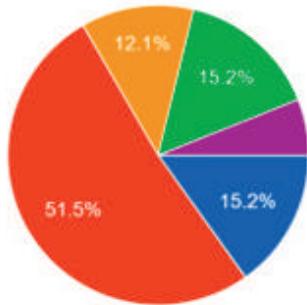
1. Emergency contraceptive use is significantly increasing.
2. Unprotected intercourse is the dominant reason for EC demand.
3. Social stigma is still the biggest barrier for youth.
4. OTC misuse is linked with menstrual irregularities and hormonal effects.
5. Social media drives awareness but also spreads misinformation.
6. Pre-marital counselling is viewed as the ideal time to initiate contraception education.

How have you observed the trend in emergency contraceptive use among women in recent years?



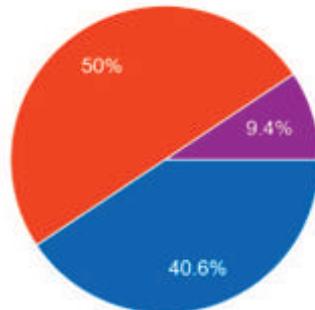


In your clinical experience, how has social media influenced patient awareness and education about contraception?



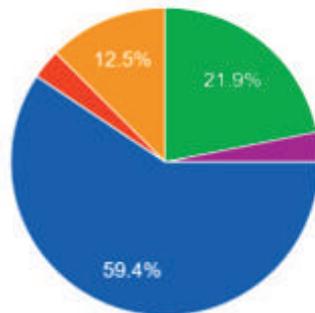
- Improved awareness and accurate knowledge
- Increased awareness, but with misinformation
- No noticeable impact
- Led to confusion and misconceptions
- Patients rarely mention social media

What is your opinion on the health risks associated with over-the-counter use of emergency contraceptive pills (ECPs) without medical supervision?



- Significant risk due to repeated/unsupervised use
- Occasional use is safe, but misuse is increasing
- Minimal risk, but overuse may hide deeper issues
- No major concern – patients use them responsibly
- Not enough data to assess

Do you believe there are significant social or systemic barriers restricting access to contraception for unmarried youth?



- Yes – cultural and societal stigma plays a major role
- Yes – pharmacists and providers often hesitate
- Somewhat – depends on setting
- No – access has improved
- Not sure

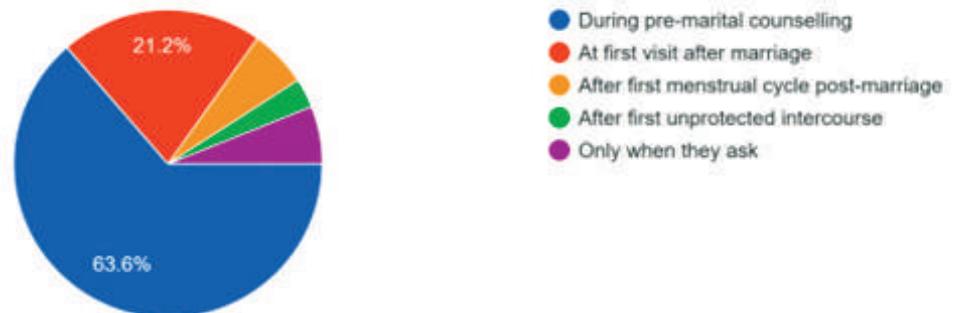
What is the most common barrier unmarried youth face when accessing contraception?



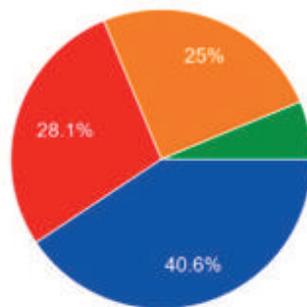
When do you most commonly initiate contraception counselling for couples?



What is the most appropriate time to initiate contraception in newly married couples who do not want immediate pregnancy?

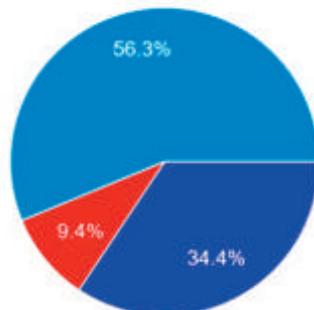


What is the most effective approach to educating patients who rely heavily on Google for contraception information?



- Acknowledge and clarify with evidence
- Gently correct misinformation
- Provide printed/digital material from trusted sources
- Encourage follow-ups
- Hard to change their opinion

Which resource do you most commonly recommend to patients for reliable contraception education?



- WHO / MOH websites
- FOGSI or national bodies
- Clinic brochures/handouts
- Trusted mobile apps
- Social media channels by professionals
- Prefer in-person counselling

2) Current challenges in OBGY Practice:

A total of 215 responses were analyzed to identify the most pressing challenges faced by obstetricians and gynecologists in current practice.

- Antenatal Care: Poor patient compliance with investigations/medications and lack of education were highlighted as the biggest hurdles, contributing to worsening outcomes in high-risk pregnancies.
- Obstetric Emergencies: Postpartum haemorrhage (PPH) and hypertensive disorders emerged as the most difficult emergencies requiring urgent, skilled management.
- Caesarean Section Rates: Fear of litigation, maternal requests, and late referrals were cited as key non-clinical drivers of rising C-section rates.
- Labour Ward Management: Communication gaps and delays in decision-making outweighed infrastructure issues.

- Contraception Counselling: Misinformation and cultural resistance remain the strongest barriers.
- Medico-Legal Stress: Obstetric emergencies and neonatal outcomes are the top sources of anxiety, fueling defensive medical practices.
- Technology Impact: While technology has improved awareness, it has also increased misinformation and led to more demanding patient expectations.
- Post-COVID Practice: The mental health burden on patients and staff is the most significant ongoing challenge.

Conclusion: The survey highlights that beyond clinical difficulties, non-compliance, misinformation, communication gaps, and medico-legal fears are shaping modern ObGyn practice. Addressing these systemic and psychosocial factors is crucial for better patient

outcomes and reduced practitioner stress.

Report on Survey Findings: Current Challenges in ObGyn Practice Total Responses Analyzed: 215

1. Pressing Challenges in Antenatal Care

- Poor compliance with investigations/medications (~37%) – the leading challenge.
- High-risk pregnancy load (~21%) and lack of patient education (~21%) followed.
- Resource limitations (~16%) and late registration (~5%) were less frequent but significant.

Interpretation: Non-compliance and education gaps remain the biggest hurdles in antenatal care, worsening high-risk pregnancy outcomes.

2. Most Challenging Obstetric Emergency

- Postpartum haemorrhage (PPH) (~53%) – the top concern.
- Hypertensive disorders (~26%) also major contributors.
- Preterm labour, shoulder dystocia, and sepsis (~21% combined) less frequent but high-risk.

Interpretation: PPH and preeclampsia dominate as the most difficult emergencies, highlighting the need for skilled management and timely referral systems.

3. Reasons for Rising Caesarean Section Rates

- Fear of litigation (~37%) – primary driver.
- Maternal request without indication (~26%).
- Late referrals/high-risk cases (~32%).
- Institutional protocols & others (~5%).

Interpretation: The rise in caesareans is not purely clinical – medicolegal concerns and patient demands are major influences.

4. Challenges in Labour Ward Management

- Communication gap with patients/relatives (~32%) – top issue.
- Delays in decision-making/referrals (~21%) and non-compliance with birth plans (~21%).
- Staffing shortages (~16%) and monitoring limitations (~11%) also significant.

Interpretation: The labour ward struggles more with communication and decision-making processes than with pure infrastructure.

5. Barriers to Contraception Counselling

- Misinformation from non-medical sources (~42%) – leading barrier.

- Cultural/societal resistance (~32%) also strong.
- Lack of follow-up (~21%).
- Time constraints (~5%).
- Cost/availability – negligible.

Interpretation: Misinformation and stigma are bigger barriers than logistics or affordability.

6. Areas Causing Most Medicolegal Anxiety

- Obstetric emergencies (~47%) – top source of anxiety.
- Neonatal outcomes (~21%) also significant.
- Surgical complications (~11%), consent disputes (~11%), communication records (~11%).

Interpretation: Practitioners fear unpredictable emergencies and neonatal outcomes more than routine procedures.

7. Impact of Technology on Patient Interactions

- More demanding/unrealistic expectations (~53%) – most common.
- Increased misinformation (~26%).
- Improved awareness (~11%).
- No major change (~11%).

Interpretation: Technology has created better-informed yet harder-to-satisfy patients, increasing consultation stress.

8. Most Significant Post-COVID Challenge

- Mental health burden on patients & staff (~47%) – the biggest issue.
- Increased high-risk pregnancies (~16%), staff shortages (~16%), and financial constraints (~16%) also noted.
- Delayed follow-ups (~5%).

Interpretation: The hidden toll of COVID is largely psychological and systemic, not just clinical.

9. Influence of Medico-Legal Fears on Decision-Making

- A large share report “Very often” or “Sometimes” letting litigation fears influence decisions.
- Few said “Rarely”, and almost none claimed “Never”.

Interpretation: Defensive medicine is common, with practitioners altering clinical choices due to fear of litigation.

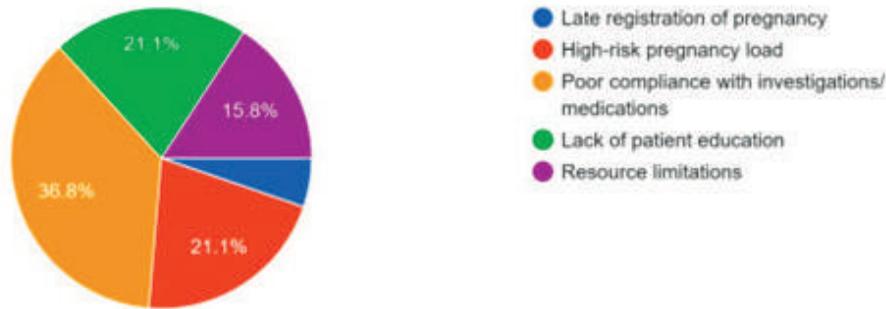
Key Insights

1. Compliance and patient education gaps remain the biggest antenatal care challenge.
2. PPH and preeclampsia dominate as the toughest emergencies.

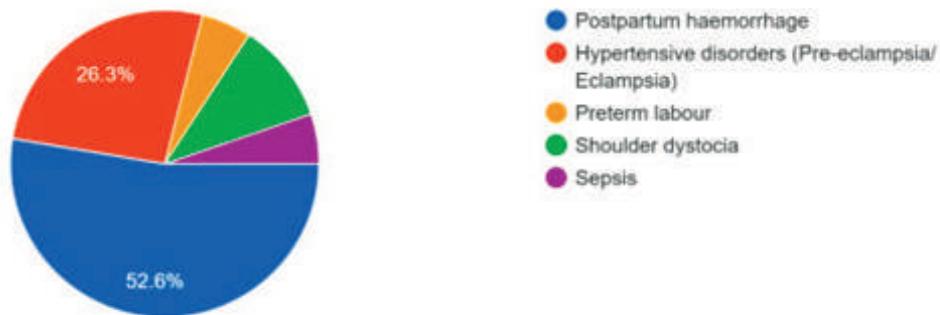
3. Litigation fears and patient demands are driving caesarean rates.
4. Communication gaps outweigh infrastructure as the main labour ward problem.
5. Misinformation and stigma still block contraception counselling.
6. Obstetric emergencies and neonatal outcomes are

- the top medico-legal worries.
7. Technology has created more demanding patients but not necessarily better- informed ones.
8. Post-COVID mental health burden is a major challenge for both patients and staff.
9. Defensive medicine is widely practiced due to litigation fears.

What is the most pressing challenge you face in providing antenatal care?



Which obstetric emergency do you feel is the most challenging to manage in your current setting?

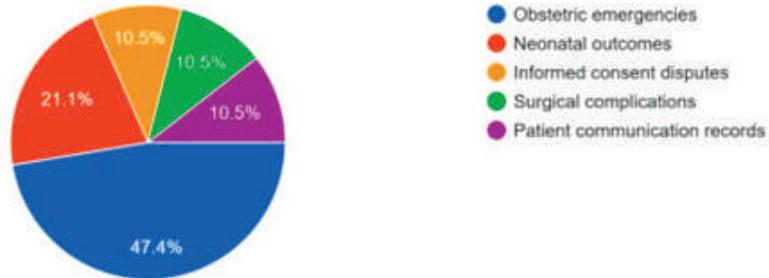


What is the biggest barrier to effective contraception counselling in your practice?

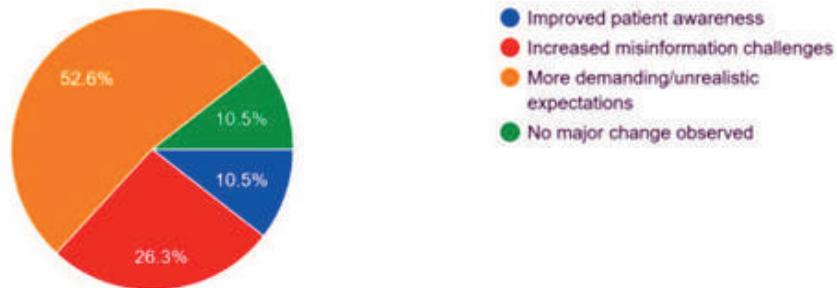


Which area causes you the most medico-legal anxiety?

19 responses



How has technology (Google, social media, online reviews) impacted your patient interactions?

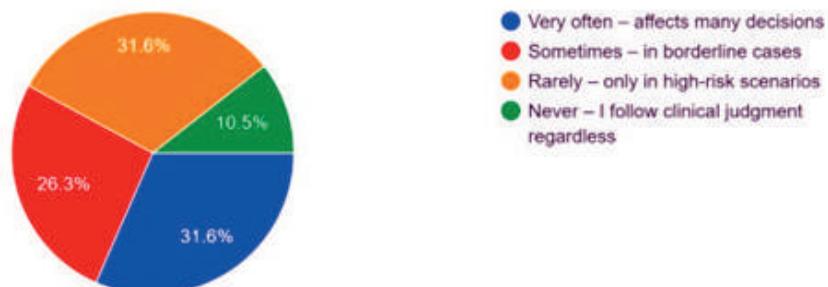


What is the most significant ongoing challenge post-COVID in ObGyn practice?

19 responses



How often does fear of medico-legal consequences influence your clinical decision-making?





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Rising Trends in Male Infertility— What's New, and What We Can Offer

Why this matters now?

Male factors contribute to about half of all infertility cases, and contemporary data indicate that semen quality has been under pressure globally. A large meta-analysis in Human Reproduction Update (HRU) reported continued declines in sperm concentration through 2018 across multiple world regions (with important caveats about heterogeneity and regional variability). These population-level trends, together with lifestyle, environmental, and demographic shifts, are increasing the number of men who present for evaluation. At the same time, professional guidelines have been updated, and several diagnostics and treatments have matured. Clinicians can now offer a more structured, evidence-based, and male-centered pathway than even a few years ago.¹

The changing landscape: key drivers and patterns

- Population trends in semen parameters. HRU 2023 added post-2011 data and non-Western cohorts, reporting a continued decline in mean sperm concentration worldwide from 1973–2018, particularly accelerated in the 21st century. While this signal is debated and not uniform across all populations, it has sharpened clinical focus on early male evaluation and modifiable risks.¹
- Lifestyle and environment. The 2025 European Association of Urology (EAU) guideline chapter on Male Infertility highlights potentially modifiable factors (obesity, heat, toxins) and the role of oxidative stress and sperm DNA damage as pathophysiological mediators, though causality and reversibility vary by exposure.³
- Later paternity and comorbidities. Increasing paternal age brings a higher prevalence of varicocele, metabolic disease, and subclinical hypogonadism—all relevant to fertility care pathways. (Guideline-level summaries.)

Updated diagnostic approach (2024–2025 practice)

• Semen analysis and lab standards

WHO 6th edition (2021) remains the standard

for semen examination methodology and reporting; ensure your laboratory adheres to the manual's procedures and internal quality control. Reference limits are descriptive, not dichotomous "normal/abnormal" cut-offs.²

• When to investigate genetics

- ◇ Karyotype is recommended for men with sperm concentration ≤ 5 million/mL or with azoospermia.
- ◇ Y-chromosome microdeletion testing should be obtained in men with azoospermia or sperm concentration ≤ 1 million/mL; this threshold was clarified in the 2024 AUA/ASRM update.³
- ◇ CFTR testing is indicated for all men with congenital bilateral absence of the vas deferens (CBAVD).

Sperm DNA fragmentation (SDF): where it fits

Routine screening of all men is not recommended; however, SDF testing may be considered for couples with recurrent pregnancy loss, unexplained infertility, repeated ART failure, or when lifestyle/clinical factors suggest high oxidative stress. Both AUA/ASRM (2024) and EAU (2025) summarize this nuanced, selective use; evidence links higher SDF with adverse reproductive outcomes, but the strength of evidence for test-directed therapy is variable.⁵

Imaging

Scrotal ultrasonography is targeted (e.g., suspected varicocele, testicular lesions); transrectal ultrasound is used selectively (e.g., suspected ejaculatory duct obstruction). Follow guideline-based indications rather than routine imaging.

What's genuinely new or newly clarified

- 1) Guideline changes you can implement today
 - ◇ Lower Y-microdeletion threshold: Test when sperm concentration ≤ 1 million/mL (and in azoospermia)—a practical change that reduces missed AZF deletions.
 - ◇ SDF testing—selective, not routine: Consider in RPL, unexplained infertility, and repeated ART failure. Avoid reflex testing in all comers.

◇ Hyaluronic-acid–based sperm selection (PICSI/HAB-Select): Current evidence does not support routine use for all couples; a large RCT (HABSelect) found no overall live-birth increase, though exploratory analyses suggested potential benefit in older women and links to better sperm DNA quality. Use judiciously. 6,7

◇ Microfluidics can be used to optimise the results of IUI and IVF8

◇ Micro-TESE preferred for NOA: Where surgical retrieval is indicated, microdissection TESE is recommended as the treatment of choice in NOA to maximize retrieval and minimize tissue loss. 9

2) Modernizing empiric medical therapy

Hypogonadotropic hypogonadism: hCG ± FSH remains standard and effective to induce spermatogenesis.

Functional/idiopathic oligozoospermia with low T/E2 ratio or obesity: Selective estrogen receptor modulators (e.g., clomiphene) or aromatase inhibitors (anastrozole/letrozole) can be tried in carefully selected men; meta-analytic evidence suggests improvements in semen parameters, with limited but suggestive effects on pregnancy rates. These remain off-label and should be individualized.

Antioxidants: The 2022 Cochrane review shows very low- to low-certainty evidence for improving live birth/clinical pregnancy; benefits, if any, are modest and heterogeneous across compounds and trials. Avoid blanket prescriptions; target use to men with documented oxidative stress or as part of clinical studies. 5

3) Varicocele: who benefits from repair?

Microsurgical subinguinal repair in men with a palpable varicocele and abnormal semen parameters is associated with improved semen quality and higher chances of natural conception; guideline panels support offering repair under these conditions. Effects on ART outcomes are less consistent; shared decision-making is essential.3

4) Testicular vs. ejaculated sperm in special scenarios

For non-azoospermic men with persistently high SDF and infertility despite optimization, the AUA/ASRM 2024 guideline states that using testicular sperm for ICSI may be considered (expert opinion/low-moderate evidence). This is not first-line but can be discussed after counseling on benefits/risks and local expertise.

5) Sperm selection beyond density gradients

Microfluidic sperm selection (e.g., inertial or labyrinth chips) shows favorable effects on SDF and some embryology endpoints in early studies; meta-analytic clinical signal is promising but not definitive—consider as

an adjunct in high-SDF cases or after ART failure, ideally within audit protocols.

MACS (annexin-V) and Zeta potential methods: mixed evidence; not for routine use. Reserve for research or selected repeat-failure scenarios. (Guideline-level positions.)

Hyaluronic-acid selection (PICSI): Not routine; may be discussed for older couples after counseling on uncertain live-birth benefit. 6,7

A practical, evidence-based care pathway (what we can offer)

Male-first, early evaluation

History, examination (including varicocele grading), WHO-compliant semen analysis (x2), targeted hormones (FSH, LH, total testosterone ± estradiol, prolactin), and lifestyle audit (heat, BMI, smoking, alcohol, recreational drugs, anabolic steroid use). 2

Risk and lifestyle optimization package

Weight management, exercise, sleep, cessation of tobacco/nicotine and recreational drugs, managing heat exposures (sauna, tight garments, prolonged laptop-on-lap), and interval ejaculation strategies where relevant. Provide written guidance and follow-up metrics. (Guideline-level recommendations.) 3

Guideline-driven genetic testing3

Karyotype if ≤ 5 million/mL or azoospermia.

Y-microdeletion if azoospermia or ≤ 1 million/mL.

CFTR for CBAVD. Offer genetic counseling and cascade testing as appropriate.

Selective advanced diagnostics

SDF testing in RPL/unexplained infertility/repeated ART failure, or when oxidative stress is suspected. Use a validated assay (e.g., SCSA, TUNEL, Comet) within a lab that reports method-specific thresholds; interpret in clinical context.

Inflammation/ROS work-up where indicated; treat confirmed genital tract infection/inflammation per guidelines. 3

Tiered medical therapy

Hypogonadotropic hypogonadism: hCG ± FSH.

Idiopathic/functional cases: Consider SERM or aromatase inhibitor in selected phenotypes (e.g., low T/E2, obesity), with objective monitoring (testosterone, estradiol, hematocrit, semen).

Antioxidants: Use judiciously; set expectations (uncertain live-birth benefit).5

Varicocele management

Offer microsurgical repair for palpable varicocele with abnormal semen parameters in infertile men; counsel on expected timeline (3–6 months for parameter changes), and on natural conception vs. proceeding to

ART depending on female age and duration of infertility.³

Surgical sperm retrieval

Obstructive azoospermia: MESA/PESA/TESE with ICSI (choose based on etiology and center expertise). Non-obstructive azoospermia: Micro-TESE as first choice for retrieval. Plan cryopreservation strategies and coordinate with the IVF lab. ⁹

ART laboratory enhancements (case-by-case)

Consider microfluidic selection or PICSI in repeat-failure or high-SDF contexts after counseling about uncertain live-birth advantages; audit outcomes. Testicular sperm for ICSI may be considered in non-azoospermic men with persistently high SDF after optimization.⁹

Integrated counseling

Align male and female timelines (especially when female age ≥ 35). Discuss probabilities (natural conception, IUI, IVF/ICSI), the time-cost of each step, and when to escalate. Include genetic counseling when indicated (Klinefelter, Yq deletions, CFTR), with implications for offspring and use of donor gametes.

What to say about “adjuncts”

Antioxidants: Low-certainty evidence for live birth; reasonable to use selectively or when men prefer a low-risk adjunct while undertaking lifestyle changes. Avoid polypharmacy and long, unmonitored courses. ⁵ SDF-directed strategies: Short abstinence intervals, varicocele repair, and optimized lab selection methods may reduce SDF; clinical benefit is most plausible in RPL/repeat-failure cohorts. (Guideline-level.)

Novel selection tools (microfluidics, MACS, zeta): Consider in research or quality-improvement frameworks; ensure patients understand the evidence gaps. ^{8,9}

Take-home messages

- ★ Evaluate the man early with WHO-compliant testing and guideline-driven genetics.
- ★ Offer selective SDF testing (RPL, unexplained infertility, ART failure) and treat remediable causes. ³
- ★ Use micro-TESE for NOA, and consider testicular sperm in persistently high SDF after counseling. ⁹
- ★ Varicocele repair helps the right patients; use microsurgical techniques and align with female factors.
- ★ Be cautious with adjuncts (antioxidants, sperm-selection add-ons); evidence for live-birth benefit is mixed—apply selectively and audit outcomes. ^{5,6,7}

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4. European Association of Urology. EAU Guidelines on Sexual and Reproductive Health 2025—Chapter 11: Male Infertility. Arnhem: EAU Guidelines Office; 2025. (Limited update March 2025).

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doi:10.1002/14651858.CD007411.pub5. (Very low- to low-certainty evidence for live birth/clinical pregnancy).

6. Miller D, Pavitt S, Sharma V, et al. Physiological, hyaluronan-selected intracytoplasmic sperm injection (PICSI) for infertility treatment (HABSelect): a parallel, two-group randomised trial. *Lancet.* 2019;393(10170):416-422. (No overall live-birth improvement).

7. West R, Coomarasamy A, Frew L, et al. Sperm selection with hyaluronic acid improved live birth outcomes among older couples and was connected to sperm DNA quality. *Hum Reprod.* 2022;37(6):1106-1125. (Exploratory age-stratified benefit; DNA quality linkage).

8. Aderaldo BV, Lemos CLC, Rosseto M, et al. Microfluidic sperm selection and its impact on clinical pregnancy rates in intrauterine insemination and in vitro fertilization: a systematic review. *Reprod Biol Endocrinol.* 2025;23:5. doi:10.1186/s12958-025-01397-1. (Promising but inconclusive clinical signal).

9. EAU Guideline Recommendation: “Use microdissection TESE as the treatment of choice to retrieve sperm in patients with NOA.” In: EAU Guidelines on Sexual and Reproductive Health 2025—Male Infertility, p. 157 (Strength: Weak; context and evidence base summarized).

10. EAU Male Infertility chapter—epidemiology, risk factors (oxidative stress, endocrine disruption) and diagnostic work-up sections. EAU Guidelines on Sexual and Reproductive Health 2025. pp. 124–150.

11. EAU Guidelines on Sexual and Reproductive Health 2025—reference list entries 1564–1573; guideline text p. 240–241.



QUIZ Time: By Dr. Amey Chugh

1) The prophylactic antibiotic of choice for preterm premature rupture of the membrane is

- A) Ampicillin
- B) Amoxicillin
- C) Erythromycin
- D) Azithromycin

2) Shock Index in Pregnancy is

- A) 0.5 - 0.7
- B) 0.7 - 0.9
- C) 0.9 - 1
- D) 1 - 1.2



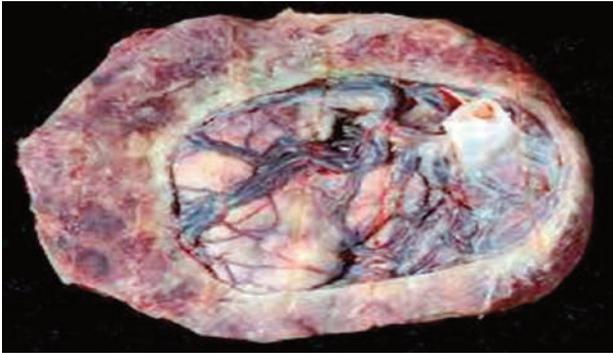
3) Name the Laryngoscope used in Neonatal Resuscitation ?

- A) Macintosh
- B) McCoy
- C) Miller
- D) Bullard

4) All is true about obstetric cholestasis except

- A) Severe pruritus
- B) It is mostly worse in the morning
- C) it usually develops in the second half of pregnancy
- D) it is more in palms and soles

5) Identify?



- A) Placenta Succenturiata
- B) Placenta Marginata
- C) Circumvallate placenta
- D) Circummarginate placenta

6) Neurogenic shock results from impairment of

- A) Descending parasympathetic pathway
- B) Descending sympathetic pathway
- C) Ascending parasympathetic pathway
- D) Ascending sympathetic pathway

7) Name this manoeuvre, usually done during our residency days, in which fundal pressure is given to cut short the second stage of labour.



- A) Rubins
- B) Gaskin
- C) Kristeller
- D) Barnum

8) Which of these immunosuppressants used after organ transplantation is contraindicated in pregnancy

- A) Tacrolimus
- B) Cyclosporine
- C) Mycophenolate Mofetil
- D) Azathioprine

9) The most common arrhythmia encountered in a pregnant lady is

- A) AF
- B) Atrial flutter
- C) PSVT
- D) Bradyarrhythmia

10) Following changes occur in the urinary system in pregnancy except :

- A) Increased GFR
- B) Increased Renal blood flow
- C) Hypertrophy of the bladder musculature
- D) Increased activity of the ureters

11) Maternal mortality following pulmonary aspiration of gastric contents with general anaesthesia is:

- A) 0.5 - 1%
- B) 1 - 2%
- C) 5 - 15%
- D) 25 - 35%

12) The maximum negative pressure used in ventouse is

- A) 1kg/cm²
- B) 0.9kg/cm²
- C) 0.8kg/cm²
- D) 0.6kg/cm²

13) All the blood coagulation factors are increased in pregnancy except :

- A) Factor. VII & X
- B) Factor II & VIII
- C) Factor IX & XI
- D) Factor XI & XIII

14) Which Type of IV cannula has the maximum flow rate among

- A) Yellow
- B) Grey
- C) Pink
- D) Green

15) All of the following are causes of metabolic alkalosis except ?

- A) Mineralocorticoid deficiency
- B) Hypokalemia
- C) Thiazide diuretic therapy
- D) Recurrent Vomiting

16) Which of the following best explains pathogenesis of macrosomia in GDM ?

- A) Bennowitz hypothesis
- B) Priscilla White hypothesis
- C) Penderson Freinkel hypothesis
- D) O Sullivan Mahan hypothesis

17) According to American college of obstetricians , macrosomia is defined as , fetal birth weight of

- A) > 3kg
- B) > 3.5kg
- C) > 4.5kg
- D) > 55kg

18) At what Shock Index Threshold does the red light flash in a CRADLE VSA?



- A) $SI > 0.9$
- B) $SI < 0.9$
- C) $SI 0.9 - 1.69$
- D) $SI \geq 1.7$

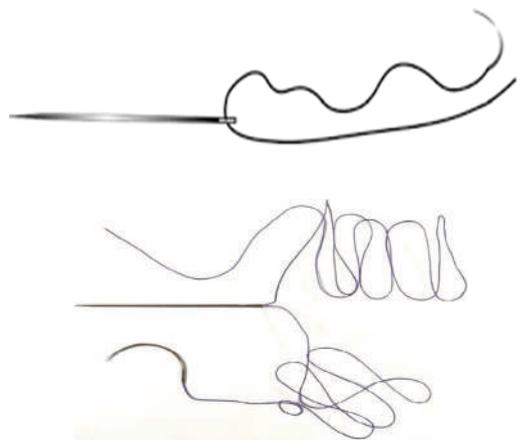
19) The risk of an ectopic pregnancy increases by how many fold after a previous ectopic pregnancy?

- A)1
- B) 2
- C) 5
- D)10

20) When MTP (Massive Transfusion Protocol) is activated , the ratio of transfusion of PCV : FFP : Platelets is ?

- A) 1:2:2
- B) 1:1:1
- C) 3:2:1
- D) 1:4:2

21) Name of this suture technique for management of PPH



- A) ASST technique
- B) Aboufalah technique
- C) COMOC-MG technique
- D) MY suture

22) The picture shown here is commonly associated with a Trisomy. Which of the following heart defects is associated with the same?



- A)Tricuspid atresia.
- B)Hypoplastic left ventricle
- C)Aortic Stenosis
- D)Atrioventricular septal defects

23) A resident doctor Raj sustained a needle stick injury while sampling blood of a pt who is HIV positive. Which of the following is the best for Post exposure prophylaxis

- A) Zidovudine + Lamivudine for 4 weeks
- B) Lamivudine + Tenofovir + Efavirenz for 4 weeks
- C) Lamivudine + Tenofovir + Dolutegravir for 4 weeks
- D) Zidovudine + Lamivudine + Nevirapine for 4 weeks

24) The value of fetal fibronectin predictive of pre-term labour is

- A) > 15 ng/ml
- B) > 1.5 ng/ml
- C) > 5 ng/ml
- D) > 50 ng/ml

25) In modified Liley's (Queenan) chart, which zone represents a severely affected fetus ?

- A. Zone 1
- B. Zone 2
- C. Zone 3
- D. Zone 4

ANSWERS

- 1-C
- 2-B
- 3-C
- 4-B
- 5-C
- 6-B
- 7-C
- 8-C
- 9-C
- 10-D
- 11- C
- 12- C
- 13- D
- 14- B
- 15- A
- 16- C
- 17- C
- 18- D
- 19- C
- 20- B
- 21- C
- 22- D
- 23- C
- 24- D
- 25- C

GYNAECOLOGY QUIZ

ELIMINATION ROUND

DR KANCHAN DURUGKAR

• 1) ALL INCREASES THE RISK OF TOLAC FAILURE EXCEPT:

- A) Increased maternal age
- B) Labour Induction
- C) Preeclampsia
- D) Prior vaginal birth

2) Estimated rupture rate of on low transverse incision:

- A) 0.2-0.9%

- B) 2-9%
- C) 3-5%
- D) 0.9-1.8%

3) the residual myometrial thickness of 2.3 mm is ... risk of rupture:

- A) High risk
- B) Intermediate risk
- C) Low risk
- D) Non of the above

4) Interdelivery intervals \leq 18 months increases risk

of symptomatic rupture by :

- A) Threefold
- B) Fourfold
- C) Tenfold
- D) Sixfold

5) Which of the following is absolutely contraindicated for Labor induction during TOLAC—

- A) Amniotomy
- B) Pitocin
- C) Misoprostol
- D) Foleys

6) The most common sign of uterine rupture is a

- A) Scar tenderness
- B) Maternal tachycardia
- C) Low abdominal pain
- D) Nonreassuring FHR pattern

7) With rupture and expulsion of the fetus into the peritoneal cavity, the chances for intact fetal MORTALITY:

- A) 10-20%
- B) 50 -75 %
- C) 2-3%
- D) 1-2%

8) Single- versus double-layer closure and locking versus unlocking suture for uterine closure, rates for uterine dehiscence did not differ significantly.

- A) TRUE
- B) FALSE

9) The visceral peritoneum is intact it is typically called:

- A) Scar tenderness
- B) Isthmocele
- C) Uterine dehiscence
- D) Uterine rupture

10) Most often injuries during repair of hysterotomy extensions into the broad ligament or vagina

- A) Ureteral Injury
- B) Bladder injury

- C) Pudendal nerve injury
- D) Bowel injury

11) Most common site of bladder injury during LSCS is

- A) Dome
- B) Trigone
- C) Base
- D) Neck

12) Estimated Rupture rate on Prior T shaped Uterine incision is

- A) 0.2 %
- B) 1.5%
- C) 3-5%
- D) 4-9%

13) Zavanelli maneuver is classically performed for

- A) Shoulder dystocia
- B) After head of breech
- C) Breech delivery
- D) Obstructed labour

14) The negative pressure in ventouse is:

- A) 6-8 kg/cm²
- B) 0.1-0.2 kg/cm²
- C) 0.6-0.8 kg/cm²
- D) 10-20 kg/cm²

ANSWERS

- 1-A
- 2-A
- 3-A
- 4-A
- 5-D
- 6-D
- 7-A
- 8-A
- 9-A
- 10-A
- 11- D
- 12- D
- 13- C
- 14- C

Upcoming Programs:



Fertility Carnival 2025
Innovations in Fertility Rejuvenation in Goa

WORKSHOPS **FRIDAY, 3RD OCT. 2025**

11.00 -12.00 pm	Registration & Breakfast
12.00 - 2.00 pm	Gen Alpa - The future of Ovarian Induction <ul style="list-style-type: none"> ● Endocrine Principles of Ovarian Stimulation ● Individualization of Ovarian Stimulation ● Adjuvants for OS ● Surprises in OS ● Panel on Ovarian Stimulation in IUI - Science, Art or Gamble
	Workshop 2 : USG in Infertility - The 3rd Eye <ul style="list-style-type: none"> ● Evaluation of Adnexal Disease by USG ● Role of USG in Unexpected Ovarian response in IVF ● Endometrial Evaluation for Infertility by USG ● Evaluation of Male Sub-Fertility by USG
2.00 - 3.00 PM	LUNCH BREAK
3.00 - 5.00 pm	Workshop 3 Androfert - Mastering Sperm Retrieval in modern era <ul style="list-style-type: none"> ● Principles of Sperm Retrieval Techniques ● Microfluidics ● MACS ● mTESE ● TESA ● PESA ● PICSI (Live + Video)
	Workshop 4 : Fertility Reboot & FERTILITY Preservations (An AMOGS Mi Manasvi Initiative) <ul style="list-style-type: none"> ● Assesment of Ovarian Reserve ● Scope of Oocyte Freezing ● Ovarian Rejuvenation - PRP and Stem Cell ● What's New in Medical Management- ● PRP Preparation- Live ● Panel on POR management across different age groups
6.00 pm onwards	Carnival Theme Beach side Event

Fertility Carnival 2025

Innovations in Fertility Rejuvenation in Goa

SATURDAY
4th Oct. 2025

Hall Pearl
Where expertise shines...

8.00 - 9.00 am	Registration and Breakfast	
9.00 - 10.00 am	Session 1 : Panel discussion	
9.00 - 9.45 am	● Legal challenges in IVF Practice	
9:45 – 10:00 am	● Audience Poll	
10.00 - 11.00 am	Session 2 : Bird's Eye View In IVF	
10:00 – 10:15 am	● Asynchronous Follicular Growth in IVF - Management strategies	
10:15 – 10:30 am	● Fertility enhancing Robotic Surgery	
10:30 – 10:45 am	● The POSEIDON Wave - How to tackle	
10:45 – 11:00 am	● Difficult ET Videos with different catheters	
11.00 - 12.00 noon	Session 3 : Keynote Address	
11:00 – 11:15 am	● Thymosin Alfa in Recurrent IVF Failure	
11:15 – 11:30 am	● My Experience with Individualised Endometrial preparation for FET	
11:30 – 11:45 am	● Newer Guidelines for Ovarian Stimulation	
11.45 -12.00 noon	● Current concepts in management of Genital Kochs	
12:00 – 12:30 pm	Session 4 : Fertility Carnival Oration	
	● Newer age Luteal Phase Support- iLPS	Ameet Patki
12:30 – 1:00 pm	Session 5 : POGS MSR Oration 2025	
	● Transforming Fertility Care - Newer Horizons	Jatin Shah
1:00 – 1:45 pm	LUNCH BREAK	
1:45 - 2:30 pm	Session 6 : Panel Discussion	
	● What's new in RIF Treatment?	
2.30 - 3.20 pm	Session 7 : Special Guest Lecture	
2.30 - 2.55 pm	● Management of FSH and LH Receptor Polymorphism	Kamini Rao
2.55 - 3.20 pm	● AI in Reproductive Medicine - Insights & Tech Based Monitoring of IVF	Pankaj Talwar
3.20 - 4.15 pm	Session 8 : Behind the Best Blastocyst - Clinician Embryologist Crosstalk	
3.20 - 3.30 pm	● Optimising clinical aspects for good blastocyst	
3.30 - 3.40 pm	● Culturing the best blastocysts	
3.40 - 4.15 pm	● Panel - When success drops.....Clinician Embryologist Dilemmas	
4.15 - 5.00 pm	Session 9 - Panel discussion	
	● Endometrium Speaks - Are we listening enough?	
5.00 - 5.15 pm	KBC Quiz- One Lakh at finger tips (Academic initiative by ZUVENTUS)	
5.15 - 6.00 pm	AMOGS MCOG ABCDI & ABCD - AG Convocation Ceremony	
6.00 - 7.00 pm	Inauguration of Conference & ISAR Awards	
7.30 pm onwards	Conference banquet	



SATURDAY
4th Oct. 2025

Fertility Carnival 2025
Innovations in Fertility Rejuvenation In Goa

Hall Wave
Where dreams set sail...

8.00 - 9.00 am	Registration and Breakfast
9.00 - 10.00 am	Session 1 : Panel Discussion
9.00 - 9.50 am	● Optimising success rates in my IUI practice
9.50 - 10.00 am	● Audience Interaction- Poll
10.00 - 11.00 am	Session 2 : PCOS - Walking through the Fertility Journey
10:00 - 10:10 am	● Lifestyle Modification in PCOS - The Right Step
10:10 - 10:25 am	● Spectrum of Fertility treatment in PCOS
10:25 - 10:50 am	● Reverse Panel - Managing adverse events in ovarian stimulation in PCOS
10.50 - 11.00 am	● Audience Interaction
11.00 - 12.00 noon	Session 3 : Panel Discussion - IVF in special situations
11.00 - 11.50 am	● Advanced maternal age, HIV, Cancers, Transgenders
11.50 - 12.00 noon	● Audience Interaction - Poll
12:00 - 12:30 pm	Session 4 : Fertility Carnival Oration (Plenary session in Hall Pearl)
	● Newer age Luteal Phase Support- iLPS Ameet Patki
12:30 - 1:00 pm	Session 5 : POGS MSR Oration (Plenary session in Hall Pearl)
	● Transforming Fertility Care - Newer Horizons Jatin Shah
1.00 - 1.45 pm	LUNCH BREAK
1.45 - 2.00 pm	Session 6 : Special Guest Lecture
	● Elagolix in Fertility
2.00 - 3.00 pm	Session 7 : Protocol Carnival in IVF
2:00 - 2:15 pm	● Antagonist and Related Protocols
2:15 - 2:30 pm	● Agonist and Related Protocols
2.30 - 3.00 pm	● Reverse Panel - Choosing the Right Protocol
3.00 - 4.00 pm	Session 8 : The Missing Half- Male Fertility Solutions
3:00 - 3:15 pm	● Diagnosing & Managing High Sperm DFI
3:15 - 3:30 pm	● Azoospermia de-coded : Diagnosis to mTESE
3.30 - 4.00 pm	● Reverse Panel - Optimising Male SubFertility before IVF
4:00 - 5.00 pm	Session 9 : What if ? (Challenging Case scenarios in ART)
4.00 - 4.10 pm	● My Experience with Extremely Low AMH
4.10 - 4.20 pm	● Unique way of Dealing with Thin Endometrium
4.20 - 4.30 pm	● The Rescue ICSI that worked
4.30 - 4.40 pm	● My hopes with GV eggs
4.40 - 4.50 pm	● How PRP worked when I had no hopes in POR
4.50 - 5.00 pm	● My Experience with Tacrolimus
5.00 - 5.15 pm	KBC Quiz- One Lakh at finger tips (Academic initiative by ZUVENTUS)
5.15 - 6.00 pm	AMOGS MCOG ABCDI & ABCD - AG Convocation Ceremony in Hall Pearl
6.00 - 7.00 pm	Inauguration of Conference & ISAR Awards in Hall Pearl
7.30 pm onwards	Conference banquet

Fertility Carnival 2025

Innovations in Fertility Rejuvenation in Goa

SUNDAY
5th Oct. 2025

Hall Wave
Where dreams set sail....

8.00 - 9.00 am	Registration and Breakfast
9.00 - 10.00 am	Session 1 : Stump the Expert - Open forum on tricks for successful IVF practice Experts Jatin Shah, Ameet Patki, Kedar Padte, Kundan Ingale
9.00 - 9.15 am	● My Experience with IVF
9.15 - 9.30 am	● How to have great success rates in difficult scenarios
9.30 - 9.45 am	● Trouble Shooting scenarios in IVF practice
9.45 - 10.00 am	● Q and A
10.00 -12.00 pm	Session 2 : Certificate Course on OVUM PICK UP & Embryo Transfer Demystified
10.00 -10.30 pm	● SOP of OPU
10.30 -11.00 pm	● Embryo Transfer Techniques
11.00 -11.30 pm	● Difficult OPU- Videos
11.30 -12.00 pm	● What to do in case of Difficult ET?
HANDS ON SIMULATOR OPU Simulator ET Simulator	
12.00 - 1.00 pm	Session 3 : Third Dimension in Fertility Practice
12.00 - 12.20 pm	● Aesthetic Gynecology for IVF Consultant
12.20 - 12.40 pm	● How to Set up a good Financially viable IVF unit
12.40 - 1.00 pm	● Future of IVF
1.00 - 1.15 pm	VALEDICTORY CEREMONY
1.15 pm onwards	LUNCH.....GOODBYES.....& TILL WE MEET AGAIN!

RESIDENTIAL PACKAGE

Per Person	UPTO 31/8/2025	UPTO 30/9/2025
On SINGLE Occupancy	55,000/-	
On DOUBLE Occupancy	30,000/-	35,000/-
On TRIPLE Occupancy	25,000/-	30,000/-

FORM YOUR OWN GROUP OF 3 DELEGATES AND REGISTER UNDER TRIPLE OCCUPANCY BY MAKING THE FULL PAYMENT THROUGH A SINGLE DELEGATE

NON RESIDENTIAL PACKAGE

PER PERSON (CONFERENCE FEES + ALL MEALS)

UPTO 31/8/2025	UPTO 30/9/2025	1/10/25 - ON SPOT
16,000/-	18,000/-	20,000/-

IMPORTANT POINTS. PLEASE NOTE :

- Rates are inclusive of :
 1. Conference Fees and any 2 workshops.
 2. Are inclusive of all taxes
 3. Stay of 2 nights / 3 days stay at Holiday Inn Goa.
Checkin Friday 3.00 pm and checkout Sunday 11.00 am.
 4. Friday lunch/PM Tea/Beach side banquet cockatils and dinner
 5. Saturday Breakfast, AM Tea, Lunch, PM Tea, Conference Gala cocktail dinner
 6. Sunday Breakfast, AM Tea and lunch
 7. Airport transfer to & fro from **DABOLIM AIRPORT ONLY** in AC coach for groups of 20 guests. (Bus will wait for minimum 20 guests to fill in)
- No cancellations permitted. However **ONLY ONE** name change is permitted. Children below 6 yrs complimentary and above 12 yrs. are considered adults.
- For children between 6 -12 yrs, charges will have to be paid for food & extra mattress at the hotel directly.
- For any assistance on this please contact :
Ms. Tanisha - Holiday Inn , Goa @ - 9552595815
- Non residential Packages does not include breakfast at Holiday Inn.



2 STEPS FOR REGISTRATIONS

STEP - 1

SCAN THE CODE OR PAY THROUGH BANK. SAVE THE TRANSACTION ID OR THE SCREENSHOT OF PAYMENT

BANK DETAILS

A/c Name	Pune Obstetric and Gynecological Society
A/c No.	60007236975
Bank	Bank of Maharashtra
Branch	Swargate, Pune
IFSC Code	MAHB0000100

QR SCAN



STEP - 2

**CLICK
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**AND FILL IN
YOUR DETAILS
TO COMPLETE
THE
REGISTRATION**

POGS MOBILE APP

**FOR THOSE
REGISTERING
THROUGH APP**



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CONFERENCE SECRETARIATE

**POGS OFFICE : 3RD FLOOR, DR NITU MANDKE
IMA BUILDING , TILAK ROAD, PUNE - 411002**

Tel. No. : 020 24491000

WhatsApp No. : 9403969415



Corporate Event & Corporate Gifts

raegalos65@gmail.com renuka_sangle@hotmail.com
Renuka Sangle : 9373718171 / 8308116116

STAR Samporna Presidential Conference 2025

नमस्कार Pune-kars 🙏🏠 Pune- where medicine meets mindfulness and tradition sparks tomorrow! We send you a heartfelt invitation on behalf of FOGSI and the Organizing Committee of the STAR Samporna Presidential Conference 2025. The most prestigious academic event of the year — the FOGSI Presidential Conference: STAR Samporna 2025, is scheduled to be held at JW Marriott, Pune on 14th, 15th, and 16th November 2025. The theme for this year, “STAR – Strategy, Transformation, Advancement & Research for Comprehensive Women’s Health,” captures our vision of advancing women’s healthcare by bringing together the finest minds in obstetrics and gynecology to learn, collaborate, and lead change. This conference will feature a rich, evidence-based, and multidisciplinary scientific program — spanning from adolescent health, maternal-fetal medicine to geriatric gynecology, from innovation to implementation, and from clinical practice to community impact. There are over 10 Pre-Congress workshops scheduled on Friday, the 14th November. The main conference will exhibit a plethora of topics on 15th & 16th November. As the President FOGSI, and a proud POGSian, I am confident that the attendees will significantly enhance their academic depth at this landmark event. Register now! Make yourself a part of this journey towards shaping the future of women’s health in India and beyond. Registration link https://in.eregnow.com/ticketing/register/starsampornaconference2025?_rid=30357&_single=1

Dr Sunita Tandulwadkar
President FOGSI 2025
Organizing Chairperson,
Star Samporna FOGSI
Presidential Conference



FOGSI PRESIDENTIAL CONFERENCE
STAR Samporna
Strategy, Transformation, Advancement & Research
For Comprehensive Women’s Health
November 14 - 15 - 16, 2025 | JW Marriott, Pune

Save the Date

14 15 16 November, JW Marriott, Pune

MMC & ICOG
Points applied



SCAN THE QR CODE TO REGISTER NOW!



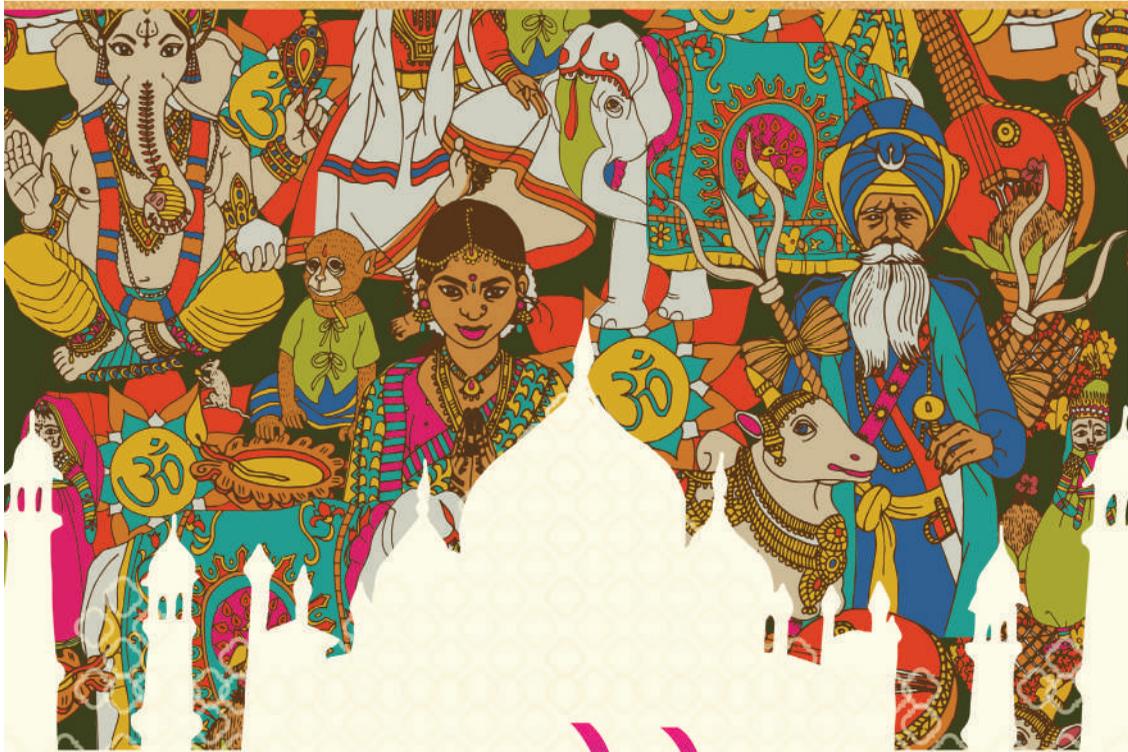
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FOGSI PRESIDENTIAL CONFERENCE
STAR Samporna

Strategy, Transformation, Advancement & Research
For Comprehensive Women's Healthcare

November 14 - 15 - 16, 2025 | J W Marriott, Pune



rang-e-bharat

A dazzling 7-minute tapestry where every state unfurls its glorious heritage through a medley of song, dance, drama, narration, and trivia.

Blending music, dialogue, and storytelling with evocative props, each performance will blossom into a radiant portrait of India's timeless cultural splendour—strictly within the time frame of 7 minutes per State"

Date: 14th November, 2025 | Time: 7.30 pm

'Let's drape our souls with the vibrant heritage of India!'

CONFERENCE SECRETARIAT:
POGS: Office No. 302 / 303, 3 rd Floor, Dr.Nitu Mandke IMA House, 992
Shukrawar Peth, Tilak Road,Pune-411002
Tel: 020 - 24491000 | Mobile : +91 94039 69415

FOR REGISTRATION RELATED QUERIES:
Ms Siddhi Sawant - info@starsampornapune.com / +91 89287 63008
FOR CONFERENCE RELATED QUERIES:
Ms Mahima Agarwal - +91 75840 77416

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Pune Obstetric and Gynaecological Society
announces

Save the Dates



13th And 14th December, 2025

POGS Annual Conference

PLENARY SESSION

Convener : Dr Pooja Lodha



In conversation with the
Maestro - Prof S Suresh

14th December 2025
11:00AM to 1:00PM

11:00AM - 12:00 NOON

IN CONVERSATION WITH THE MAESTRO:

FETAL INFECTIONS CODED

Prof S Suresh Dr Pooja Lodha

12:00 NOON - 1:00 PM

TWIN TALES THAT SHAPE SCIENCE:

A MASTERCLASS ON TWINS

PROF. S. SURESH



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President
POGS 2025-26



Dr. Vaishali Chavan
Organising Chairperson &
Vice President POGS



Dr. Nilesh Balkawade
General Secretary
POGS 2025-26



Dr. Kalyani Ingale
Clinical Secretary
POGS

Rx **In Male Infertility**

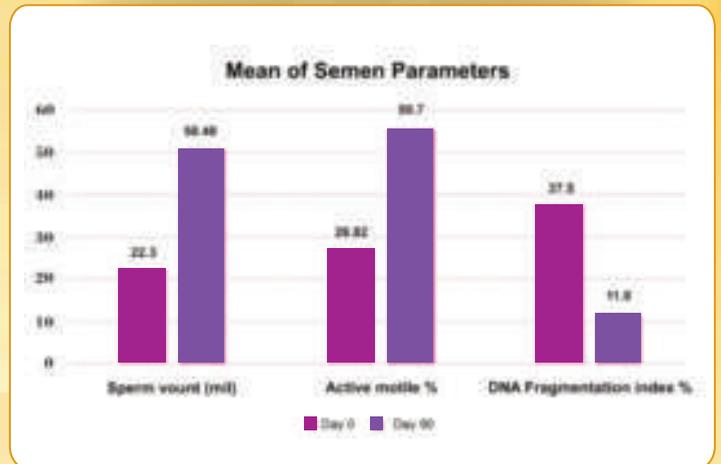
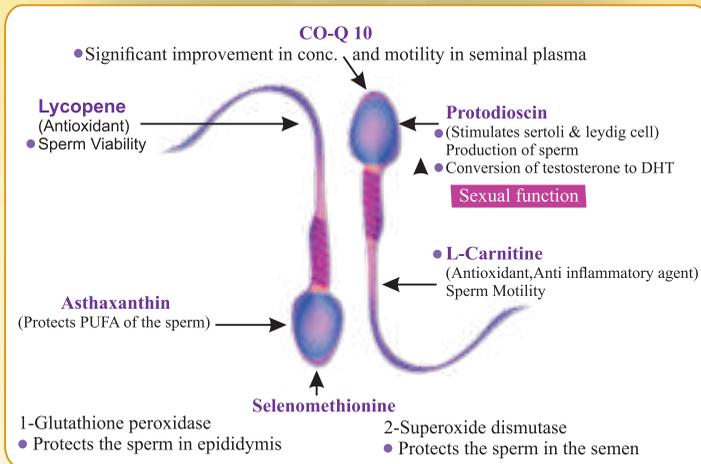
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Lycopene 1250mcg + Selenomethionine 40mcg Tablets

Role of adjuvants (Zoafrag) in male infertility

Original
Research

Clinical Trial



Dose:
1 Tablet
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