PUNE OB-GYN SOCIETY ESTD. 1953

# Womb & Wellness

The POGS Chronicle ♦ Issue 7, October 2025

POGS FOR HER
स्त्रिया: हिताय प्रवतमाल:
Striving For The Betterment Of Woman

## CASES I FUMBLED...

# Presidential Address

**Dr Manish Machave**
President, POGS

**Dear esteemed member of POGS,**
Greetings from the team,
This is our seventh , theme based, dedicated and all encompassing newsletter of POGS.
I begin with enriching words,
FACTS ARE STRANGER THAN FICTION…..
Every now and then, we encounter cases that defy logic, challenge our training, and leave even the most seasoned clinicians scratching their heads. These are the stories that don't fit the textbooks — patients who present with symptoms that lead us down the wrong path, scans that hide what should have been obvious, or outcomes that surprise us despite our best efforts. These are not just rare cases. They're reminders of the unpredictability of medicine, especially in a field like ours where two lives are often in our hands. In OBGYN, where physiology is constantly in flux and where the line between normal and abnormal can be razor-thin, even the most ordinary presentation can turn out to be something extraordinary.
What makes these cases so memorable is not just their rarity, but how they challenge our clinical instincts, highlight our cognitive biases, and push us to become better, more curious, and more cautious.
In this issue, we present stories of cases that stumped us — where the truth turned out to be far more bizarre, complicated, or unexpected than any fictional scenario we could have imagined……LIKE THE DOOSARA BOWL IN CRICKET.
These are the stories that stay with us.
But these cases are not just clinical puzzles — they're teachers in disguise. They force us to revisit our assumptions, to listen more closely to our patients, to look again at that scan or test result we thought we understood. They also remind us of the value of clinical curiosity, teamwork, and the humility that should accompany every patient interaction.
It is tempting to see being "stumped" as a sign of weakness. In reality, it's a mark of growth. Every difficult case is a step toward becoming a better clinician. Because sometimes, the greatest teachers are the cases that didn't go as planned.
Because in medicine, and especially in OBGYN, reality truly is stranger than fiction — and each patient teaches us that there is always more to learn, and always room to grow.
Do take out time and post us a feedback.
Happy reading.
Looking forward to see you all soon.
Till Then, Auf Wiedersehen, NAMASKAR….

**Dr Manish Machave**
**President, POGS**

**Dr Nilesh Balkawade**
Secretary, POGS

# Secretary's Address

***Ya Devi Sarvabhuteshu, Shakti Rupena Samsthita,***
***We bow to the strength, the grace, the Shakti eternal, infinite.***
***Nine nights of devotion, nine days of light,***
***May knowledge and service always shine bright.***

**Dear Esteemed Members,**

The month of August and September was full of academic vibrance and celebration for POGS.
The first program was the AMOGS–POGS CME on 22nd August. Topics covered included Labetalol use in pregnancy-induced hypertension and Drospirenone in PCOS. Along with this, the Fertility Carnival – Goa meet was conducted with great enthusiasm and active participation.

BreastCon 360°, held on 23rd and 24th August at Lonavala, was a grand success. Congratulations to Dr. Charulata Bapaye, Dr. Mangala Wani, and entire team POGS for an excellently organized conference. The event witnessed superb attendance from faculty and delegates, with power-packed scientific sessions, orations, and keynote addresses. Delegates, faculty, and pharma partners alike were enriched, engaged, and delighted.

On 12th September, POGS I-Evolve CME was conducted in collaboration with Alembic Pharmaceuticals. The program saw remarkable participation from both juniors and seniors.
POGS also initiated impactful public awareness activities during this month — including a newspaper article on the lunar eclipse and a talk on Akashwani by POGS President Dr. Manish Machave, highlighting laws relating to women's health.

The POGS–AFMC Undergraduate Quiz was conducted on 16th September at AFMC. It was coordinated by Dr. Amey Chugh (POGS) and Colonel Sirisha Aane (AFMC), under the guidance of HOD Dr. Madhusudan Dey.
BJ Medical College emerged as winners. The event was graced by dignitaries including POGS President Dr. Manish Machave, General Secretary Dr. Nilesh Balkawade, Vice Presidents Dr. Vaishali Chavan and Dr. Vaishali Korde Nayak, Past President Dr. Charu Chandra Joshi, and Senior Prof. Dr. Himadri Bal.

Elevate CME, in collaboration with Johnson & Johnson, focused on patient healing and experiences in obstetrics and gynecological surgeries. Several committee chairpersons, including Dr. Swapnali Sansare and Dr. Vaishali Biniwale, contributed to the success of this initiative.

**Upcoming Events**

POGS Dandiya , with IMA, on 28th September – let's celebrate together with music and rhythm!

Fertility Carnival Conference – Goa: A meticulously planned event with eminent national faculty.

FOGSI Presidential Conference at Hotel Westin , Pune, on 13th–15th November.

POGS PG Rotating Trophy on 23rd November – we encourage wholehearted participation from all medical colleges.

With Navratri's spirit of energy and new beginnings, let us continue to take POGS to greater heights. Together, with enthusiasm and unity, we will make every program a memorable success!

Warm regards,
**Dr. Nilesh Balkawade**
**General Secretary, POGS**

# Editorial

**Dr Kalyani Ingale**
Editor

Warm greetings from Team POGS !

Dear seniors, colleagues & friends, welcome to the world of the unique scenarios full of surprises in the field of obstetrics & Gynaecology.
We all have been taught & trained to assess, examine, investigate & analyse each & every patient's case to reach the diagnosis by ruling out other differential diagnoses.
'Life is an aggregate of experiences which continuously surprises us' quote by Ron Carlson.
We as OBGYN consultants are always prepared & ready to receive & treat the patients in emergencies. Also, we have strict protocols & SOPs to be followed. But each one of us is caught in the situations we have never expected, imagined at that time, a very unguarded moment. With an immense experience, with the help received very much in time, with the timely decisions, we have taken good care of our patients.
This issue of the chronicle witnesses such situations our seniors & mentors have faced, with the theme - 'Cases I fumbled'.
Team POGS brings this unique collection of the cases which will enlighten the thought process in our minds. It will stimulate us to think differently or consider all unexpected possibilities to reach the correct diagnosis at times. It's a great guide for all of us to treasure as each & every scenario has unique take home messages.
We are sure that you all will appreciate the stalwart's contributions that will give you an insight to upgrade & improve your services to the community.
Thanking all the contributors for parting their experiences with us.
Wish you all a very happy reading, learning & growing!!!

**Dr Kalyani Ingale,**
Clinical Secretary,
POGS 2025 – 26

**Dr Charulata Bapaye, MD, FICOG,**
Director GEMS hospital and endoscopy center, Chairperson breast and Puerperal Health Committee, FOGSI, Chairperson, Quiz Committee, POGS

# Foreword

Turning missteps into milestones!
In the practice of obstetrics and gynecology, clinical decision-making often rests at the intersection of science, experience, and judgment. While evidence and guidelines provide us with direction, the realities of patient care are complex, and not every decision unfolds as intended. At some point in our professional journeys, each of us has faced situations that, in retrospect, we might have approached differently.

Cases I Fumbled is conceived with the purpose of bringing these experiences into the open. By revisiting such cases with honesty and humility, we are able to transform individual reflections into collective learning. These narratives are not accounts of failure, but rather opportunities to strengthen our clinical acumen, enhance our sensitivity to patients' needs, and reinforce the importance of lifelong learning in our specialty.

In medicine, mistakes are inevitable, but learning is essential. It is my hope that this initiative will foster a culture where we can share, reflect, and grow together as a professional community. By learning from our own fumbles, and from those of our colleagues, we contribute to the ultimate goal of safer, wiser, and more compassionate care for women.

I extend my sincere gratitude to all contributors who have chosen to share their experiences. Their willingness to reflect openly will undoubtedly enrich us all.

# POGS CORE TEAM

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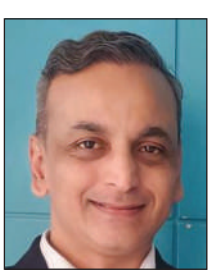

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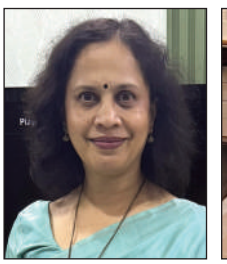

Dr Vaishali Biniwale

Dr Sanjay Sharma

# 12th to 14th/09/2025: Cloud Nine CME

The Cool Topics in Perinatology Annual Conference of Cloudnine Hospitals was held in Pune this year on 12th,13th and 14th September 2025 in association with POGS. The conference commenced on 12th September with 11 pre conference workshops on various topics of interest in paediatrics and neonatology, obstetrics, fertility, robotic surgery and anesthesia. The workshops were held in all four units of Cloudnine Hospital , Pune as well as institutes like Bharati Vidyapeeth , Deenanth Mangeshkar Hospital and D Y Patil Medical College. All the workshops were very well attended and appreciated for the excellent scientific content and hands on training.

The main conference was held on 13th and 14th September at Westin hotel, Pune. Dr Manish Machave, President POGS, Dr Vaishali Chavan Vice President POGS and many other POGS members were faculty for the conference with other nationally and internationally acclaimed speakers. Dr Manish Machave moderated a panel on Medicolegal issues which was truly an eye opener for the delegates and garnered widespread praise and acclaim.The conference was attended by 250 delegates from Pune and all over India.

The highlights of the conference include

Conference oration by Prof Tanis Fenton, eminent epidemiologist from Canada on When to use ultrasound charts and preterm infant charts, which was applauded by all, followed by her felicitation in traditional Puneri style.

Keynote address by Dr Chittaranjan Yajnik , Director and Consultant of Diabetes unit, KEM Hospital , Pune.

Extremely interesting talk by Dr R Kishore Kumar, Founder Chairman of Cloudnine Hospitals on AI use case based scenarios which earned rave reviews.

The conference witnessed a soulful and heart-touching moment where Dr Ravindra and Dr Smita Kolhe , a doctor couple from Melghat , who have devoted their life in the field of maternal and child care, were conferred upon with the Lifetime Achievement Award by Cloudnine hospital for their exemplary and path breaking work. The accomplishments of the couple left everyone in the audience teary eyed.

The rich academic content, collaboration among diverse healthcare professionals and appreciation of the unsung heroes were the main pillars of the extremely successful CTP conference.

# 14 /09/2025: I-Evolve

This month of September witnessed the i-evolve scientific program held on 14th September 2025 at JW Marriott, Pune, brought together leading minds in obstetrics and reproductive medicine for a power-packed day of knowledge sharing.

Guided by eminent POGS, ISAR and MSR faculty, the sessions explored the latest advances in gynecology and fertility care.

Fortunate highlights included Dr. Rohit Gutgutia's excellent talk on Evolution to Revolution in Endometriosis, Infertility & ART and Dr. Nozer Sheriar's super engaging session on Mastering Progestogen Use in Gynecology and Obstetrics.

Both the talks received a standing ovation and the Pune city was in awe of it.



A dynamic panel discussion on Recurrent Pregnancy Loss, moderated by Dr. Kundan Ingale with expert insights from Dr. Bharati Dhore Patil and an esteemed panel, enriched the dialogue.

The event fostered vibrant discussions, practical updates, and valuable networking, reaffirming POGS and ISAR's commitment to advancing obstetrics and reproductive health education.

From morning breakfast to the closing discussion, the hall buzzed with energy and new perspectives.

Great science, great conversations, and plenty of inspiration—i-evolve Pune truly lived up to its name!

# 16/09/20025: POGS AFMC PG Quiz

The AFMC–POGS Intercollegiate Rotatory UG Quiz 2025 was successfully conducted under the stewardship of Col. Madhusudan Dey, Prof and Head & the Dept Of OBGY & Maj Gen Atul Seth, Dean AFMC on 16th September 2025 at the Armed Forces Medical College, Pune . The event was coordinated by the Quizmasters Col. Sirisha Anne and Dr. Amey Chugh
A total of seven teams representing medical colleges across Pune participated in the quiz. The participating institutions included Smt. Kashibai Navale Medical College, B. J. Government Medical College and Sassoon General Hospital Pune, Bharatiya Atal Bihari Vajpayee Medical College Pune, MIMER Medical College Pune, P. A. H. Government Medical College , Baramati , Pune , Dr. D. Y. Patil Medical College Pune and the Armed Forces Medical College Pune.
The quiz consisted of five engaging and intellectually stimulating rounds. At the conclusion of these rounds, there was a tie between B. J. Government Medical College Pune and Dr. D. Y. Patil Medical College Pune. A fiercely contested tie-breaker round was then held, which resulted in B. J. Government Medical College and Sassoon General Hospital Pune emerging as the winners, while Dr. D. Y. Patil Medical College Pune secured the position of runners-up.


The winners, Puri Lahoti and Himanshu Sadulwad from B. J. Government Medical College Pune, were awarded the championship trophy.

The Quiz was attended by Dr Manish Machave , President POGS , Dr Nilesh Balkawade , Gen Secretary, POGS , Dr Vaishali Chavan , Vice President POGS , Dr Vaishali Korde Nayak , Ex Vice President POGS . Dr Charu Chandra Joshi, Past President POGS & Dr Himadri Bal, Professor Emeritus, Dr DY Patil Hospital, were present for this UG event.

# 19/09/2025: J&J Program:

The Elevate ObGyn Program, conducted on September 20th 2025, by Pune Obstetrics and Gynaecologist Society (POGS ) in collaboration with Johnson & Johnson, was a resounding success. The event featured crisp, structured lectures and case presentations on advanced suture techniques, enhancing patient healing and experiences in Obstetrics and Gynaecology. Special thanks to President Dr Manish Machave, Secretary Dr Nilesh Balkawade, and Clinical Secretary Dr Kalyani Ingle for their outstanding contributions to make this event happen.

The program boasted informative lectures by:
- Dr Manish Machave - President POGS (2025)
- Dr Ambalal Gurram - Senior Practitioner

Lectures were very informative, well structured. Especially PG students who attended the Program found the Lectures very helpful.

Sessions were expertly chaired by:
- Dr Milind Dugad
- Dr Purushottam Neurogaonkar
- Dr Kishore Pandit

The chairpersons appreciated all the lectures for their valuable insights. Expert chairpersons added some extra valuable points from their experiences, which was the cherry on the cake.

Engaging case presentations were delivered by:
- Dr Jytosna Angom
- Dr Kunal Shinde

Overall, the CME was highly informative, covering practical points that will significantly benefit our practice.

**Dr. Dipak Kolate**
Associate professor & Consultant Obstetrician Gynaecologist Infertility Endoscopic Surgeon

# An Ominous Case of Uterine Rupture in an Unscarred Womb and Its Subsequent Management

**Abstract**
Uterine rupture is a rare but critical obstetric complication that demands a swift and decisive intervention to ensure the well-being of the mother and fetus. We present a case report detailing the surgical management of a bizarre uterine rupture in a multigravida female with two previous vaginal deliveries and a previously unscarred uterus. This case highlights the challenges of treating and diagnosing, particularly in the Indian setting, an antenatally unregistered patient with rare obstetrical complications. Emphasizing the clinical challenges faced and the multidisciplinary approach employed for optimal outcomes, this report underscores the importance of a high degree of suspicion, early diagnosis, timely intervention, and comprehensive intraoperative and postoperative care in addressing this rare obstetric catastrophic event.
This article's main focus is multicentric, aiming to showcase the obstacles to maintaining low maternal mortality and morbidity, the presence of inadequate awareness in society, and the importance of multimodal treatment and planning.

**Introduction**
Uterine rupture in pregnancy is a rare but serious complication that endangers maternal and fetal health [1]. Despite its infrequency, its potentially catastrophic outcomes require prompt intervention and a thorough understanding of its causes, risk factors, and presentation.
The etiology of uterine rupture is multifactorial, often involving intrinsic and extrinsic factors. Key contributors include uterine scars from previous surgeries such as cesarean sections, myomectomy, dilation and evacuation, uterine septum removal, and trauma. Other risk factors are grand-multiparity, malpresentation, obstructed labor, assisted delivery, and macrosomia [2,3].
Scarred uterine areas are especially vulnerable during subsequent pregnancies. Uterine anomalies, fetal factors like macrosomia and malpresentation, and maternal factors such as advanced age and excessive uterotonic use also increase risk [2]. The compromised uterine wall integrity in scarred regions predisposes to rupture, which jeopardizes fetal oxygenation and maternal health, leading to hemorrhage, shock, and DIC [4].
Clinically, uterine rupture presents with sudden abdominal pain, abnormal fetal heart patterns, and maternal shock signs. Timely diagnosis through obstetric history, clinical assessment, ultrasound, and fetal monitoring is vital to reduce adverse outcomes. Management requires a prompt, multidisciplinary approach involving obstetricians, anesthetists, and surgeons. Diagnostic tools like ultrasound and MRI aid early detection. Surgical intervention, typically emergency laparotomy with uterine repair or hysterectomy, remains the mainstay of treatment.
This case highlights uterine rupture in an unscarred multiparous woman, underscoring the importance of antenatal registration, suspicion, clinical vigilance, diagnosis, surgical management, and postoperative care.

**Case presentation**
A 36-year-old woman, gravida 3, parity 2 (G3P2L2), presented with two days of sudden abdominal pain and foul-smelling discharge. She previously had two term vaginal deliveries

with instrumental assistance, resulting in live births, and has no significant medical or surgical history. She did not report current pregnancy or missed periods. Her history indicates instrumental delivery in both prior pregnancies, with baby weights of 1.9 and 2.1 kg. The casualty medical officer suspected a gynecological issue and referred her to our department.

On arrival, she was in severe pain. Abdominal examination revealed a uterine size consistent with full-term pregnancy, with palpable fetal parts. The fetal head was 0/5th palpable, and tenderness and mild infraumbilical bulging were observed. Fetal heart rate was absent, prompting urgent intervention.

**Diagnosis and decision**

The patient was unaware of her pregnancy, with no antenatal registration or immunization. Without scans or reliable history, a vaginal exam showed the cervix fully dilated and effaced, fetal head in occipito-posterior position, absent membranes, and foul-smelling discharge resembling tobacco juice. Mild suprapubic bulging persisted after bladder emptying, and uterine contractions were lost.

On arrival at 1:00 PM, BP was 140/86 mmHg, HR 114 bpm with sinus tachycardia. Clinically, a diagnosis of G3P2L2 with uncertain dates, obstructed labor, intrauterine fetal demise, and suspected uterine rupture was made. Ultrasound confirmed fetal demise, and an emergency cesarean section was performed due to the maternal condition and high suspicion of rupture.

**Surgical intervention**

A multidisciplinary team of obstetricians, anesthesiologists, and neonatologists performed an emergency cesarean section under general anesthesia via Pfannenstiel incision. The abdomen was explored, revealing foul-smelling hemoperitoneum and a uterine rupture involving bilateral broad ligaments extending laterally, with no placental or structural anomalies (Figures 1, 2).

Given the extensive rupture, an obstetric hysterectomy was decided after explaining the situation to the relatives and obtaining consent. The uterovesical fold was meticulously dissected, and the bladder was pushed downward and reflected. Then the bilateral uterine arteries were clamped, and the downward lateral extension was reassessed and noted to be extended to the vaginal angle before clamping Mackenrodt's ligament and uterosacral ligament. No ureteric pulsatile movements were noted. Given the above findings and to prevent ureteric injury, emergency cystoscopic ureteric Double-J stenting was carried out by a urosurgeon. Finally, the obstetric hysterectomy was completed.

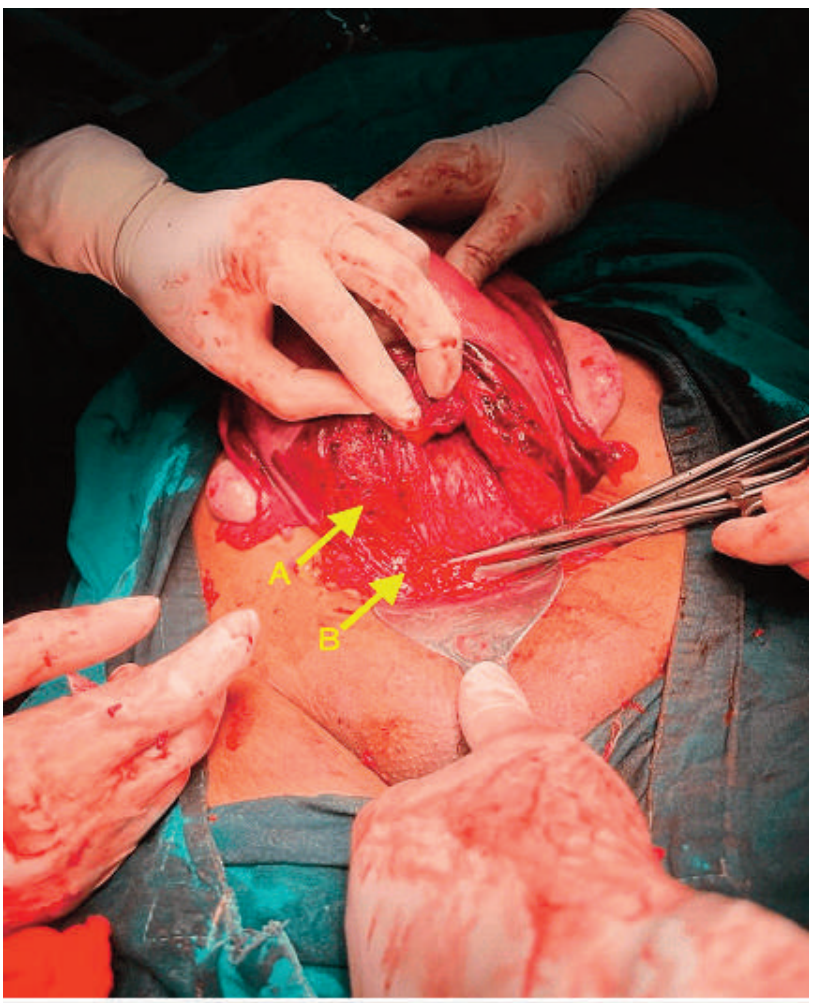


FIGURE 1: Intraoperative view of uterine rupture.

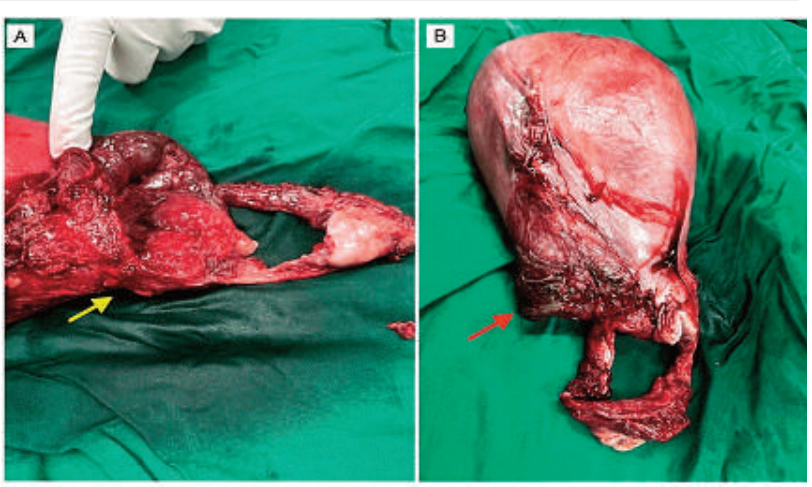


FIGURE 2: Postoperative specimen showing uterine rupture.

**Postoperative management**

Postoperatively, the patient was monitored in the ICU, receiving 2 units each of packed red blood cells and fresh frozen plasma, along with antibiotics. Her maternal prognosis was favorable, and she was discharged in stable condition on day 19 after thorough evaluation. The histopathology indicated acute endomyometritis with necrotizing cervicitis, extensive hemorrhage, and ischemic changes.

**Discussion**

The rupture of an unscarred uterus is undeniably a major, life-threatening emergent condition, defined as a complete or partial tear of the uterine wall in a pregnant uterus, often involving the myometrium and the overlying serosa. It can present with per vaginal bleeding, acute abdomen and fetal distress, and atypical contractions. Most uterine ruptures occur in women with a history of previous cesarean sections or other uterine surgeries, so unscarred uterine ruptures present a unique challenge due to their atypical clinical presentation, rarity, lack of timely diagnosis, and potential for severe consequences.

The overall incidence of uterine rupture was around 0.2 per 10,000 women [5], and rupture in an unscarred uterus was observed at a rate of 2 in 39,529, approximately 0.0051% [6]. By contrast, uterine rupture occurred in 0.8% of scarred uteri [7]. However, the incidence of uterine rupture varies globally, so the exact incidence is difficult to determine [8].

Occurrence of unscarred uterine rupture is associated with factors such as advanced maternal age of over 35 years old, multiparity, having a postdated pregnancy, multifetal gestation, the utilization of labor induction or augmentation, traumatic history (e.g., manual or instrumental obstetric maneuvers), external traumas, domestic violence, manual placental removal, and the presence of infective etiologies (e.g., chorioamnionitis) [8-11]. Rupture of the uterus is more commonly observed in women attempting vaginal birth after a cesarean or hysterotomy. It is also more common in women with a previous history of fetal surgery or uterine surgery, such as myomectomy or septoplasty. Scarred uteri are most vulnerable to rupture in the late third trimester of pregnancy or during labor [12].

Most unscarred uterine ruptures do not have notable risk factors, and it is important to note that this is an exceptionally rare event. In the absence of any known causative factor, it may be wise to presume a concealed history of previous pregnancy or surgery [8]. In addition, we must consider factors such as an unreliable history of unwanted pregnancy or unsafe abortions in the context of social taboos and cultural practices in developing countries.

Our case is a multigravida female with a previously unscarred uterus of advanced maternal age who was antenatally unbooked and reported with intrauterine fetal demise. Though there is no notable cause, possible risk factors like advanced maternal age, multigravida, prolonged labour, and previous history of operative vaginal delivery might have possibly contributed to the uterine rupture in this case. In such a situation, we prioritized maternal well-being and condition. Clinical acumen and a high degree of suspicion are paramount to prevent the loss of golden time. The use of resources such as ultrasound and magnetic resonance imaging is of added value whenever available and practical. Mourad et al. reported a similar case of a rupture in an unscarred uterus; the authors had opined that premature rupture of membranes with an abruption of placenta with Couvelaire uterus could be the most likely event in pathophysiology; however, unlike our case, a hysterectomy was not performed because the rupture and damage were to a lesser extent [13].

Sakr et al. reported a similar case with a scarred uterus [3], and Purdie et al. reported a ruptured uterus with disseminated intravascular coagulation [4]. The occurrence of uterine rupture poses life-threatening complications for both the mother and the infant. Primary indicators typically involve intense abdominal pain, frequently coupled with fetal distress, atypical heart rate patterns, and maternal shock [9]. It is imperative to promptly diagnose and intervene to minimize the risks linked with uterine rupture.

Uterine rupture, a critical obstetric emergency, typically requires immediate surgical intervention, commonly via emergency cesarean section, aiming to promptly deliver the baby and repair the uterine tear [12]. Extensive ruptures may necessitate a hysterectomy to control bleeding and avert further complications. Healthcare providers should prioritize preventing complications and ensuring successful patient outcomes, such as ureteric DJ stenting [14]. A multidisciplinary approach involving urologists, anesthesiologists, and intensivists can significantly mitigate complications, as observed in the current case [14]. Preventing uterine rupture in unscarred uteri involves thorough antenatal care, vigilant labor monitoring, and elective cesarean delivery in some cases. Monitoring for coagulation factors and signs of shock is crucial, with supportive measures such as intravenous fluids and blood transfusions

aiding stabilization in cases of significant blood loss [12]. Management decisions hinge on the severity of the rupture and the maternal-fetal condition.

**Conclusions**

Uterine rupture in an unscarred uterus, although rare, poses a significant threat to maternal and fetal health, necessitating a judicious balance between prompt identification and coordinated medical interventions. Such case scenarios , push the importance of thorough antenatal care, vigilant labor monitoring, a multidisciplinary approach, early clinical suspicion, timely intervention, and anticipatory measures in high-risk pregnancies. Although the risk factors for unscarred uterine rupture are not entirely preventable, continuous research and shared clinical experiences are imperative to refine management strategies and optimize outcomes Addressing psychological impacts and providing postpartum support are integral to comprehensive care.

Therefore, synthesizing current knowledge from scientific literature can enhance the understanding of such cases in diverse obstetric settings. Ultimately, uterine rupture poses a significant challenge to the mother, child, and attending obstetrician, underscoring the importance of maintaining a delicate equilibrium among this trio for favorable results.

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# The Firm Fundus That Fooled Me



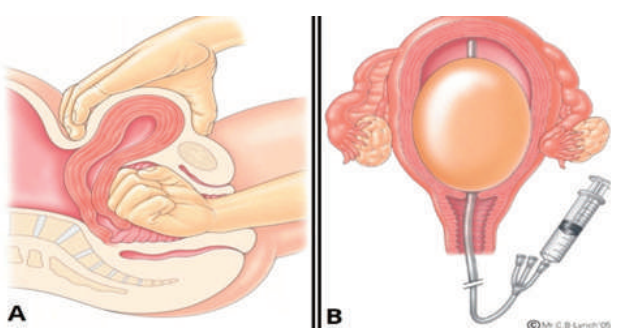
**The set-up**

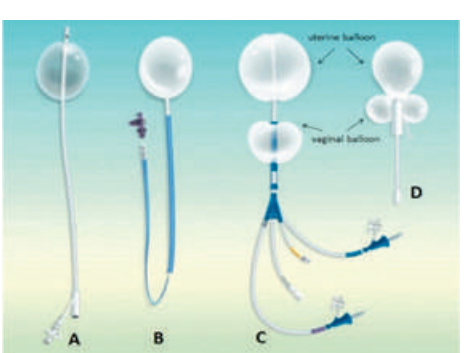
It was a calm afternoon on the labour ward when my next patient walked in,36 years old, a doctor herself, and someone I'd cared for from 26 weeks. She'd had one prior miscarriage and then an uneventful spontaneous vaginal birth in the Netherlands three years ago. This pregnancy had been reassuringly ordinary. That lullaby word, 'low risk', was already humming in my head.

She arrived at 38 + 6 weeks in spontaneous labour, 4 cm dilated, 40% effaced, with mild uterine activity. She ambulated, kept oral hydration, and her fetal heart tracings on intermittent auscultation were reassuring. Seven hours later she was fully dilated. At that point she requested epidural analgesia, which we administered. With EA in place, we switched to continuous CTG as per our unit's protocol. Second stage was managed with my usual disciplinarian duo: 'masterly inactivity and watchful expectancy'.

Two and a half hours later she began to crown and delivered a 3.4 kg, vigorous baby. We proceeded with active management of the third stage, the uterus felt well retracted, and the placenta delivered within 5–6 minutes. (For context: AMTSL remains a cornerstone for reducing postpartum blood loss and is to be used universally in all births. [1][2])

That's when my fumble began.




**The pivot**

Just as I was mentally filing this away as "textbook," torrential bleeding began.
Reflexes kicked in: call for help, assign roles, estimate loss, uterine massage, uterotonics, Tranexamic acid. We examined the lower genital tract and cervix no lacerations. The fundus remained firm, yet bleeding continued. That dissonance, a firm fundus with heavy bleeding should scream a short differential: lower uterine segment (LUS) atony or occult cervical/lateral tears. Our quick re-examination again found no trauma. (LUS atony with a contracted fundus is a described, easily missed cause of PPH and can even show a "ballooned" lower segment on ultrasound. [3][4])
She was normotensive, so we added methylergometrine (methergine) to the oxytocics. (Ergometrine/oxytocin combinations are effective but carry hypertensive side effects; selection should be individualized. [5]) I packed the uterus and vagina with surgical sponges 4 in number to buy time and asked for a uterine balloon. We placed it into the lower segment and confirmed position on ultrasound; the bleeding stopped. (Guidelines and contemporary evidence support uterine balloon tamponade (UBT) when atony persists despite uterotonics; ultrasound guidance or confirmation improves first-pass success and helps detect malposition. [6][5][7][8]).
Exactly I clocked the time and at twenty-six minutes post-birth the balloon was placed and bleeding stopped.
We deflated the balloon sequentially at 6 hours and removed it at 12 hours. The ward exhaled with me.

**The twist the next day**

On day 1 postpartum, my patient, usually stoic described sudden, unbearable cramping pain. My first thought: 'a retained pack or sponge?' We re-checked meticulously; ultrasound was negative. The uterus was well involuting, lochia appropriate, vitals steady.
Staring at the scan, and replaying the night, an old whisper turned into a plausible explanation: adenomyosis. She had sonographic features noted antenatally, and now I was seeing the clinical logic of myometrial disarray and altered junctional zone function can produce disordered contractility ("dysperistalsis"), predisposing to labour dystocia, retained placenta, focal/segmental atony and PPH. In cohort data, adenomyosis has been associated with increased risks of adverse obstetric outcomes—including PPH; pathophysiologically, impaired uterine contractility is a suspected mechanism. [9][10]
With that in mind, I labelled the episode what it likely was: intermittent atonicity primarily in the lower uterine segment, in a uterus with adenomyosis, now manifesting as severe after-pains. (Several reports describe primary LUS atony with a firm fundus, and adenomyosis is increasingly recognized as a risk context for atony/PPH even if formal guidelines haven't universally elevated it to a "major" antenatal risk factor. [3][4][10])

**Where I fumbled (and what I changed)**

1) Anchoring bias on "low risk." I was lulled by an uneventful labour and a well-retracted fundus. PPH often strikes without classic risk factors, and LUS atony can bleed torrentially while the fundus feels firm. Now, when bleeding is disproportionate to a firm fundus, I immediately examine cervix/vaginal vault again and consider LUS atony, with a low threshold for ultrasound. [11][3]
2) Not pre-positioning the UBT early. We lost precious minutes waiting for the balloon. Today, for any atony that's not responding promptly to uterotonics, we open the UBT kit immediately and a colleague preps ultrasound for guided placement. (WHO/FIGO and contemporary reviews endorse UBT when uterotonics fail, and US guidance improves speed and accuracy. [6][5][7])
3) Under-using point-of-care ultrasound (POCUS). A quick scan can reveal LUS distension/ballooning, confirm balloon position, and rule out concealed hematoma turning guesswork into action. [7][8]
4) Antenatal flags for adenomyosis. When antenatal imaging suggests adenomyosis, we now tag charts to anticipate third-stage issues and focal atony, keep UBT/POCUS ready, and agree on a clear escalation plan. (Large registry and review data link adenomyosis with several adverse perinatal outcomes; altered contractility is a consistent mechanistic thread. [9][12])
5) Reinforcing the bundle mindset. Our drills re-emphasize AMTSL, timely uterotonics, consideration of TXA within 3 hours when PPH is diagnosed, UBT before shock, and team choreography because speed saves uteri. (Cochrane/FIGO/WHO-aligned summaries: AMTSL reduces blood loss; TXA based on WOMAN trial evidence—reduces mortality; UBT controls >80% of non-responding atony cases before shock in many series. [1][5])

**What went well?**

System 1 but verified by System 2. We didn't wait for hypotension; methergine was appropriate given normotension, and we escalated to UBT rapidly once trauma was excluded. [5]
Imaging-assisted hemostasis. Ultrasound confirmation of low-segment balloon placement likely shortened

time to control. [7][8]
Thoughtful day-after review. We did not dismiss her pain; ruling out retained sponge and considering adenomyosis-related dysperistalsis/intermittent atony gave us a coherent explanation and a counselling point for the future. [9][10]

**Pearls for younger gynaecologists**
If the fundus is firm but bleeding is torrential, think LUS atony. Re-inspect the cervix/vaginal walls and use ultrasound to look for lower-segment ballooning. [3][4]
Don't hesitate on the balloon. UBT is guideline-supported once uterotonics fail; ultrasound guidance/confirmation improves success and avoids time-consuming repositioning. [6][7]
AMTSL is still your best friend. It reduces postpartum blood loss; tailor the uterotonic (and watch for ergot-related hypertension). Consider TXA early when PPH is diagnosed. [1][5]
Adenomyosis is not just a fertility story. Antenatal imaging suggestive of adenomyosis should prompt heightened vigilance for atony/PPH and planning for rapid escalation tools (UBT, POCUS). [9][10]
Document, debrief, and drill. PPH outcomes improve with team rehearsal and bundle adherence. (WHO's recent guidance and roadmaps emphasize standardized bundles and timely escalation pathways.) [13][14]

**A closing word to my patient (and to you)**
That day, a "low-risk" labour taught me (again) that obstetrics stays humble. The firm fundus fooled me, but LUS atony didn't once I listened harder, scanned sooner, and ballooned faster. And adenomyosis quiet through pregnancy made itself known only when the orchestra stopped playing.
If my fumble helps you anticipate yours, this story has done its job.

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**Dr. Charuchandra Joshi**
MD FICOG
Past President POGS

# This story goes back more than 35 years

**"देव तारी, त्याला कोण मारी !"**

A beautiful young woman came to me with a request for termination of her early pregnancy. She was in a 'live in' relationship with a man who was already married and therefore, she was not in a position to continue the pregnancy.

Mind you, in those days, in Pune, sonography was not very widely used. Also, oral medication for termination of pregnancy was not yet invented. Therefore, every termination of pregnancy had to be a Surgical procedure (of suction- evacuation.)

So, we took her up for the procedure of suction evacuation. General anaesthesia was administered, and I started to dilate the cervix.

For a practising gynaecologist, cervical dilatation is a day to day, routine thing and is easily done without difficulty.

But, on that particular day, the cervix just refused to dilate.I tried all the tricks in the book, but without success. Finally, in order to avoid injury, we decided to abandon the procedure.

I explained to the couple what had happened and got a sonography done to see if the pregnancy sac was disturbed. To my surprise, not only had the pregnancy escaped unhurt, but it was a twin pregnancy! I suggested that we may try a second-trimester procedure after a few weeks. In the meantime, I also suggested to them to reconsider whether they could continue with the pregnancy.

They gave it a good thought and came back to me a few days later, with a decision to continue with the pregnancy, irrespective of their marital status or the lack of it.

I respected their wish and offered her proper antenatal care. At term, I delivered her with Caesarean section and two healthy boys, each weighing about three kgs, were born.

They became a happy family. The two boys grew up to become fine young. lads. They found two beautiful girls for themselves and were happily married to them. Each had two children.

Today, when I look at the happy family, complete with the original couple that have become grandparents, and the two boys who have their own families, I can't stop wondering about the God's hand in our lives.

Only if on that fateful day, my Hegar's dilator had gone 2 centimetres ahead beyond the internal os, I would have been able to successfully terminate the pregnancy, as was initially planned.

But then, these beautiful people would not have come into existence.
In Marathi, there is a proverb ,"देव तारी, त्याला कोण मारी", meaning thereby, no evil can affect someone who is protected by God.

Though, technically, it was the failure of the surgical procedure, the end result was good for everyone including myself and I am thankful to God for it.

**Dr Deepshikha Dwivedi**
**MBBS ,DNB,FICS (obgy),**
**Fellowship in Endoscopy and Infertility**
**Director of LIfetree Hospital, Hinjewadi, Pune**

# The Night Science Bowed to Faith

As doctors, we are trained to trust science—data, evidence, and established protocols. Yet every so often, a case comes along that humbles us, reminding us that medicine is not only about numbers. It is also about faith, intuition, and the extraordinary persistence of families who refuse to give up.

It was 2 a.m. on a quiet October night in 2017 when my phone rang. The call was from the Emergency Department.
A 39-year-old woman, weighing 126 kilos, had been admitted with severe abdominal pain. Her blood pressure was alarmingly high at 160/110 mmHg, and on examination, her abdomen was rigid and tender.

The surgeon on call attended to her and requested an urgent ultrasound and X-ray abdomen. She could not recall her last menstrual period. Her history made us pause: three failed IVF cycles, a decision to adopt a daughter, and even two dogs to fill her life with love. Motherhood, for her, had seemed like a closed chapter.

The X-ray revealed what none of us expected—a fetus.

Because of her morbid obesity, it was nearly impossible to determine the gestational age. On per vaginum examination, we found meconium-stained liquor. The diagnosis was now Elderly Primigravida with severe preeclampsia with an unknown gestational age and meconium-stained liquor with morbid obesity—an obstetrician's nightmare.

As I stood there, anxious, my mind racing with risks and complications, her husband held her tightly, tears of joy in his eyes. While I was worried about her blood pressure, he was celebrating the impossible—that she could be a mother.

This was a completely unsupervised pregnancy: no check-ups, no scans, no vaccinations, no tests. We had no roadmap, only risks. We explained everything and prepared for an emergency caesarean section, taking consent for possible complications—NICU admission, eclampsia, congenital anomalies, meconium aspiration.

The NICU team stood ready.

In the operating theatre, we delivered a healthy 3.5 kg baby boy, covered in thick meconium yet breathing strong. To everyone's relief, he needed no NICU admission. The mother's blood pressure slowly began to settle. When the baby was handed to the family, the room was filled with tears, laughter, and disbelief.

One line kept echoing in my mind that night: "Jake rakhe Saiyan, maar sake na koi."

The next morning, her husband came to me, asking for a letter stating that they had been completely unaware of the pregnancy. Even for them, the reality was difficult to believe.

And then came the final twist: the woman was an accomplished IT professional, a gifted writer, and the daughter of an anesthetist.

That night reminded me of something every doctor must carry in their heart: medicine is not just science. It is also mystery, hope, and sometimes—miracles we cannot explain

**Dr Vivek Joshi**
**Director, Department of ObGyn, KEM Hospital, Pune**

# Expect the unexpected, believe in the unbelievable, Achieve the unachievable

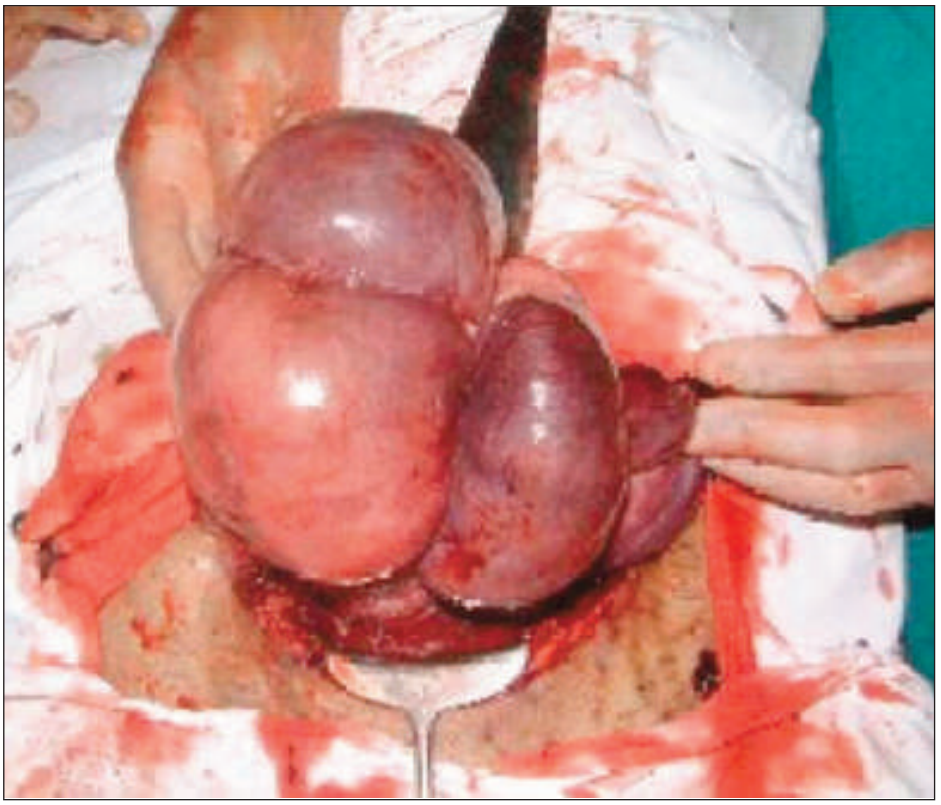
Mrs. AK, a primipara aged 26 years, was referred 12 hours after a caesarean section and B-Lynch procedure with coagulation failure and shock.

She had a normal pregnancy till near term when she developed pregnancy-induced hypertension (PIH) for which she was treated with antihypertensives. Following the spontaneous onset of term labour at a peripheral hospital, thick meconium stained amniotic fluid was discovered at 6 cm cervical dilatation and an emergency caesarean section was done only to deliver a fresh still- born baby. There was no placental abruption. During the caesarean section, an atonic postpartum haemorrhage failed to respond to uterotonic agents and a B-Lynch proce- dure was performed using a gauge 1 polyglactin suture. Haemostasis was confirmed before abdominal closure. However, post-operatively she developed hypotension, oozing of blood from the abdominal incision and haematuria. There was little vaginal bleeding. After 12 units of whole blood transfusion, she was referred to our unit. On admission, she had a pulse rate of 140/min, a res- piratory rate of 42/min, a systolic pressure of 70 mmHg and an oxygen saturation of 86%. The abdomen was distended and she was oozing blood from the incision with minimal vaginal bleeding. The scanty urine was frankly blood stained. The haemoglobin was 6.8 gm/dL, haematocrit 20%, platelet count 18,000/mm3, prothrom- bin time 37 seconds (control 15 seconds), partial throm- boplastin time was 54 seconds (control 30 seconds), plasma fibrinogen was 170 mg/dL, serum glutamate aspartate transferase (SGPT) was 167 IU/mL and serum creatinine was 1.2 mg/dL. Abdominal ultrasonography showed the uterus deviated to the right side and was surrounded by multiple haematomata, suggestive of uter- ine rupture.After 6 units of FFPs and platelet concentrate trans- fusions, her platelet count rose to 36,000/mm3, prothrombin time improved to 21 seconds (control 13 seconds), partial thromboplastin time to 34 seconds (control 27 seconds). At laparotomy, the uterus was congested and distended be- tween the compression sutures giving it a lobulated appear- ance. The sutures had cut through and embedded in the uterine wall while the intervening portions of the uterine wall had distended with blood. There was bluish black discoloration on the uterine surface with blood oozing out (Fig. 1) The suture line on the lower segment was intact. There was haemoperitoneum of about 2 L. A total hys- terectomy with bilateral internal iliac artery ligation was done. Haemostasis was confirmed before closure and place- ment of appropriate closed drains. In the post-operative period, she had an episode of generalised convulsions on post-operative day one from vasogenic brain oedema, febrile morbidity on post-operative days six and seven, and the syndrome of inappropriate secretion of antidiuretic hormone from day nine which responded to desmo- pressin. She made a good recovery and was discharged on the 20th day.

**Discussion**

The B-Lynch suturing technique1 involves a pair of vertical brace sutures around the uterus, essentially to appose the anterior and posterior uterine walls. It was designed for the control of massive postpartum haemor- rhage avoiding difficult and hazardous surgery while pre- serving the patients' uterus and fertility. Modifications2 have been used in case of postpartum haemorrhage at caesarean section for placenta praevia. The modification may have the added advantage of being simpler to perform avoiding the need to open the uterus Although B-Lynch used gauge 2 chromic catgut for the uterine brace sutures, polyglactin has been used by others.3

In this patient, haemorrhage was apparently controlled at the time of caesarean section by the brace sutures. The coagulopathy might have developed in the post-operative period and along with severe atony led to continued bleeding in the uterine cavity with the resultant out-pouch- ing of the uterine walls as seen in the photograph.



B-Lynch mentioned that 'such suturing techniques may not achieve adequate control of bleeding from an atonic uterus'. However, if such a pathology develops after closure of the abdomen on immediate post-operative peri- od, the likelihood of the brace suture's failure to control haemorrhage is high.

The brace suture works by direct application of pressure on the placental bed bleeding and by reducing the blood flow to the uterus. The tension is probably critical to success. Too tight sutures may compromise the blood supply of the uterus or prevent spontaneous uterine retrac- tion or even stimulation by uterotonic agents in the post- operative period. Too loose sutures may allow uterine filling by inadequate compression.

The present report shows that the sutures' most important mechanism of action is direct pressure on the uterus. For the sutures to exert significant pressure on the walls of the uterus, it is essential for the uterine walls to have some inherent tone. As a result, the compressive force would limit the blood loss. On the other hand, severe atony would encourage collection of blood in uterine cavity between the sutures as in this case in a perpetuating manner leading to further atony.

**Acknowledgements**

The authors would like to thanks Dr Suhas R. Otiv, Hon. Assoc. Professor, Department of Obstetrics and Gynaecol- ogy, KEM Hospital, Pune for his substantial contribution in writing the manuscript.

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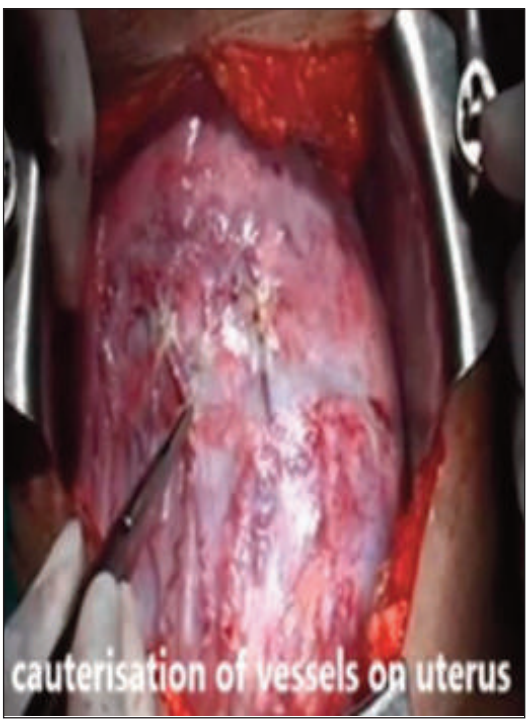
# 'Depth - not everyone can handle it - a word of caution'

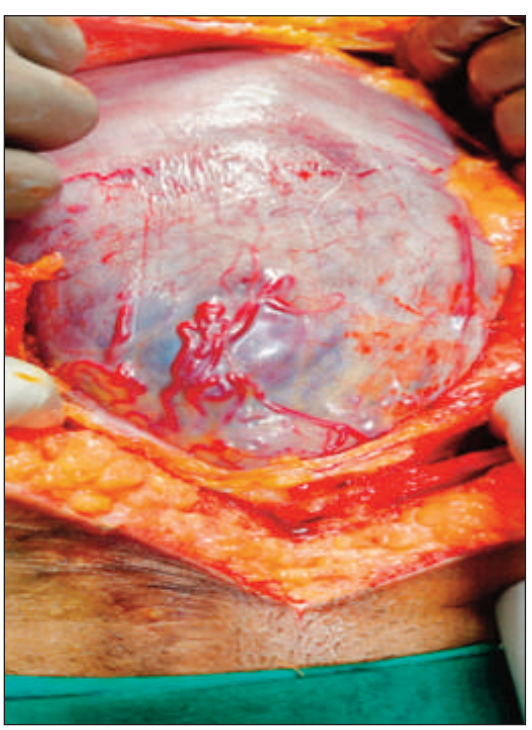
**Dr Vivek Joshi**
**Director, Department of ObGyn, KEM Hospital, Pune**

Dr Vivek Joshi has devised new techniques of Uterine and Vault suspension to the Pectineal ligaments, which are internationally accepted and being done

A patient G3P2/ 37 weeks pregnancy/ previous 2 LSCS was referred to our hospital with Placenta Previa. There was no history of bleeding. All the antenatal ultrasound examinations reported central Placenta Previa and there was no mention of placenta accreta spectrum.
The patient was posted for cesarean section keeping blood and blood products ready.
Laparotomy was done with midline incision excising previous scar.
At laparotomy the uterus had bluish hue and there were multiple vessels running on the surface of uterus.
Due to suspicion of placenta accreta at laparotomy, I started dissecting the bladder in anticipation of possibility of peripartum hysterectomy.
During this procedure the papery thin lower segment gave away and there was massive hemorrhage .
I took out the baby through the lower segment incision and found that the placenta was adherent and could not be seperated.
A difficult hysterectomy was performed after dissecting the bladder
Meanwhile, there was massive postpartum hemorrhage from the thin lower segment to which the placenta was attached.
After multiple blood and blood products transfusions the patient was resuscitated.
There was injury to the bladder which needed repair .

TAKE HOME MESSAGE :
1)- Whatever is the preop USG or MRI findings , a patient with placenta previa and prior uterine scar ( LSCS, myomectomy etc) the patient should be considered as having placenta accreta spectrum and necessary preparations should be made . The final diagnosis of PAS is always at laparotomy
2)- In case the diagnosis of PAS comes as a surprise at laparotomy , the abdomen should be closed and patient referred to a tertiary care centre.
3)- Diagnostic criterion for PAS at Laparotomy are bluish discoloration of uterus and blood vessels running across the serosa as shown in Fig 1 and Fig 2.



**Dr Milind Dugad**
Managing Director
Dugad Hospital (P) Ltd

# 'The two most powerful warriors - Patience & Time' quote by Leo Tolstoy is true

My friend was on vacation when I got a call from his hospital regarding a case of ruptured ectopic pregnancy. The patient was hemodynamically stable but complained of lower abdominal pain, and I was requested to come urgently for laparoscopic management. I immediately cancelled my OPD appointments and rushed to the hospital with my team and the necessary laparoscopic equipment. While driving, I called the anaesthetist to reach as early as possible, since it was a ruptured ectopic pregnancy. I also instructed the staff to send blood for cross-matching and to arrange urgent hemogram and other necessary investigations.

On reaching the hospital, I asked my assistant to prepare the trolley and requested the duty sister to bring the patient to the operation theatre so I could clinically examine her before surgery. I was expecting to see a patient with severe abdominal pain and sweating. To my surprise, the patient walked into the operation theatre on her own and reported only mild lower abdominal discomfort. She had conceived after seven years of infertility, but it was a natural conception. I considered the possibility of a leaking ectopic pregnancy with haemoperitoneum.

We usually insert the uterine manipulator which helps in lifting uterus with both fallopian tubes, thereby, making tubal assessment for site of ectopic pregnancy easy. At times, in ruptured Ectopic pregnancy, both fallopian tubes & uterus are completely immersed in blood & are not visible at all. However, because I was doubtful about the presentation, I instructed my assistant not to use the uterine manipulator. After giving general anaesthesia, we inserted the laparoscope. To my utter surprise, we found a large amount of yellow-coloured fluid, most likely from the corpus luteum, and no evidence of ectopic pregnancy. I suspected the pregnancy to be intrauterine but too small to detect due to wrong dates. Therefore, we decided to abandon any further procedure.

A repeat ultrasound done two weeks later confirmed an intrauterine pregnancy, which continued uneventfully, and the patient later delivered a healthy baby.

**Take-home message:** If your clinical judgment and investigation reports do not support each other, do not blindly rely on investigations alone. Instead, rethink, and plan your treatment strategy accordingly.

# THE CASE OF THE MISPLACED IUCD: A Lesson in Vigilance

**Dr Uma Wankhede**
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Nearly two decades ago, when I was a newly appointed Associate Professor at Sasoon General Hospitals, I encountered a case that continues to resonate with me—not just for its surgical complexity, but for the important lessons it taught me about clinical vigilance and humility.

A staff nurse visited our outpatient department with a rather straightforward concern: she was unable to feel the threads of her Copper-T which had been inserted two years earlier following her last childbirth. A speculum examination confirmed her concern,the threads were indeed not visible.

An ultrasound was promptly performed, which revealed the IUCD to be displaced but still within the uterine cavity. We scheduled her for removal under general anaesthesia two days later. However, just before her admission, she informed us that she had begun her menstrual cycle. We advised her to return a week after her period had ended.

When she was finally admitted, we proceeded with the planned removal under general anaesthesia. Initial attempts with a hook to retrieve the IUCD failed. We then carried out a thorough dilatation and curettage  but again, to no avail.

At this point, our unit head decided that a laparotomy was necessary, as laparoscopic facilities were not available at the time. I made a subumbilical incision and conducted an exhaustive search: the uterus, omentum, bowel loops, and paracolic gutters were all explored meticulously. No trace of the IUCD.

We called in our surgical colleagues, who extended the incision upwards for a more comprehensive search. Still, nothing. A C-arm was brought in from the orthopaedic OT and intraoperative X-rays were taken. While waiting for the films to be developed, our unit head suggested one last check,an incision into the uterus to manually explore the cavity. It was, as feared, empty.

Eventually, the X-ray films were reviewed,no sign of the IUCD. We concluded, albeit with sinking hearts, that the IUCD must have been spontaneously expelled during her recent menstruation, and we had failed to reconfirm this post-menses. The long incision was closed. Postoperatively, we explained the events to the patient. Despite being a medical professional herself, she was adamant that she had not seen or felt any expelled IUCD. Seven days later, before her discharge, our unit head,still concerned,ordered a standing abdominal X-ray in the radiology department, noting that intraoperative C-arm imaging may not have covered the full field.

To our astonishment, the IUCD was clearly visible in the left subphrenic region,lodged under the diaphragm. It had perforated the uterus and migrated into the upper abdomen, a rare but known complication.

The patient, being a staff nurse, understood the situation and graciously consented to a second surgery. This time, a full midline incision from xiphisternum to symphysis pubis was made, and the elusive IUCD was finally retrieved.

**Lessons Learned**

1. Reinvestigate When Plans Change

A patient's clinical status can evolve rapidly. If surgery is delayed for any reason, repeat imaging and re-evaluation should be standard practice.

2. Never Underestimate a "Missing" IUCD

A lost IUCD is not a trivial matter. Migration, though rare, can lead to serious complications. Proper localisation is critical before any surgical intervention.

This case remains etched in my memory—not for the rarity of the IUCD's location, but for the invaluable clinical wisdom it imparted. Sometimes, medicine humbles us not just with its complexity, but with its ability to remind us of the basics: always confirm, always recheck, and never make assumptions.

# An Unforgettable Case of My Life

**Dr Uma Wankhede**
HOD & Professor Department of Obstetrics & Gynaecology GMC, Baramati

Nearly 15 years ago, a case came to me that I still recall with a heavy heart and the many lessons it had taught me

A 22-year-old pregnant woman was referred to Sassoon General Hospital from Satara. She was at 28 weeks of gestation and had been diagnosed with Primary Pulmonary Hypertension (PPH) on 2D echocardiography a condition known for its high maternal mortality, especially during pregnancy, with fatality rates reaching up to 50%.

For years, I had taught students that PPH in pregnancy is an absolute indication for termination, particularly in the early stages. Yet here she was asymptomatic, cheerful, and completely unaware of how serious her condition was. Her relatives were also skeptical about the need for hospitalization. It took considerable counseling to convince them to admit her.

She remained admitted for nearly 10 weeks without showing a single cardiac symptom. Comprehensive evaluations were done, involving a physician, cardiologist, and anesthesiologist. A repeat 2D Echo confirmed the diagnosis of Primary Pulmonary Hypertension.

After multiple discussions and careful planning, we decided to proceed with an elective Lower Segment Cesarean Section (LSCS) at 38 weeks, under epidural anesthesia. I performed the surgery, with a full team of senior staff present, including the anesthetist, cardiologist, and neonatologist.

The delivery went smoothly. She gave birth to a healthy baby girl, and not once during the operation did any of her vital signs fluctuate. As a precaution, she was monitored in the ICU for 48 hours, where her vitals remained perfectly stable.

Throughout her stay, we repeatedly counseled her husband about the high-risk nature of her heart condition, urging him to consider vasectomy to prevent any future pregnancies, which could be fatal for his wife. However, he was only 24 years old, and each time, he refused, saying he was too young to take such a step.

She continued to do well postoperatively no symptoms, stable vitals, smooth recovery.

Looking back, we felt some reassurance that we hadn't opted for an MTP, given that she had come after she had crossed 20 weeks and had managed to go to full term with a successful delivery.

Soon, she was ready for discharge. We removed her sutures and began the discharge process.

**Then, the unthinkable happened.**

We received an urgent call from the ward nurse: the patient had been found unresponsive. We rushed to the ward, but it was too late. She had passed away suddenly.

A postmortem examination revealed the cause a massive pulmonary embolism.

The loss was devastating. What made it more painful was that her husband who had refused vasectomy despite months of counseling now turned around and said, "I didn't do it because I'm only 24. I have my whole life ahead of me."

**Reflections and Lessons Learned**

1. Textbooks are right more often than we'd like to admit.

Primary Pulmonary Hypertension remains a lethal condition in pregnancy. Even in the absence of symptoms, the risk is real and unpredictable.

2. Decisions about sterilisation must be approached with empathy and foresight.

In cases of severe maternal illness, it is important to counsel partners thoroughly but also with the understanding that the woman's prognosis may be limited. Permanent solutions like vasectomy should be weighed carefully, considering the emotional, social, and personal implications for a young partner who may have to move on in life.

This case taught me more than any textbook or classroom ever could. It was a reminder that medicine is not always about statistics or clinical stability but about respecting the unpredictability of the human body and the delicate interplay of life and death.

It remains one of the most unforgettable experiences of my career.

# HOLT ORAM SYNDROME AND CONGENITAL HAERT BLOCK: A RARE CASE REPORT

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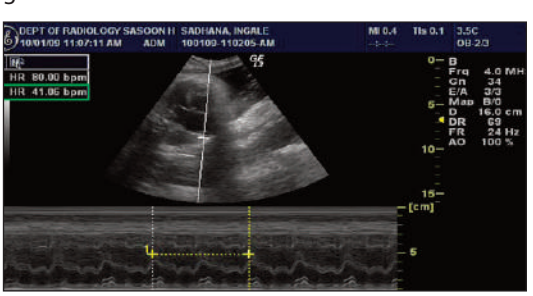
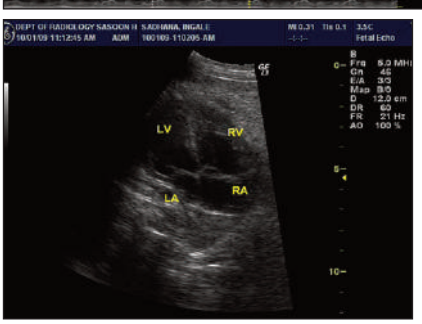
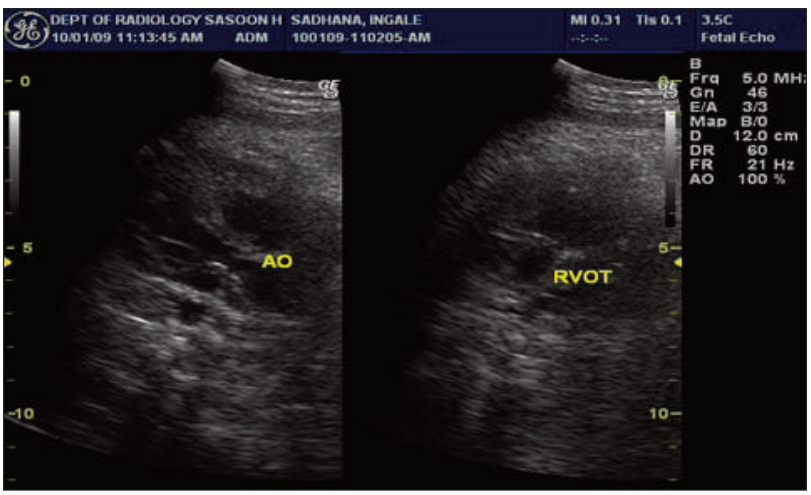
HOD & Professor Department of Obstetrics & Gynaecology GMC, Baramati

**Dr.Laxmikant Behele**
**MBBS MS OBGY**
Director Lotus Hospital Wagholi, Pune

• 38 year old primigravida
• h/o 9 months of amenorrhea
• MENSTRUAL HISTORY : LMP – 24th april 08. EDD – 1st feb. 09.
• On :30th Dec. 08.
• Gestational age by dates 35weeks , 5 days.
• Gestational age by USG 35 weeks , 5 days (21 weeks,5 days) 34 weeks, 4d, (34 weeks,1day), enlarged fetal heart with bradycardia ( FHR – 96 / min.), AFI – 24 cm.
• Senior level USG : 35 weeks , 6days. The findings were same.
• OBSTETRIC HISTORY : G2 ,A1 , married since 2 years (Both the husband and the wife were having their second marriage after being divorced from their previous spouses ). Spontaneous conception .
• G1 – MTP done at 2 months.
• G2 - The present pregnancy , registered at 22 weeks , immunised .
• Past / Personal / Family history of the wife apart from having a divorce was not contributory .
• Husband : 40 years ,pharmacist. K/c/o Holt Oram syndrome , diagnosed and was operated for ASD at the age of 12 years.
• He had two children from his prior wife.
• FIRST :Female baby, had only ASD.
• SECOND : Male baby, severely affected with ASD, VSD and mild pulmonary hypertension, with hand deformities
• Both babies are alive .
• EXAMINATION OF THE CASE
• O/E :GC Stable ,afebrile.
• P- 84/min , BP – 160 / 110 mm Hg.
• Pedal edema was present. No pallor.
• CVS Exam. Normal
• RS Exam . Normal .
• P/A : Uterus FT, Relaxed,
• Cephalic, Head was floating .
• FHR – 45 beats / min.
• Liquor clinically increased
• EFW – 2.7 kg.
• P/S exam – no discharge.
• P/V exam – os closed , uneffaced.
• Pelvis was adequate
• INVESTIGATIONS :
• Hb (10.5 gm%), urine (proteins 1+), blood group - O positive , HIV and VDRL negative .
• O' Sullivan at 22 and 26 weeks – Negative.
• Repeat O'Sullivan at 36 weeks- BSL – 218 mg % but the BSL profile was found to be normal .
• The couple was advised Quadruple test .
• (not done, not affording )
• 31st Dec. USG : 35weeks , 6 days pregnancy with AFI -21 cm with no other sonografically detectable congenital anomalies except diffuse cardiomegaly without hypertrophy and severe bradycardia with AV block.
Atrial rate – 110 beats/min.
Ventricular rate – 40 beats /min.
Structural relationship of the heart chambers is normal. Flow across the valves is normal. No IVC dilatation, ascites or pleural effusion is seen to indicate CCF.
EFW – 2.9 kg.
Obstetric doppler – normal
SPECIFIC INVESTIGATION: MOTHER
• Anti cardiolipin antibodies – Normal.
• Anti ds DNA – Negative .
• L E Cell phenomenon- Negative.
• ESR ( Wintrobe method ) – Raised , 44 mm at the end of 1 hr.
• CRP -Normal
• SPECIFIC INVESTIGATIONS :FETUS
• FETAL HEART RATE :41 BPM
• Diffuse cardiomegaly without hypertrophy.
• Normal relation of the heart chambers with the great vessels.



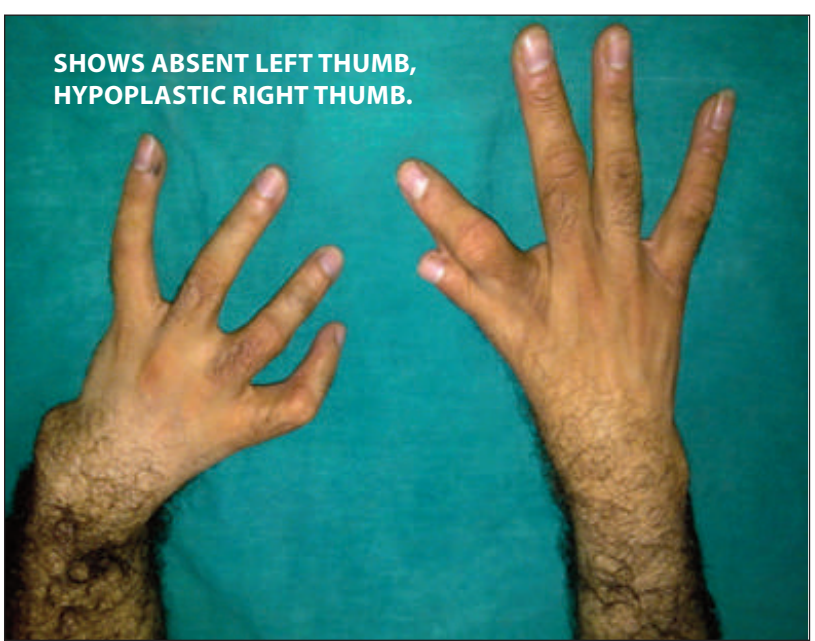


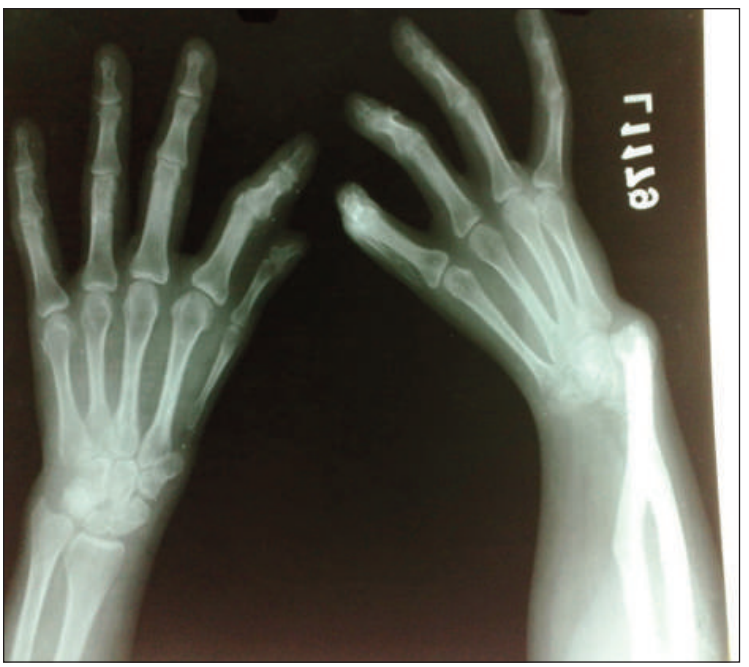

**SPECIFIC INVESTIGATIONS :FATHER**
**X RAY – FATHER – BOTH THE HANDS**

1. Absent left thumb.
2. Hypoplastic right thumb.
3. Radioulnar synostosis.4. extra phalanx at proximal metacarpal of little finger.

**MANAGEMENT OF THE CASE**

• MONITORING – Severe Pre eclampsia
• BSL Profile – Normal
• Tab.Alpha methyl dopa 500 mg thrice daily..
• Consultation with specialists in Fetal medicine and pediatric cardiology.
• ADVICE : a. Rule out SLE in the mother
b.Steroids- T.Dexa 8 mg thrice daily, to be tapered while stopping.
c. Explain the couple about the disease of the baby, mode of delivery and need for good NICU care and pacemaker implantation postnatally as per the hemodynamic status of the baby.
• Repeat pediatric cardiologist reference: with investigations)



• ADVICE : Taper steroids. The cardiac disease in the baby is secondary to the Holt Oram syndrome in the father.
• Early delivery, to shift the baby to DMH – NICU for better care and pacemaker implantation as per the need.
• Joint decision was taken.
• Elective cesarean delivery was performed with senior pediatrician attending the baby immediate postnatally

**POSTNATAL EXAMINATION OF THE BABY**

• Female ,2.7 kg.
• Cried immediately after birth .
• APGAR:1 min-5 , 5min – 7, 10min – 7.
• Drying , suctioning was done.Baby was found cyanosed.Given Oxygen, colour improved.
• Euthermic,euhydrated.
• HR- 40 beats/ min, RR – 48/min. CRT – 3 sec.
• CVS exam. No murmur,Severe bradycardia.
• RS exam . Clear, AE BE.
• PA exam . Normal
• Umbilical cord : 2A+1V.
• Both the hands showed the thumb in alignment with other fingers. Left thumb was triphalangeal. Low set ears.
• Inj.isoprenaline for first three days,maintained HR 60-75 bpm and oxygen alongwith dobutamine drip.
• On 15th Jan. temporary epicardial pacemaker was inserted with the battery attached to the anterior abdominal wall. HR was set at 110 bpm. Hemodynamic stability and oxygen saturation of the baby was found within normal limits.

# Secrets & trust are patient's own treasures, they think twice before handing over to us.. learn to be trustworthy

**Dr Manish Machave**
**MBBS, MD - Obstetrics & Gynaecology, DNB - Obstetrics & Gynecology**
President, POGS

INTRODUCTION- During my stint as a student and clinician in our amazing branch of Obstetrics and Gynecology, I encountered a lot number of cases that challenged not only my clinical reasoning but also my understanding of the broad spectrum of presentations in women's health. While many cases followed predictable patterns, some presented with vague and overlapping symptoms that defied initial diagnostic impressions.
Here is one case where we missed a lot of important information.

**CASE-**

44 year old patient P2 L2 with previous 2 vaginal deliveries and interval sterilization done was posted for Total Laparoscopic Hysterectomy with Bliateral Salpingectomy for Abnormal Uterine Bleeding ,unresponsive to medical management
Clinical examination revealed that Vitals and Systemic Examination were normal
P/A -midline vertical scar….of Tubectomy seen
Pelvic examination- bulky tender Uterus, rest no abnormality detected
Lab Investigations were within normal limits
USG- Bulky Uterus with Adenomyosis
Hysteroscopy With Endometrial biopsy-Endometrial Hyperplasia without atypia
Preop investigations, Fitness, counseling and consents done and patient was posted for the said surgery under GA.

**Intraoperative-**

As expected due to previous Tubectomy-Omental Adhesions seen and adhesiolysis done with harmonic – pic 1
While this was on inadvertently the bladder opened-pic 2
Bladder was dissected away from Cave of Retzius-pic 3
It was sutured in 2 layers with Vicryl no 1 and procedure completed….uneventful-pic 4 and 5
Post op bladder drainage for 15 days with Foley's done.
Patient and her daughter were counseled post op who showed no signs of concern or panic over the Bladder injury

**QUESTIONS BOTHERING US-**

1. Why so many and dense adhesions after Tubectomy??
2. Now the TUBECTOMY SKIN incision looked a little larger, why???
3. Why Bladder was adherent to the Tubectomy omental adhesions???

**ON DISCHARGE-**

We tried to get the answers from the patient…
…who readily complied.
1. She had two induced abortions and her husband was not willing for Tubectomy or IUCD.
2. She went to stay with her parents at Nashik and got Tubectomy done there, without telling her husband.
3. During Tubectomy her Bladder got opened and was sutured and Foley's was kept for 3 weeks.
4. None of this was ever discussed with her husband or at her house to keep the Tubectomy a secret.

And to our dismay and surprise, on discharge she kept a hand on my shoulder and said "Dr, you diagnosed and managed my Bladder problem so well. My Bladder only is at fault and somehow opens at every surgery. But u don't worry, I always make a super recovery".
And she kept her word. This year I delivered her daughter.

**CONCLUSION-**

This is the case that stumped me—and ultimately taught me one of the most valuable lessons in clinical medicine. We think we follow a systematic approach—take down pts symptoms, perform a thorough physical exam, and order all appropriate investigations, nevertheless we need to lend more ears and dig deep into the most important aspect of clinical medicine……..History taking.

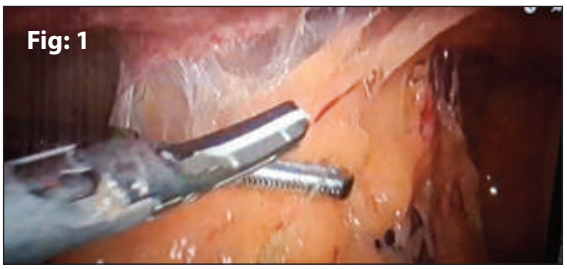


Fig: 1

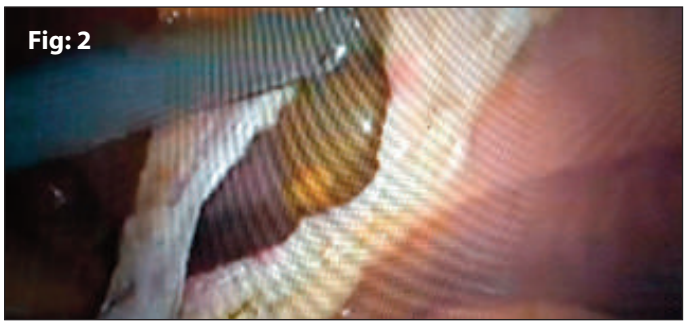


Fig: 2

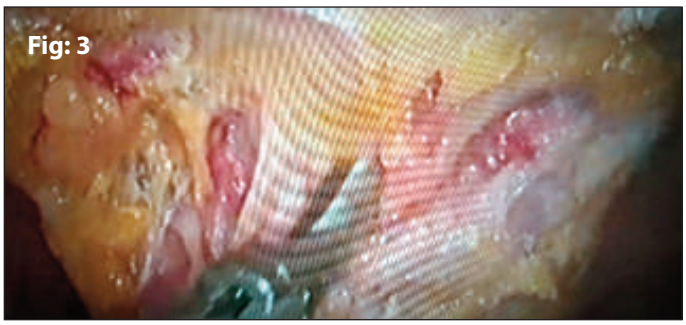


Fig: 3

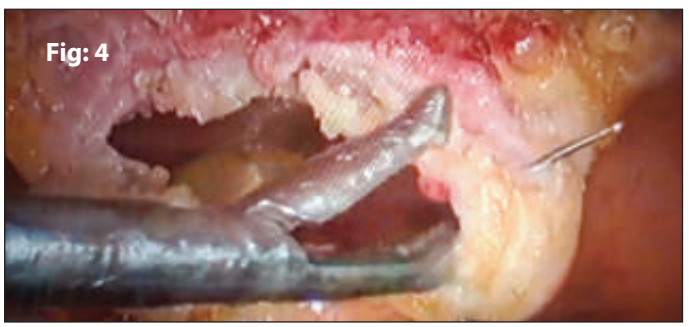


Fig: 4

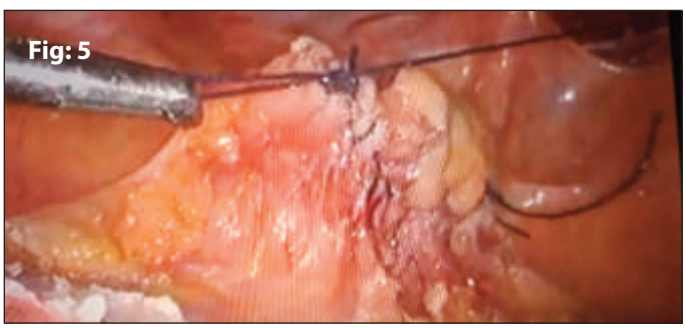


Fig: 5

**LINK FOR VIDEO-** https://youtu.be/3LCmNvRUdPU?si=mHyWLRpVIrhyLvP2

# POGS App

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

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

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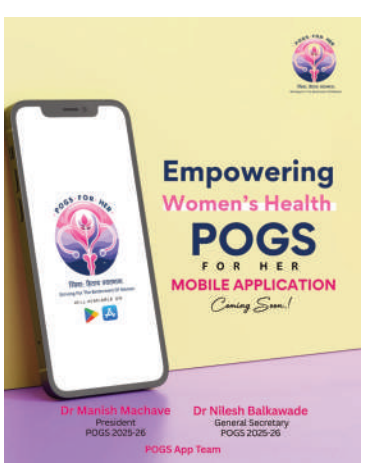
President POGS 2025-26
**Dr Nilesh Balkawade**
General Secretary
POGS 2025-26
**POGS App Team**
Dr Mahima Lalwani
Dr Mrinmayee Dharmadhikari

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# Abnormal Bleeding After First-Trimester Abortion: A Diagnostic Dilemma

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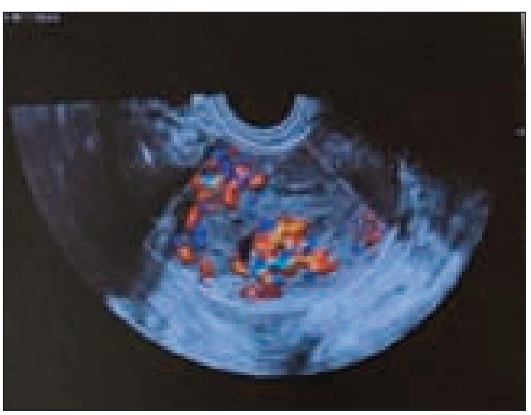
**Dr Madhura Kelkar DNB ObGyn**

**Abstract**
Retained products of conception (RPOC) are a common cause of abnormal vaginal bleeding following first-trimester abortion, but their presentation can mimic other etiologies, creating diagnostic challenges. This case describes a 31-year-old woman with recurrent vaginal bleeding post-dilatation and evacuation (D&E) for a missed abortion. Initial imaging suggested a possible invasive mole or uterine arteriovenous malformation (AVM), but further evaluation confirmed RPOC as the cause. The case was successfully managed with repeat evacuation and medical management with low dose methotrexate, highlighting the importance of targeted imaging and clinical correlation in resolving postabortal bleeding dilemmas.

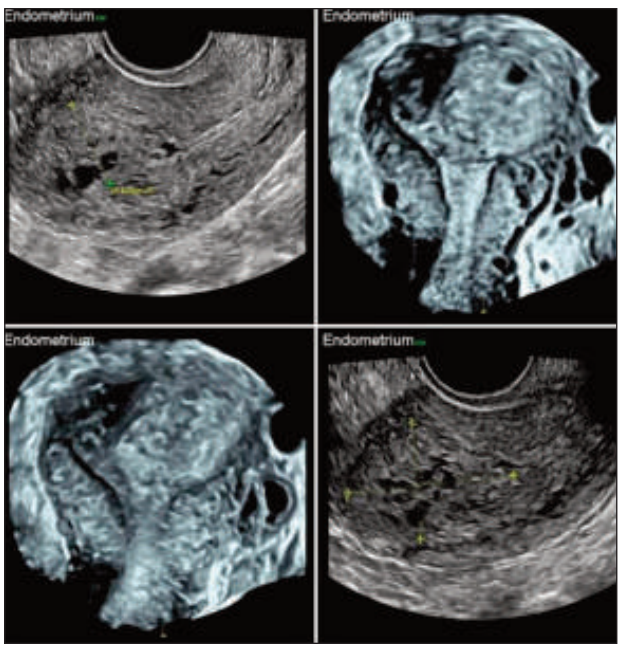
**Introduction**
Minor vaginal bleeding after an elective abortion is relatively common; however, persistent or heavy bleeding warrants further investigation. Abnormal uterine bleeding after first-trimester abortion is frequently attributed to RPOC, occurring in approximately 1-5% of cases. [1] Other etiologies could be gestational trophoblastic disease, acquired arterio-venous malformations, uterine perforation or cervical laceration and coagulopathy. RPOC can present with persistent bleeding, elevated beta-human chorionic gonadotropin (β-hCG), and ultrasound findings that overlap with gestational trophoblastic disease (GTD) or vascular anomalies like uterine AVM. Accurate diagnosis is critical to avoid unnecessary interventions and preserve fertility. This case illustrates the diagnostic process and management of RPOC mimicking more complex pathologies.

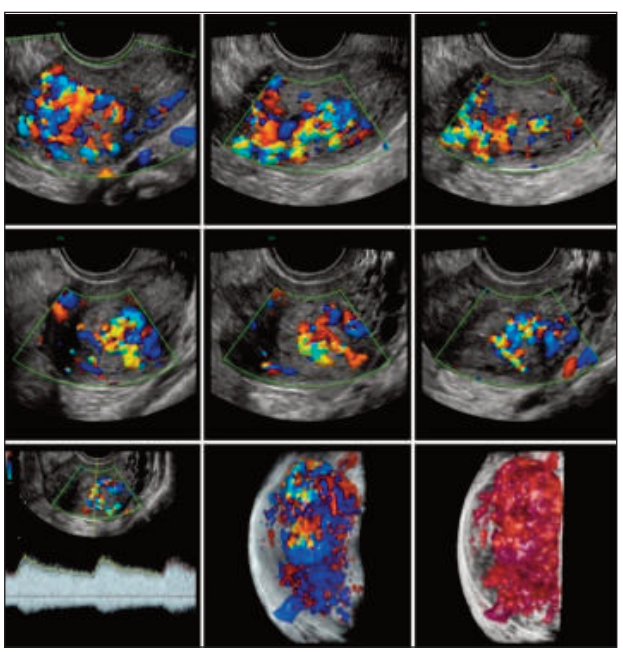
**Case Presentation**
A 31-year-old primigravida, presented to our hospital with recurrent vaginal bleeding 40 days after a D and E. She gave history of a missed miscarriage at 7 weeks for which she underwent D&E, post the procedure she kept bleeding on ad off for over 15 days, USG revealed multiple heterogenous echoes suggestive of RPOC. She then underwent a hysteroscopy, where few blood clots were seen near left cornua, rest of the cavity was normal. The clots and some tissue were removed. Histopathology confirmed it to be retained products of conception. Her β-hCG was 40.



She reported intermittent minimal bleeding, lower abdominal pain, and mild dyspareunia, without fever, dysuria, or systemic symptoms. She was not known to have any coagulopathy/ a repeat USG showed endometrium 12 mm and 36 mm lesion in the left half of cavity and myometrium near fundus with marked vascularity probably invasive gestational trophoblastic disese. On examination, she was hemodynamically stable.

Bimanual examination revealed a mildly enlarged uterus (approximately 6-8 weeks' size) with no tenderness. Speculum examination showed minimal bleeding without foul-smelling discharge.
Laboratory results included hemoglobin of 11.2 g/dL, normal white blood cell count (8,800/µL), platelets (204,000/µL), β-hCG of 28 mIU/mL, and a normal coagulation profile.



A repeat biopsy was planned, and gentle curettage was done. The histopathology report came as retained products of conception. A multidisciplinary approach was decided with a medical oncologist and patient was started on a low dose methotrexate protocol with dose of 30mg/m2 with repeating β-hCG every week. After the first dose β-hCG came down to 9 mIU/mL and after the second dose patient had heavy menstrual flow with passage of clots and β-hCG came down to <2, USG also revealed an empty cavity and disappearance of myometrial mass. Patient had bleeding for 6 days which stopped completely. At 3-month follow-up, she reported regular menses and no recurrence of symptoms.

**Diagnostic Dilemma**

The differential diagnosis included RPOC, invasive mole, or uterine AVM. Elevated β-hCG and the heterogeneous endometrial mass initially raised suspicion for GTD, while increased myometrial vascularity suggested a possible AVM. A multidisciplinary team (gynecology, radiology, hematology, oncology) concluded that RPOC was the most likely diagnosis, and surgical intervention was planned to avoid unnecessary hysterectomy in this young patient desiring future fertility.

**Discussion**

RPOC is the most common cause of postabortal bleeding, resulting from incomplete evacuation during D&E or medical abortion. In a retrospective cohort study Vashnavi et al. [4] reported incidence of RPOC after manual vacuum aspiration (MVA) and medical management as 13% and 29.4%, respectively. Risk factors include incomplete uterine emptying, prior uterine surgery, or mifepristone use. An endometrial thickness of more than or equal to 15 mm after two weeks of induced abortion or early pregnancy loss has been used as an ultrasonographic criteria to define retained products of conception [2].

The diagnostic challenge arises from overlapping features with GTD (elevated β-hCG, heterogeneous mass) or AVM (increased vascularity on ultrasound).

| Condition | Typical Historical Clues | Symptomatology | Risk Factors |
|---|---|---|---|
| RPOC | Recent miscarriage, termination of pregnancy, delivery; sometimes delayed expulsion | Prolonged uterine bleeding (spotting-to-heavy), pain, sometimes infection signs | Incomplete evacuation, instrumental abortion, infection |
| GTD | Prior molar pregnancy, abnormal first trimester ultrasound, very high β-hCG | Heavy or irregular bleeding, uterine enlargement, possibly signs of metastases (e.g. pulmonary complaints) | History of GTD, extremes of maternal age, prior pregnancies |
| AVM | Prior uterine surgery / instrumentation (curettage, CS, myomectomy), or association with RPOC or GTD; often unexpected after a "routine" procedure | Recurrent heavy bleeding, sometimes sudden; hemorrhage may be life threatening | Uterine trauma, scar tissue, coexistent vascular anomalies |

**Diagnostic Tools**

- β-hCG levels
- RPOC: may be low or decreasing; often modest elevation if any.

• GTD: markedly elevated; often rising or plateauing rather than declining.
• AVM: generally negative for β-hCG, unless coexisting with RPOC or GTD. Several
recent case reports show AVM with raised β-hCG causing confusion.

**Ultrasound (Transvaginal + Doppler)**
• RPOC: echogenic mass in endometrial cavity; Doppler may show vascularity but typically confined to cavity or contiguous endometrium.
• GTD: heterogeneous mass, "cystic" spaces (hydropic villi), often with diffuse or marked
vascularity, low resistance flow.
• AVM: myometrial vascular channels, serpiginous anechoic/hypoechoic areas, very high velocity flow, low resistance; Doppler aliasing and "tortuous" vessels. Avoid blind curettage in suspected AVM.
MRI / Other Imaging Modalities
• MRI: useful for flow voids, for extent, and to distinguish vascular structures; cutoff
"flow-void diameter" (fv-D) in parametrium/myometrium has been shown to help distinguish AVM from RPOC or GTD. In one study, fv-D > 2.6 mm in parametrium had high sensitivity and specificity. [3] Sridhar et al., 2024, described use of MRI, Doppler and ultrasound together to differentiate RPOC and AVM, stressing the importance of quantifying vascularity and observing flow characteristics. [5]
Overlap in imaging of RPOC and GTD: Khalifa et al., 2025, showed that USG and MRI findings sometimes overlap, making distinction difficult without combining lab, imaging, and clinical history [6]
TVUS with Doppler is the first-line imaging modality to differentiate these , with RPOC typically showing low-velocity flow (<30 cm/s) and heterogeneous echotexture, as opposed to the high-velocity, turbulent flow of AVM or the invasive myometrial involvement of GTD. MRI is valuable for confirming RPOC by demonstrating a lack of flow voids or myometrial invasion.
Management of RPOC involves expectant, medical, or surgical approaches. In this case, surgical evacuation was chosen due recurrent bleeding and persistence of intrauterine mass and need for histopathological confirmation. Misdiagnosis as GTD could have led to unnecessary chemotherapy, while mistaking RPOC for AVM might have prompted invasive embolization.
This case underscores the importance of multimodal imaging and histopathological confirmation to guide management.

**Conclusion**
RPOC should remain the primary consideration in post-abortal bleeding, even when imaging suggests rarer etiologies. They are associated with both early complications (like vaginal bleeding and infection) and late complications (like placental polyps, AVM) and their consequences (massive bleeding, infertility, morbidity, and mortality). A systematic approach using Doppler ultrasound, clinical correlation and MRI if necessary can resolve diagnostic dilemmas, enabling targeted management that preserves fertility and minimizes complications.

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# Upcoming Programs:


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


| | |
|---|---|
| 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 HERE**

AND FILL IN YOUR DETAILS TO COMPLETE THE REGISTRATION

## POGS MOBILE APP

FOR THOSE REGISTERING THROUGH APP

**CLICK HERE**

## CONFERENCE SECRETARIATE

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

Tel. No. : 020 24491000
WhatsApp No. : 9403969415

Raegalos .....Smart ideas

Corporate Event & Corporate Gifts

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

# STAR Sampoorna Presidential Conference 2025

नमस्कार Punekars 🙏 🔲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 Sampoorna Presidential Conference 2025.The most prestigious academic event of the year — the FOGSI Presidential Conference: STAR Sampoorna 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/starsampoorna-conference2025?_rid=30357&_single=1

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

FOGSI PRESIDENTIAL CONFERENCE
**STAR Sampoorna**
Strategy, Transformation, Advancement & Research For Comprehensive Women's Healthcare
November 14 - 15 - 16, 2025 | J W Marriott, Pune

**Date: 14th, 15th & 16th November, 2025 | Venue: J W Marriott, Pune**

*"Under the visionary leadership of*
**Dr. Sunita Tandulwadkar,**
the STAR Sampoorna Presidential Conference 2025 proudly presents the following highlights, blending academic excellence with cultural vibrance."

# Conference HIGHLIGHTS

**Cutting-Edge Scientific Program**
Keynotes, orations, masterclasses, and panel discussions by global experts.

**Unmatched Networking & Exchange**
Meet and connect with renowned national & international faculty.

**Hands-On Pre-Conference Workshops**
Specialized training sessions across diverse disciplines on 14th November 2025.

**Grand "Range Bharat" Cultural Evening**
A vibrant celebration of India's heritage, music, and traditions.

**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@starsampoornapune.com / +91 89287 63008
**FOR CONFERENCE RELATED QUERIES:**
Ms Mahima Agarwal - +91 75840 77416

**SCAN THE QR CODE TO SUBMIT YOUR ABSTRACT**

**SCAN THE QR CODE TO REGISTER FOR THE CONFERENCE**

FOGSI PRESIDENTIAL CONFERENCE
STAR Sampoorna
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**

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**FOR CONFERENCE RELATED QUERIES:**
Ms Mahima Agarwal - +91 75840 77416

CLICK HERE TO REGISTER NOW

SCAN THE QR CODE TO REGISTER FOR THE CONFERENCE

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

**Dr. Manish Machave**
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

℞ In Male Infertility

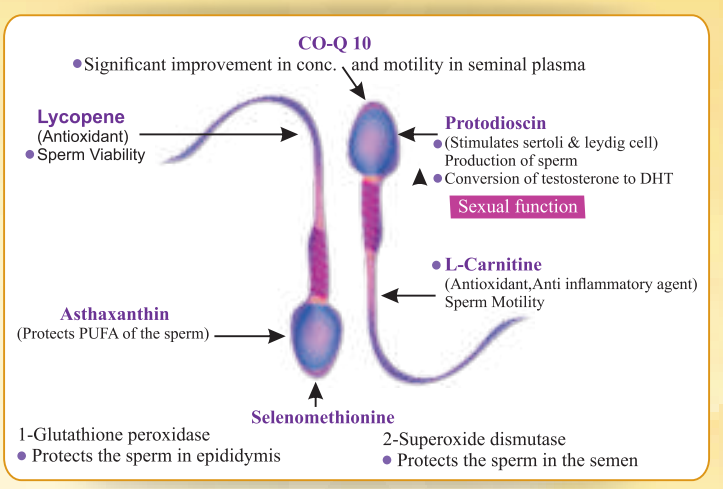
# Zoafrag

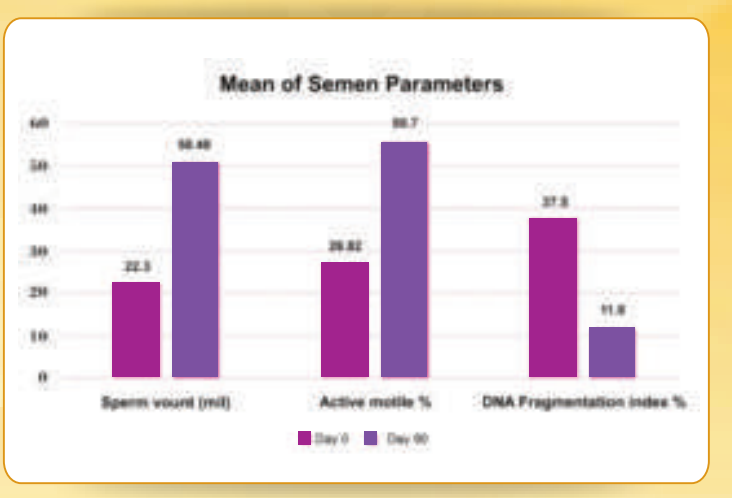
L-Carnitine 500mg + COQ10 100mg, Protodioscin 40mg + Astaxanthin 10mg + Lycopene 1250mcg + Selenomethionine 40mcg Tablets

## Role of adjuvants (Zoafrag) in male infertility

Original Research

## Clinical Trial




Dose: 1 Tablet BID


BellaFem
The Fem Era

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