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YOUR HEALTH

An Official Monthly Publication in English of the Indian Medical Association since 1952 for the people to propagate Health Awareness in the Community

**We shall help
forge a gender
equal world**

**International
Women's Day issue**

#InspireInclusion

Highlights

**Go Viral ! As Early
As Possible**

**Robotic
Gynecological Surgery**

**Impact on women 'health due
to MALE INFERTILITY....**

**Infertility and impact
on Women's Health**

**Combined Oral
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**India's Journey to Global
Vaccine Supremacy**

**When "Normal" is
NOT ALWAYS Normal**

**As a women how you will tackle
challenges from position of strength?**

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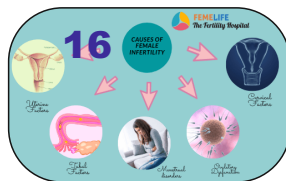


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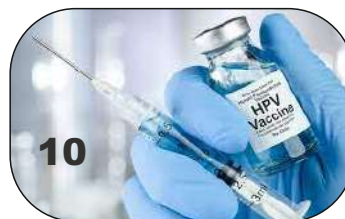
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Fertility Concerns and Preservation for Women

Many cancer treatments affect fertility temporarily or permanently. Fertility is the ability to become pregnant. Infertility is an inability to become pregnant or maintain a pregnancy.

Before treatment begins, talk with your health care team. Ask how treatment could affect your fertility. And ask about your options for preserving fertility.

How cancer treatments affect fertility

Fertility problems for women from cancer or its treatment occur in 2 main ways:

- Damage to organs involved in reproduction, such as the ovaries, fallopian tubes, uterus & cervix
- Damage to organs involved in hormone production, such as the ovaries

The ovaries store a woman's eggs. Damage to these organs can decrease the ovarian reserve. The ovarian reserve is the total number of immature eggs in both ovaries. Women are born with all the eggs they will have. Once these eggs are lost, they cannot be replaced. Loss of healthy eggs causes infertility and early menopause.

Cancer treatments that affect fertility

These cancer treatments have known or possible fertility-related side effects:

Chemotherapy. Chemotherapy, particularly drugs called alkylating agents, may affect fertility. These include:

- Busulfan (Busulfex, Myleran)
- Carmustine (BiCNU)
- Chlorambucil (Leukeran)
- Cyclophosphamide (Neosar)
- Doxorubicin (Adriamycin)
- Lomustine (CeeNU)
- Mechlorethamine (Mustargen)
- Melphalan (Alkeran)
- Procarbazine (Matulane)

Other drugs used in cancer treatment may also have



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fertility risks. Ask your doctor about the specific drug(s) recommended in your treatment plan.

Radiation therapy. Radiation therapy to these body parts may affect fertility:

- The abdomen
- The pelvis
- The lower spine
- The ovaries and areas near the ovaries
- The uterus
- The pituitary gland in the brain
- The entire body, for bone marrow transplantation

Surgery. Surgical removal of these reproductive organs may affect fertility:

- The uterus, in a procedure called a hysterectomy
- The cervix, in a hysterectomy or a procedure called a trachelectomy, which preserves the uterine body
- One or both ovaries, in a procedure called an oophorectomy

Additionally, surgery to remove pelvic lymph nodes may affect fertility.

How to find help with fertility issues

Consider meeting with a reproductive endocrinologist. This is a doctor who specializes in conditions affecting fertility. Some reproductive endocrinologists specialize in cancer-related fertility issues.

Evaluating menstruation and fertility after cancer treatment

Women with menstrual periods after cancer treatment may become pregnant. But menstruation is not proof that you are fertile.

In some women, cancer treatments stop menstrual periods permanently. This is called early menopause. It causes permanent infertility.

Other women's menstrual periods stop during treatment but return later. Women who have periods after chemotherapy may still have lowered fertility. Even a woman who menstruates during treatment and remains fertile afterward might have lowered fertility or early-onset menopause.

It generally takes longer for older women and those who had higher doses of radiation therapy or chemotherapy to start menstruating again. Also, menstrual cycles are less likely to restart after treatment in these women.

Your doctor can refer you for ovarian reserve testing. This is tested with sensitive hormonal tests, such as the anti-Müllerian hormone.

Children and younger women have a larger ovarian reserve than older women. They are less likely to experience menopause and infertility right after chemotherapy. But this does not mean younger women will not lose their fertility. With radiation therapy to the pelvis and lower abdomen and strong chemotherapy, even young girls can have menopause right away.

Pregnancy after cancer treatment

To become pregnant without reproductive assistance, you need:

- At least 1 healthy ovary with enough remaining eggs
- One healthy fallopian tube
- A healthy uterus where the baby can grow
- An ideal level of specific hormones

Your health care team may recommend waiting before trying to become pregnant. The amount of time depends on:

- Type and stage of the cancer
- Type of treatment
- Your age

For example, women taking hormonal treatments may need to delay pregnancy.

Delay can further reduce fertility because women lose eggs through aging. If you experience delay, consider fertility-preserving options.

About having a baby after cancer. Recommendations for preserving fertility,

The Oncologists recommends that all women with cancer discuss the risk of infertility and fertility preservation options with their doctors as soon as possible before cancer treatment begin. If you are interested in preserving fertility, you should ask for a referral to a reproductive specialist, even if you are unsure whether you want to have children in the future.

The options depend on several factors:

- Age
- Relationship status, such as having a partner who could provide sperm
- Physical and sexual maturity
- Personal preferences and feelings about different procedures

ASCO's recommendations for preserving fertility include:

Embryo freezing. This is the most successful way of fertility preservation. It is also called in vitro fertilization.

A woman takes fertility drugs for about 2 weeks. Then, a member of the health care team collects her eggs. These are fertilized by sperm in a laboratory. The resulting embryos are frozen until later.

Oocyte (unfertilized egg) freezing. This procedure is similar to embryo freezing. But the eggs are frozen without being fertilized by sperm.

This is an option for women without a male partner to provide sperm. But it is slightly less successful than embryo freezing.

Fertility-preserving surgery. Some types of cervical or ovarian surgery can preserve fertility.

- Surgery for cervical cancer: Sometimes, surgeons can remove the cervix while keeping the uterus. This allows a woman to deliver a baby by C-section. It is an option for some women with early-stage cervical cancer.
- Surgery for ovarian cancer: Sometimes, surgeons can remove only 1 ovary. It is an option for some women with early-stage cancer located in 1 ovary. This preserves the healthy ovary for reproduction and prevents early menopause.

Radiation therapy that protects the ovaries. Some women may receive radiation to only 1 ovary. This preserves fertility. Another option is a procedure called an oophoropexy. A surgeon moves 1 or both ovaries where radiation will not reach them. Then, the surgeon puts them back in place after treatment. However, this method is not always successful. Radiation is not precise and may still reach the ovaries or the ovarian blood supply.

Ovarian suppression. This is an investigational approach to fertility preservation. It involves taking hormones that suppress ovarian function. This may protect eggs from cancer treatment.

Researchers have not yet demonstrated this strategy's effectiveness. It is generally not recommended over other standard fertility preservation options when those are available.

Ovarian tissue preservation. This involves surgically removing and freezing ovarian tissue. Then, the surgeon transplants the tissue after cancer treatment. This may be the only option for young girls who cannot undergo oocyte or embryo freezing. For example, some girls may lack time or sexual maturity. Many pregnancies have occurred with this technique, and researchers are continuing to evaluate this option.

These options for protecting fertility are not

appropriate or right for everyone. Consider these factors:

- Health insurance may not cover the cost of fertility-preserving procedures
- Their effectiveness varies
- The added stress of fertility preservation in an already stressful time

You may benefit from counseling for fertility-related decisions. People considering fertility preservation should make the decision that feels right to them based on these and other factors.

Questions to ask your health care team before treatment

Consider asking your health care team these questions:

- What is the risk of infertility from the recommended treatments?
- Would potential infertility be temporary or permanent?
- Are there other effective treatments that do not pose as high a risk?
- What options do I have to preserve my fertility?
- Will these options postpone the start of my treatment? If so, what effect could this delay have on my chance of recovery?
- Will these fertility preservation options increase the risk that the cancer may come back?
- Should I talk with a fertility specialist or a reproductive endocrinologist?
- What clinical trials are available for me?
- Where can I find support for coping with fertility issues?
- Where can I find help for talking with my partner about fertility?
- How will I know if I am fertile after cancer treatment?

From the Desk of Secretary

Theme of the International Women's Day 2024 campaign is #InspireInclusion. The campaign theme for International Women's Day 2024 is Inspire Inclusion. When we inspire others to understand and value women's inclusion, we forge a better world. And when women themselves are inspired to be included, there's a sense of belonging, relevance, and empowerment.

The history of International Women's Day stretches back more than 100 years, when the day was first observed across Europe and America. International Women's Day is commemorated in a variety of ways worldwide. International Women's Day was celebrated for the first time by the United Nations in 1975. Since then every year they come out with a theme.

Theme of the International Women's Day 2023 campaign was EmbraceEquity. Equity isn't just a nice-to-have, it's a must-have. A focus on gender equity needs to be part of every society's DNA. And it's critical to understand the difference between equity and equality. The aim of the IWD 2023 #EmbraceEquity campaign theme is to get the world talking about, Why equal opportunities aren't enough? People start from different places, so true inclusion and belonging require equitable action.

Theme of the International Women's Day 2022 campaign was #BreakTheBias. Imagine a gender equal world, A world free of bias, stereotypes, and discrimination, A world that is diverse, equitable, and inclusive, A world where difference is valued and celebrated, Together we can forge women's equality, Collectively we can all #BreakTheBias.

The theme for International Women's Day in 2021 was "Women in leadership: Achieving an equal future in a COVID-19 world," which celebrated the tremendous efforts by women and girls around the world in shaping a more equal future and recovery from the COVID-19 pandemic and highlights the gaps that remain. Yes, among the healthcare fraternity, women also



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contributed as men in each segment of healthcare right from healthcare workers to scientists, who were involved in the development of vaccines and medicines.

So, every year we observe Women's Day with various theme for the upliftment, equality of Women. It will take years and continuous efforts to achieve the goal.

It is a pity that even before a female child is born, she is treated unequally. Female Foeticide rates in India, especially in states like Haryana are quite high and in spite of stringent laws against it we have not been able to stop it.

As the female child sees the light of the day, many of them do not reach their first birthday (Female infant mortality rate is one of the highest in India). The girl child is neither given proper nutrition, nor the adequate newborn care needed in the first year.

When the girl reaches adolescence, she faces a different kind of discrimination as compared to her

brother. A lot of rules are imposed on her which does not apply to her brother. She has to come back early from school or college, she cannot go out for parties with her friends, etc.

The world is changing & we hope a great change in gender equality which has already been started. Our women leaders of various spheres already proving their ability for example our women cricket team is the best example. In India our lady chief minister of Bengal as well as central finance minister & one Indian origin

lady representative in American assembly are the fruitful examples. In IT sector, medical fraternity & lawyers women are placing them in right way & in right prospective.

Your Health of IMA, the publication of Indian Medical Association from Kolkata for the awareness common masses on various issues & for upliftment of basic knowledge of commonest diseases has dedicated its March 2024 issue on "International Women's Day. I am really grateful to all the authors

Pioneer Lady Doctors of India



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Dr Rukhmabai Raut

Dr Haimabati Sen

Dr Muthulakshmi Reddy

Dr Mary Poonen Lukose

Dr Jerusha Jhirad

Guest Editorial

Dear Readers,

March 8th is celebrated as **International Women's Day**. On this occasion it gives me immense pleasure to become guest editors of the special edition of **Your Health Publication**.

As a Gynaecologist I deal with women's health directly, as a fertility specialist we create human life (embryo) in our laboratories.

In that process we have observed that oocytes transfer mitochondria solely to embryo so oocytes supplies energy the embryo its strengthen the fact that womens are the real source of energy (**SHAKTI**) without women human civilization can not progress, so now medical science its shifting its focus on to women's health.

In the last few years there have been newer developments in the field of gynaecology and obstetrics, which has brought a positive impact on women's health.

There has been significant improvement in the field of



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Gynaecological laparoscopy almost all the gynaecological surgeries are possible by laparoscopic nowadays that has improved postoperative recovery and surgeries outcome.

Now robotic surgery has also made inroads in the field of gynaecology.

It will definitely improve the quality of life of women, there has been significant improvement in the field of IVF in the last few decades with an improved success rate the burden of infertility has reduced.

Improvement in the field of infertility has brought positive change in women's life.

Now when a woman conceives it becomes our responsibility to take her though this journey safely with the help of advanced obstructive and fetal medicine care, safe pregnancy outcome has ensured.

In this edition of your health we have tried to cover the advances in the field of obstetric and gynaecology.

Go Viral ! As Early As Possible.

Going viral with HPV Vaccine is the way forward as prevention is better than cure

The Benefits of HPV vaccine outweighs any of the side effects associated with vaccination.

HPV vaccination however can prevent as many as 90% of cancers caused by HPV. Cancer usually takes years, even decades, to develop after a person gets HPV but there is no way to know who will develop cancer and when.

That's why HPV vaccines work best when given at an early age (11–12 years) but can be given as early as 9 years before contact with the HPV virus.

As 9 out of 10 cases of cervical cancer are proved to be caused by HPV, almost all cervical cancers can be prevented by HPV vaccination.

Benefits of HPV vaccine.

HPV vaccine not only protects cervical cancer but also against genital warts and cancer of the vagina, vulva, penis or anus caused by HPV. The HPV vaccine also protects against mouth, throat, head and neck cancers caused by HPV. You can also get the HPV vaccine to protect yourself against new infections of HPV which can cause genital warts or cancer.

HPV can cause cancers of the:

- Cervix, vagina and vulva in women
- Penis in men
- Anus in both men and women
- Oropharyngeal , Mouth including tongue and tonsils (oropharynx), in both men and women

How do you get HPV infection ?

Through close skin-to-skin touching usually during sex. A person with HPV can pass the infection to others even when the person has no signs or symptoms. A person can get HPV infection by having vaginal, anal, or oral sex with someone who has the virus (most commonly by vaginal or anal sex).

HPV infection is the most common sexually transmitted viral infection that cause cancers or skin or mucous membrane growths (warts). There are more than 100 varieties of human papillomavirus (HPV).



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Some types of human papillomavirus (HPV) infection cause warts, and some can cause different types of cancer. People with weak immune systems more likely to develop infection with exposure to HPV.

In most people virus is cleared by their own immune system. There are treatments available for the symptoms caused by the virus but there is currently no cure for an existing HPV infection. The only way to lower your chances of getting HPV is by taking a vaccine.

Human papillomavirus (HPV)

Human papillomavirus (HPV) is a small DNA virus that infects skin or mucosal cells. At least 13 of more than 100 known HPV genotypes can cause cancer of the cervix and are also associated with other anogenital cancers and cancers of the head and neck. The two most common "high-risk" genotypes of HPV 16 and

18) cause approximately 70% of all cervical cancers. Two "low-risk" genotypes (HPV 6 and 11) cause genital warts

Lab Diagnosis of HPV Infection

Methods to diagnose HPV infection are:

- Colposcopy and acetic acid test
- Biopsy
- DNA test (PCR, Southern Blot Hybridization, In Situ Hybridization)
- Pap smear

Two new tests for HPV tests

- Hybrid capture HPV DNA Test 2 (hc2) in conjunction with the Pap test
- PCR-based detection methods

Vaccines

The vaccine gives the body a safe way to build immune system awareness of some HPV strains so that the body can clear out those strains of the virus if a person catches them later.

Two prophylactic HPV vaccines prepared from virus-like particles (VLPs) of the major capsid (L1) protein of HPV produced by recombinant technology.

- A bivalent vaccine comprised of HPV types 16 and 18 protein
- A tetravalent vaccine comprised of HPV types 6, 11, 16 and 18
- 9-valent HPV vaccine is a recombinant vaccine prepared from HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58.

HPV vaccines are highly immunogenic. More than 98% of recipients develop an antibody response 1 month after completing a full vaccination series.

Who should take the vaccine?

As per CDC HPV vaccination should be given to: -

- All preteens (including boys and girls) at age 11 or 12 years (or can start at age 9 years).
- Everyone upto age 26 years, can be vaccinated.
- Ideal age for vaccination is before a person is sexually active.

Vaccination is not recommended for persons older than 26 years who are likely to be sexually active and

already exposed to HPV infection.

Once a person gets HPV, the vaccine may not be as effective as the vaccine's goal is to prevent a new infection. Vaccines cannot treat an existing HPV infection. Even if a person gets the virus, might still benefit from the vaccine as it can protect you from other strains that you don't yet have.

Vaccine Dose

People younger than age 15 can be vaccinated with two doses, 6 to 12 months apart.

People who start the vaccine series later, at ages 15 through 26, should get three doses of the vaccine.

These shots are given over six months.

This vaccine can be taken along with other vaccines.

Does the HPV vaccine have any side effects?

The HPV vaccine has been found to be safe with only mild side effects.

The most common side effects of HPV vaccines include soreness, swelling or redness at the injection site.

Sometimes dizziness or fainting occurs which can easily be treated by sitting for 15 minutes after the shot. Headaches, nausea, vomiting, fatigue or weakness may occur.

Conclusion

HPV vaccine effectiveness against cervical cancer at the population level is high among girls vaccinated younger than age 20 years.

If vaccinated before being exposed to the virus, the HPV vaccine is 97 percent effective in preventing cervical cancer and intraepithelial neoplasia. Plus, it's almost 100 percent effective in preventing external genital warts.

Robotic Gynecological Surgery

Robotic Surgery provides an innovative surgical tool to manage a variety of gynecological benign and malignant conditions including uterine preserving Robotic myomectomy for fibroid uterus, complete resection of deep infiltrating endometriotic lesion, Robotic hysterectomy for abnormal uterine bleeding (where medical management has failed and patient opts for definitive management), pelvic organ prolapse, sacro-colpopexy for post hysterectomy vaginal vault prolapse and treatment for cancer endometrium [1,2].

Robotics has evolved into the armamentarium of minimally invasive gynecologic surgeons providing patients benefits of surgery with greater precision and efficiency. For the patient, Robotic procedure offers all the potential benefits of a minimally invasive procedure, including less pain, less blood loss thereby less need for blood transfusions, shorter hospital stay, a quicker recovery and faster return to normal daily activities [3,4]. For the Surgeon da Vinci system offers autonomous camera control for a stable, immersive, highly magnified 3D high-definition (HD) view of surgical field. Surgeon's hand movements are scaled, filtered and seamlessly translated to instrument tips for precise instrument control. A large, open working space provides unrestricted range of motion without instrument crowding. Surgeon's console features multiple ergonomic adjustments for increased comfort and reduced fatigue during surgical procedures. Advanced system software correlates the surgeon's hand movements to instrument tips, restoring intuitive control to what would otherwise be cross-handed surgery.

Advantages of Robotic Surgery for Patient

A) Benefits of robotic surgery in comparison to open surgery include following:

- **Minimal scarring:** In Robotic surgery 3 to 4 small incisions (less than 10 mm) are made along the abdomen and surgical equipments are inserted through these incisions. In traditional abdominal surgery a 7–8 inches long vertical or horizontal incision is usually given over anterior abdominal wall which takes longer to heal, more pain at surgical site and prolonged stay in hospital. This is overcome in Robotics where a transumbilical entry enables a virtually scarless surgery, providing patients one of the most cosmetically appealing results of any available surgical approach.
- **Minimal pain:** Robotic System's **remote center technology** is designed to limit cannula movement at the patient's abdominal wall, minimizing potential port-site trauma and postoperative pain [5,6]. Reduced blood loss, low conversion rate to open surgery, lower rate of complications, reduced requirement for pain medication in post-operative period, short duration of hospital stay.
- Other advantages include precise dissection EndoWrist instrumentation and precise suturing of uterine defect in myomectomies for a durable, multilayer closure.



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- **Robotic assisted Pelvic reconstructive surgery** – Sacrocolpopexy, sacrocervicopexy and vesicovaginal repair all seem particularly suited for Robotic surgery given the necessity large amount of intracorporeal suturing, finer dissection of spaces required and important structures involved.

B) Benefits of Robotic surgery in comparison to Laparoscopic surgery include following:

- Robotic offers high resolution 3-D operating view with depth perception & magnification. Surgeon has control of camera and all three operative arms provide ultimate accuracy in maintaining surgical autonomy, accuracy and efficiency [7]. Robotic is a computer interface between the surgeon and patient. It offers increased operating accuracy, far greater precision, reduced number of errors, tremor filtration, down scaling of movements and superior instrument articulation. There is ease in suturing and knotting as compared to laparoscopic surgery.

C) **Benefits for the Surgeon:** For the operating surgeon performing a Robotic surgery is ergonomically beneficial and comfortable in terms of the surgeon sitting on the console and operating rather than prolonged standing which takes a toll on the surgeons spine and causes fatigue. Teleoperating is possible in present times where miracles of technology has advanced worldwide leaving an indelible mark for generations to come.

Learning curve of the Surgeon is shorter in Robotic surgeries as compared to Laparoscopy especially when complex cancer surgical procedures are concerned. Having a shorter learning curve, Robotics has the advantage of giving more reproducible results with less surgeon to surgeon variation. During intraoperative maneuvers surgical trauma is less in Robotic surgeries as there is less tissue damage. This helps in early patient recovery and less post op pain. Patient being admitted for shorter duration after Robotic surgeries as compared to open surgeries making beds available for other needy patients. It is important for patients to return back to their normal routine faster. Robotics helps them to resume their work faster and with least amount of pain. It brings to the patient all the advantages of minimal invasive surgery with more precision and accuracy.

As Gynecologists we are committed to serve women with compassion and excellence, ensuring that they have access to the latest advancements in medical technology. Through initiatives like Robotic surgery, we are transforming lives and empowering women to reclaim their health and well-being.

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Impact on Women 'health due to MALE INFERTILITY....



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Infertility is growing concerns now a days and is a devastating experience for both partners as they try to conceive. Historically, when a couple could not conceive, the woman has carried the stigma of infertility; however, men and women are just as likely to contribute to the couple's infertility. With the development of assisted reproductive technology (ART), the treatment burden for male and unexplained infertility has fallen mainly on women. Equalizing this burden requires reviving research on male infertility to both improve treatment options and enable natural conception.

The contribution of men and women to reproduction is uneven. While men provide the sperm and women provide the egg, women must also carry and deliver the pregnancy. Therefore, it is a biological inevitability that women are physically burdened more than men by fertility treatments. However, a woman undergoing extensive fertility treatments for male infertility is not a biological inevitability. Instead, we argue that deficiencies in our understanding of the biology of male fertility and the common practice of solely employing traditional semen analysis to diagnose

male infertility have led to an uneven distribution of treatment.

This situation is largely due to the success and availability of assisted reproductive technology (ART), which disproportionately burdens women. Infertility is quite common, with approximately one out of eight couples reporting the inability to conceive after one year of trying . Through the use of traditional semen analysis and other classic diagnostic tests, approximately 1/3 of infertility is attributed to male factors, 1/3 attributed to female factors, and in 1/3 of couples no cause can be identified, also known as unexplained or idiopathic infertility .Some of the unknown causes of infertility may be due to obscure disorders in the man, the woman, or the couple (i.e., male and female factors that, when combined, result in that couple's infertility]. Therefore, in general, men are as likely as women to be responsible for infertility. Due to the lack of direct treatments for men, many treatments for male infertility involve treating the woman. The woman may carry most of the treatment burden when the man has a low count, reduced motility, or has abnormal sperm morphology, Furthermore, even if a potential cause of the woman's infertility is identified, it does not preclude the man from also having a fertility problem that is contributing to the couple's infertility .

When a couple is unsuccessful with pregnancy it is common for the female partner to be the first to seek medical advice . The initial evaluation of the infertile female patient involves an extensive history and diagnostic assessment, including multiple laboratory tests, ultrasound imaging, and a hysterosalpingogram . Conversely, the evaluation and diagnosis of male patients is far less thorough and far less invasive. If the diagnosis is male infertility or an unknown cause of infertility, the main treatments available disproportionately affect women and usually include ART treatments such as intrauterine insemination (IUI), in vitro fertilization (IVF), or intracytoplasmic sperm injection (ICSI) and its variants.

Timed intercourse (TIC) involves determining the window of ovulation and planning intercourse during that timeframe to maximize the chance of achieving pregnancy. This treatment can be equally stressful on the couple because both partners need to perform on-demand. IUI (intrauterine insemination) is the direct deposition of sperm into the uterus with a catheter that is threaded through the cervix and into the uterus, often after the woman has taken hormonal medications to stimulate the ovaries. These hormones have many potential side effects such as hot flashes, headache, nausea, and an increased chance of multiple gestations. While, IUI is physically uncomfortable, it is relatively non-invasive, and is less expensive than other forms of ART.

Interventions like IVF and ICSI involve hormonal stimulation and oocyte retrieval from the female. There is a potential for serious side effects from medications or during the actual oocyte retrieval process such as ovarian hyperstimulation syndrome (OHSS), which, while rare, can lead to significant morbidity. These treatments are a clear case of a greater burden being placed on the woman rather than the man when she is potentially not the infertile partner. Additionally, these treatments cannot overcome sperm with defective interior components. Unfortunately, it is often thought that male causes for infertility can be overcome with ART, even without a complete male andrological evaluation. Consequently, 18–27% of the time, in a couple presenting with infertility, the man does not undergo any infertility evaluation. This bias in diagnosis could lead to lengthening the time of treatment, undermining women's health, and ability to achieve the birth of a healthy child.

Traditional Semen Analysis Only Tests General Sperm Properties, Which Are Not Necessarily Predictive of Fertility These limitations are partially because the

reference values for semen analysis are based on information gathered solely from men in fertile couples. Therefore, men who have a normal semen analysis may still have deficient sperm that cannot reach the oocyte, fertilize the oocyte, or contribute to a healthy pregnancy.

Because we now realize the importance of sperm health, diagnostic experimental tests focusing on recently discovered essential sperm components are being designed and investigated by scientists and includes: DNA fragmentation assessment, RNA—Sperm Transcripts, Proteins—Sperm Proteome Oocyte activation factors and Centrioles defects.

Male factor infertility also exposes women immense psychological stress and also sometimes detrimental for their sexual health where erectile dysfunction and ejaculatory disorders are the causes behind.

Semen analysis, combined with a molecular understanding of sperm function, should be able to point to the pathways and components that are involved in infertility. The understanding afforded by some of the advanced sperm tests that are not routinely used, but should be, and others that are in development, could point to the molecular cause of many cases of male infertility. Because of our limited understanding of the male contribution, women endure the health risks of treatments for a disease that may not be theirs. Infertility must be seen as a problem that affects couples, not as an individual failure of the female to conceive. Without further investigation of male infertility by both clinicians and researchers, this stigma will persist. Indeed, future research and treatments should be aimed at correcting the underlying cause of male infertility, thereby minimizing the risks of treatment and even allowing for natural conception that enables the birth of a healthy child.

Infertility and Impact on Women's Health

Infertility is defined by the World Health Organisation (WHO) as a disease of the male or female reproductive system characterized by an inability to conceive after 12 months or more of regular unprotected intercourse. The global burden of infertility is huge, with approximately one in six couples having experienced difficulty in conception at some stage of life. The estimated lifetime prevalence of infertility is 17.5%.

Though India is a large and populous nation, the burden of infertility is also enormous. The prevalence of infertility in India is estimated to be between 3.9-16.8% by the WHO and over 30 million couples are known to be affected. The prevalence of infertility may be on the rise in view of delaying marriage and childbirth, demanding lifestyle, rising obesity, stress, consumption of energy dense processed food and increase in smoking, drug and alcohol consumption. Universality of marriage and motherhood often being the norm in India, infertility can have devastating social, psychological and economic consequences on the couple. It is hence vital to address this important medical condition with effective treatment methods and good psychological support. Reproductive health and to beget a child is a basic fundamental right. It is our duty as health care providers to assist couples to achieve their dream of parenthood.

Inability to conceive despite regular unprotected intercourse for a period of 12 months (in a woman < 35 years) or 6 months (woman of age > 35 years) is an indication for investigation to evaluate the factor causing infertility. Basic infertility evaluation includes documentation of ovulation, tubal patency, uterine factor (anomalies, endometrial polyps, fibroids), semen analysis, pelvic factors (pelvic inflammatory disease, endometriosis), endocrine abnormalities (polycystic ovarian syndrome, hyperprolactinaemia, hypogonadotropic hypogonadism, hypothyroidism) and estimation of ovarian reserve. Infertility can be because of a problem with the male partner, female partner or both. Male and female factor each account for 35% of cases, in 20% of cases have combined /



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more than one factor and 10% have unexplained infertility.

Significant advances in infertility treatment have benefited many couples to conceive with medical assistance. The treatment offered depends upon the factor causing infertility. Anovulation is due to polycystic ovarian syndrome, hyperprolactinaemia, hypothyroidism, hypogonadotropic hypogonadism or hypergonadotropic hypogonadism. The mainstay of treatment is correction of the endocrine abnormality and ovulation induction using oral ovulogens (clomiphene or letrozole) or injectable gonadotropins. Tubal patency is assessed by sonosalpingography, hysterosalpingography or laparoscopy. Some tubal blocks can be surgically corrected by adhesiolysis or hysteroscopic cannulation. Uterine abnormalities are diagnosed with the help of ultrasound. Endometrial polyps, submucous fibroids and septate uteri are surgically removed with minimally invasive surgical methods such as laparoscopy or hysteroscopy. Pelvic factors such as endometriosis and pelvic inflammatory

disease require laparoscopic surgery or In vitro fertilisation (IVF).

The most important prognostic factor that determines success rates in fertility treatment is the woman's age and her ovarian reserve. Women have a finite number of oocytes and these are present at birth. The number and quality of oocytes gradually declines with age due to constant consumption. This reduction in quantity and quality reduces a woman's fertility especially so after the age of 35 years. There is a corresponding decline in success rates with fertility treatment. Ovarian reserve is assessed by hormones tests such as Anti mullerian hormone (AMH) and antral follicle count on ultrasound. Women with low ovarian reserve are advised to expedite treatment and achieve pregnancy at the earliest.

Assessment of the male is usually begun with a semen analysis. Low sperm counts, low progressive motility or morphology can result in male infertility. Other lifestyle factors such as male obesity, smoking, drug abuse, heavy alcohol consumption, uncontrolled diabetes, advanced age, exposure to heat and harmful chemicals are known to have an adverse impact on semen quality. Men with azoospermia can be evaluated to understand the cause – etiology can be pre testicular (hypothalamic / pituitary), testicular or post testicular (obstructive). Successful surgical sperm retrieval techniques are performed, the retrieved sperm are utilised for intracytoplasmic sperm injection (ICSI) and many successful pregnancies can be achieved with the help of assisted reproductive techniques.

In vitro fertilisation (IVF) is the most advanced modality of treatment for infertility. Indications for IVF include tubal block, severe oligoasthenospermia or azoospermia, severe endometriosis, low ovarian reserve or failed intrauterine inseminations. Ever since the first birth following IVF in 1978, live birth rates with IVF have steadily improved over the last decades in view of advancements in stimulation protocols and embryo culture conditions, making it the most successful of all treatment methods. Recent innovative stimulation protocols and modified ovulation triggers have made IVF safer than ever before by eliminating Ovarian hyperstimulation syndrome (OHSS). Better

incubators, embryo culture media, improved embryo freezing methods such as vitrification have rendered IVF more efficient and successful. Reduction in the number of embryos transferred to one or two have prevented higher order multiple pregnancy such as triplets and quadruplets. Third party reproduction using donor oocyte, donor sperm and surrogacy offers a beacon of hope for people with very low ovarian reserve, no viable sperm or uterus respectively. Increasing accessibility, availability and affordability of IVF has helped to transform many unhappy lives and realise their dream of parenthood.

ART has also been utilised for non infertility indications. Intrauterine insemination is recommended to HIV serodiscordant couples to prevent transmission of infection. Pre implantation embryos can be biopsied and screened for aneuploidy (PGT-A), mutations (PGT-M) and structural rearrangement of chromosomes (PGT-SR). PGT-A is offered to women who are more likely to produce abnormal embryos such as advanced maternal age, severe male factor, recurrent pregnancy loss or recurrent IVF failures. PGT-M and PGT-SR are used in couples with known genetic diseases to prevent disease transmission to the offspring. Women with absent uterus, damaged uteri or with a medical contraindication for pregnancy can opt for surrogacy.

The ardent wish to beget a child is a basic fundamental right. The consequences of childlessness in India and other developing countries are often brutal. Women are often stigmatised, blamed, disrespected, ostracised and ill-treated by their husbands, family and their community. Many may be subject to domestic violence, lack of freedom, psychological distress or polygamy. Women often bear the brunt and suffer from a poor quality of life, anxiety, depression and lack of self esteem. Hence, providing adequate psychological support to these fragile minds and empowering them is as important as good quality medical care.

International Women's day was first celebrated in 1911 to promote equal rights but we are still carrying the burden of our gender. Infertility is a major public

health concern with far reaching psychological consequences. It is our duty as health care providers to improve availability and accessibility to all infertility treatment services and to make treatment more affordable. Recent advancement in infertility care has now helped most infertile couples achieve their

dreams and has improved safety. In addition, women empowerment through better education, employment and its resultant economic and financial independence will assist women to take the right reproductive decisions for themselves. So let us “Invest in women: Accelerate progress”.

Eminent Lady Doctor of our Country



Dr Ketayun Ardeshir Dinshaw

Dr Ketayun Ardeshir Dinshaw Born in 1943 in Kolkata to a Parsi family, Ketayun Ardeshir Dinshaw went to Christian Medical College, Vellore where she pursued her degree in medicine. Dr. Dinshaw later went on for post-graduation to Addenbrooke's Hospital, Cambridge, where she specialized in radiation therapy and oncology. She later started her career as an assistant radiotherapist at Tata Memorial Hospital in 1974, and went on to work with the organisation for 35 years, including 13 years as director. She played a significant role in the evolution of modern cancer care and the development of effective radiation therapy in India with the President conferring her with a Padma Shri in 2001.

Combined Oral Contraception

Most women who seek contraception are healthy and young, and present with fewer problems than the over 35s, teenagers, and those with intercurrent disease. What we should all favour, and promote, is sex and relationships education (SRE). Some of the guidelines that healthcare practitioners must follow, can be summarised as follows :

- **U** Must ensure the young person **UNDERSTANDS** the potential risks and benefits of the treatment given
- **P** is legally obliged to discuss the value of **PARENTAL** support, yet the client must know the confidentiality is respected whether or not this is given
- **S** should assess whether the client is likely to have **SEXUAL** intercourse without contraception
- **S** should assess whether the young person's physical/mental health may **SUFFER** if not given contraception advice or supplies
- **I** must consider the client's best **INTERESTS** to give contraception without parental consent
- **C** Must respect the duty of **CONFIDENTIALITY** that should be given to a person under 16, and which is as great as that owed to any other person.

Combined Oral Contraceptives, or combined hormonal contraceptives, are one of the most popular choices in contraception. Capable of providing virtually 100% protection from unwanted pregnancy and taken at a time unconnected with sexual activity, the COC provides enormous reassurance by the associated regular, short, light and usually painless withdrawal bleeding at the end of the 21 day pack.

Common COCs include :

Ethinyl estradiol/ norethisterone type : Loestrin 20/30 (EE 20/30 ug + Norethisterone 1000/1500ug)

Ethinyl estradiol/ levonorgestrel : Microgyn 30 (EE 30ug + LNG 150ug)

Ethinyl estradiol/desogestrel : Mercilon

In the public sector, there is Mala-N which has LNG 0.15mg and EE 30ug, and 7 Ferrous fumarate tablets.



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Mechanism of action :

They primarily prevent ovulation, and have secondary contraceptive effects on the cervical mucus (thickening) and impedes implantation.

Conditions before start	Start when?	Extra precautions for 7 days
1. Menstruating	On Day 1 or 2 of period On Day 3 or later Any time in cycle (Quick Start)	No ^a Yes Yes ^b
2. Postpartum (a) No lactation (b) Lactation	Day 21 ^c (low risk of thrombosis: first ovulations reported after Day 28) Not normally recommended (POP or injectable preferred)	No
3. After induced abortion/miscarriage	Same day or Day 2 (Day 21 if beyond 24 weeks' gestation)	No
4. After trophoblastic tumour	1 month after no hCG detected	As 1.
5. After higher dose COC	Instant switch or use condoms after PFI for 7 days ^d	No
6. After lower or same-dose COC	After usual 7-day break	No
7. After POP	First day of period	No
8. During POP-induced secondary amenorrhoea	Any day (end of packet)	No
9. Other secondary amenorrhoea including after DMPA (pregnancy excluded) ^e	Any day	Yes
10. First period after postcoital contraception	By Day 2 when woman sure her flow is normal or Quick Start ^f , i.e. immediately (see p. 131)	No Yes

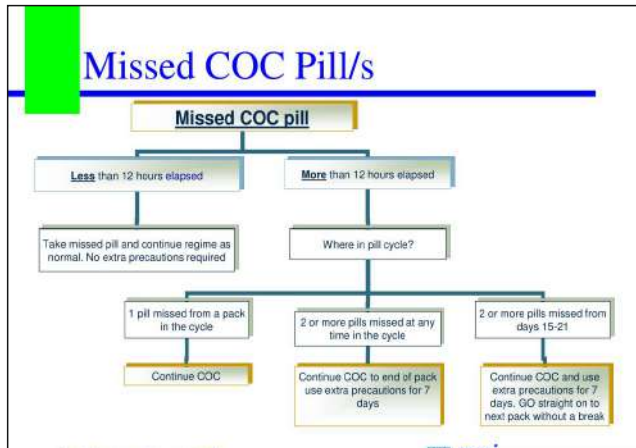


Table 28-2 • CONTRAINDICATIONS TO COMBINED HORMONAL CONTRACEPTION

Absolute Contraindications	Relative Contraindications
Previous thromboembolic event	Severe vascular headache (classic migraine, cluster)
Cerebral vascular disease	Severe hypertension (if younger than 35-40 years and in good medical control, can elect OCP)
Coronary occlusion	Diabetes mellitus (prevention of pregnancy outweighs the risk of complicating vascular disease in a diabetic who is younger than 35-40 years)
Impaired liver function	Gallbladder disease (may exacerbate emergence of symptoms when gallstones are present)
Known or suspected breast cancer	Obstructive jaundice in pregnancy
Smokers (>15 cigarettes/day) older than 35 years	Epilepsy (antiepileptic drugs may decrease effectiveness of OCPs)
Congenital hyperlipidemia	Morbid obesity

Non- Contraceptive Benefits of COCs :

- Decreased risk of endometrial, ovarian and colorectal cancers
- Improved bone mineral density in older women
- Induction of amenorrhoea for lifestyle considerations

- Menstrual cycle irregularity
- Treatment of acne, hirsutism
- Treatment of dysmenorrhea, menorrhagia
- Treatment of pelvic pain from endometriosis, and Pre menstrual syndrome.

Eminent Lady Doctor of our Country



Dr. Manjula Anagani

Dr. Manjula Anagani At a time when minimally invasive surgery was a field dominated by male doctors, Gynecologist and obstetrician **Dr. Anagani** tried her hand at the technique, which later on, helped several women avail themselves better treatment options. **Dr Anagani** has been primarily recognized for her contributions to the field of laparoscopic surgery, especially for primary amenorrhea wherein autologous stem cells were used to regenerate the endometrium and also for a technique that created a Neovagina for women with absent vaginas.

India's Journey to Global Vaccine Supremacy

Pre-Independence Era in India:

In the pre-independence era, India had its own history of vaccination practices. The ancient Indian medical system, Ayurveda, had principles resembling the concept of immunization. Variolation, a practice involving the introduction of small amounts of infectious material to induce immunity, was also observed in some communities. However, the formalization of vaccination as we know it began with the introduction of smallpox vaccination by the British in the 19th century.

Colonial Era and Smallpox Vaccination:

The British colonial administration, recognizing the devastating impact of smallpox, initiated vaccination programs in India. Smallpox vaccination became more organized with the establishment of vaccination boards and the enactment of laws to make vaccination mandatory. Although these efforts were aimed at curbing smallpox, there were instances of resistance and skepticism among the local population.

20th Century Developments:

The early 20th century witnessed the expansion of vaccination efforts in India. Vaccination campaigns targeted not only smallpox but also other diseases like cholera and plague. The establishment of medical institutions and research centers played a crucial role in vaccine development and deployment.

Post-Independence Era:

After gaining independence in 1947, India continued to prioritize vaccination as a key public health strategy. The country faced challenges such as a high burden of infectious diseases, large and diverse populations, and limited resources. However, the government initiated various vaccination programs to address these challenges.

Eradication of Smallpox:

One of the most significant milestones in India's vaccination history was the successful eradication of smallpox in 1977. Intensive vaccination campaigns,



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Asst. Prof.

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surveillance, and coordination efforts led to the elimination of smallpox, showcasing the effectiveness of mass vaccination programs.

Expansion of Immunization Programs:

In subsequent decades, India expanded its immunization programs to target a broader range of diseases. The Universal Immunization Program (UIP) was launched in 1985, aiming to provide free vaccines against several preventable diseases to all eligible children.

Introduction of New Vaccines:

India continued to introduce new vaccines into its immunization schedule, including those targeting polio, hepatitis B, measles, and rubella. The country actively participated in global efforts to combat vaccine-preventable diseases.

Pulse Polio Campaign:

India played a crucial role in the global campaign to eradicate polio. The Pulse Polio campaign, launched in 1995, involved mass vaccination drives to reach every child in the country. India was officially declared polio-free in 2014.

COVID-19 Vaccination:

In response to the COVID-19 pandemic, India launched an ambitious vaccination drive. The government prioritized vaccinating frontline workers, elderly individuals, and the general population. The effort involved a combination of domestically produced vaccines and international collaborations.

Challenges and Achievements:

- While India has made remarkable progress in

vaccination, challenges persist, including reaching remote populations, addressing vaccine hesitancy, and ensuring equitable access. Nonetheless, the country's vaccination history reflects a commitment to public health and the ongoing pursuit of comprehensive immunization coverage

- India's vaccination journey from the pre-independence era to the present day encompasses significant achievements, challenges, and a commitment to improving public health through immunization. The evolution of vaccination practices in India reflects a dynamic response to changing health priorities and global challenges.

Eminent Lady Doctor of our Country



Dr. Indira Hinduja

Dr. Indira Hinduja was one of the pioneers who brought In Vitro Fertilization (IVF) technique to India. She is often credited to carrying out the delivery of the first test-tube baby in India in 1986, as well as the first Gamete Intrafallopian Transfer (GIFT) child in 1988. She received her training as a gynaecologist and infertility expert at King Edward Memorial hospital in Mumbai. She now continues to help couples with infertility issues at her practice at Hinduja hospital in Mumbai.

When “Normal” is NOT ALWAYS Normal



Dr. Prajnanika Gurung

MBBS , MD (OBG), AIIMS, New Delhi,
Founder & MD- PHS Fertility IVF & Womencare

WOMEN'S HEALTH AND ENDOMETRIOSIS

Endometriosis roughly affects 10-11% of women in reproductive age. It is a growing global concern, that has a considerable impact on women's lives, with diminished work productivity and quality of life. It is a chronic, inflammatory, oestrogen-dependant gynaecological condition which is characterized by endometrial-like lesions outside the uterus, most commonly in the pelvis, on ovaries, fallopian tubes, bowel, and bladder but also sometimes in the lungs, nose, and almost every other organ

Endometriosis can affect women of all age groups and has variable clinical presentations. We still do not know exactly what causes endometriosis or what factors exacerbate the disease. It could be due to a combination of environmental factors, dietary and nutritional factors, and genetics.

Endometriosis has been called a “Silent Epidemic” and usually presents as pain and/or infertility in a woman.

It is linked with a wide variety of symptoms, mainly chronic pelvic pain, dysmenorrhea (pain during periods), menorrhagia, painful urination or bowel movements, dyspareunia (pain during intercourse), and chronic fatigue. These symptoms adversely affect women's physical, mental, sexual, and social function/well-being.

Despite the serious impact endometriosis can have on the quality of a woman's life, it alarmingly takes on average eight years from its onset of symptoms for a woman to be diagnosed with endometriosis, and as many as six out of every ten women remain undiagnosed. The main reasons endometriosis can be a challenge to diagnose is because symptoms vary between affected individuals and can change in timing and nature. Delays in diagnosis and misdiagnosis are also due in part to a lack of proper insight on the presentation of endometriosis on the part of medical professionals. Numerous studies show that endometriosis is not considered as part of differential diagnosis when a patient presents with chronic pain, backache or gastrointestinal symptoms. More often than not, there is a tendency to normalize or trivialise severe period pain as common menstrual cramps. Women are often told to bear it and it is “all in your head.” This normalization pattern of dysmenorrhoea and other menstrual pain symptoms cause women, particularly adolescents, to avoid seeking medical attention leading to delays in diagnosis and progression of the condition with further negative impacts on quality of life and fertility. Too much stigma surrounds menstrual cycle and associated painful symptomology so that, women and girls don't talk about it, or learn not to bring it up.

Unfortunately, at present, there is no cure for endometriosis. But there are various treatments available to manage symptoms and improve quality of life. Treatment includes pain-relief medications, hormonal therapy, and surgical removal of lesions.

If a young woman is presenting with painful periods

usually a conservative approach is adopted which starts with pain relief medications to ease painful menstrual cramps. Hormone therapy, including birth control pills, patches and vaginal rings, may also be used to slow the growth of endometrial tissue. Progestins, either in the form of dienogest or of medroxyprogesterone acetate, and combined oral contraceptives as first line therapy. GNRH-agonists and levonorgestrel intrauterine system could be considered as second line treatment

If hormone therapy doesn't alleviate the chronic pelvic pain or if a patient is trying to become pregnant, the next step would be laparoscopic surgery to remove the tissue growths. While the pain will subside for a period of time, the tissue almost always grows back. The standard of practice is the excision of the endometrial implants as well as the excision of the endometriomas. In general, it is advised to handle the ovarian tissue as atraumatic as possible, to reduce the decrease of ovarian reserve. Ablation of the ovarian endometriosis is a second line therapy, while pharmacological therapies are in principle not recommended, except depot injections like GNRH-agonists that can be used as a downregulation therapy before IVF or surgery.

Women who suffer a great deal from endometriosis and have tried multiple therapies and are done with childbearing may choose to have a hysterectomy and remove their ovaries.

Endometriosis afflicts millions of women, but few people feel comfortable talking about it. Too many women wait too long to access the diagnosis and care they need to treat this painful and isolating disease. It is still a poorly understood disease. Education and awareness of endometriosis is the key. Taking charge of one's own health can lead to earlier diagnosis. Living with endometriosis and how one is perceived in the health care encounters have a great impact on these women's lives.

So, what one perceives as "Normal may not be always normal". As women, we need to step forward and help ourself, friends and family members to better understand endometriosis, its symptoms, its causes and its treatment and most importantly, seek help. As health care professionals we need to be more aware of endometriosis as an invisible disease and be more sensitive for individual pain pattern among women.

Eminent Lady Doctor of our Country



Dr. Gagandeep Kang

Dr. Gagandeep Kang Dr Kang was the first Indian woman scientist to be elected as a fellow of the Royal Society. This leading virologist is credited with conducting tremendous research on viral infections in children. She has also conducted extensive research on the rotavirus and was the key scientist behind the development of Rotovac, a vaccine from Bharat Biotech International that targets diarrhoea. She was presented with the Infosys Prize for her research and discoveries. Dr Kang is also known for combining her scientific discoveries with policy-making to deliver holistic results on many vaccines. Her work has led to her being hailed as the "vaccine godmother" of India.

As a Women how you will Tackle Challenges from Position of Strength?

As a woman, tackling challenges from a position of strength involves embracing your unique qualities and taking proactive steps to overcome obstacles. Here are some strategies to consider

Build self-confidence: Cultivate a positive self-image by recognizing and appreciating your strengths, accomplishments, and capabilities. Surround yourself with supportive individuals who uplift and encourage you.

Develop resilience: Understand that challenges are a part of life, and setbacks can be opportunities for growth. Develop resilience by viewing failures as learning experiences and finding ways to bounce back stronger.

Set clear goals: Define what you want to achieve and create a roadmap to get there. Break down larger goals into smaller, manageable tasks. Stay focused on your objectives and track your progress to maintain motivation.



Miss. Soma Chakraborty
Founder cum MD Goodace Hospital

Enhance your skills and knowledge: Continually invest in your personal and professional development. Seek opportunities to expand your skill set, pursue relevant education or training, and stay updated in your field of interest. Acquiring expertise will boost your confidence and open doors for advancement.

Cultivate a supportive network: Surround yourself with positive, like-minded individuals who share your values and goals. Build relationships with mentors, role models, and peers who can offer guidance, support, and valuable connections.

Advocate for yourself: Learn to assertively communicate your needs, ideas, and boundaries. Practice self-advocacy in both personal and professional settings. Speak up, negotiate for what you deserve, and take ownership of your achievements.

As a women what is the best way to stand out in a male dominated profession?

If you do your job extremely well, and have personal flair that expresses your particular philosophical approach to the work you do, I think it is usually unnecessary to add something extraneous to 'brand' yourself or try to get attention that might pass over you due to market saturation or discriminatory perceptions in your industry.

You don't owe them living up to what preconceptions may exist, but they don't owe you a job. Passion, dedication, patience, and sacrifice seem to be the road to success no matter your gender or the social state of your field of practice. Research the adversity you might face, and have informed and balanced ways to deal with the social and economic dynamic common to your situation

Remember, every woman's journey is unique, and it's important to embrace your own path and define what strength means to you.

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Managing health and hygiene at home is easy, but in an external environment like offices, it is important to be in control rather than be controlled. Without proper care, women face great health risks.

Eating healthy, nutritious meals ensures the body is healthy and happy.

Exercise is especially important for women to keep aches & pains at bay.

Keeping track of the menstrual cycle enables one to be prepared especially in the office. In recent times, there are many online tracking apps available.

During periods, it's important to eat right, drink lots of water, change regularly and wash up to remain fresh and clean.

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