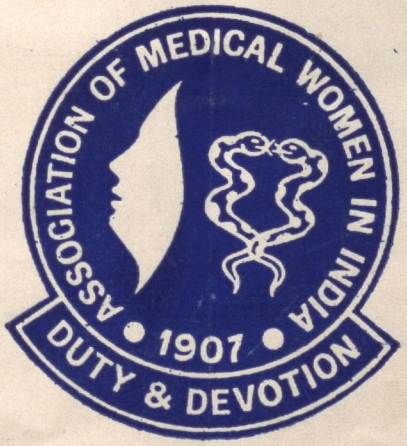
THE JOURNAL

OF THE

ASSOCIATION OF MEDICAL WOMEN IN INDIA



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CONTENTS

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Dr. M. Ghosh
Signature of the Editor

Date 15th July. 1988.

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President :	Dr. Winnifred Fernandes M. D. F. C. P. S., F. R. C. O. G. 14, Kahun Road, Pune-4110 007.
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EDITORIAL

I have been asked by many in our profession both women and men, why there should be an association for women doctors only. As members of the profession all the doctors are same, so why should we feel any necessity of having an association for women only?

Women are claiming equality in all the spheres of life and we shall be the first to clamour, if there is any hint of discrimination. So if the rights are equal, field of work is the same, why should women identify themselves as a seperate entity and form themselves into an association exclusive for themselves ?

In theory, I agree with all these arguments, In spite of that, I find justification for this association.

Historically this association is the oldest medical association in India. So, women thought up of forming an association before men did. At that time there difinitely was not equal opportunity, with no constraint for women doctors. Women doctors had to struggle against many obstacles both social and professional. It was much more important for them at that time to form into an association, to be able to assert their rights and sort out their problems. Even to-day in the male dominated society there is discrimination. There is some idea among people in general, that women doctors are suitable for certain specific type of work and men doctors are to be preferred in all other fields.

There is no other way to fight this bias of course, except women doctors to enter into every branch of medicine and prove their worth. Naturally there is some hesitation due to fear of rejection, but women are gradually entering into practice of different branches of medicine. When they prove their worth, they will ultimately be accepted

I do not see why an association which has such a long history should be liquidated. It has a tradition of its own Even otherwise, I do think that justification for having an association for women only., is still there. Women may be equal to men, but they are not the same. They have problems of their own, which are specific to them and which would be appreciated better by women.

Marriage is an institution whose importance is equal to men and women. There is no reason why a woman doctor should deprive herself from this necessity of life. But as soon as a woman doctor marries, she puts herself under many obligations, which interfere with her profession. There are no such problem with men. The responsibility of looking after home bearing children & bringing them up, puts restrictions on her activities in her profession. She has to work at a disadvantage as against her male colleague, till the children grow up. Many women doctor had to give up their profession or had to be happy with some nominal work because, if they wanted to do justice to their home & children, they could not afford to pay wholehearted attention to their profession. So years of studying and training go to waste. I believe our association should pay particutar attention to this problem. We should try to find some solution. A young woman doctor who is also a young mother responsible for bringing up her child, must not be forced to give up her profession, or neglect her children. We should try to find out problems of our members in this respect and try to find solution. If we try as an association, we can help these members to get part-time appointment or have some special concessions as they are not free to give their whole attention to the profession. In that way their training would not go to waste. We should take initiative in building up good creches for children of medical women, where their children would be looked after properly when they are away at work.

This is a competetive age. So people who can not join in the race and work wholeheartedely are likely to be left behind. But can our country afford to waste the work power of these women who had becn trained professionally ? Our association can try and find out how to utilise best, the service of these women, keeping in mind their other obligations. We should try to find out ways to help and advice them, so that they do not lose touch and get opportunities to work when they are free to work fulltime Women doctors face other types of problems as well It is difficuit for them to work in isolated remote places, where there are no proper security for them. There are other similar problems which they face.

We could use this journal, for giving expression to different problems faced by women doctors and give some thought towards solution.

M. GHOSH

We have been able to bring the journal after some interval. The west Bengal branch has taken the responsibility of publishing it. We appeal to all the members to contribute articles, case reports etc. & help to make it a success.

DR. ANJALI CHATTERJEE MEMORIAL ORATION

SOME ASPECTS OF EPIDEMIOLOGY OF CHILDHOOD ONCOLOGY AND MALIGNANCY IN NEWBORN

Dr. Shanti Indra, M. B. B. S. (CAL.),*
F. R. C. P. (Edin.), D. C. H. (Eng.)

I am honoured to be chosen as an orator for Dr. Anjali Chatterjee Memorial Oration organised by A. M. W. I., West Bengal. I must thank the organisers, but I must confess that to deliver a lecture on paediatric oncology for a general pediatrician is a difficult job. In recent years, paediatric oncology is considered a special branch of paediatrics and is dealt by paediatric oncologist. Therefore, I have to depend on mostly statistical data of western countries due to lack of adequate data of early childhood oncology in India. However, I have collected some data from the articles published by Prof. B.N.S. Walia et al of Chandigarh.

Table No. 1 and 2 give the incidence of childhood malignancy in U. S. A. and India.

TABLE 1

Occurance of Malignant Neoplasms in Children under 15 Years of Age (United States Data)

Neoplasm	Rate (per million year) White	Black
Leukaemia	42.1	24.3
Central Nervous System	23.9	23.9
Lymphoma	13.2	13.9
Sympathetic Nervous System	9.6	7.0
Kidney tumor	7.8	7.8
Bone tumor	5.6	4.8
Soft tissue Sarcoma	8.4	3.9
Retinoblastoma	3.4	3.0
Gonadal & germ call	2.2	2.6
Liver tumor	1.9	0.4

Results of the 3rd National Cancer Survey modified from Yonus T.L., Miller R W., J. Pediatr 86 : 254, 1975

*Formerly Head of Dept. of Paediatries, R. G. Kar Medical College, Calcutta,

Malignant tumors other than leukemias

Diagnosis	Number	%
Lymphoma	156	25.9
Central nervous system	92	15.3
Soft tissue Sarcoma	86	14.3
Bone Sarcomas	63	10.5
Retinoblastoma	53	8.7
Wilm's tumor	51	8.5
Neuroblastoma	28	4.5
Teratoma	24	3.8
Liver tumors	7	1.1
Epithelial tumors	30	5.0
Miscellaneous	15	2.4
Total	605	100.0

Under five years of age majority of children suffer from following malignancies—Acute Lymphatic leukaemia, Neuroblastoma, Wilm's Tumor, Retino-Blastoma and primary liver cancers. Many of the tumors occuring in this age group are embryonal in nature and constitute about 40% of all childhood cancer. Prenatal factors are thought to affect the incidence of tumors in children under the age of 5 years.

Over the age of 10 years common malignancies are Hodgkins, Non-Hodgkins lymphoma, testicular malignancy and bone marrow tumor. Post natal effects may be related to the incidence of tumor in older children and the post natal factors may include enviormental influences as well. Almost two third of the neonetal tumors are found within the first week of life.

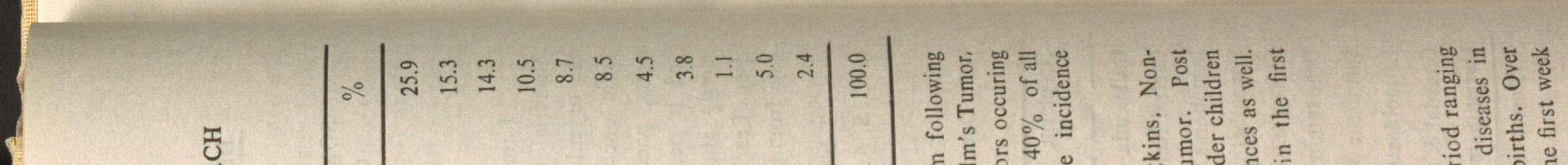
CONGENITAL MALIGNANT DISORDER :

The study by Fraumeni and Miller during the 5 years period ranging from 1960 to 1964 revealed the death rate from malignant diseases in infants under 28 days and was about 6.24 per million live-births. Over one half of cancer deaths in the neonatal period occured on the first week of life and over one third was on the first day.

TABLE III

Incidence and Mortality of Malignant Tumor in United States Neonates and Infants

Tumor Type	INCIDENCE <29 days No.	<29 days Rate	<12 months No. (A)	<12 months Rate (Per Million	Mortality <29 days No.	<29 days Rate	<12 months No. (B)	<12 months Rate	Ratio A/B
Leukaemia	5	4.7	34	31.8	101	2.6	807	20.8	1.5
Neuroblastoma	21	19.7	67	62.7	70	1.8	302	7.8	8.0
C N S	1	0.9	15	14.0	12	0.3	257	6.6	2.1
Kidney	5	4.7	21	19.7	21	0.5	141	3.6	5.4
Reticuloen Dotheliosis	0	0	3	2.8	7	0.2	131	3.4	—
Sarcoma	4	3.7	19	17.8	29	0.7	129	3.3	5.4
Liver	0	0	8	7.5	15	0.4	99	2.6	2.9
Lymphoma	1	0.9	2	1.9	2	0.1	60	1.5	1.3
Teratoma	0	0	3	2.8	11	0.3	28	0.7	4.0
Carcinoma	1	0.9	6	5.6	6	0.2	18	0.5	11.2
Germ cell excluding Teratoma	0	0	0	0	0	0	6	0.2	—
Retino blastoma	0	0	17	15.9	1	0.1	4	0.1	159.0
Others	1	0.9	1	0.9	20	0.5	62	1.6	—
	39	36.4	196	183.4	295	7.7	2044	52.7	3.5



On the report of Third National Cancer Survey (1969 to 1971), Badar and Miller found the incidence of malignant neoplasms in U.S.A. to be 183.4 per million live births in infant younger than one year and 36.5 per million live births in new born younger than 29 days. The cancer incidence in those under 1 year was almost 3.5. times greater than mortality, determined from death certificate from 1960 to 1969. When mortality of infants under 1 year of age is used as an indicator of frequency, leukaemia appears to be the most common cancer followed by neuroblastoma, CNS tumors and renal tumors. When ranked by incidence, neuroblastoma is most common followed by leukaemia, renal tumors, sarcomas retinoblastomas and CNS tumors.

TABLE IV

Mortality from malignant neoplasms in USA under 5 years as compared with those under 28 days of age 1960-64

Neoplasm	No. Deaths under 5 years	Deaths under 28 days		
		No.	Rate per 100 live birth	Percent
Leukaemia	4592	44	2.11	1.0
Neuroblastoma	1049	27	1.30	2.6
Brain Tumor	1035	7	0.34	0.7
Wilm's tumor	696	9	0.43	1.3
Liver cancer (Primary)	196	10	0.48	5.1
Teratoma	111	9	0.43	8.1
Sarcoma, Type, specified	1940	12	0.58	
Other		12	0.58	1.2
Total	9619	130	6·25	1·4

Because retinoblastoma is so often cured, the incidence is 159 times greater than the mortality. Among newborns the incidence of neuroblastoma is more than 10 times greater than the mortality for this tumor, whereas the incidence of leukaemia is less than two times greater than its mortality. Thus a study of mortality differs markedly from one of incidence, since, certain malignancies are rapidly fatal; others lead to death beyond the neonatal period and a large numbers are curable or undergo spontaneous regression. Data from the Third National Cancer Study indicate that approximately 653 cancers are diagnosed annually in infants in U. S. A. and that 130 of these cancers are found in newborn.

There are many factors which have been attributed to influence the incidence and prognosis of the childhood and neonatal cancer.

TABLE V

Deaths from Neonatal cancer according to specific diagnosis, Age and Sex.

	AGE			SEX	
Neoplasm	24 Hrs.	6 days	1-4 weeks	Male	Female
Leukaemia	10	9	25	21	23
Neuroblastoma	13	2	12	15	12
Sarcoma	7	1	4	7	5
Liver cancer (Primary)	4	3	3	6	4
Wilm's Tumor	1	6	2	6	3
Teratoma	7	1	1	4	5
Brain tumor	3	1	3	4	3
Other	6	5	1	4	8
	51	28	51	67	63

TABLE VI

INSTITUTE OF MEDICAL EDUCATION & RESEARCH, CHANDIGARH

Age, sex, distribution of benign tumors (0–15 yrs)

	0–5 yrs.		6–10 yrs.		11–15 yrs.		Total	
	M	F	M	F	M	F	M	F
True benign tumors	48	26	49	38	134	95	231	149
Non-neoplastic tumor like lesions	114	56	59	56	89	65	262	177
Total	162	82	108	84	223	160	493	326

Total Cases = 819

VARIATION OF SEX : Males are affected more than females ratio being 1.2 : 1. the variation being more evident in prepubertal patients. Tumors of the Gonads and skin are more frequent in females, whereas more common paediatric tumors i e. acute lymphatic leukaemia, lymphoma and medulloblastoma are frequent in males. No difference between males and females in neonatal tumor type.

2. RACIAL—ETHNIC AND GEOGRAPHIC VARIATIONS

In U S. A. 6000 to 7000 cases are newly diagnosed as paediatric cancer annually. The annual incidence of childhood cancer is about 12.1. per 100,000 white children and 9.3 per 100,000 black children. Israel has got highest incidence with 30.6 per 100,000 individual in both European and American born fathers. The lowest incidence of childhood cancer is in India with a rate of 6.8 per 100.000 males.

Institute of Medical Education and Research, Chandigarh

Relative incidence of malignant tumors

	Present series (1971-80)	Chandigarh (1964-72)	Delhi (1956-80)	Bhopal (1960-69)	Bombay (1941-60)	Vallore (1960-62)
Total No. of Cases	598	280	198	193	498	177
1. Lymphoma (total)	26.0	26.2	24	25.6	18.0	21.4
(a) Hodgkin's	15.3	9.3	12	15.0	11.4	11.8
(b) Non-Hodgkin's	10.7	16.9	12	10.6	6.6	9.6
2. Embryonal tumors	23.2	22.5	36	25.8	36.2	20.9
3. Bone sarcoma	10.5	9.0	5.5	9.3	18.0	9.5
4. Other sarcomas	14.3	16.0	13.5	5.7	8.0	18.7

Incidence of Wilm's Tumor is constant world-wide, Leukaemia varies amongst countries and it is higher in white children in Israel. Denmark, Japan and U.S.A. Liver cancer incidence is highest in the Far East. Retinoblastoma occurs excess in India (Probably also in Central America). Ewings tumor occurs more in blacks, whereas Melanoma's may have worldwide increase in white children and adults.

3. Host Factors : Certain host factors seem to predispose an individual to develop neoplastic diseases. An increased incidence of Leukaemia is seen in Down's Syndrome,the individual with immunodeficiency disorder such as ataxia telangiectasia, Wiskott-Aldrich Syndrome and all of them are prone to get Leukaemia and Lymphomas.

Similarly phenytoin depresses immune function and the immune deficiency occurs in children with fatal alcohol syndrome. The chance of developing Leukaemia in a monozygotic twin is more. The co-twin will have 25% chance of developing Leukaemia within weeks or months of diagnosis in the sibling

Hereditary and Familial Factors : In certain cases hereditary and familial factors also play an important role such as neurofibramatosis, tubcrous Sclerosis and basal cell Carcinoma.

There are younger persons who are at extremely high risk for development of malignancy either because of constitutional predisposition or environmental exposure to carcinogens or deficient inherent defence mechanism. Individuals with predisposition include persons with various hereditary cutaneous syndrome, hereditary neurocutaneous syndrome, Chromosomal abnormalities, immunodeficiency syndromes, Congenital malformations and individuals with sibling with malignancy or survivors of prior cancer.

Cutaneous and Neuro-Cutaneous Syndromes Associated with Tumor Susceptibility

Table—IX

Cutaneous Syndrome	Neuro-cutaneous Syndrome
Nevoid basal cell carcinoma Syndrome	Neuro-fibromatosis
Multiple tricho epithelioma Syndrome	Von-Hippel-Lindau
Tylosis	
Xeroderma Pigmentosum	
Warner's Syndrome	
Familial Atypical	
Mole-pigment Melanoma Syndrome	
Dy skeratosis Congenita	

A. The Neuro Cutaneous Syndromes : Increased tumor susceptibility often show autosomal dominant inheritance. There is also an increased frequency within these individuals of optic and cerebral glioma, meningioma, acoustic neuroma, Pheochromocytoma and medullary carcinoma. Recently there has been reported an unexpected increased frequency of Leukaemia, rhabdomyosarcomas and Wilm's Tumor among patients with neurofibromatosis. The percentage of individuals having malignant degeneration of neurofibromatosis varies from 24 to 29% of patients.

B. Gastro-Intestinal Syndromes Associated with Increased Tumor Susceptibility: Hereditary as well as acquired inflammatory bowel disease is often associated with an increased incidence of malignancy involving not only the bowel but other sites also. Polyposis coli is associated with adenomatous polyps of the colon and rectum.

Adenocarcinoma of the Colon is present in the polyps about 40% of patients. Peutz-Zaghers Sybdrome develops gastrointestinal carcinomas. In individuals with ulcerative Colitis there is high risk of development of carcinoma, 3% in first 10 years and 20% of cases thereafter.

Chromosome Syndromes With Predispostion To Cancer

Table—X

Aneuploidy	— Down's Syndrome (Trisomy 21)
	Klinefetter's Syndrome (47 XXY)
	Female XY Mosaicism (47 XO/46 XY)
Deletion	— 13q-retinoblastoma
	11p-aniridia, Wilm's tumor
Translocations	— 3, 8 renal cell carcinoma
	4q—7p-osteosarcoma
Increased Chromosomal	— Bloom's Syndrome
Fragility	Fanconi's Syndrome
	Ataxia telangiectasis

C. Susceptibility in Relation to Chromosome Syndromes: Aneuploidy, deletion, translocation and fragility are among the recognised morphologic changes within the chromosome. Aneuploidy in association with Cancer, one should consider Down's Syndrome-commonly seen in associations with either Lymphocytic or non-lymphocytic leukaemias-15 times more common.

Klinefetter's Syndrome has increased incidences of breast Cancer, Germ cell tumor and leukaemia-lymphoma as well chromosomal deletion synodrome associated with cancer is seen in 12q and 11p-retinoblastoma

and Wilm's Tumor respectively. In case of chromosomal transplantation in between 3 and 8 shows increased incidence of renal cell Carcinoma.

Increased chromosomal fragility has been identified in Bloom's Syndrome, Franconi's anaemia and ataxia telangiectasia-leukeamia and lymphoma are common.

D. Susceplibility in Association with Sporadic Congenital Malformation : Certain sporadic congenital malformation has been associated with malignancy such as hemi-hypertrophy in association with Wilm's tumor, hepatoblastoma and adrenal carcinoma as seen in Beckwith Syndrome.

E. Familial Occurence of Cancer : Childhood cancer occuring more than one within a family may be chance or explained by Chromosomal or Mendelian traits or by exposure to environmental carcinogens.

When Cancer has occured in one sibling, the risk of cancer in remaining siblings is three times more than the expected risk in normal population. Some families may have cancer all of one cell type, whereas others may have diverse cell-types.

F. Family Cancer Syndrome : Some families have greater risk to develop cancer than normal population. There is a higher frequency of cancer within the family. These families usually have more than 25 percent of the family members affected with Cancer at sometime within their life time. These families have the occurence of various malignant tumors in consecutive generations. On some occasions, diverse patterns of malignancy may be seen in both children and adults. Carcinomas are very rare in children such as colo-rectal carcinoma (12% in children), nasopharyngeal, carcinoma, melanoma, hepato cellular carcinoma, thyroid, adrenal, renal, pancreatic, basal cell, squamous cell and salivary gland carcinoma Rhabdomyosarcoma occurs in paediatric age group.

Environmental Factors Associated with Cancer : Direct cause and effect relationship between environmental agents and human cancer are difficult to establish because of the long latent period. Fraumani and Miller showed no significant annual variation of neonatal cancer cases in U.S.A. Children exposed prenataly to the atomic bombs in Hiroshima and Nagasaki did not have increaesd incidence of leukaemia.

On the other hand many authors have reported increased risk of leaukaemia of those children whose mother had abdominal radiation.

1. Physical Agents May be Associated with the Development of Carcinoma

a) Ultraviolet Irradiation : Various Skin cancer - melanoma, basal cell and Squamous cell carcinona.

b) Ionizing Radiation : At any dose may be unsafe. Types of irradiation as well as varions host factors may influence the dose response curve, as does the individual sensitivity of specific tissues to irradiation carcinogenes, It is for these reasons. that Leukaemia and thyroid cancer are among the most easily induced radiation associated malignancies. In Japan, the survivors of atomic bomb irradiation below 15 years suffered from breast and thyroid Cancer and acute leukaemia.

c) There may be some risk of radiation associated carinogenes following prenatal irradiation, it is dose dependent.

d) Exposure to asbestos in childhood may cause mesothelioma after a latent period of 30 to 40 years.

e) A recent report suggest four types of childhood cancer in association with fathers specific radiation related occupations, rhabdo-myosarcoma among children whose fathers were petroleum foreman, retinoblastoma among offspring of fathers who were Radio or Telivision repairmen, central nervous system cancer and lymphatic cancers among children of Air Force Fathers.

II. At Least 54 Chemical Agents have been Identified as Probable human Carcinogens.

a) Exposure of children to these agents may occur by transplacental passage.

i) In 1971, Herbst and Co-workers reported, that large doses of diethylstilbesterol (DES) given to pregnant women were related to the development of adeno-carcinoma of the vagina in their daughters even after 14 to 22 years. The exposure to stilbesterol and its synthetic analogue in uterus during the first half of pregnancy is known to develop clear-Cell adeno-carcinoma of vagina and cervix, when the mother was treated for

threatened abortion. The risk of developing such tumors is approximately 0.14 per 1000 diethylstilbesterol (DES) exposed females up until the age of 24 years. Besides neoplastic changes, other types of changes have been observed in females with exposure to these types of drugs. Males being exposed to DES in uterus showed increased frequencies of testicular hypoplasia, cryptorchidism, epididymal Cysts. microphallus, increased abnormal sperm forms and lowered sperm counts and a small number of males either will be infertile or will have seminomas. The maternal chemical carcin gen exposure may result in an increased incidence of tumors not only in the offspring, but also in later generations untreated descendants.

ii) Contamination of food, water and air by such products as affatexin B1 (a potent liver carcinogen) which has been found to grow on various nuts, beans, grains and other food in association with hepato-cellular carcinoma.

iii) Benign as well as malignant tumors in individuals receiving androgen treatment for various conditions.

iv) And following the use of anti-cancer chemotherepy for Childhood malignant solid tumors and leukaemias.

b) Certain Industrial Chemical Agents : have been attributed to be a causative factors.

i) Vinyl Chloride is associated with the development of angio-sarcoma of the liver.

ii) Benzene-Prolonged exposure to it may be followed by acute non-lymphocytic leukaemia.

iii) Exposure to arsenical insecticides of the vineyard workers has caused hepatic angio-sarcoma.

iv) Chronic phenytoin usage has been follow.d by lymphoma. The exposure of the newborns in utero to phenytoin also been reported to have neuroblastoma, extra-renal Wilm's tumor and malignant mesendymoma.

v) Fetal alcohol syndrome occuring in children of mothers consuming excessive amount of alcohol are noted to have delayed development, growth deficiency multiple abnormalities and besides these they are prone to develop neuroblastoma, hepatoblastoma and adreno-cortical carcinoma.

III. Biologic Agents are also Associated with Cancer :

i) Schistosoma haematolunim is associated with development of urinary bladder cancer within second decade of life.

ii) Epstiein—Barr virus infections including infectious mononucleosis is associated with Burkitt's lymphoma, nesopharyngeal Carcinoma and X-linked lymphoproliferative syndrome.

iii) Leukaemias and lymphomas of T-Cells are known to be associated with human T-Lymphotropic retro-Viruses (HTLV-1 and HTIV III), HLTV -1 has been demostrated to be etiologic agent of clinically aggresive adult T-Cell Leukaemia-Lymphoma, Whereas HLTV III has been isolated from patients with AIDS.

Hypothesis for Cancer Inductions : The, "Two-hit" model of cancer induction has been proposed by Knudson. The hypothesis proposes that two discrete mutational events possible at the same genetic locus may be required to transform a normal cell into a cancer cell. By this explanation, Cancer may occur when a cell is homozygous for a specific mutated cancer gene. These genetic mutations may be either pre-zygotic or post-zyotic. The second event is virtually always post zygotic. Pre-zygotic mutations. therefore, of hereditary nature ; whereas Post-zygotic mutation may be mutated, "Cancer gene" may have this defect present in all cells of the body requiring the second event for expression of malignancy. These second events may occur as a result of irradition, chemical carcinogens, or an oncogenic virus. These individuals might be expected to develop a specific tumor. With high frequency at multiple sites, usually at an age earlier than those requiring two separate post-zygotic events. These observations are consistent with bilateral retinoblastoma.

Cytogenetic studies in recent years substantiated hypothesis that morphological chromosomal aberrations with abnormal Karyotype being limited to the malignant clones, this indicating that the mutational events responsible for the neoplasm were post-zygotic. In rare instances the Karyotypes of specific tumors had been transmitted in familial Prezygotic fashion such as in the 3 : 8 translocation with renal cell carcinoma, 11p deletion with Wilm's tumor, 13q deletion with retinoblastoma and trisomy 21 with acute leukaemia.

Childhood Cancer Mortality and Prospect For The Future.

Recent reports indicates the decline in Childhood Cancer mortality below 15 years in Western countries. It has noted less mortality in the following malignancis since 1950 ; Leukaemia 50% less, Hodgkins disease 80% less, Non-Hodgkin lymphoma 32% less, Bone Cancer 50% less and all other types of cancer 31% less.

It has been attributed due to improved therapy, but there also may be less incidence in the recent years specially of leukaemias.

In conclusion, I would just like to mention the role of General paediatrician in management and diagnosis of cancer in a child. The parents of the child may or may not have any concern that the signs and symptoms are "Serious". The family is usually shocked at knowing the diagnostic possibity of malignancy. The encouragement, support and availabity of the paediatrician or physician during transition period sets the stage for acceptance of treatment. It is important to give factual information to the parents initially. The details of management, prognosis and survival statistic should be discussed with the parents by the oncologist in presence of the paediatrician.

The parents should be asked to avoid over protective, attitude towards the child and rather keep him cheerful and happy.

References : 1) Text book of Schaffer's Diseases of Newborn 5th Ed.

2) The Paediatric Clinic of North America - Oncology June, '85 - N. 3

MATERNAL MORTALITIES REVIEWED—1965—1984

By

Dr. Kaizad R. Damania, M.B.B.S., D.G.O. ★

Dr. Vinita Salvi, M.D., D.G.O. ★★

Dr. Dina N. Patel, M.D.F.C.P.S., F.I.C.S. ★★★

Introduction

There is no tragedy so great as that of preventable maternal death. Fewer than 1% of pregnant women in the world today are under the care of specialist obstetricians and out of necessity most women are still delivered by either midwives or handy women.

In the last several decades, policies aimed at universal hospital confinement have been promoted in the interest of both mother and infant. But how significant has been the decline in maternal and perinatal mortality ?

This study reviews the maternal mortalities over 20 years at the Nowrosjee Wadia Maternity Hospital, Bombay, and aims to study the changing trends in the same and differentiate the preventable from the non-preventable causes.

Material and Methods

Maternal mortalities over the past 20 years from 1965-1984 at the Nowrosjee Wadia Maternity Hospital were reviewed. The number of live births in this period were 1,68,329. 335 mothers lost their lives over this time -span while pregnant or within 42 days of termination of pregnancy.

All maternal mortality rates were calculated per 100,000 live births and all statistical significance calculated using the chi-square test.

★ House Surgeon

★★ Registrar

★★★ Honorary Director, Sir Ness Wadia Research Centre

Nowrosjee Wadia Maternity Hospital,

Acharya Donde Marg, Parel,

Bombay-400 000.

Table I

Incidences of Maternal Mortalities

Years	Maternal Mortality Rates
1965-69	347/100,000 Live births
1970-74	191/100,000 Live births
1975-79	158/100,000 Live b'rths
1980-84	82/100,000 Live births

Table II

Gravidity Mortality

Gravida	M. M. R./100,000 live births
I	209/100,000 live births
II—IV	189/100,000 live births
V and avove	360/100,000 live births

Table III

	No. of deliveries	No. of Mortalities	M.M.R
Booked cases	153,651	85	55/100,000 live births
Emergency cases	14,678	250	1703/100,000 live births

Table IV

Cause of Death

Cause of death	Number	Percent
Obstetric	213	63.5
Medical aggravated by obstetric	107	32
Non-obstetric	10	3
Anaesthetic	5	1.5
Total	335	

Table V

Preventability

	Number	Per cent
Preventable	267	79
Non-preventable	68	21
Total	335	

Responsibility

Patient	159	59.5
Doctor	39	14.5
Social	13	5
Blood	10	4
Combination	46	17
Total	267	

Results

Total deaths	...	335
Total live births	...	1,68,329
Maternal Mortality Rate (M.M.R.)	= 199/100,000 live births	

See Table I

The incidence of maternal mortalities has steadily declined from 347/100,000 live births from 1965-1969 to a statistically significant 82/100,000 live births over the last 5 years.

SeeTable II

The maternal mortality at the hospital is highest amongst grandmultis being 360/100,000 live births followed by primis with a death rate of 209/100,000 live births. This substantiates the fact that grandmultis form a high risk group.

See Table III

Booked cases in our study had a significantly low maternal mortality at only 55/100,000 live births (0.05%) as against a disasterously high 1703/100,000 live births (1.7%) in emergency cases showing thus that gradually increasing recognition of antenatal care has paid rich dividends.

See Table IV

Table IV analyses the cause of death as being either direct obstetric death resulting from obstetric complications of pregnancy, labour or the puerperium and from intervention or the lack of them thereof or indirect obstetric deaths resulting from a non-obstetric disorder aggravated by pregnancy.

63.5% of our patients died of a direct obstetric cause while at least 32% of the cases had their deaths attributed to an indirect obstetric cause. 3% of patients had a non-obstetric cause of death; such as medical disorders not aggravated by pregnancy along with a stray case of suicide.

Five patients died of an anaesthetic complication. These deaths are doubtly tragic in so far as they are largely preventable in the hands of experienced personnel who choose their anaesthetic wisely.

Table VI

Changing trends amongst common causes of maternal mortality

	1965-69	1970-74	1975-79	1980-84	Total
Haemorrhage	49	17	23	15	104
Infection	42	24	15	1	82
Anaemia	31	15	5	2	53
Eclampsia	15	9	5	5	34

Table VII

		1965-69	1970-74	1975-79	1980-84
Placenta previa	(I)	0.60	0.58	0.34	0.41
	(II)	2.44	2.95	2.36	0
Accidental haemorrhage	(I)	0.99	0.73	0.46	0.45
	(II)	1.06	1.66	2.32	2.05
Post-partum haemorrhage	(I)	0.86	0.65	0.59	0.42
	(II)	3.92	2.62	3.19	4.37
Eclampsia	(I)	0.32	0.27	0.21	0.17
	(II)	7.84	8.10	5.13	8.33
Lower segment caesarean section	(I)	2.87	3.19	3.83	6.02
	(II)	0.51	0.84	0.49	0.27
Vesicular mole	(I)	0.11	0.14	0.15	0.17
	(II)	3.70	0	3.57	2.77
Ectopic gestation	(I)	0.10	0.08	0.16	0.14
	(II)	8.16	2.94	0	0

(I)=Incidence (II)—% Maternal mortality

See Table V

79% of deaths in our study were found to be preventable.

Preventable deaths have traditionally been charged to deficiencies in one of three areas, namely physician care, patient actions and community resources, however in a given case two or more factors may be interrelated.

In this study the patient herself was responsible for her own death in 59.5% of our preventable cases. The majority of these mothers would have been saved had they been timely registered for antenatal care or had follow-up regularly in the antenatal clinics.

Even today 14.5% of the preventable deaths are attributable to the doctor alone. Delayed transferral of a moribund patient constitutes the bulk of this category.

Social traditions leading to a delay in seeking and accepting help contributed to 13 deaths while 10 patients lost their lives because of non-availability of blood, belonging as they were to uncommon blood groups.

See Table VI

Reviewing the trends in maternal mortalities over the years in common obstetrical conditions, haemorrhage of pregnancy (31%), infection (24%), anaemia (16%) and eclampsia (10%) have always remained the major killers, though each of these have shown a statistically significant decline in the mortality rate.

See Table VII

There has been a statistically significant fall in the incidence of placenta praevia, accidental haemorrhage, post-partum haemorrhage and eclampsia over the past 20 years. Significant success in reducing maternal mortality was achieved in cases of placenta praevia, however, no significant fall in percentage mortalities for accidental haemarrhage, post-partum haemorrhage and eclampsia was noted.

The situation appeared to be the same when analysing mortality rates for caesarean section and molar pregnancies.

A significant success in reducing maternal mortalities was noted for ectopic gestations.

Discussion

The overall maternal mortality rate at our hospital was 199/100,000 live births.

The maternal mortality rate has declined over the years being 82/100,000 live births in the last five years, compared to 703/100,000 births (Rao, 1980) in a F.O.G.S I. multicentric study.

The decline in maternal mortality rates at our institution could be attributed to :

1) Shift of deliveries from home to hospital.
2) The increase in number of mothers seeking and receiving better antenatal/postnatal care and identification of a high risk group.
3) The rise in availability of skilled personnel and theatre facilities in peripheral hospitals.
4) The availability of blood, antibiotics and safer anaesthetics.
5) The presence of better communication and transport facilities.
6) The increased safety of operative interventions.
7) Identifying weaknesses in our health care-delivery system and rectifying them.

Our study confirms that grandmultis and unbooked cases form a high risk group for maternal mortalities. However Mitra and Khanna (1983) in their report, considered primigravidas to be at the greatest risk.

79% of the deaths in the current study were preventable compared to 69% in the Indian multicentric study.

Preventable factors have been reported in 54 to 85% of maternal deaths. Dhar et al (1979) 82%, Lakshmi (1976) 65%, Bhargave (1979) 60.7%, Mitra and Khanna (1983) 84.4%.

In the current study the patient was responsible for her own death in 59.5% of the cases while the doctor was responsible in 14.5% as compared to the F.O G.S.I. study where the patient was responsible for 50% of mortalities while 30% were due to physician error or negligence.

Haemorrhage appeared to be the commonest killer in the current study constituting 31% of all maternal deaths ; followed by infection (post abortal-puerperal sepsis) in 16%. This is in contrast with the F.O G.S.I. collaborative finding of relatively lower incidence of mortalities attributed to haemorrhage (22%) while infection were responsible for a higher 88% mortalities. Mitra and Khanna (1983) quote an incidence for deaths due to haemorrhage at 17.06% and 32.56% for those due to sepsis.

Significant success in reduction of maternal deaths was not achieved in cases of post-partum haemorrhage, accidental haemorrhage, eclampsia and patients developing complications from caesarean section or vesicular mole. To put this simply a parturient in 1984 stood a lesser chance of developing eclampsia, but should she develop the same her chances of not surviving were still the same as they were before.

The autopsy rate at our hospital was 39.6%. Rao (1980) reports an autopsy rate of just 3.2% ; however a rate of at least 35-50% would be commendable to be of real value.

Conclusion

1) The maternal mortality rate in our study was 199/100,000 live births.
2) The maternal death rate has shown a decline over the years ; the reason for the same have already been enumerated.
3) Grand multis and unbooked cases formed a high risk group for maternal mortalities.
4) 79% of deaths were preventable, responsibility shared by the patient herself and the doctor in a ratio of 4 : 1.
5) The major causes of maternal deaths were haemorrhage,infection,anaemia and eclampsia.

Acknowledgement

I wish to thank the Dean, Nowrosjee Wadia Maternity Hospital, for allowing me to use hospital data.

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A CASE OF MONOAMNIOTIC TWIN

Dr. Ratna Sanyal D.G.O. M. D. Cinical Tutor,
Calcutta National Medical College
Prof. A. K. Bose. F. R. C. S. Ph D. Ex-Professor of obstetrics
and Gynaecology, Calcutta National Medical College.

Monoamniotic twin is a rare variety of twin pregnancy where there is single placenta, single chorion and single amnion. Previously it was thought to be the result of fusion or atrophy of partition wall between two amniotic sac (Mudaliar 1978), Now it is known to result from late fission of the develping embryo after formation of the single amniotic sac e.e. after 8th day of fertilisation (Walker 1976. Prichard 1980, Dawn 1986, Dutta 1987).

Case History : We are presenting here one such rare case. Mrs. A.M., 20 yrs., primigravida was admitted in to Calcutta National Medical College in 1984. She had attended Antenatal Clinic and was diagnosed to have multiple pregnancy. At 32 weeks she had developed mild toxaemia which disappeared after adequate rest. On admission she had pulse 82/ min. Blood pressure-130/80, Slight oedema and both the foetuses were presenting by vertex. She was expected to have vaginal delivery. There was a good progress of the 1st stage of Labour, but 2nd stage was prolonged and when it exceeded 2 hours, caesarean section was decided upon. Lower segment caesarean section was performed, but after delivery of first head, the body could not be pulled out and 2nd head was visible. We were afraid if it was a conjoined twin ; after delivery of both the babies together, we noted that two babies were separate but they were closely tied together, by inter-twining of the cords and there was a true knot between the two cords but it was not too tight to kill the babies. The babies weighed 4.5 lbs. and 5 lbs. and cried at birth. There was no complication in the neonatal period and both the babies were discharged with the mother on 8th day in a healthy condition.

DISCUSSION :

Preeclamptic toxaemia is a known complication of multiple pregnancy (Mudaliar, Williams, Dawn, Dutta, Loc. Cit.) Monoamniotic twin shows a very high foetal death rate due to intertwining of the cords and formation

Fig. Shows placenta with two cords showing true knot.

of true knot (Williams has shown such a case with dead foetus). There was locking of the twin due to intertwining of the cords which caused unusual delay in 2nd stage. Raques 1961 has mentioned that whenever there was unusual delay in 2nd stage in twin, some form of locking should be considered and conjoined twin should not be forgotten. We had to undertake caesarean section in this case and we could save both the babies. Prichered 1980 mentioned that increased LUCS in twin pregnancy has markedly reduced preinatal mortality.

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(a) Report of the Secretary AMWI Bombay Branch– 1987

The same board of Trustees and Office Bearers elected in 1986 continued for the year 1987.

The Second Dr. Jhirad Oration was held at the Jaslok Hospital, Bombay on 4th April 1987. Dr. Winifred Fernandes was the guest speaker and gave a talk on "Achievement of Health for all by 2000". Dr. Miss Sankholkar, Jt. Director of Health, Government of Maharashtra was the Chief Guest on the occasion

A debate was held on 5th October 1987,at the N.W.M. Hospital on"Recent Advances in Medicine have done more harm than good to the patients". The moderator was Dr. Manju Mataliya.

A function was also held on 5th October 1987 to present the Golden Jubilee Certificates of the M.W.I.A to the 3 senior members of our association, viz. Dr. Gool Vazifdar, Dr. S. Soman and Dr. S. Bhatia. Only Dr. Vazifdar could attend in person.

Dr. Dina Patel was felicitated on being appointed Vice President for Central Asia by the MWIA.

A Health Clinic has been started at the slum at Narialwadi Compound, Reay Road. The clinic is run once a week at present and is attended by 3 of our members.

Dr. Kamal Deshmukh, Jt. Secretary, Bombay Branch has continued to conduct the cancer detection centre at the Arogya Salah Kendra, Mazgaon.

Our Cytology Clinic continues doing good work. Dr. Bhanuben Nanavati Trust has promised a donation of Rs. 1,00,000/- to this clinic during the year, for renovation of lecture hall.

Five of our members attended the International Conference at Sorrento, Italy. Dr. Vinita Salvi was awarded the Young Forum Scholarship and

Dr. Manju Mataliya the Lovejoy Scholarship. At the conference Dr. Dina Patel was elected Vice President for Central Asia.

Two News letters were sent out during the year to keep the members abreast of our activities.

Thank you,

Dr. Dinoo Dalal
Secretary

The Association of Medical Women in India (W.B), has been engaged in Scientific, Socio-Medical Welfare Cancer. Detection, Family Planning and Immunisation Programme supplying free medicines, advising on Community health. All these are done by :

1) Mobile Van Health Clinic which caters to three slum centres in the City which have been reduced to two due to high cost of petrol and medicines.

2) Medical Social Welfare and Cancer Detection Clinic at 136, Lenin Sarani on Tuesday and Fridays.

Immunisation Camp including B.C.G. and Measles is held on last Friday of the month with the help of Down Town Ladies Inner Wheel.

Total number of cases treated at the Clinic & Mobile Van were-30, 913

Number of Children immunised were 856

Family Planning : About 100 patients attended the family planning clinic. Pills were supplied to them and fair number had Cu. T. insertion.

Cancer Detection & Screening : 280

Breast Lumps 5, 2 of which proved to be cancerous and operated at Chittaranjan Hospital by Prof. U. Khanna.

Lump abdomen— one—negative

Cervical Smears 5 doubtful cases referred to Cancer Hospital only one has reported as negative.

Arrangements are being made to have Laparoscopic Ligation Camps. Eye Camp was held along with Calcutta Lioness Club.

Hospital : has all the departments now and is getting more popular and busy.

"Prof. Anjali Chatterjee Memorial Oration" was delivered by Dr. SHANTI INDRA a very popular ex-Prof. of paediatrics on "Review of Epidermological aspects of Oncology in Childhood Malignancy in New born."

"Prof Anjali Chatterjee A.M.W.I. Award for out-standing Voluntary medical services" went to Dr. Marie Catchatoor.

"Prof. Anjali Chatterjee Award for Lady Medical Research worker in Bio-Chemistry below 35 years of age" was awarded to Dr. Roychowdhury All functions were well attended.

Scientific meeting was also held in Lady Dufferin Victorial Hospital where lively discussions on various topics took place.

Social : One of the social function was having two stalls in Basant Mela organised by Down Town Ladies Inner Wheel. The stalls also had posters depicting our work. The maximum attendance was there. Posters on Family Planning and Welfare Immunisation and First Aid were displayed.

Scholarship : Golden Jubilee scholarship from A.M.W I. was again awarded to West Bengal Branch.

Journal : Journal of A.M.W.I. has been transferred from Bombay to Calcutta and Dr. Meenakshi Ghosh F. R. C. O.G. has been entrusted with it and she is the Chief Editor. Council Meeting of A.M.W.I. was held at Bombay. Members were shown the dummy copy of the Journal. All the members specially Dr. Dina Patel, the president Dr. Fernandes, Dr. Manju Mataliya were very hospitable and understanding towards our problems. Dr. Patel requested for the photos or slides of the work we are doing, to send to M.W.I.A. Secretarial

Medical Protection and Insurance work is also going on. On the whole due to lack of funds we have been very handicapped to carry on full work as we would like to.

Meetings : General Body—1

Executive Committee-4, Scientific—2, Social—2.

Secretary A.M.W.I. (W B.)
Dr. Tulsi Basu

(c) Annual Report of Women Doctors Association of Tamil Nadu and Pondicherry (1987)

1. The IX Annual Conference of Women Doctors Association of Tamil Nadu and Pondicherry was held on 27th Sep. 1986 at Hotel Pandian -Madurai.

   Dr, (Mrs.) Malathy Madhavan, Prof. of Pathology, P. G. Institute of Basic Sciences, Madras, inaugurated the function. Dr. Lalitha Kameswaran, the president of Women Doctors Association presided over the fuction. Dr. Usha Luthra, Senior Dp. Director General ICMR, New Delhi gave an oration on 'Towards Control of Cancer Cervix'.

   The Women Doctors Association has instituted an annual oration called Susrutha Oration to be delivered every year by an outstanding women doctor of our country at the annual conference.

2. The Women Doctors Association organised a talent competition for young women Medical Graduates at Kasturba Gandhi Hospital among the nine women doctors who presented the papers, the best three were selected and prizes given.

3. The Mid-term conference of Women Doctors Association of Tamil Nadu and Pondicherry was held on 3-5-87 at TTDC Hall, Kodaikanal. The theme of the conference was 'Strategies to improve comprehensive health care of women and children in Rural, Tribal and Urban areas. The conference was inaugurated by Dr. Kothaipillai, Vice Chancellor, Mother Theresa's Women University. The conference was attended by a large number of Women Doctors and Guest Lecturers were given. There were 15 free papers.

4. On 27-9-87 the women Doctors Association arranged a quiz, essay and oratorical competition on the subject of 'Population control' for college students of Madras city. There was a preliminary competition at Ethiraj Arts college for women and final competition was held at K.J. Hospital, Madras. The competition for arts college students and

medical students were held separately. Prizes were given for Essay, Quiz and Oratorical competition in each category. The function was attended by Dr. Kariyali, IAS, Director of family welfare. Dr. Lalitha Kameswaran, Director of Medical Education and there was a Guest Lecture by Dr. Dawn, Secretary of NAUSI.

5. The Women Doctors Association of Tamil Nadu and Pondicherry conducted two seminars in collaboration with Indian Association of Paediatrics, Southern chapter on 'Universal Immunisation and Oral rehydration and on 'Breast Feeding'.

6. The Women Doctors Association and 'Physicians for Peace' group organised a public seminar on 'the prevention of Nuclear warfare'.

7. A pain clinic was planned at Adayar Cancer Institute to be run by Women Doctors of the Association and the Institute.

8. Twelve Executive Committee Meeting were held this year. The Annual conference is planned on 14-2-88. The theme of this year's conference is 'welfare of girls' and is to be held at Port Trust Hospital.

9. It is planned to join costed India, The Kovalevskais foundation to organise a workshop on 'Health care in Developing countries and role of women Health Scientist in the same' in January 1989. The AMWI Council may offer suggestions and plans.

Journal only in young Southern Scientists

Editor — Dr. Tara Natarjan.

Secretary

Women Doctors Association

Tamil Nadu

February 1988

Presidents's New Year Message

A happy 1988 to everyone :

Let us hope that 1988 will bring all of you personally success, and in your work for MWIA great achievment on behalf of our Association.

As we enter 1988-there is improvment within our National Associations following the last MWIA Congress held in Sorrento in April/May 1987-we are, like in the past-"on the way."

I wish that everyone of us will strive to increase the membership of MWIA through an increased membership of our National Associations.

Our Association is unique within the world. Our participation in governmental and non-governmental medical Associations is very important. For this reason the contribution of each Member of MWIA in every country must remain professional, continuative and at a high level of activity.

In an ever changing world new social and medical problems appear daily. We as Medical Women require to face these problems and strive to find solutions in a world which is often very confused ; genetic engineering, transplantations, new methods of research and new thereapies are just a few of the fields we must take an interest in.

I ask every Association, whose value I know, to continue its important work involving an increasing number of colleagues, so that we will have a larger active Membership at our XXIst congress in Seoul, 1989.

With affection and friendship and best wishes for a productive successful year.

Anguri a tutte di tutto cuore.

Prof. Fernanda De Benedetri Venturini.

Medical Women's Federation, United Kingdom 1917-1987

Prof. Ruth Bowden, emeritus professor of anatomy of the University of London and head of the anatomy department, Royal College of Surgeons of England, has written a history of the MWF (UK . It was published in 'Medical Womens', Bulletin of the Medical Women's Federation, November 1987 and prof. Bowden and the Editor, Dr. Eve Hammer have given the editor permission to include a synopsis of the article in this newsletter. The original research and writing were undertaken by Ruth Bowden.

In the last 19th Century women in the U.K. struggled to establish women's rights to medical education - some succeeded-names such as Elizabeth Blackwell, Elizabeth Garrett, Sophia Blake remind us of those who became registered medical women but these together with a steadily increasing number of medical women were not accepted for membership of professional societies. This led to the founding on 6th may 1979 of the Association of Registered Medical Women in London These women read papers on a wide variety of clinical subjects, medical ethics, training of consultants and proposed legislation. Memoranda were sent to appropriate bodies. Within a few years medical women were qualifying in other universities and others left London. Association of Registered Medical Women appeared in other parts of the U.K. In 1914 it became obvious to those involved that a single representative body was required to speak on behalf of women doctors and in 1917 the Medical Women's Federation was formed from groups in London, Scotland, Ireland and North East, Northern and the Midlands of England. The first president was Jane Walker, a distinguised physician with an interest in the treatment of pulmonary tuberculosis. She also believed in the need for occupational therapy to prepare patients for useful employment when they were discharged from hospital.

Throughout its existence the MWF has had no political affiliations but has provided the U.K Government with advice on such matters as public health, welfare, specific medical problems including venereal disease, medical education and conditions of service affecting both men and women.

Today the MWF still provides advice on careers and was instrumental in obtaining part-time appointments for women returning to medicine after a break in service. The Government still seeks its advice on important medical matters and the MWF is represented on many important National Committees in the U.K.

The MWF was a founder member of the Medical Women's International Association and the MWF has organised four MWIA Congresses and one Northern European Regional Congress. Four MWF members have been president of MWIA.

The question is often asked if there is still a need for a Medical Women's Organisation in the U.K. since there is now legislation against sex discrimination. Women are still under-represented in decision making committees and in certain medical and surgical specialities. Women doctors have not as yet attained equal opportunity in U. K. and their talents are underused. There is still usefull work to be done by the MWF.

U. N. I. C. E. F. And M. W. I. A.

Adelina Husslein Chairman of the Mother and Child Committee, has now completed the arrangements for M.W.I.A.'S contribution to the child immunisation programme in Nepal. UNICEF have accepted USS 10,000 from MWIA. This is MWIA'S first collaboration activity with UNICEF and strengthened our WHO status ; Adelina has worked very hard over many months to achieve this and we must congratulate her and thank her for her hard work on behalf of the Mother and Child Committee of MWIA.

WHO European Meeting, Bruges, Belgium, September 1987.

MWIA was represented by Vibeke Jorgensen, Denmark and she reports from the Meeting.

The main theme of the meeting was Health for All (HFA) by the year 2000 and several topics-Aids, tobacco, health manpower supply, HFA and declining economic resources for WHO-were discussed. Of special interest to MWIA is the oversupply of medical doctors in virtually all European Countries (resulting in unemployment and under utilisation of doctors.) How that a higher percentage of new doctors are women who may find difficulty in finding employment in traditional hospital and research work, Vibeke suggests that MWIA could encourage the European National Associations to carry out research to ensure that women doctors can be employed to fulfil HFA strategies.

Medical schools and post graduate education will require to adjust their curriculum to fulfil the needs of HFA.

Vibeke made contact with the International Federation of Medical

Students Association, a female Belgian doctor and a Belgian nurse (who had contact with women doctors in Belgium) to try to stimulate interest in MWIA. She distributed MWIA pamphlets to interested people.

W. H. O.

Ruth Bonner, MWIA representative at WHO spoke to the Assembly in Sorrento bringing the financial problems of WHO to our notice and reminding us that HEA was benefitting not only the developing countries, but the developed as well as this has introduced better health targets and reduced the soaring cost of medical services through expert guidance from WHO.

She writes of WHO reflections for 1988 - 89 -

One of the roles of WHO is to directly influence multilateral, nongovernmental and voluntary organizations involved in health matters, especially at the district level, in order to establish a sound health infrastructure at the grass -root level.

The **objectives** for 1988-89 were defined as follows :—

1) to strengthen national capacities to prepare and implement strategies for HFA 2000 .

2) To focus technical cooperation in activities within regional programme activities

3) to ensure good management of all these activities.

4) to advocate HFA in all national and international forums.

5) to train HFA Leaders in countries, as well as in WHO. in bilateral and multilateral agencies and in NGOs and voluntary organizations.

6) to promote the introduction of health research for HFA in countries.

7) to make available valid information on HFA to all who need it.

8) to coordinate resources for HFA among governments, NGOs. etc.

In order to ensure that these objectives can be reached, the Director-General published GUIDELINES for regional programme budget policy (i.e. criteria for using resources, for building up national health systems, etc.)

Education for Health

Ruth Bonner has been asked to prepare a draft syllabus on "Education for Health". This will be an integral part of the curriculum within the framework of the middle years of schooling for the member schools of the international Schools Association (ISA).

Ruth Bonner has 20 years experience in international education and she would appreciate information from National Corresponding Secretaries as to the teaching programmes in the field of Education for Health at the secondary school level in their countries.

This is an extremely important project and is in line with the resolution passed at the MWIA Congress in Sorrento concerning health education programmes throughout school years.

Address for correspondence :—

Ruth Bonner,
MWIA Representative.
34 Chemin Pont Ceard,
1290 Versoix,
Switzerland.

MWIA Members of Distinction

Dr. Fe del Mundo, Philippines Medical Women's Association, a pioneer in the development of family planning programmes in the Philippines has received the triennial "IAMANEH-BOURGUILBA AWARD" in recognition of her lifetime devotion to maternal and child health-It was presented on 7. 11. 87 during the 3rd International Congress of Maternal and Neonatal Health held in Lahore. Pakistan.

Dr. Yang-Ja Joo, immediate past President of the Korean Medical Women's Association became the first womaen Director of the National Medical Centre in Korea.

Interesting Publication

The Circumcision of Women - a strategy for eradication. Dr. Koso-

Thomas, a Nigerian doctor living in Sierra Leone, is the author. She works mainly with women patients and medical staff and has advised and treated large numbers of women suffering from the physical and spsychological problems attributed to circumcision.

The following precis of the book appears on the order form :—

African women have begun in recent years to research and campaign against the practice of female circumcision. Dr. Koso-Thomas shows that female circumcision is not confined to the Horn of Africa, or the Muslim areas of the Continent. Her study of the practice in Sierra Leone demonstrates its important role in the traditional initiation of females into both womanhood and society in parts of West Africa.

Perhaps, the most important and innovatory contribution Dr. Koso-Thomas makes here is to set out detailed and practical proposals for a 20-years programme to end what she rightly designates as the crippling of women by this operation. Based on her extensive experience as a general practitioner in Sierra Leone, she has provided a clear and down-to-earth model which could be adopted by other countries where female circumcision is the norm.

Cost Circumcision of women, cloth £ 19.95, paper £ 5.95 plus 0.75 postage, from zedbooks Ltd., 57 Caledonian Road, London NI 9BU, U.K. or, 171 First Avenue, Atlantic Highlands, New Jersey 07716, USA.

Letters to the Editor

Although no formal letters have been received by the Editor this term, some members have written informally and I quote from **Lorna Lloyd Green,** Australian Medical Women's Association and a past president MWIA.

"I enjoyed the Newletter June 1987. It was good to have the various funds spelled out".

"All of us have great hopes for the MWIA with the active young Forum and the enthusiasm of the student group " : :

Letter from the Editor

Dear Readers :

This edition of the newsletter has been delayed as I had so very little

news. I am sure medical women must have some activity worth writing about or National Associations some good news to tell us.

I would like to send out another newsletter in April or May but only if you send me contributions by 15. 4. 88.

With Great Hope and Expectations,

Dorothy M. B. Ward·

Young Forum

At the XX Congress in Sorrento, Italy the young Forum Project selected was to provide medical aid to Eritrea, as an area immediately north of Ethiopia, Any medical supplies or equipment, new or used, or money to buy supplies would be welcome, Dr. Liz Adamson, the young Forum Member from the UK is in charge of this project, and can assure that the supplies will get to their destination. It would be very much appreciated if the donations could be sent directly to :

Dr. Liz Adamson
2 Bracote Drive
Wollaton
Nottingham, N68
United Kingdom

The deadline for this project is August 1989.

Dr. Gertrud Zlckgraf has informed the Secretariat that the German Medical Women's Association has created a Young Forum Committee within their Association, that has no age limit. They feel that respective problems are not confined to a certain age groups

The German Young Forum Committee hopes that there will be a good cooperation with other Youing Forum Groups within MWIA.

XXIst Congress Seoul

Dr. Duk Hee Chung - Secretary General of the Organizing Committee of MWIA's XXIst Congress - has informed the Secretariat that the preparations of the XXIst Congress Seoul, Korea are progressing.

The Secretariat has received the generous offer of the Association of Medical Women from India to support a guest speaker at the Korean Conven-

tion to honour Dr. Thirad - a foundling member of the Indian Association. On behalf of the MWIA the Secretariat has thanked the AMWI for their loyalaty and interest.

MWIA's President Prof. De Benedetti Venturini made the following suggestions re Congress Workshops in Korea :

1. Organ Transplantation
2. Conditions and Chances of retired Women Doctors.

MWIA's XXIInd Congress Guatemala

The Secretariat has obtained from the Guatemala Embassy the confirmation, that Guatemala does not refuse any Nationality the entry permit. They advise to apply for a visa at least four weeks before the entry.

Scientific Programme ¾ XXIst MWIA Congress in Seoul. September 3-8-1989

TOPIC— INCIDENCE OF CANCER in Women in different countries All Colleagues are invited to contribute to the Scientific Programme on the topic.

The following Sub-headings are suggested as a guide line for the reports.

1) Incidence, predisposing factors and epidemilogy :
   a) Hygiene
   b) Environment and culture
   c) Public education and prevention
   d) Habit, diet
   e) Others
2) Biological, pathological and immunological aspects
   a) Growth pattern
   b) Current concept
   c) Others
3) Early detection and diagnosis
   a) Women's role
   b) Physician's role
   c) Radiographic studies (imaging onchology)
   d) Harmonal receptors and tumor marker
   e) Cytology and histopathology
   f) Mass Screening programme
   g) Others
4) Management (treatment)
   a) Surgical
   b) Chemotherapy
   c) Radiotherapy and organ preservation
   d) Immunotherapy

e) Reconstruction

f) Multiple discriplinary approach

g) Miscellaneous.

5. Advanced cancer management and rehabilitation

a) Management of pain and common symptoms

b) Psychological support and recovery programme

c) Hospice

6. Future investigation

7. Other related subjects

Name of authors and Titles of papers, together with a short outline, should reach the followihg address by June 1 1988.

Abstracts of approx 150-200 words should be submitted by November 1, 1988.

Speaking time of reports including demonstrations : Upto 35 minutes of short papers : 10 minutes

Address to be submitted

Chung Hie Oh M.D.
Chairman of Scientific programme committee Department of Rehabilitation Medicine Korea University Hoehura Hospital 2—4 Ka MYUNGYUN-DONG, CHONGRO-KU SEOUL, KOREA 110-522.

Registration fee : W 280. 000 (U.S. $ 350)

Exchange rate : US $ 1 ; W 800

(Based as of September 1981)

Social programmes are considered to be included in the registration fees.

Medical Women's International Association Officers 1987-1989.

PRESIDENT	: Fernanda De Benedetti-Venturini via. Fratelli Ferrari 32/5 1-16031 Genova, Bogkasco Itally.
PRESIDENT ELECT	: 11 OK CHOO 90 Cheelen-Dona Chongro KU Seoul Korea
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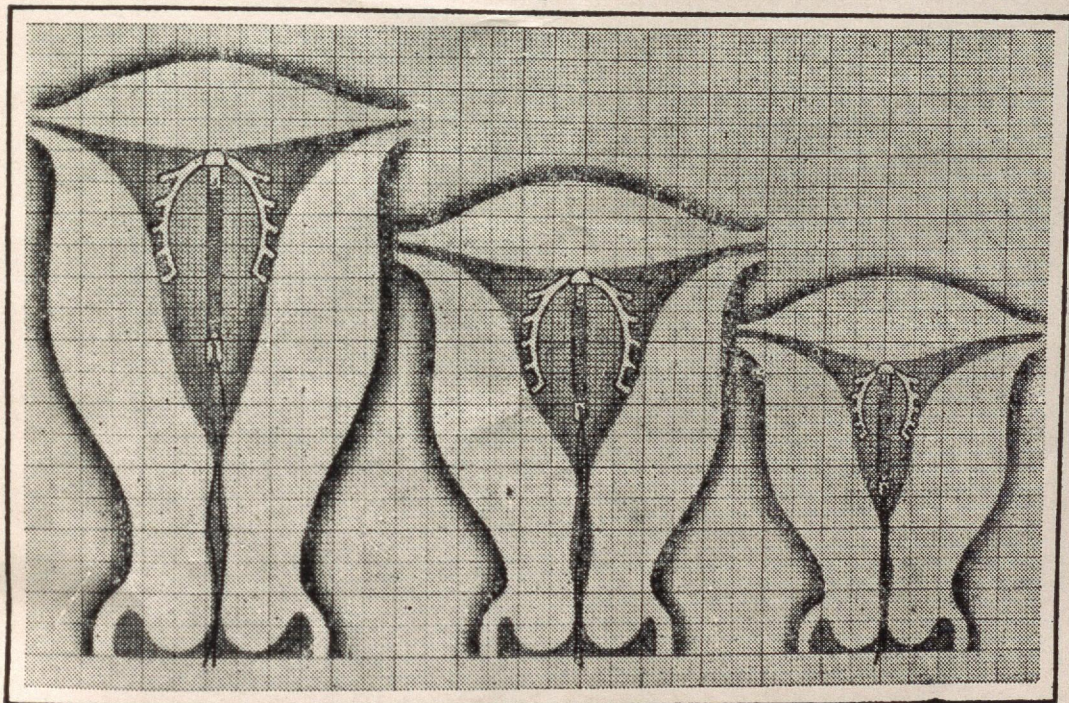

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