

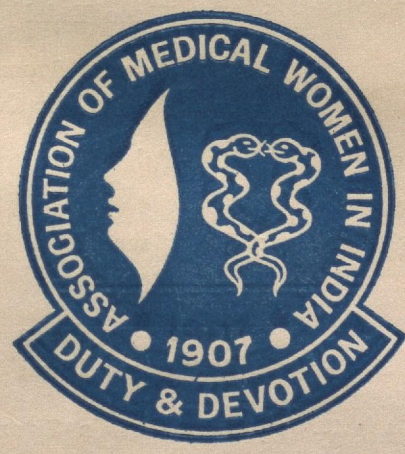
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MEDICAL WOMEN
IN INDIA

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VOL. LXXIV

JANUARY-APRIL, 1984

No. 1

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ROLE OF VAGINAL CYTOLOGY FOR EARLY DETECTION OF CERVICAL CANCER

by

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The effective role of exfoliative vaginal cytology for detection of genital cancers in their early stages specially in asymptomatic women, for hormonal evaluation and for the study of disorders of the female genital tract is beyond dispute.

Early attempts at cytodiagnosis were made in the middle of the last century. The first publication of gynaecological cytology was by Pouchet in 1847 on Ovulation. This was followed by Lastaste (1892), De Retterer (1892) and by Stockard and Papanicolaou (1917) on studies of the vaginal epithelium.

In 1933 Papanicolaou published his first paper on epithelial changes during the menstrual cycle of women and finally in 1944 Papanicolaou and Traut published their monograph "Diagnosis of uterine cancer by vaginal smear".

Human studies have shown that a clinically malignant disease is preceded by a variety of epithelial abnormalities referred to as mild, moderate and severe dysplasias. It is known that dysplasias are forerunners of intraepithelial carcinoma, micro invasive carcinoma and invasive cancers. There is difference of opinion as to which fraction of dysplasia progresses to carcinoma in situ or preinvasive carcinoma. Until more is known of immunological and biochemical aspects of malignant cells our hope to reduce mortality and morbidity of carcinoma of cervix and to increase salvage lies in the early detection and treatment of these pre-malignant conditions.

Clinical observation of the ectocervix does not provide satisfactory results as far as early diagnosis is concerned. Detection and diagnosis of early cancer and its precursors by cytological study provides the best type of salvage for an individual or community.

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OBJECTIVES OF THE STUDY

(1) To detect dysplasia and early cancers and give appropriate treatment.

(2) To assess the prevalence of precancerous lesions of the cervix in women attending the Nowrosjee Wadia Maternity Hospital for gynaecological complaints.

(3) To compare the cytology of the abnormal smear pattern with histopathology of the cervical biopsies and hysterectomy specimens of these patients.

Material and Methods

Cytological studies were undertaken in 1605 women attending the gynaecological out-patient department at Nowrosjee Wadia Maternity Hospital. In the present study each woman was interviewed regarding her history and examined clinically and the findings were noted.

After speculum examination a wooden spatula was used to take smear from the posterior vaginal fornix and the squamocolumnar junction. Smears were made on clean dry slides and fixed in equal parts of ether and alcohol and stained by slight modification of Papanicolaou technique.

Cervical biopsies were undertaken in 47 cases showing an abnormal smear pattern and compared with the cytology of those smears. The smear interpretation and classification were based on the cytomorphological changes into 5 groups.

Results and Discussion

A total of 1605 women were screened and 1531 smears were studied.

TABLE I
Classification

Class I	Negative	Normal cell population, absence of atypical or abnormal cells
Class II	Mild dysplasia	Atypical cells with no evidence of malignancy
Class III	Severe dysplasia	Atypical cells suggestive of but not conclusive of malignancy
Class IV	Suspicious	Severe dysplasia with few cells showing malignant features i.e. atypical cells strongly suggestive of malignancy
Class V	Positive	Definite malignant cells present—conclusive of malignancy

TABLE II
The age distribution was as follows

Age (years)	No. of cases	Per cent
Less than 20	73	4.76
20-29	862	56.30
30-39	349	22.79
40-49	150	9.79
50-59	56	3.65
60 and above	41	2.67

Majority of patients were between the age groups 20-39 years.

TABLE III
The parity distribution is charted below

Parity distribution	No. of cases
Nullipara	536
I	231
II	238
III	170
IV	129
V	166
VI +	61

TABLE IV
On per speculum examination the condition of the cervix was

Condition of cervix	No. of cases	Per cent
Normal	1156	75.50
Erosion	306	19.98
Unhealthy cervix	32	2.09
Growth	21	1.37
Polyp	16	1.04

TABLE V
The major symptoms with which the patients presented were

Symptoms	No. of cases	Per cent
1. Sterility	585	38.21
2. Leucorrhoea	263	17.17
3. Irregular menstrual bleeding	193	12.60
4. Pain in abdomen	130	8.49
5. Amenorrhoea and pregnancy	121	7.90
6. Prolapse	112	7.31
7. Asymptomatic	66	4.31
8. Miscellaneous	55	3.59
9. Burning micturition	6	0.39

Sterility and leucorrhoea were the main presenting symptoms in 38.21% and 17.17% cases respectively. 4.31% of cases who came for routine check-up were asymptomatic.

Smear Classification

Distribution of cytological classification was as shown in the table. 437 cases of sterility were excluded from the smear classification. Smear classification was done on 1094 smears.

TABLE VI
Smear Classification

		Per cent
Total number of smears analysed—	1094	
Negative smears	986	90.12
Mild dysplasia	38	3.47
Severe dysplasia	28	2.55
Suspicious	11	1.00
Positive	15	1.37
Clinically diagnosed cancers	16	1.46

The incidence of dysplasia:

The incidence of dysplasia of all grades worked out to be 6.02% which is comparable to the incidence of 2.3% to 3.1% reported by different authors (Mackey *et al*, 1959; Wahi *et al*, 1969). The increase in incidence in the present study may be due to difference in parameters used in the selection of cases. Poor hygienic care, poor socioeconomic conditions early marriage, high parity may be contributory factors in the higher incidence seen in this study.

Histopathological correlation of biopsies and operated specimens:

Histological correlation was sought in as many cases as possible. Many women who were asymptomatic but with moderate to severe dysplasia refused to have cervical biopsies in spite of our advice or failed to report for the biopsy.

(1) Out of 12 cases with positive smear report, histopathology report concurred with cytology in 11 cases (91.76%). In 1 case even though reported as chronic inflammation the patient was subjected to hysterectomy and the post-operative specimen showed early infiltrative carcinoma with endocervical involvement.

(2) Out of 11 cases with suspicious smears, malignancy was confirmed by biopsies in 7 cases (63.6%).

(3) 48% of cases with severe dysplasia i.e. 24 cases were available for multiple punch biopsies and single punch biopsies. Of these, 9 cases were reported as histopathologically diagnosed severe dysplasia. Three

TABLE VII
Histopathology of the biopsies in cases of abnormal smears

Cytology report	No. of biopsies	Histopathology report
1. Positive	12	11 — Early invasive carcinoma
		1 — Ulceration with chronic inflammation. Same patient operated (hysterectomy) and specimen shows early invasive carcinoma
2. Suspicious	11	2 — Early invasive carcinoma
		4 — Intra-epithelial carcinoma
		4 — Chronic inflammation with ulceration
		1 — Adenocarcinoma
3. Severe dysplasia	24	9 — Chronic inflammation with polyp formation
		3 — Inadequate biopsies for section
		9 — Severe dysplasia
		3 — Pre-invasive carcinoma or carcinoma in situ

(12.5%) were reported as intra-epithelial carcinoma and the rest were reported as having chronic inflammation with polyp formation.

The cytopathological correlation would have been perhaps better had we taken four quadrant or cone biopsies instead of single punch biopsies.

Maximum incidence of abnormal smears (i.e. both grades of dysplasia, suspicious and positive smears) was seen to occur in women with symptoms of irregular menstrual bleeding. Correspondingly, clinical cancers were also highest in women with this complaint. The incidence of severe dysplasia, however occurred in pregnant women in whom the occurrence of epithelial abnormalities is known to be inherently high. Leucorrhoea is the next most commonly associated symptom.

There is no definite clinical impression which leads us to suspect the cases of dysplasia. This once again stresses the importance of cytological examination in detecting abnormal lesions.

Conclusion

Over a period of 8 months there were 1605 patients who visited the Nowrosjee Wadia Maternity Hospital for the various gynaecological complaints. Out of these vaginal cytology was done in 1531 cases.

The incidence of dysplasia of all grades was found to be 6.02%.

Sterility and leucorrhoea were the main presenting symptoms (38.21% and 17.17% respectively).

Interestingly, the cervix was seen to be normal in 75.5% of cases stressing the importance of cytological examination in detecting abnormal lesions in the cervix.

Positive smear patterns were seen in 1.37% (12 cases) and confirmed on cervical punch biopsies in 11 of these cases. Similarly, 7 cases out of 11 with suspicious smears and 3 out of 24 cases with severe dysplasia showed the evidence of malignancy on histopathology of cervical punch biopsy and hysterectomy specimens.

Maximum number of abnormal smears were seen in patients who complained of menstrual irregularity.

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CAESAREAN SECTION — ITS ROLE IN THE MANAGEMENT OF DYSFUNCTIONAL LABOUR

by

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Introduction

The practising obstetrician is often tested to the limits of his clinical skill when faced with a patient in abnormal labour. Many aspects of diagnosis, evaluation and management can only be learnt through years of clinical training and the niceties of clinical judgement acquired through many years of clinical experience. Hence obstetrics has been considered a clinical art for many years. However, today the application of definitive clinical parameters to obstetrics for determining progress in labour has led to a more scientific approach to this process and made it possible to recognise dysfunctional labour earlier in time.

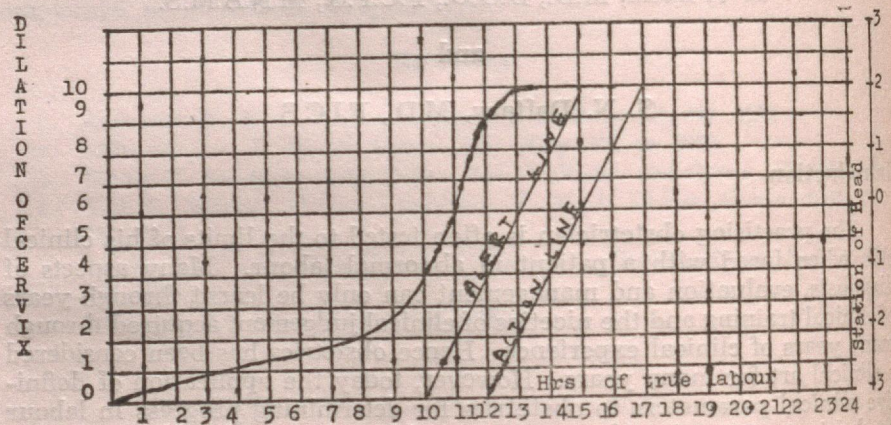
For many years, labour was not considered prolonged unless 24-48 hours had elapsed. It was not until Friedman published his pioneering graphic studies in 1955, was it apparent that this was far too lengthy. He demonstrated that the dilatation-time curve of labour showed a sigmoid pattern consisting of a latent phase, an active phase and a terminal phase of deceleration. These studies led to the application of partography to clinical obstetrics and laid the foundation for the visual observation of the progress of labour and enabled the recognition and timely correction of dysfunctional labour.

The present study is an analysis of the labour records from a private series of 342 primigravid women between the ages of 18-35 years having no recognisable obstetric or medical complications prior to labour. Their labour progress was observed on partograms. The authors observed an incidence of dysfunctional labour of 15.2% in their series. Further analysis of the outcome of labour in these patients revealed that 50% of them required a caesarean section thereby stressing the vital role that caesarean section plays in the outcome of dysfunctional labour.

For proper identification of dysfunctional labour the partogram has unlimited value and for correct interpretation of a partogram the concept of Alert and Action lines are of tremendous significance. Years ago Philpott and Castle, because of the needs of the clinical situation prevailing in their practice developed a simple method of ensuring that patients with developing problems in labour be recognised early in peri-

pheral areas, and be transferred to a central area for intensive care. These authors developed two arbitrary lines called the Alert and Action lines to recognize early dysfunctional labour, adopt corrective measures and institute obstetric interference in time.

John Studd of Birmingham developed normograms based on the average rates of cervical dilatations of primigravidae and multiparae. He showed that plotting the progress of any given patient along this monogram would provide an early evidence of dysfunctional labour.



Daftary and Mhatre developed a nomogram for Indian primigravidae. They developed an "alert line" corresponding to the rates of cervical dilatation of the lowest 10% of the patient and an "action line" parallel to the Alert line two hours later in time to determine whether the corrective measures adopted had yielded satisfactory results or not.

TABLE I

Incidence

	Eufunctional labour		Dysfunctional labour	
	No.	Per cent	No.	Per cent
1. Total number of cases studied	290	84.8	52	15.2
2. Caesarean section required in	8	2.7	26	50.0

The above table indicates that while the per cent incidence of dysfunctional labour is 15.2% in our series, the per cent incidence of caesarean section in the dysfunctional group is almost 20 times higher than in the eufunctional group.

TABLE II
Classification of dysfunctional labour groups

Type	No. of cases	Per cent
1. Prolonged latent phase	6	11.5
2. Primary dysfunctional labour	36	69.2
3. Secondary arrest of labour or early deceleration	10	19.3
Total	52	100.0

As observed by different authors the incidence of dysfunctional labour varies from 8% to over 20%. The above classification gives the basic dysfunctional patterns most easily recognised.

TABLE III
Outcome of labour in patients with dysfunctional labour

	No. of cases	Per cent
1. Number of cases	52	100.0
2. Spontaneous vaginal delivery	6	11.5
3. Oxytocin stimulation	18	34.6
4. Forceps or vacuum extraction	14	26.9
5. Caesarean section	26	50.0
6. Average rate of cervical dilatation	0.8 cm/hr.	Normal group- 1.7 cm/hr.
7. Average birth weight	3.350 kg	Normal group- 2.750 kg

Above table reveals that with dysfunctional labour obstetric interference was required in 87.5% of cases. Out of this group 26 patients (50 of total) went in for a caesarean section while about 30% required forceps/vacuum assistance. Thus caesarean section forms the prime form of interference required in patients with established dysfunctional labour.

TABLE IV
Perinatal outcome

Groups of babies	Distribution of Apgar scores					
	0		1-5		6-10	
	No.	%	No.	%	No.	%
1. Normal group (290)	1	0.34	10	3.44	279	96.2
2. Dysfunctional group (52)	2	3.84	6	11.53	44	84.6

Perinatal outcome worsens as dysfunctional labour sets in. As shown above, the incidence of foetal hypoxia was 3 times higher in the dysfunctional group. This would have been much worse had not timely interference been carried out. With caesarean section accounting for the

majority, this proves that caesarean section is of vital importance in improving perinatal outcome.

Incidence of neonatal problems is also increased in babies born to mothers who have suffered from dysfunctional labours. All babies born to such mothers should have special care in the neonatal nursery to improve perinatal outcome.

TABLE V
Comparison of Neonatal outcome

Neonatal problem	Dysfunctional group (52)		Eufunctional group (290)	
	No.	%	No.	%
1. Neonatal asphyxia	8	15.3	11	3.7
2. Neonatal jaundice	20	38.4	26	8.9
3. Neonatal sepsis	8	15.3	4	1.37
4. Cephalhaematoma	6	11.5	8	2.75
5. Other neonatal injuries	9	17.3	5	1.72

In conclusion, partograms provide a visual impression of the sequence of events occurring in labour and enable the obstetrician to adopt timely measures in the interest of mother and child.

Dysfunctional labour exerts a deleterious effect on the foetus, often subtle, which usually manifests itself in neonatal life causing increased neonatal morbidity. Non-recognition of dysfunctional labour is disastrous and an important factor in the causation of maternal morbidity and perinatal wastage. Judicious usage of caesarean section as judged from the partogram can go a long way in overcoming this important problem.

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FETAL OUTCOME IN CASES WITH MECONIUM STAINED LIQUOR

by

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The presence of meconium in the amniotic fluid is said to be the sign of 'fetal distress' which may result in the birth of an asphyxiated or still-born infant. The perinatal mortality rate when meconium is present with no other sign of fetal distress, ranges in the various reports from 4.5% to 9.0%. However, Fenton and Steer (1962) state that "The passage of meconium in the absence of any changes in the fetal heart rate is clearly not a sign of fetal distress". The aim of the present study is to find out the incidence of this phenomenon and its correlation with significant obstetrical conditions and fetal outcome.

Material and Methods

Over a period of seven months from November 1982 to May 1983, 4902 patients delivered at N.W. Maternity Hospital, meconium stained liquor amnii was found in 250 cases, giving an incidence of 5.09% all delivery cases. The patients with confirmed intrauterine fetal death, breech presentation, obstructed labour were not included in the study.

Antepartum, intrapartum and postpartum evaluation was done. The following maternal and fetal factors were continuously monitored during labour:

- (1) Maternal pulse, blood pressure, hydration.
- (2) Uterine activity.
- (3) Partographic progress of labour.
- (4) Fetal heart rate clinically and recorded externally by a ultrasound array transducer, uterine activity was recorded by an external transducer and fetal movement with an event marker.

Fetal scalp blood study could not be done. Meconium stained liquor

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amni was detected after spontaneous or artificial rupture of membranes. These cases were observed carefully frequently for evidence of changes in fetal heart sound. Fetal risk index code sheets were completed for all patients. After delivery, condition of cord and placenta was also noted. Neonatal well-being was assessed by apgar score at 1 minute and 5 minutes as well as by general observation of neonate during its stay in the hospital.

Results and Discussion

Over a period of 7 months from November 1982 to May 1983 there were 4902 deliveries at N.W. Maternity Hospital. Out of them 250 patients showed evidence of meconium in the liquor. Thus incidence of meconium stained liquor amni (MSLA) was found to be 5.09%. Out of 250 cases, 238 were registered and 12 were unregistered. 172 patients were primigravida whereas 78 were multigravidae.

The age distribution was as shown in Table I.

TABLE I
Age distribution

Age in years	No. of patients
Less than 20	12
20-24	116
25-29	93
30-34	25
35 and over	4

Table II shows the stage of labour at the time of detection of MSLA.

TABLE II

	No. of patients	Per cent
1st stage — latent phase	61	24.4
— active phase	145	58.0
2nd stage	44	17.6

The colour of liquor was reported as thinly meconium stained, moderately thick meconium or thick meconium stained liquor.

Table III shows important antepartum and intrapartum factors.

TABLE III

Factors	No. of cases
1. Anemia	43
2. Toxemia of pregnancy	41
3. Cord around the neck	35
4. Rh negative patient	13
5. Postmaturity	11
6. Chronic placental insufficiency leading to IUGR	10
7. Adolescent pregnancy	9
8. Abnormality of cord	7
9. Hydramnios	5
10. Congenital malformation	2
11. Cephalopelvic disproportion	5
12. Cord compression	2
13. Abruptio placenta	2

TABLE IV
Fetal heart rate pattern with MSLA

Pattern	No. of cases	Per cent
Normal FHR	158	63.2
Fetal tachycardia	45	18.0
Deceleration—		
— Early deceleration	22	8.8
— Late deceleration	19	7.6
— Variable	6	2.4

In all the cases FHR was monitored clinically. Whenever required electronic fetal monitor was used. Abnormality of FHR, rhythm and tone, delay in gaining normal rate after slowing during an uterine contraction and exaggerated fetal movement were recorded. Exaggerated fetal movement is a subjective sign and hence is not a reliable phenomenon.

Intra-uterine fetal hypoxia is the main cause of neonatal asphyxia. Intra-uterine fetal hypoxia may be because of some of the known and unknown factors. Some of the known factors are immaturity, placental insufficiency or inadequate placental reserves, interference with placental and cord circulation from large variety of causes, action of drugs, mechanical stresses in labour, general anaesthesia, maternal asphyxia.

Table V shows modes of delivery in the MSLA cases.

TABLE V

		Sp vaginal	Forceps/ vacuum	Caesarean section
Normal FHR	158	149 (94.3%)	8	3
Tachycardia	45	23	18	4
Deceleration—				
— Early	22	18	4	0
— Late	19	4	1	11
— Variable	6	0	1	5
Total	250	194	32	24

Out of 250 cases of meconium stained liquor amnii 194 patients had normal vaginal delivery giving an incidence of 77%, forceps/vacuum 32 cases (12.8%) and 24 cases caesarean section (9.6%). If we consider cases with MSLA with abnormal FHR, the incidence of forceps/vacuum in them is 26% and that of caesarean section is 22.8%.

TABLE VI
Fetal outcome in MSLA

	No. of cases	Per cent
Live birth and well	235	94.0
Fresh still birth	4	1.6
Asphyxia neonatorum	6	2.4
Neonatal death	5	2.0

TABLE VII
Apgar score distribution

	Normal	Mild	Asphyxia Moderate	Severe
One minute	216 (86.4%)	20 (8.0%)	10 (4.0%)	4 (1.6%)
Five minute	235 (94.0%)	2 (0.8%)	9 (3.6%)	4 (1.6%)

TABLE VIII
Perinatal mortality

	Cases	Per cent
Fresh still birth	4	1.6
Neonatal death	5	2.0
Total perinatal mortality per 1000 livebirth	9	3.6 i.e. 36/1000

No perinatal death was recorded in cases who had MSLA but normal FHR. Thus perinatal mortality rate was 9.8% (9/92) in cases with MSLA and FHR abnormality 98/1000 live births.

Summary

Over a period of 7 months there were 4902 deliveries. Of them 250 cases showed meconium stained amni. This incidence was found to be 5.09%.

- 63.2% of these patients had normal FHR whereas 36.8% had FHR abnormality.
- 94.3% of patients with normal FHR delivered normally. Whereas only 48.9% of patients with MSLA + FHR abnormality had normal delivery thus in latter group 51.1% required interference.
- There was no perinatal death in cases with normal FHR, whereas perinatal mortality rate was 9.8, 98/1000 live birth in cases with FHR abnormality.
- It is important to note that all patients with normal FHR had thinly meconium stained liquor.

Conclusion

Variable antenatal and intrapartum factors are responsible for the intra-uterine hypoxia. To reduce neonatal mortality and morbidity patient needs careful watching, screening and active intervention during labour. Meconium stained liquor amni must be considered a real warning sign of fetal distress and proper clinical vigilance is mandatory in these cases. Use of electronic fetal monitor would go a long way in improving perinatal outcome in these cases.

Although unanswered question remains regarding the significance of passage of meconium a more rational approach is now possible for the management of labour with meconium in the amniotic fluid.

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Caesarean section
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194 patients had forceps/vacuum
If we consider forceps/vacuum

Per cent
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2.0

Severe
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(1.6%)
4
(1.6%)

Per cent
1.6
2.0
3.6
i.e. 36/1000

MSLA but nor-
2) in cases with

A STUDY OF AWARENESS OF MEDICAL TERMINATION OF PREGNANCY AND THE FACTORS INFLUENCING IT

by

N. P. Pai*
Gopa Kothari**

and

Suraja Prabhu

The Medical Termination of Pregnancy Act, 1971, enacted by the Indian Parliament has been regarded as a great step forward towards the emancipation and acceptance of the rights of women to decide 'to be or not be a mother'. The Act has liberalised the existing provisions in the Indian Penal Code on abortion. As a method of population control this has been found to be successful in reducing the population by legalising abortions in Japan and the Scandinavian countries. Even in our country, it is felt that instead of remaining passive victims of unwanted motherhood, women can terminate it without any sociological consequences. The permissive attitude towards legalising abortions is hailed by many as a step in the right direction to save the nation.

During 1972-73, 24,142 terminations were reported for the entire country. For 1976-77 the figure was 2,78,013. Even though there is a significant increase in the number of terminations, it has not touched even the fringe of the problem when one realizes, that the lowest estimate about 4 million illegal abortions are being performed annually in the country.

Keeping this in mind it was felt that it is necessary to evaluate the awareness among the female population regarding medical termination of pregnancy. It was also felt that certain characteristics of the environmental and social background may play a role in determining the acceptance of M.T.P. by pregnant women. The present study was undertaken to find the degree of awareness of medical termination of pregnancy and the factors influencing it among patients admitted for M.T.P. at the Lokmanya Tilak Municipal General Hospital, Bombay.

Material and Methods

A group of 180 patients who had come to seek M.T.P. from June 1979 to June 1980 at L.T.M. General Hospital were interviewed.

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Observations and Discussion

Out of the total patients 43.3% belonged to the 26-30 years group and 40% in 21-25 years age group. (Table I). Julian Gold *et al* (1979)

TABLE I

Distribution of age-wise frequency of M.T.P. with relation to gestational age of patient and willingness for post-M.T.P. sterilisation

Age of patient in years	Frequency	Willing for sterilisation	Not willing for sterilisation	Mean gestational age in weeks
16-20	30	2	28	12.40 ± 3.87
21-25	42	20	22	10.76 ± 3.19
26-30	78	52	26	9.08 ± 3.19
31-35	24	16	8	10.17 ± 4.22
36-40	6	6	—	13.33 ± 4.62
Total	180	96	84	

had about 66% of patients under 25 years of age. Soni *et al* (1976) had 29% of women in the group of 20-25 years and 35% of the group of 30-40 years.

In the present study in the age group 36-40 years all the patients underwent sterilisations whereas an analysis of M.T.P. all over India in 1975-76 as reported by Krishna Menon (1979) shows 72% acceptance of contraceptives of which 25% underwent sterilisation.

The mean gestational age of the whole group in the present study was 10.3 ± 3.7 weeks while Ratnam *et al* (1979) at Singapore reported mean gestational age of 10.4 weeks in 1970 and 8.4 weeks in 1974. Julian Gold *et al* (1979) reported maximum incidence of gestational age between 4 and 8 weeks. Soni *et al* (1976) reported mean gestational age of 8 weeks in 67% and 10 weeks in 22%.

In the present study 53.4% of the patients were literate, 18.9% had secondary education (Table II). In Soni *et al*'s study 80% had high school education though only 29% passed S.S.C.

TABLE II

Distribution of M.T.P. acceptors according to the educational level of the patient

Education	No. of cases	Per cent
Illiterate	84	46.6
Primary	30	16.6
Secondary	34	18.9
Matriculate	24	13.4
University	8	4.5

59% of the women in the present study belonged to the income of Rs. 201 to Rs. 600 per month (Table III). The main reason in these

women was poverty for accepting M.T.P. Kamala Mankekar (1973) had similar observations in one of the Maternity homes of Bombay.

TABLE III
Distribution of M.T.P. acceptors with relation to their socio-economic condition

Income in Rupees p.m.	No. of families	Per cent
Upto 200	38	21.0
201-400	60	33.5
401-600	46	25.5
601-800	26	14.4
801 and above	10	5.6
Total	180	100.0

Ratnam *et al* (1979) at Singapore had 95% of M.T.P. in the first year due to socio-economic reasons. Other reason for accepting M.T.P. is the failure of contraceptive device in 25% of the cases in the present study.

86.7% of women in the present study were married (Table IV). The unmarried constituted 7.7% and widows were 5.6%.

TABLE IV
Distribution of M.T.P. acceptors according to their marital status and with relation to the knowledge and use of contraceptive devices used before this pregnancy

Marital Status	Knowing and using contraceptive devices	Knowing and not using contraceptive devices	Not knowing contraceptive devices	Total	%
Married	22	78	56	156	86.7
Unmarried	—	—	14	14	7.7
Widowed	—	—	10	10	5.6
Total	22	78	80	180	100.0

Julian Gold *et al* (1979) in U.S.A. noted that abortions in unmarried women were three times more than in the married women in 1973 and in 1976, they were 16 times higher than in married women.

In the present study, out of 156 married women 22% knew about family planning devices and were using them. Krishna Menon (1979) reported that in the All India Statistics for M.T.P. for 1975-76, 25% women were using contraceptives prior to abortions. 80% of the women in the present study were Hindus, while Christian and Muslim women were less in number and they were also found to be not using contraceptive devices (Table V). Soni *et al* (1976) had 79% Hindus, 14% Muslims and 1% Christians in their study.

TABLE V
Religionwise distribution of M.T.P. acceptors with relation to the previous use of Family Planning methods

Religion	Using F.P. method	Not using F.P. method	Frequency	Per cent
Hindu	20	124	144	80.0
Muslim	—	14	14	7.7
Christian	—	18	18	10.0
Others	2	2	4	2.3
Total	22	158	180	100.0

67.8% of the women in the present study had nuclear families as they preferred to have small family (Table VI). 72% of the women had 2 or more children (Table VII), only 11.2% were primis. Soni *et al* (1976) observed that 93% of women had 4 or less children out of which 35% had 2 children.

TABLE VI
Distribution of M.T.P. acceptors in relation to the type of family

Type of family	Number of cases	Per cent
Joint	58	32.2
Nuclear	122	67.8
Total	180	100.0

TABLE VII
Number of M.T.P. acceptors in relation to number of living children and the willingness for post M.T.P. sterilisation/post M.T.P. contraception

No. of living children	Willing for sterilisation	Willing for contraception	Not willing for any	Total	%
0	—	—	20	20	11.2
1	—	18	12	30	16.8
2	32	14	8	54	30.0
3	44	6	2	52	28.8
4 & above	20	4	—	24	13.2
Total	96	42	42	180	100.0

Out of the total 180 patients in the present study 53.33% were willing for sterilisation and 23.33% were willing for contraceptives (Table VII), while on analysing the M.T.Ps. done all over India in 1972-73 as per the report of Krishna Menon 72% accepted family planning methods.

Soni *et al* (1976) reported 45.2% post-M.T.P. sterilisation in their study.

Out of the 180 patients in the present study, 84.44% were undergoing M.T.P. for the first time (Table VIII), 18% for the second time

TABLE VIII

Number of M.T.P. acceptors in relation to number of living children per patient and number of M.T.P. the patient is undergoing

No. of living children	Number of abortions			Total
	1	2	3	
0	20	—	—	20
1	26	3	1	30
2	36	18	—	54
3	48	4	—	52
4	22	2	—	24
& above				
Total	152	27	1	180

and only one person for the third time. Soni *et al* (1976) had observed 14% of the women undergoing M.T.P. second time. In U.S.A. (Julian Gold *et al*, 1979) in 1976, 18% of the women had previous M.T.Ps. In the present study family physician is the source of knowledge of M.T.P. in only 27.8% (Table IX).

TABLE IX

Source of motivation for the M.T.P. acceptors

Motivation	Number of cases	Per cent
By husband	26	14.4
By relative/friend	48	26.6
By advertisement	36	20.0
By family physician	50	27.8
Self	20	11.2
Total	180	100.0

Out of the total 180 cases in this study 7.7% had complications though not fatal (Table X) Ratnam (1979) reported 5% incidence of complications after M.T.P. at Singapore.

TABLE X

Complications after M.T.P.

Complications	No. of cases (out of 180)	Per cent
Cervicitis	4	2.22
Cervical tear	2	1.11
Menorrhagia	3	1.66
Retained products	4	2.22
Anemia	1	0.55
Total	14	

It has become evident that the demand for abortion is steadily on increase in the lower socio-economic group as seen in the Municipal hospitals. At Lokmanya Tilak Municipal General Hospital, Sion, in the year 1978-79, there were 105 M.T.Ps., in 1979-80, there were 180, and in 1980-81 there were 445 M.T.Ps. As reported by Julian Gold *et al* (1979) there was increase in M.T.P. in U.S.A. from 1974 to 1976.

Modern methods of termination of pregnancy employed in hospitals with good expertise facilities have yielded results fairly comparable to those reported from other countries, though only a small fraction of the real problem of illegal abortion is solved. Complications due to M.T.P. are known but seem to be low. Ideally termination services should exhibit low repeat rates. Every effort must be made to have the abortion patient become an acceptor and user of contraceptives instead of repeated M.T.Ps. A desire to curb population growth in the interest of economic and social development will be fulfilled only if the above mentioned goal is achieved.

Summary

This is a study of the Degree of Awareness of Medical Termination of Pregnancy and the factors influencing it.

The present study was undertaken with a view to evaluate the degree of awareness of M.T.P. amongst 180 patients who had undergone M.T.P. at Lokmanya Tilak Municipal General Hospital, Sion. A majority of M.T.P. acceptors were below 30 years of age group. The higher age group patients were willing to undergo post-M.T.P. sterilisation though the younger age group showed resistance. Majority of them belonged to lower socio-economic group. Most of the patients were married though a few were unmarried and widows. There were very few complications after M.T.P. There were however, no deaths.

Acknowledgement

We thank the Dean, L.T.M. General Hospital, Sion, Bombay 400 022, for permitting us to report the hospital data.

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A COMPARATIVE STUDY OF DIFFERENT METHODS OF SECOND TRIMESTER ABORTIONS FOR FERTILITY CONTROL†

by

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Introduction

Induced abortion is an essential factor in limiting population growth and is generally one of the methods adopted in a society to achieve family limitations. As Malcolm Potts puts it "No society has ever seen its birth rate fall without a recourse to abortion and it is unlikely that further fertility declines will take place in the course of the twentieth century unless abortion plays an inescapable role."

When faced with an unwanted pregnancy, a woman frequently uses denial in the first trimester. In the second trimester, when physiologic changes make pregnancy evident, she may become depressed or even suicidal. In the third trimester she is obviously pregnant and may accept the fact. After delivery however, continued basic rejection of the pregnancy can lead to child abuse, failure to thrive and other parent child problems which are commonly seen in juvenile courts. Women with enough strength and motivation will get abortion done. Others may rely on another person, an institution or society with the vague hope that somehow things will work out (Tanner and Liston, 1975). Therefore in our opinion, whenever a woman desires an abortion for some valid reasons, she should not be turned down, be it in the first trimester or the second.

In the hope of finding better techniques for terminating pregnancy in the second trimester, various methods have been tried. As we express our opinion on the various methods, we realise fully that there is room for honest difference of opinions in this subject. Without doubt, in many

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cases, equally satisfactory results may be obtained by more than one method.

Materials and Method

We have carried out a study of 400 cases of second trimester abortions performed at the Nowrosjee Wadia Maternity Hospital, Bombay, over a period of five years from January 1978 to December 1983. The methods employed were as follows:

- (1) Intra-amniotic 20% (hypertonic) saline 200 ml was administered in 240 cases.
- (2) 0.1% Ethacridine lactate was instilled extra-ocularly in 40 cases.
- (3) 15(S)-15 methyl analogue for PG F₂-alpha was injected intramuscularly in 80 cases.
- (4) Hysterotomy with tubal ligation was done in 40 cases.

The data regarding dose/volume of drug used, induction record and complications experienced have been studied.

Results and Analysis

The data collected from these 400 cases was analysed as follows:

TABLE I
Age

Age (years)	Cases (400)	Per cent
11-15	16	4.0
16-20	140	35.0
21-25	92	23.0
26-30	84	21.0
31-33	52	13.0
36-40	10	2.5
41-45	6	1.5

Table I shows that 35%, almost one-third, of the patients were from 16-20 years age group showing the young age at which they underwent MTP. 4% cases were below 15 years of age.

TABLE II
Current Marital Status

Status	Cases (400)	Per cent
Unmarried	160	40.0
Married	202	50.5
Widowed	16	4.0
Divorced	6	1.5
Separated	16	4.0

40% as seen from the above table were unmarried, which suggests the need for an educational programme on sex.

TABLE III
Parity

Parity	No. of prior pregnancies	No. of live births	No. of sp. ab.	No. of ind. ab.
	%	%	%	%
0 Gravida-1	47	—	—	—
1	8	10.5	1.5	3
2	17	16	—	—
3	15	14	—	—
4	8.5	4.5	—	—
5 and over	4.5	3.5	—	—

It is interesting to note that 47% were primigravidas. Most of them were unmarried. The others were initially motivated to continue the pregnancy. But on their refusal were taken up for MTP. 3.5% had more than five live births and all of them were sterilized after the MTP. 3% had one induced abortion in the past.

TABLE IV
Reason for seeking abortion

Reasons	Cases (400)	Per cent
Humanitarian grounds	176	44.0
As a FP measure	166	41.5
Marital problems	28	7.0
Medical grounds	6	1.5
Miscellaneous	24	6.0

Reasons for seeking abortion have been shown in Table IV. 44% had abortions on humanitarian grounds—4% being widows and 2 cases were those of pregnancies following rape. 1.5% had abortions on medical grounds—most of them having malignancy and requiring either radiotherapy or chemotherapy.

TABLE V
Weeks of gestation

Weeks	Cases (400)	Per cent
12	4	1.0
14	48	12.0
16	82	20.5
18	124	31.0
20	138	34.5
Above 20	4	1.0

Table V shows the weeks of gestation at which the patients presented and MTP was carried out. 34.5% came at 20 weeks of gestation and 31.0% at 18 weeks of gestation. This shows that majority of the patients turn up late for seeking abortion.

TABLE VI
Induction record

	I/AS	E/O EL	IMPG
Induction—Ut. cont. interval (Hrs: Min)	16:45	15:00	4:10
Induction—Vag. Bl. interval (Hrs: Min)	27:25	26:15	16:00
Av. induction—Abort. interval (Hrs: Min)	32:45	31:30	25:30
Dilatation achieved	6 cms	6 cms	6 cms

The induction record of the different methods shows that the onset of uterine contractions was earlier in the IM PG group. The average induction-abortion interval was shortest with IMPG, whereas with intra-amniotic saline and with extra-ovular ethacridine lactate the average induction-abortion interval was almost the same. The final dilatation achieved with all the methods was 6 cms.

TABLE VII
Expulsion of Placenta

	I/AS %	E/O EL %	IMPG %
Complete	60.83	50.0	72.5
Incomplete—			
Partial	20.0	10.0	10.0
Retained	18.38	25.0	2.5
Failures	0.83	15.0	2.5
Management of incomplete expulsion of placenta			
With oxytocics	5.83	5.0	7.5
Surgical removal	5.0	—	5.0
Oxytocin + Surgical	28.33	30.0	15.0

With IMPG 72.5% had complete abortion which was more than the other methods. 15% was the failure rate in Ethacridine lactate which was significantly higher than the other methods. About 30% had surgical removal of placenta along with oxytocin in both I/A saline and E/O EL methods. This shows that with IMPG there were more complete abortions and with EL the number of failures and those requiring surgical intervention was high.

TABLE VIII
Complications

	I/AS %	E/O EL %	IMPG %	Hysterotomy %
Fever	5.0	5.0	7.5	7.5
Nausea-vomiting	1.67	10.0	20.0	—
Diarrhoea	—	—	15.0	—
Bronchospasm	—	—	2.5	—
Shock	—	—	2.5	2.5
Haemorrhage	—	—	2.5	—
Coag. failure	0.83	—	—	—
Rupture uterus	—	—	2.5	—
Cervical tear	—	—	2.5	—

IMPG had the highest number of complications. Serious complications like bronchospasm, shock, hemorrhage, and cervical tears were seen mainly with IMPG. Two patients in the IMPG group were transferred from private clinics to our hospital with rupture uterus. One underwent a hysterectomy after resuscitation. The clotting time was prolonged in only 2 cases (0.83%) in the I/A saline group, which was promptly managed by the administration of blood, fresh frozen plasma and fibrinogen. There were no mortalities in this series.

Conclusion

We are therefore of the opinion that both E/O Ethacridine and I/A saline are almost equally effective with respect to induction-abortion interval, duration of hospitalisation and total cost of procedure. We would like to recommend the use of E/O Ethacridine in the earlier mid-trimester upto 16 weeks and I/A saline thereafter upto 20 weeks. IMPG is expensive and has serious complications if not used judiciously and we recommend its use in cases of failures of the above methods. Lastly and definitely the least to be used should be hysterotomy, as it involves major surgery, spinal or general anaesthesia with its associated risks and is also expensive from the patients point of view.

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PG	Hysterotomy
%	%
5	7.5
0	—
0	—
5	—
5	2.5
5	—
—	—
5	—
5	—

Serious complications were seen in 5 cases. In 4 cases, the babies were transferred to the neonatal unit. One under 1 year of age was prolonged which was promptly treated with plasma and fibrinolytics.

thacridine and I/A procedure-abortion. In the earlier mid-trimester, up to 20 weeks. IMPG was used judiciously and the methods. Lastly, the procedure, as it involves associated risks and

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HAEMATOLOGICAL AND BIOCHEMICAL VALUES OF CORD BLOOD IN FULL TERM NEW BORN†

by

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Introduction

Knowledge of certain normal haematological and biochemical values in newborn is essential for correct diagnosis and evaluation of diseases like anaemia, haemolytic disorders and liver dysfunctions. Several workers have reported widely variable values at birth. The present study is undertaken to establish the normal values in Indian babies of low socio-economic group, as seen at Nowrosjee Wadia Maternity Hospital, Parel, Bombay 12.

Material and Methods

Cord blood samples were collected in 101 mothers who had delivered full term normal babies and had no complicating factors. Blood samples were collected from 4.00 am to 9.00 am. Blood samples were collected in 3 penicillin bulbs, 2 cc. in ETA, bulb, 2 cc. in fluoride and 5 cc. in plain bulb. On an average 2-3 samples were collected daily. Investigations were carried out within 6-8 hours after collection by standard methods. All the samples were investigated for complete haemogram, Blood Sugar, BUN, Serum creatinine, serum bilirubin, SGOT, SGPT and proteins.

Results

Even though 101 cord blood samples were collected, either because of hemolysis or clotting of blood, less number of samples were available for investigation. Haemoglobin. A wide range of haemoglobin value was reported from 11.3 to 25 gm%.

Table 1A shows the distribution of haemoglobin value in 63 cases

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TABLE 1A

Hb gm%	11-11.9	12-13.5	13.6-15.5	15.6-17.5	17.6-19.5	19.6-20.5
No. of cases	2	0	14	25	20	2
Percentages	3.17	0	22.22	39.68	31.74	3.17

Average haemoglobin 16.76 gm% and range 11.3-20.5 gm% which is comparable to others as seen in table No. 1B.

TABLE 1B

Gupte S. <i>et al</i>	17% (12.5-25%)
Vora <i>et al</i>	15.84 ± SD 1.29
Upadhyaya	17.8%
Chaudry	17.31%
Oski and Naiman	16.8% (11.3-20.5%)
Smith	16.4% (14.19%)
Present study	16.76% (11.3-20.5%)

Packed cell volume:

Haemoglobin values alone have got no meaning especially when done by pin-prick method. So to get better idea, packed cell volume together with haemoglobin must be done especially when on Intra venous fluid therapy.

Table 2A shows distribution of PCV in 61 cases.

TABLE 2A

Range in %	35-40	41-45	46-50	51-55	56-60	61-65
No. of cases	2	3	25	21	9	1
Percentage	3.23	9.95	40.98	34.42	14.75	1.63

Table 2B shows that PCV value of 49.30% and range of 36-62% is comparable to others:

TABLE 2B

Vora <i>et al</i>	50-90%
Smith	56.6%
Forhar and Avneil	55% (45-65%)
Present study	49.36% (36-62%)

E.S.R.

E.S.R. has got limited value in diagnosis of diseases but it is useful for follow up of a disease. Table 3 shows distribution of E.S.R. values in 48 cases.

Average of 8.47 mm/hour and range of 1.50 mm/1 hour was observ-

ed. Seventy seven per cent had E.S.R. upto 10 mm/1 hour. Nelson has reported value of 2 mm/1 hour by Wintrob's method.

TABLE 3

Range in mm	1-10	11-20	21-30	31-40	41-50
No. of cases	37	7	0	1	3
Percentage	77.08	14.58	0	2.08	6.25

Reticulocyte Count:

Reticulocyte count in the neonate compares well with the haemoglobin status of the mother during pregnancy. A low value of reticulocyte was generally observed in the present series except in two cases, mothers had haemoglobin level of less than 8 gm% and were treated for anaemia in last trimester and Hb rose to 10 gm%, so they were included in the study.

TABLE 4A

Range in %	Less than 1	1-3	3.1-5	5.1-7	7-1-10
No. of cases	6	28	30	2	0
Percentage	9.09	42.42	45.45	3.03	0

Average value of 2.9% and range of 0-5.6% which is comparable to others as seen in Table 4B.

TABLE 4B

Gupte S. <i>et al</i>	1.4% (0.2-10%)
Vora S. <i>et al</i>	6.29% \pm SD 2.2%
Smith	0.5-1.5%
Todd and Stanford	3.7%
Forhar and Avheil	5% (3-7%)
Present series	2.93% (0-5.6%)

W.B.C. Count:

Cord blood value of WBC depends upon the status of mother. A subclinical infection in a mother will be reflected in the newborn. In foetus there is a thymus gland which continues to function in neonatal life and so higher values of lymphocytes are understandable.

Table 5A shows the distribution of WBC count in 63 cases.

TABLE 5A

	Total/ cmm	Neuro- phils	Lympho- cytes	Eosino- phils	Mono- cytes
Maximum	9800	78%	68%	8%	2%
Minimum	3800	36%	24%	—	—
Average	7023	54.36%	43.38%	1%	0.5%

Monocytes were detected in only 4 cases. Eosinophils were found in 21 cases.

From table 5B it will be seen that our values of total count were much lower than others and relatively higher values of lymphocytes.

Khanna and Malhotra—1 Forhar and Areneil—2

	Total		Neutrophil		Lymphocytes		Eosinophils		Monocytes	
	1	2	1	2	1	2	1	2	1	2
Maximum	—	30,000	89	80	64	—	4	—	7	14
Minimum	—	9,000	31	40	7	—	0	—	—	7
Average	14475	18000	66.7	60	30.5	32	0.45	2	2.15	—

Platelet count:

Platelet count is useful in cases of bleeding disorders in newborn. It is also affected by drugs taken by mothers in later part of pregnancy.

Table 6A shows distribution of values in 50 cases.

TABLE 6A

Range in thousand (1000)	Less than 1	1.1-1.5	1.6-2.0	2.1-2.5
No. of cases	2	24	18	6
Percentage	4	48	36	12

Table 6B shows that platelet count is slightly on lower side as compared to others.

TABLE 6B

Khanna & Malhotra	38,000/cmm
Upadhaya	28,600/cmm
Pauwal	29,600/cmm
Smith	25,100/cmm
Present series	18,400/cmm

Blood sugar:

Blood sugar value is useful in cases of neonatal convulsive disorders because a common cause of convulsions in newborns being hypoglycemia. Table 7A shows distribution of value in 61 cases.

TABLE 7A

Range mg%	81-90	91-100	101-110	111-120
No. of cases	28	26	2	5
Percentage	45.90	42.62	3.27	8.19

The levels of reducing substances especially glucose levels have been measured in blood of human infants since 1911 when they were studied by Norvac *et al.* Although extensive literature exists, there is still disagreement over which levels of blood glucose are normal in neonatal period. Even though our paediatricians take the value of blood sugar less than 20 mg as hypoglycemia, it is still debatable about values which can be defined as hypoglycemia or hyperglycemia and requires some evaluation and standardisation of technique of estimation of blood sugar.

Table 7B shows that our value of sugar is much higher than others. This is because of estimation which was done by Folin and Wu method which not only measures glucose but also other reducing substance in blood.

TABLE 7B

Nelson	30-89 mg%
Forhar & Avneil	60-100 mg%
Hoekelman	45-96 mg%
Present study	81-120 mg%

BUN:

Table 8 shows distribution of BUN value in 63 cases.

TABLE 8

Range mg%	4.5-7.5	7.6-10.5	10.6-13.5
No. of cases	49	11	3
Percentage	74.59	20.67	4.75

Average value of 7.04 mg% and range 5.4-13.1 mg% which is comparable to that of Hoekelman 6-28 mg%.

Serum Creatinine:

Table 9 shows distribution of values in 74 cases.

TABLE 9

Range mg%	Less than 1	1.1-2.0	2.1-3	3.1-4
No. of cases	10	58	4	2
Percentage	13.50	78.57	5.40	2.43

Range of 0.6-3.2 mg% and average of 1.48 mg% which is comparable to that of Hoekelman 0.8-1.4 mg%.

BUN and Serum creatinine values are good parameters of kidney function. They will be altered in case when there is severe dearrangement of kidney functions in new borns. Since our study has included only normal infants for establishing standard values, there is not so much of variation in reading.

Liver function test:

Liver has got two fold functions excretory and enzymetic. Both of them are less developed as compared to adults which is witnessed by higher values of Serum bilirubin and lower values of SGOT and SGPT. Table 10A shows distribution of various values in 97 cases.

TABLE 10A

	Sr. Bili-rubin T.	Ser. Bil. D	SGOT	SGPT	Total proteins	Albumin
Maximum	1.7	0.8	128	63	8.0	5.1
Minimum	0.41	0.4	31	18	4.9	3.05
Average	0.878	0.445	53.57	31.07	6.05	3.35

Table 10B shows that serum bilirubin values are comparable to the others. It is a useful guide in Rh-isoimmunized baby, for deciding exchange transfusion.

TABLE 10B

Gupte S. et al	Total	0.6-2.8 mg%
	Mean	1.1 mg%
Hoekelman	Total	0.8 mg%
	Direct	0.4 mg%
Nelson	Total	2 mg%
	Direct	0.1 mg%
Present series	Total	0.87 mg%
	Direct	0.4 mg%

SGOT and SGPT values are comparable with the Hoekelman SGOT 0-54 and SGPT 27-54.

Protein values are comparable to the others as seen in Table 10C.

TABLE 10C

Forhar and Avneil	Total	4.6-7.7 gm%
	Albumin	2.5-5.0 gm%
Nelson	Total	4.6-7.3 gm%
	Albumin	3.6-5.4 gm%
Hoekelman	Total	6.1 (4.8-9.3 gm%)
Present series	Total	4.9-8 gm%
	Albumin	3.05-5.1 gm%

Conclusion and Summary:

An attempt has been made to establish a normal value of haemotological and biochemical parameters of cord blood in neonates of low socio-economic group.

Since all the mothers who were included for study, had no complicating factors, there is not much of variation in readings which are comparable to others, except for (a) Blood sugar values which are higher than others because of technique of estimation by Folin and Wu method. (b) Lower values of total WBC counts with lymphocytosis and slightly lower values of platelet count.

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Total proteins	Albumin
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4.9	3.05
6.05	3.35

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0.4 mg%
2 mg%
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4 gm%
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A STEP IN THE SKY

(Cytology Clinic, AMWI Bombay Branch,
Cama & Albles Hospital, Bombay)

by

Darshana Daftary

Ninth August 1942 was history day for India when the "Quit India" movement was launched. Exactly 41 years later, we too called quits to the old order and shifted from the tiny cubicle in the laboratory of Cama & Albles Hospitals, Bombay to the higher and larger space on the first floor of the O.P.D. building, of the same hospital.



Gracing this occasion and doing the honours of inaugurating the new premises, our public Health & Welfare Minister of Maharashtra State, Honourable Dr. Lalita Rao (who arrived on the dot, without any fanfare and so completely unlike a minister that she took us all by surprise) stressed the importance of cytology and praised the work done by the Clinic in the last 15 years of its existence.

This clinic was started in 1967 with the funds collected by the AMWI (Bombay Branch) during its Diamond Jubilee Year. Late Dr. Shirin Mehtaji, Dr. Winifred Fernandes, Dr. Usha Soraiya and Dr. Mohini Garud have been the inspiring and initiating forces of this clinic from the very beginning. The clinic started in a small room of the Pathology Laboratory of Cama & Albles Hospitals, Bombay. Cytology was only a small obscure branch then and had many more critics than today. However, through the years the activities of this clinic have multiplied

and it has played a key role in increasing the popularity of this simple, cheap and yet effective tool to diagnose not only precancerous and cancerous lesions but also in diagnosing many other conditions.

The clinic has been conducting an annual teaching course. Many students from outside Bombay attend it and there is always a problem about accommodation. This year the Government of Maharashtra has deputed a special batch of 15 doctors to this course.

As the activities of the clinic expanded, we needed more space and with the tremendous zeal and co-operation of the present Superintendent of Cama & Alless Hospitals, Dr. (Mrs.) Korde this dream became a reality. In Dr. Lalita Rao we found the ideal person to open our new premises, for apart from being a successful politician, she is a successful doctor to whom welfare of poor is near and dear, Dr. Dina Patel, Secretary of AMWI, who has always encouraged and helped us, welcomed the gathering. We took this opportunity to felicitate our respected senior colleague Dr. Winifred Fernandes who has been the moving spirit of this clinic. She announced a donation of Rs. 60,000 from Mr. Yusuf Patel in memory of his mother for a colposcope, for the clinic.

While speaking at length on the history of AMWI, Dr. Fernandes traced the Association's origin to an event in 1883 when the Medical Woman for India Fund was formed by a group of cosmopolitan businessmen. This was formed to encourage women doctors in our country, where women died in childbirth for want of women doctors, because they refused to be examined by male doctors. However, though special hospitals for women and children were established with the help of such funds, conditions for doctors working there were far from satisfactory, and women were reluctant to join the local medical colleges.

And so in January of 1907, medical women in charge of some of these hospitals met and formed the Association of Medical Women in India. It was the first such association in the world. In 1919, when the International Association was established in the U.S., the Indian Association became affiliated to it. The Indian Association has helped tremendously in offering medical aid to women, in gaining admission for women into Medical colleges and forming Women Medical Services. The Lady Hardinge Medical College was started as a medical college for women and has remained so, partly through efforts of AMWI. Many free clinics have also been established under the auspices of AMWI and free services offered to women. This cytology clinic is one of them.

Dr. Fernandes also emphasised the fact that the new premises were being inaugurated by a minister, who was a woman doctor.

Dr. Matalia read the messages received on this occasion from many eminent personalities. Dr. J. Roy Chowdhury, President of Indian Academy of Cytopathologists and Director of Chittaranjan National Cancer Research Centre, Calcutta, while expressing her happiness for this progress, praised the entire staff of the clinic for their unstinted devotion and co-operation in making this success possible. Dr. P. N. Wahi, Exeritus President of Indian Academy of Cytopathologists and one of pioneering Indian Cytopathologists, while sending his sincere good wishes, praised the good work done by the clinic under the leadership of

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Dr. Usha Saraiya, and added that the clinic had not only done considerable academic work to popularise cytology and promote the cause of Indian Academy of Cytologists but had done great public service by saving many women from certain death by diagnosing and treating the disease. Messages of congratulations and best wishes were also received from Dr. Usha Luthra, Senior Deputy Director-General ICMR, Director Cytology Research Centre and Chairperson Accreditation & Examination Committee, Indian Academy of Cytologists, Dr. Jyoti Trivedi, Vice-Chancellor SNDT University, Mrs. Shalinitai Patil and many branch Presidents of AMWI.

At the conclusion of the function Dr. Usha Saraiya proposed a vote of thanks on behalf of the AMWI, Clinic staff and also on behalf of "About 30,000 patients who have benefited by the facility extended by the Clinic". Dr. Saraiya said it had taken about 10 years of hard work to see this building constructed. Although ten years is a long time in life of an individual, it is not the same thing in the life of an institution. She hoped that the Clinic in due course would go on to celebrate its centenary.

She in particular wanted to thank the first few donors, who had donated so generously when there was no work to show but only dreams and ideas. Today, the donations are still flowing in but now there is 10 years of work to show.

She thanked the Government of Maharashtra, and especially the P.W.D. for the excellent and artistic construction.

Finally, she thanked all those who had come to attend the inaugural function and said "Time is the most scarce commodity today. It cannot be bought, nor can it be stored, but only shared. Today you all have given us of your time and shared this moment with us and I truly appreciate that".

This was a landmark in the history of our Clinic and AMWI. We hope that with so many good wishes behind us, only sky will be our limit.

REPORT OF T

The Annual Co
n India was held
November, 1982, at

The following

1. Dr. M. Ca
2. Dr. S. Bh
3. Dr. Marik
4. Dr. Dina
5. Dr. R. Ch
6. Dr. Mehru
7. Dr. Sowm
8. Dr. Jyoti
9. Dr. Elsa
10. Dr. Saras
11. Dr. L. Su
12. Dr. Chan
13. Dr. S. Sa
14. Dr. Ruk
15. Dr. Kane
16. Dr. Krish
17. Dr. Saroj
18. Dr. Paur
19. Dr. Sath
20. Dr. G. S

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1. Condolence

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2. Apologies

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REPORT OF THE ANNUAL COUNCIL MEETING OF AMWI

The Annual Council Meeting of the Association of Medical Women in India was held at the Guild of Service Auditorium, Madras, on 7th November, 1982, at 4-00 p.m.

The following members were present:

1. Dr. M. Catchatoor	President
2. Dr. S. Bhatia	Past President
3. Dr. Marikar	—do—
4. Dr. Dina Patel	Secretary & Treasurer
5. Dr. R. Chacko	Chairman—Madras Branch
6. Dr. Mehroo Pardiwalla	Secretary—Bombay Branch
7. Dr. Sowmini	Secretary—Madras Branch
8. Dr. Jyoti Trivedi	Council Member
9. Dr. Elsa Benjamin	Member
10. Dr. Sarasa Bharati	—do—
11. Dr. L. Sulochana	—do—
12. Dr. Chandra Xavier	—do—
13. Dr. S. Sachdev	By invitation, Delhi
14. Dr. Rukshani Sowrirajan	—do—
15. Dr. Kanakshi Kabir	—do—
16. Dr. Krishnaswami	—do—
17. Dr. Saroja Lakshmi	—do—
18. Dr. Paune	—do—
19. Dr. Sathia Sundari	—do—
20. Dr. G. Sakuntala	—do—

The meeting started with the All India President Dr. M. Catchatoor in the chair. She welcomed all the council members and the invited doctors from Madras. She was particularly thankful to Dr. Bhatia for coming all the way from Bangalore and also to Dr. Marikar, one of the seniormost members.

1. Condolence

Two minutes silence was observed to mourn the said and untimely death of Dr. Joya Chowdhury, a very active member from East Bengal Branch and member of the Editorial Board who has rendered valuable service to our Association. The following Resolution was passed: "We the members of the AMWI deeply mourn the passing away of our Active Member, Dr. Joya Chowdhury."

2. Apologies

Apologies were received from Dr. J. Jhirad, Dr. Juliet Desa Souza, Dr. Sathe, Dr. Dinoo Dalal, Dr. Virkar and Dr. A. Billimoria.

3. Confirmation of Minutes

The Minutes were circulated, confirmed and signed.

4. Business arising out of the Minutes of the last Meeting

- (i) The International Affiliation fees for 1980 and 1981 amounting to Rs. 12,284.05 at the rate of 5 Sw. Fr. per member was remitted to MWIA. So far there has been no reduction of this amount and we are awaiting the decision of MWIA at the next Conference in Manila in November 1982.
- (ii) Office rent was paid at Rs. 30 per month.
- (iii) The salary of the typist-cum-clerk for posting journals was increased from Rs. 50 to Rs. 75 per month.

5. Increase in Incidental expenses

There was a discussion over the amount for incidental expenses of Rs. 5 instead of Rs. 3 in view of the increase in postal rates. It was finally decided that for 1983 Rs. 5 would be given for incidental expenses without increasing the membership fees. Member bodies were requested to get atleast two advertisements as the cost of printing had increased.

In spite of repeated requests there are no receipts from State Branches for incidental expenses—this has delayed the accounts.

6. Golden Jubilee Scholarship

Members were requested to encourage the junior members to apply for the Golden Jubilee Scholarship which is regularly advertised in our journal.

7. International Dues

The membership fees should be paid regularly by the first week of January each year so that international due are not delayed. Dr. Chacko who was to attend the Manila Conference was requested to put up the proposal to the International Association that member bodies from developing countries could send a fixed reasonable sum for affiliation fees instead of individual members.

8. All India Conference

There was a request to the members from Delhi to revive this branch and to hold the next All India Conference in Delhi in 1984. Dr. Sachdev who was the representative from Delhi was present and she was willing to revive the branch and make arrangements to have the Conference in Delhi.

9. Office Bearers

According to the Constitution the office bearers should be elected for the coming year. All the members present agreed to this.

10. Reports

(i) Central Office:

The Secretary Dr. Dina Patel read out the report of the centre. It was a happy occasion to learn that a new branch of the AMWI

had been started at Madras with 20 members. They are a very active branch and we congratulate them on organising a very successful conference of the AMWI. The Central Office continues as usual at Bombay.

The Golden Jubilee Scholarships for the year 1980 and 1981 were not awarded as there were no applicants.

It was noted that the Delhi branch of the Association was not very active and some attempts should be made to revive the same.

(ii) State Branches:

(a) West Bengal

The report of the West Bengal Branch was read.

The Mobile Health Clinic has carried on with the good work it had been doing. It is visiting different slums of the city 4 days a week and rendering medical care, supplying free medicines and carrying on an immunisation programme and giving advice on public health.

The Social Welfare & Cancer Detection Clinic at 136, Lenin Sarani is also carrying on with its work. Patients are seen twice a week in the afternoon and treated and supplied with free medicine.

We have treated 17,800 patients during 1981-82, among them 6322 patients were adults and 8147 were children, 1059 children have been immunised and the number of health care cases were 2272.

Grants

We had a grant of Rs. 10,000 from the Government and Rs. 14,000 from OXFAM last year. The cost of petrol, maintenance of the van, medicines, is rising and we are hard put to keep up with the expenses.

We have been able to maintain supply of medicines to the poor with the help of samples of medicines from our members and from Pharmaceutical firms.

We are sorry we lost Sister Freda in 1981—she worked from the inception of the Clinic in 1970, on a very nominal pay.

The Hospital

The hospital was inaugurated by our Chief Minister, Shri Jyoti Basu on 11-4-1981.

The Hospital is now well equipped. Thanks to the untiring efforts of Dr. Marie Catchatoor who is also the Administrator of the Hospital. It is situated at 45 Jagdish Chandra Bose Road, Calcutta.

We held an Eye Camp in December last year at the Hospital. The camp was sponsored by the 'INNER WHEEL'. We thank Dr. Lalita Seth for bringing the 'INNER WHEEL' in contact with us.

Twenty seven cataract patients were operated. All of them were successful.

We are running a day Creche for the sick children of the poor and have had great success with this department. Most of the children attending the Creche improved wonderfully with treatment and care. There are some disabled children who improved remarkably and two of these children had been supplied with Calipers free of cost. 'INNER WHEEL' donated one of these and The Lutheran World Service the other.

During Christmas Dr. Catchatoor arranged a party for the Children and gave each one a woollen blanket and their mothers a food packet. Mrs. Hodne and her daughter donated money, blankets and clothes. There was a khoi bag and a short drama arranged by Dipali Sur, which they enjoyed enormously.

The Out-door Department of the Hospital has been working since May 1981, and 3630 patients have been treated in 1981 and 6022 upto November 1982.

Eye Out-door has also been a busy department. We have started admitting patients since the last few months and have treated 127 patients in the Indoor.

We have done a few gynaecological operations and have started taking in labour cases.

DONATIONS

Donations to the Hospital have been forthcoming both from this country and abroad. Soroptomists of Yorkshire have shown special interest and collected donations for this Institution.

SOCAL AND CLINICAL MEETINGS

We had a Socio-Medical Meeting at the Sindhi Panchayat Hall jointly arranged by Dr. Urmilla Khanna and Dr. Tulsi Basu. The Meeting was very well organised and attended. A symposium was held on the use of Diazepam and Clotrimazole in various branches of medicine.

There was a very good Cultural Show followed by refreshments. Dr. Tulsi Basu presented the performers with some presents. Another Scientific Meeting was held under the auspices of the Institute of Child Health and our Association. Several very interesting cases were presented.

DR. ANJALI CHATTERJI—MEMORIAL ORATION

Dr. Anjali Chatterji Memorial Oration was held on 10th July 1982. Speaker was Dr. M. Konar. She gave an exhaustive lecture on Cancer

in Women with stress on genital Cancer. The Meeting was well attended. Dr. M. Konar donated Rs. 500 which she had received for the oration, to the Hospital.

EXECUTIVE MEETINGS

Five Executive Committee meetings and one general body meeting, were held during the year.

I mention with deep sorrow the loss of Dr. Joya Choudhyri, an active member of the Association during the year. A condolence meeting was held in her memory and an insertion in the 'In Memorium' Column of the Statesman was put from the Association.

We are hoping to have Scientific Meetings more often in the future and I hope members will show more interest. I also hope our members will make an effort to make all the women doctors they know, members of the association.

Thank you.

(b) Bombay Branch

The Bombay Branch report was read out by its Secretary.

There was one General Body Meeting and 2 clinical meetings. 2 Refresher Courses were also held during the year. Dr. Jyoti Trivedi, a senior member of the Association was felicitated on being appointed Vice Chancellor of the SNDT University, Bombay—The felicitation was followed by a symposium on "Health for All by 2000" by Dr. Saroj Jha.

The Refresher Courses were held on 'Infertility' and 'Pediatrics'. 15 junior doctors attended the first course and 20 doctors attended the second course.

A best paper Award Competition was also held for those doctors who had graduated within 7 years. 12 papers were received. The first prize was awarded to Dr. Aspi Irani for his paper 'Need for Revision of Thyroxine dose in Hypothyroid children.' 3 consolation prizes were awarded. The prize money was a gift from M. Shah and Co. through the kind courtesy of Dr. Shirish Shah. The Bombay Branch thanks Messrs. M. Shah & Co. for their kind courtesy.

The Cytology Clinic of the Bombay Branch continues doing its good work.

The total number of patients screened was 3236 during the year. The no. of smears examined was 7061. There were 25 cases of invasive cancer, and 8 cases of suspicious smears. There were only 2 cases of C.I.S. and 1 of severe dysplasia.

The 9th Annual Course in Cytology was held in March 1982 and a total of 20 doctors and 7 technicians attended.

An outdoor camp was held in collaboration with the Lionettes club and 25 smears were taken.

Some of our workers attended the annual Conference of the Indian Academy of Cytologists and Dr. Jaya Gogari won the prize for the best paper.

Dr. Maya Lulla received the Diamond Jubilee Medical Research Scholarship of the Women Graduates Union Bombay. She has started her research work on 'Cytology Patterns in Tuberculosis' from February 1982.

The clinic has successfully concluded the ICMR Project on 'In-depth Comparative Study of Dysplasia'. The project on CEA is being continued in collaboration with the Breach Candy Hospital. A project on "Colposcopic Evaluation of Cervical Lesions" is being carried out in collaboration with the Harkisondas Hospital.

The new building of the Cytology Clinic is under construction and is expected to be completed by May 1983.

It was suggested that the same Cytology Sub-Committee be continued for the year 1983 and certain plans are not yet complete, especially regarding the new building.

The final accounts of the Cytology clinic were not completed.

(c) Latur Branch

The Annual report of the Latur Branch was read out. One General Meeting was held and elections were held at the time Dr. Mrs. Sonawane was elected President of the Branch and Dr. Mrs. Phirke was Secretary cum Treasurer. Meetings and get together was held every second Wednesday of the month where interesting cases were discussed.

Polio and Triple inoculations were given every month to the children of creches. A cancer detection camp was held at the Municipal Hospital, Latur and 232 gynecological cases were examined. 85 slides were taken for rush smears and 20 biopsy taken for histopathology. 7 cases of cervical cancer stage I were diagnosed.

A laparoscopic Sterilisation camp was held at the M. C. Latur hospital.

Secretary Dr. Phirke attended the obstetric Congress at Sholapur.

(d) Madras Branch

This is a relatively new branch. The report read out by its Secretary mainly dealt with the aims and objects of the Women Doctors Association of Tamil Nadu and Pondicherry. The AMWI Madras Branch is a part of this above association which was started in 1975. Not all members of the WDA are members of the AMWI.

The WDA has started a creche in the Institute of Child Health, Egmore, Madras, for the Children of IV grade workers of the hospital.

They maintain one bed for a old woman at the Mercy Home since 1980.

They have adopted a village at 'Nemmili' for the total Health and Socio Economic Development along with the I.R.S. Tamil Nadu Branch and the Punjab Association. 9 General Medical camps were held. The Journal called the 'Southern Scientist' is also being published and has a wide circulation.

It is hoped that more and more lady doctors would also become members of the AMWI which is an All India Organisation.

(iii) Editor's Report

As every year in the past all 3 issues of the Journals of Association of Medical Women in India for the year 1981, were edited. There were some delays in distribution because of the delay at the press.

My sincere thanks to some of our members who have constantly helped in the collection of the articles for the journal especially our members from Bombay and Calcutta.

I am very sorry to report that because of the shortage of advertisements the expenses of the journal were very high. Also because of the increasing rise in the cost of the paper and printing the number of articles in the journal have to be restricted.

All the members are hereby requested to make an attempt to get yearly advertisements for the journal in order to make it a success.

(iv) Dr. Jhirad's Library Report

The library has had an uneventful year. The corpus stands at Rs. 15,000 and is invested in fixed deposits at 9% interest rate. No new contributions have been received during the year.

Dr. Mrs. Pophale, one of our members, got some of the library cupboards painted at her cost. A.M.W.I. is thankful to her for the same.

The following books were purchased for the library during the year at a cost of Rs. 1200.

1. Infertile Couple	Peppernells	Rs. 175
2. Microsurgery	Silber	Rs. 525
3. Clinical Gyn. Oncology	DiSAIK	Rs. 243
4. Gyn. Obst. Year Book 1981		Rs. 257

During the year some of the loose journals were bound. Some library cupboards were repaired.

The day to day work of the library is satisfactorily managed by Mrs. Suraiya Khan. As a token of appreciation of her services she is paid Rs. 250 from the library funds.

The accounts for the year have been audited. Copies of the balance sheets are attached herewith. The bank balance on 31-12-1981 was Rs. 356.83.

I wish to thank A.M.W.I. for giving me an opportunity to run the library.

12. Statement of Accounts

The statement of accounts will be published separately.

13. Appointment of Auditors

The same auditors M/s. Mama & Co. were appointed for the coming year. The resolution for the same was proposed by Dr. Mehroo Pardiwalla and seconded by Dr. Jyoti Trivedi.

MWIA News

Dr. Juliet Desa Souza our National Corresponding Secretary sent her apology for not attending the Meeting.

The International Congress will be held in Manila from 21st-27th November 1982. The Theme of the Congress is 'Humane Management in Medicine'. All the branches have been appraised of the congress news and some of the members will be attending. Among the junior members Dr. Feruza Sherdiwalla has been given some assistance from the International to attend the Conference. An appeal has been sent for the Executive Committee Meeting to consider reduction in International membership fees from the developing countries.

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BALANCE SHEET
As at 31st December, 1981

DIAMOND JUBILEE FUND:

Balance as per last Balance Sheet

10,000.00

BUILDING FUND: (Bombay branch)

Balance as per last Balance Sheet

6,505.00

India

15,000.00

DIAMOND JUBILEE FUND**INVESTMENT:**

Fixed Deposit with Central Bank of India

10,000.00

LIFE MEMBERSHIP:

Balance as per last Balance Sheet

9,389.00

LIABILITIES FOR EXPENSES:

1,985.35

CASH AND BANK BALANCES:

Fixed Deposit with Central Bank of India

6,500.00

Current Account with Grindlays Bank Ltd.

428.50

Savings Bank Account with Central Bank of India

13,129.75

Cash on hand

268.72

20,326.97

INCOME AND EXPENDITURE ACCOUNT:

Balance as per last Balance Sheet

6,660.89

Add: Excess of Expenditure Over

Income for the year

2,274.99

4,385.90

Total:

59,632.48

Total:

59,632.48

J. M. Desa Souza

Dina N. Patel

MEMBERS GOVERNING COUNCIL

For Ratan S. Mama & Co.
Partner.

CHARTERED ACCOUNTANTS

DATED: 16 JANUARY 1984

THE ASSOCIATION OF MEDICAL WOMEN IN INDIA
INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER, 1981

	Rs.	Rs.		Rs.	Rs.
EXPENDITURE:			INCOME (CASH BASIS)		
To Expenses on the Objects of the Trust:			By Membership Fees—		
EDUCATION (Journal)			Annual Contribution	5,454.00	
Printing	3,395.76		" Advertisement Receipts	100.00	
Salary	400.00				5,554.00
Postage	975.64		INTEREST:		
		4,771.40	MIDR 23/2686 Central Bank of India		
GENERAL ADMINISTRATION:			(Rs. 10,000/-)	998.58	
Audit Fees	500.00		MIDR 22/194 Central Bank of India		
Bank Charges	30.20		(Rs. 4,000/-)	400.00	
Postage	51.55		MIDR 22/112 Central Bank of India		
Rent	360.00		(Rs. 5,000/-)	515.01	
Sundry Expenses	3.00		Central Bank of India—		
		944.75	Savings Bank Account No. 16585	523.55	
" Excess of Income Over Expenditure					2,437.14
transferred to Balance Sheet		2,274.99			
			Total		7,991.14
Total		7,991.14			

J. M. Desa Souza
Dina N. Patel
MEMBERS GOVERNING COUNCIL

DATED: 16 JANUARY 1984

For Ratan S. Mama & Co.
Partner.

CHARTERED ACCOUNTANTS

J. M. Desa Souza
 Dina N. Patel
 MEMBERS GOVERNING COUNCIL

For Ratan S. Mama & Co.
 Partner.
 CHARTERED ACCOUNTANTS

DATED: 16 JANUARY 1984

BALANCE SHEET
 As at 31st December, 1982

ASSETS		
Fixed Assets		
Land and Buildings	15,000.00	
Plant and Machinery	10,000.00	
Investments	5,000.00	
Current Assets		
Stocks	2,000.00	
Debtors	1,000.00	
Prepaid Expenses	500.00	
Other Current Assets	1,500.00	
LIABILITIES		
Capital		
Share Capital	5,000.00	
Reserves	15,000.00	
LIABILITIES		
Long Term Liabilities		
Short Term Liabilities		
Current Liabilities		
Trade Creditors	1,000.00	
Other Current Liabilities	1,000.00	
LIABILITIES		

THE ASSOCIATION OF MEDICAL WOMEN IN INDIA
BALANCE SHEET AS AT 31ST DECEMBER, 1982

FUNDS AND LIABILITIES		PROPERTY AND ASSETS			
	Rs.	Rs.		Rs.	Rs.
CAPITAL FUND:			FURNITURE:		
Balance as per last Balance Sheet	5,530.98		Balance as per last Balance Sheet:		
Add: Transferred during the year	71.00	5,601.98	Furniture	150.00	
			Office Partition	2,750.00	2,900.00
CONFERENCE FUND:			CAPITAL FUND INVESTMENT:		
Balance as per last Balance Sheet	1,538.49		Balance with National & Grindlays		
Add: Transferred during the year	180.00	1,718.49	Bank Ltd.	1,459.12	
			Fixed Deposit with Central Bank of		
GOLDEN JUBILEE FUND:			India	2,500.00	3,959.12
Balance as per last Balance Sheet	24,683.66		CONFERENCE FUND INVESTMENT:		
Add: Transferred during the year	1,500.00	26,183.66	Balance with National & Grindlays		
			Bank Ltd.		5,015.69
DIAMOND JUBILEE FUND:			GOLDEN JUBILEE FUND		
Balance as per last Balance Sheet		10,000.00	INVESTMENT:		
BUILDING FUND (Bombay Branch)			Fixed Deposit with Central Bank of		
Balance as per last Balance Sheet		6,505.00	India		15,000.00
			DIAMOND JUBILEE FUND		
			INVESTMENT:		
			Fixed Deposit with Central Bank of		
			India		10,000.00

CASH AND BANK BALANCES:

LIFE MEMBERSHIP:

Balance as per last Balance Sheet

9,389.00

LIABILITIES FOR EXPENSES:

2,485.35

CASH AND BANK BALANCES:

Fixed Deposit with Central Bank of
India

6,500.00

Current Account with Grindlays
Bank Ltd.

1,346.49

Savings Bank Account with Central
Bank of India

3,289.31

Cash on Hand

10.27

11,146.07

INCOME AND EXPENDITURE

ACCOUNT:

Balance as per last Balance Sheet

4,385.90

Add: Excess of Expenditure Over

(Income for the year

9,476.70

13,862.60

Total:

61,883.48

61,883.48

Total:

J. M. Desa Souza

Dina N. Patel

MEMBERS GOVERNING COUNCIL

DATED: 16 JANUARY 1984

For Ratan S. Mama & Co.

Partner.

CHARTERED ACCOUNTANTS

THE ASSOCIATION OF MEDICAL WOMEN IN INDIA
INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER,
1982

EXPENDITURE:	Rs.	Rs.	INCOME (CASH BASIS)	Rs.	Rs.
To Expenses on the Object of the Trust			By Membership Fees		10,483.20
Education (Journal):			" INTEREST:		
Printing	7,916.32		MIDR Central Bank of India	991.60	
Salary	650.00		(Rs. 10,000/-)		
Postage	1,376.50		MIDR Central Bank of India	400.00	
		9,942.82	(Rs. 4,000/-)		
" Affiliation Fees Paid		11,082.01	MIDR Central Bank of India	495.84	
" Contribution & Fees		125.00	(Rs. 5,000/-)		
" General Administration:			Central Bank of India Savings	375.75	
Audit Fees	500.00		Account		
Bank Charges	9.00				2,263.27
Postage	75.45		" Excess of Expenditure Over Income		
Printing Stationery	6.00		transferred to Balance Sheet		9,476.70
Rent	360.00				
Conveyance	2.00				
Sundry Expenses	120.89				
		1,073.34			
Total:		22,223.17	Total:		22,223.17

J. M. Desa Souza
Dina N. Patel
MEMBERS GOVERNING COUNCIL

DATED: 16 JANUARY 1984

For Ratan S. Mama & Co.
Partner.
CHARTERED ACCOUNTANTS

LIBRARY OF THE
MUSEUM OF NATURAL HISTORY
AND
GEOGRAPHY
OF THE
CITY OF BOSTON