THE JOURNAL

OF THE

ASSOCIATION OF MEDICAL WOMEN IN INDIA

VOL. LXXI SEPTEMBER-DECEMBER 1981 No. 3

THE ASSOCIATION OF MEDICAL WOMEN IN INDIA

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Printed by Dr. D. Dalal at the Popular Press (Bombay) Pvt. Ltd., 35-C Tardeo Road, Bombay-400 034, and published by her for The Association of Medical Women in India, IMA Building, 16, Haji Ali Park, Keshavrao Khadye Marg, Bombay-400 034.

The Journal of the A.M.W.I.

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Applications are invited from members of the AMWI engaged in research work in any field of Medicine for the Golden Jubilee Scholarship.

For details please contact Dr. Dina Patel, Hon. Secretary, AMWI, IMA Building, 16, Keshavrao Khadye Marg, Bombay 400 034.

INTRAPARTUM FOETAL MONITORING

by

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Introduction

Time-honoured technics of intermittent auscultation of the foetal heart rate and observation of meconium in the amniotic fluid are of little value, in evaluating foetal distress. The usual technic, restricted to the period between contractions, involves counting foetal heart beats for perhaps 30 seconds every 15 minutes, multiplying appropriately and expressing the frequency (rate) in beats per minute. Under these conditions we avail ourselves of perhaps 3 per cent of the available information.

Continuous beat-by-beat surveillance of the foetal heart rate and uterine contractions provide reliable, reproducible and predictive information about the condition of the foetus during labour. This also provides an attentive supervision of labour, which forms a major contribution of monitoring to foetal health.

Deceleration refers to the periodic decrease in foetal heart rate associated with uterine contractions. Three types of decelerations are defined based on the shape of the wave and the timing relative to the uterine contraction.

Early deceleration is slowing of the cardiac rate coincident with a uterine contraction and return to normal as the intrauterine pressure abates. It is an innocent pattern due to pressure on the foetal head.

Variable deceleration bears no constant relation to the time of contraction and are variable in onset, duration and intensity. It is attributed to compression of the umbilical cord and are less ominous than late decelerations.

Late decelerations has a delayed onset relative to onset of uterine contractions and are due to utero-placental insufficiency and hypoxia.

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Material and Methods

Intrapartum monitoring has been applied to selected cases to judge the degree of foetal distress, with each uterine contraction by assessment of the graphic record.

A total of 43 high risk cases were monitored intrapartum at the Nowrosjee Wadia Maternity Hospital, Bombay. Observations as regards the baseline, variability, acceleration and deceleration were made, and these changes were correlated with the presence or absence of uterine contractions. The high-risk patients with intact membranes were subjected to amnioscopy. Intrapartum amnioscopy was performed on 33 of these patients utilizing various sizes of the amnioscope, depending on the dilatation of the cervix. None of these patients were subjected to internal monitoring.

The basal foetal heart rate and the type of foetal cardiac deceleration were studied, to judge the optimum time of surgical intervention. If early deceleration is seen, no therapy is indicated, as this usually indicates innocuous foetal head compression.

Variable deceleration if seen is a warning that may indicate cord compression. A change in posture should show an improvement in this graph.

Late deceleration generally identifies uteroplacental circulatory insufficiency and foetal hypoxia. In these cases supine position is avoided, whilst oxygen is administered, an artificial rupture of membranes to relieve high intrauterine pressure and intravenous fluids, together with correction of maternal hypotension may help. If no improvement is seen delivery should be effected immediately.

Results and Discussion

Of the 43 patients that were subjected to intrapartum monitoring, the indications of which are shown in Table I.

TABLE I

Indications for EFM	Number of cases
I U G R	17
Toxaemia	12
Clinical foetal distress	6
Postdatism	5
Previous stillbirth	2
Pregnancy with fibroids	1

Twenty-nine of these patients had no deceleration of the foetal heart rate, whilst 14 showed deceleration. Of the 14 that showed deceleration—

5 showed late deceleration (late FCD)

5 showed variable deceleration

4 showed early deceleration

TABLE II

	Post-datism	IUGR	Toxaemia	Clinical foetal distress	Previous still birth	Pregnancy with fibroids
Early deceleration	1	—	2	1	—	—
Variable deceleration	1	2	—	2	—	—
Late deceleration	—	2	1	1	—	1
No deceleration	3	13	9	2	2	—

Of the 5 that showed late deceleration 4 were operated upon and one delivered normally. The latter was a 2nd gravida with IUGR with previous history of a stillbirth. On admission in labour, the cervix was 8 cms dilated, well-effaced, membranes were absent, presenting part—vertex at station+1. Patient progressed rapidly in labour and delivered a 2 kg female baby. The Apgar score was 5 at 1 minute and 8 at 5 minutes. Of the 4 that required a L.S.C.S., 3 showed an Apgar of > 8 at 1 minute, one of the babies showed an Apgar of 4 at 1 min —baby could not be resuscitated.

Of the 5 with variable deceleration, change in posture to left lateral position and oxygen administration helped in 3. Two of these delivered normally and 1 was assisted by forceps. In 2 patients the line of treatment did not work. These were operated upon as they showed persistent variable deceleration both were primigravidae in early labour.

Of the 4 that showed early deceleration 2 delivered normally, whilst on 2 L.S.C.S. was performed, the operation being resorted to for foeto-pelvic disproportion.

Six of the patients were clinically categorised as having acute foetal distress requiring immediate caesarean section. Of these 2 showed no deceleration on EFM, 2 showed a variable deceleration, 1 an early deceleration and 1 a late deceleration. In 4 of these patients thus a caesarean could be averted due to EFM. Caesarean section was performed on the patient that showed persistent late deceleration and on one of the patients showing persistent variable deceleration. This patient was delivered of a live baby with a true knot and 2 loops of cord round the neck. The one with late deceleration showed multiple infarcts on the placenta.

TABLE III
Mode of Delivery

	Normal vaginal delivery	Forceps	Caesarean
Early deceleration	2	—	2
Variable deceleration	2	1	2
Late deceleration	1	—	4
No deceleration	22	4	3

It is thus seen that there was a higher incidence of caesarean sections in patients who showed late and variable decelerations, and a higher percentage of patients who showed no deceleration had a normal vaginal delivery.

In conclusion it is seen that employment of continuous cardiotachometry obtains information from the foetal cardiac response to the uterine contractions and from foetal cardiac behaviour in between the contractions. The bedside attention of doctors and nurses to the patients is also found to be increased. EFM helps us to predict hypoxia before it has a significant effect on the foetus.

Acknowledgement

We wish to thank Dr. Dina N. Patel, M.D., F.C.P.S., F.I.C.S., Dean, Nowrosjee Wadia Maternity Hospital, Bombay, for the use of the hospital data.

TRADITIONAL MIDWIVES AND FAMILY WELFARE

by

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and

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Introduction

Modern medicine although it exists to some extent in virtually every country, is an option that is often not truly available to most people. Doctors and nurses tend to be concentrated in urban areas, where the ratio is about one doctor per 2000 to 3000 people, yet in rural areas, where 60 to 80% of the population lives, the ratio is one doctor per 40,000 to 50,000 people. As the population grows and doctors emigrate the imbalance becomes even worse in many countries. Traditional midwives on the other hand, practice in almost every village and so are certainly more accessible to most women than either physicians or hospitals. In our country, traditional midwives continue to practice in large numbers and their services continue to be in demand.

Historical Background

Sumerian clay tablets from 2500 B.C. describe Nintur, the "Midwife of the Gods" along with her equipment, incantations and rituals. According to a papyrus of the 19th Century B.C., the birth of Egyptian Royal Triplets was attended by three Traditional Midwives who understood child birth. Throughout the Greek and Roman periods of European History and during the great Islamic Empire of Middle Eastern History midwives apparently practiced along-side University trained physicians without conflict.

Today Governments, International Agencies and Private Institutions have undertaken programmes to train and improve the skills of Traditional Midwives.

(i) In 1952, the UNICEF began to supply simple midwifery kits to Traditional Midwives completing brief training sessions.

(ii) In 1960's, the IPPF began to study the use of Traditional Midwives in Family Planning programmes.

(iii) In 1970's, the WHO undertook an international survey of the Traditional Midwives.

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(iv) In 1980, the USAID, the International Development and Research Centre of Canada, the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians are providing increasing help for projects involving Traditional Midwives.

Personal Characteristics of Traditional Midwives

A traditional midwife is defined by the WHO as a "woman who assists at childbirth and who initially acquired her skills delivering babies by herself or by working with other Traditional Midwives." The Traditional Midwives are called by different names in different countries all over the world.

Name of Traditional Midwives	Country
(1) DAI	INDIA PAKISTAN AFGANISTAN MAURITIUS BANGLADESH
(2) PARTERA EMPIRICA	BOLIVIA CHILE COSTA RICA COLUMBIA PERU PANNAMA
(3) KAMPONG BIDAN	MALAYSIA NEW GUINEA
(4) DUKUN	INDONESIA
(5) MOH TAM YAE	THAILAND

Duties of Traditional Midwives

The work of Traditional Midwives is as diverse as their background. They not only deliver babies but they also assist women during prenatal and postnatal periods, give advice on child care, infertility and contraception, and play important ritual and religious roles.

Prenatal Care

A pregnant woman may visit the Traditional Midwives or be visited by her in early inpregnancy at which time the Traditional Midwife might determine her delivery date, perform her first prenatal massage or advice her on diets, activity levels and sexual relations with her husband. During pregnancy the Traditional Midwives who have a highly developed sense of touch may use massage to relax muscles, relieve discomfort and estimate the progress of pregnancy. As delivery approaches, the massage is used to position the foetus or to loosen the placenta in preparation for delivery.

Labour and Delivery

In most traditional societies childbirth is a social event rather than a medical one. The Traditional midwife is a central figure, playing an active role during labour, delivering both the baby and the placenta and directing others present, in their respective roles. During labour the Traditional midwife may massage the woman and administer herbal beverages, sometimes containing oxytocic ingredients in order to accelerate labour.

One of the most important uses of the Traditional midwife is cutting and dressing the umbilical cord. While a trained midwife always carries a kit containing supplies including scissors, the Traditional midwife often uses equipment found in the house. In India the tool used to cut the cord may depend on the occupation of the family—aknife for feather workers, a sickel for farmers or scissors for tailors. Then the cord is dressed with ghee, dung, ashes or herbal preparations according to the local custom.

Postnatal Duties

In Asia, the Traditional midwife provides help in house cleaning, washing and cooking after delivery, to give the new mother an opportunity for rest and time with her baby. They also perform medical duties by providing herbs and medicines to stop heavy postpartum bleeding or to stimulate the milk supply. They hasten actively the recovery of the mother using massage, baths, binding and herbal medications. In the Philippines, the woman who has delivered is made to lie over a fire for two hours several times a day—this practise is based on the fear that if the body becomes cool after delivery, the ligaments become loose and lax and uterine prolapse and backache will result. These baths will increase the circulation, purify the blood and help the woman to regain her figure.

Rituals

Traditional midwives play an important role in the ritual and religious aspect of childbirth, all the way from using occult means of predicting the sex of the baby to participating in coming of age ceremonies. Disposing of the placenta is almost always the responsibility of the traditional midwife. In Cameroun, one reason that woman continue to deliver with the traditional midwives inspite of sufficient numbers of Government hospitals is to guarantee appropriate disposal of the placenta. In Malaysia, the child and placenta are considered to be siblings. Since it is thought that the two are reunited at death, the Kampong bidan carefully washes the placenta, cord and membranes, and wraps them in a white cloth to be buried in a rose bush. Midwives also bless new infants and try to protect them from evil forces. In the Muslim Middle East, the Traditional midwife whispers sayings from the Koran in the baby's ears. She advises the mother on how to shield her child from the evil eye.

Genital Operations

In Egypt, Sudan and Africa, some Traditional midwives also per-

form operations like "female circumcision" on young girls before puberty.

Fertility—Related Services

Traditional midwives use a great deal of techniques to try to deal with the problem of infertility—including massage to turn a retroverted uterus, warm baths herbal medicines, vaginal suppositories of unknown efficacy and secret rituals. To control fertility the most common traditional methods used by them are abstinence, withdrawl, abortion and breast feeding. More recent studies and surveys show greater knowledge and interest in family plnaning. Traditional Midwives are becoming increasingly aware of modern methods of family planning in areas where family planning programmes exists and some are already providing these services.

Traditional Midwives Training Programme in India

Since the 1950's India has experimented with a number of programmes, at both the national and state levels, training and utilising dais to improve maternal and child health care. A new programme is now planned for 1981 to train some 5,85,000 dais—4 dias for each subcenter—each being paid Rs. 300 during a 30 days training programme and then a monthly sum of Rs. 50 with an additional sum for each delivery and also for each family planning referral. Thus this new programme undertaken at a time when the dai can work with an expanding community health network and when more support will be provided by the Central Government may enable the dais to make an important contribution to improved MCH care.

Traditional Midwives and the Famity Planning Programmes

Successful involvement of Traditional Midwives in Family planning programmes is affected by 8 key factors:—

(1) Government support.
(2) Community support.
(3) Types of Family planning services.
(4) Selection of Traditional midwives.
(5) Training of Traditional midwives.
(6) Supervision of Traditional midwives.
(7) Remuneration.
(8) Evaluation.

Working with Modern Medicines

Conflict and accommodation between modern values and traditional ones is a continuing process. While Scientific evidence and lower death rates are usually on the side of modern medicine—customs, cost and client convenience are frequently on the side of traditional medicine. It is very interesting to note the comments that educated health personnel

make about traditional midwives and vice versa as collected by Dr. Melvin Thorne of the John Hopkins University.

What do the Doctors say?

(1) They are ingrained with bad habits you cannot change, like smearing dirty substances on the cut cord, and squeezing the labouring abdomen and spitting in the baby's eyes.

(2) Their standards are very low.

(3) Many complications of their dangerous practice are seen in the hospitals.

(4) They refer their patients late.

(5) They work by superstitions and magical thinking. Hence they cannot distinguish good practise from bad.

(6) Their homes are filthy and unhygeinic—contributing to infection in the mother and the infant and tetanus in the infant which is often fatal.

(7) Thus they are unhygeinic, unscientific and superstitious old women who jeopardise the lives of mother and child.

What do Traditional Midwives say about Modern Health Services?

(1) The health services give awful care. They treat patients as machines and not as human beings.

(2) They are rude, insolent and give strange treatments.

(3) They hurt and embarass women.

(4) They give pills that make women dizzy and ruin the pleasure with their husbands.

(5) They are irreligious, they do not say prayers or perform rituals to ward off evil fortune.

(6) The health services treat me poorly if we meet.

(7) When a woman needs care often the health services are not available but I am always available to help my women.

(8) They never spend with the woman the time she needs.

(9) These health services are trying to steal my clients.

(10) If they want me to promote contraception what will happen to the deliveries I depend on?

(11) It is dangerous to have dealings with such people.

Present Status of Traditional Midwives

Thus while traditional midwives do not have high status among hospital personnel, medical practitioners, and educated urban people, they are almost always respected in their own communities as a source of information and advice about baby care sexual behaviour, fertility control, and health and related matters. They are very influential in the middle east, Latin America, Indonesia, Malaysia, Phillipines and

Thailand. Only in the Indian subcontinent do most midwives have low status due to cultural concepts of clean and unclean work. In Afghanistan the dai is a skilled, clean, and respected member of the household with a dynamic personality.

Anthropologists who have studied traditional midwives closely describe them as energetic, exceptionally perceptive and able to interpret the social and emotional factors involved in each case.

Last but not the least Dr. John Bryant—Deputy Assistant Secretary of International Health for the U.S. department of Health, Education and Welfare most aptly describes the traditional midwife as follows—"There could be no greater mistake by the human race than to consider the Traditional Midwife as a dirty handed granny with a slovenly and superstitious approach to a procedure that should be neat and sterile. The woman is a priestess. She not only has important technical and domestic skills—she also ensures the sanctity and cultural and religious integrity of the event."

Acknowledgement

I wish to sincerely thank The Dean of Nawrosjee Wadia Maternity Hospital, for her valuable help and guidance.

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MIXED GONADAL DYSGENESIS WITH XO/XY MOSAICISM IN A CHILD WITH AMBIGUOUS GENITALIA

by

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and

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Introduction

The birth of a child with genital ambiguity poses both social and medical problems and requires an early diagnosis so as to assign proper sex for rearing. Ambiguous genitalia (AG) can be due to many different genetic and environmental factors. A correct diagnosis requires a co-ordinated approach by a team of pediatricians, geneticist, surgeon supported by a good steroid and cytogenetic laboratory set up. We report here a case of mixed gonadal dysgenesis with 45,X/46,XY mosaicism in a child with ambiguous genitalia.

Case Report

B/o A.K. was seen at our clinic at 5 days of age because of ambiguous external genitalia (Fig. 1). The mother had not received hormonal therapy during pregnancy and there was no family history of intersex. The mother and father age 21 and 30 years were unrelated.

On clinical examination, the height, weight and head circumference were at the 50th percentile. The infant had a triangular face with a small chin. The right ear lobule was wrinkled. The neck was short, the chest was shield shaped with wide spaced nipples. Examination of other systems was unremarkable.

Genital examination revealed a phallus measuring 2 cm with grade III hypospadius and labio scrotal fusion. A mass 1-2 ml in volume was palpable in the right inguinal region. No mass was palpable in the left inguinal region or scrotum, with these clinical findings the infant was put through a battery of tests.

The buccal smear was negative. Urinary excretion of 17-ketosteroids in 24-hours was normal. Whole blood leucocyte culture revealed a

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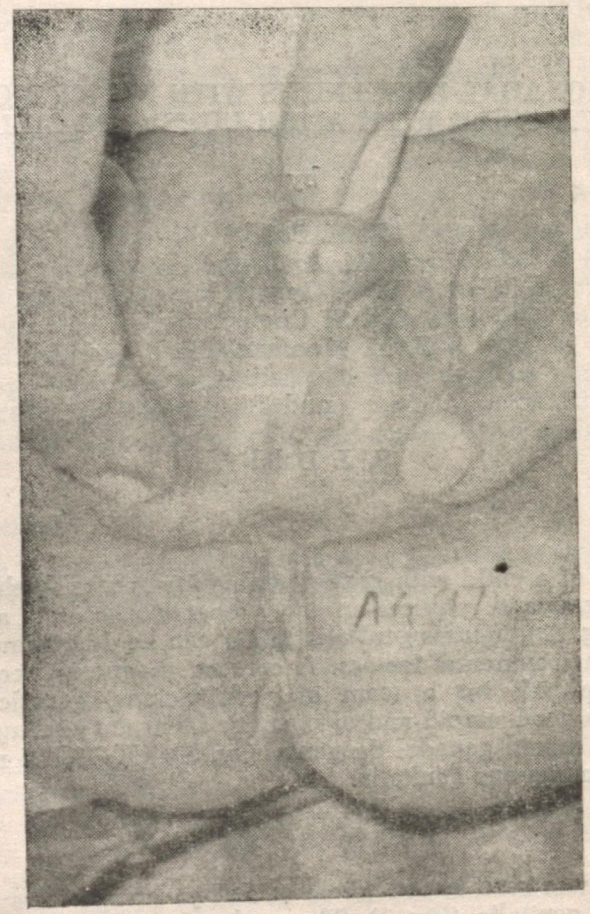

Fig. 1. External Genitalia of A.K.

chromosomal complement of 45,X/46,XY mosaicism of 30 complete metaphases counted (23 had 45,X and 7 had 46,XY). Laparoscopy was performed. A small rudimentary uterus was found. A streak occupied the left adnexa. Histopathologically this streak was composed of connective tissue and dysgenetic testicular tissue. The right gonad on histopathology was normal testicular tissue. The streak was removed due to the risk of malignancy.

Discussion

Mixed gonadal dysgenesis is a form of sexual differentiation disorder usually diagnosed in individuals having clitoromegaly, streak gonad on one side, testis on the other or bilateral hypoplastic intraabdominal gonads, rudimentary mullerian structures with a 45,X/46,XY chromosomal complement.

The dysgenetic gonads in such individuals are defective in inducing the full development of the male external genitalia. Differentiation of the male genital duct system is also impaired as shown by persistence of

mullerian ducts. Therefore individuals with both a 45, X cell line and a Y containing cell line display a variety of phenotypes ranging from near masculinisation with hypospadius, unilateral and/or descent of gonads, cryptorchidism, to females with Turner stigmata,[1-3] as was seen in our patient.

It has been known that the presence of the Y chromosome genetically predisposes the dysgenetic gonads to tumor development. The finding of 45,X/46,XY cell line is clinically significant, because an XY cell line with intraabdominal streak has a 20% risk of malignancy at puberty.[4-8]

The presence of a rudimentary uterus aided us in the diagnosis since uterine development is not associated with other forms of male pseudohermaphroditism.[4]

We believe that cytogenetic studies in patients with ambiguous genitalia, especially those with unilateral descent of gonads is important because there is little doubt that patients with unilateral descent of gonad with a 45,X/46,XY karyotype should be explored and the streak gonad should be removed as early as possible.

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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 Armenian Club, Calcutta, on Sunday 26th April, 1981 at 10.00 a.m.

The following members were present:

1.	Dr. M. Catchatoor ..	President
2.	Dr. J. M. DeSa Souza ..	National Corresponding Secretary
3.	Dr. Dina Patel ..	Secretary
4.	Dr. Dinoo Dalal ..	Editor
5.	Dr. Mehroo Pardiwalla	Secretary—Bombay Branch
6.	Dr. Swarup Mitra ..	Secretary—W. Bengal Branch
7.	Dr. K. Sengupta ..	Treasurer—W. Bengal Branch
8.	Dr. Tulso Basu ..	By Invitation
9.	Dr. Pillai ..	—do—
10.	Dr. Aruna Sengupta ..	—do—
11.	Dr. Urmilla Khanna ..	—do—
12.	Dr. Shanti Indre ..	—do—
13.	Arati Roy ..	—do—

The Meeting started with Dr. M. Catchatoor in the Chair. She welcomed the members of the Council and Dr. DeSa Souza. She apologised for not having the Council Meeting in 1980 for various reasons. She stressed the lack of interest in the Association and felt that more importance and more status should be given to the Association.

1. *Condolence*

Two minutes silence was observed to mourn the sad death of Dr. Shirin Mehtaji, Dr. Dorothy Satur and Dr. Kanak Das Gupta. All three members had been actively involved with the Association and had rendered considerable services.

2. *Apologies*

Apologies were received from Dr. J. Jhirad, Dr. K. Sathe, Dr. Aloo Billimoria.

3. *Confirmation of Minutes*

The minutes were confirmed and signed subject to the following correction:

No. 7—(i) Central Office. "The secretary has met the lady doctors of Akola and Amravati and hopes to start new branches. The President contacted the Women Doctor's Association of Tamil Nadu and hopes to start a branch at Madras.

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

(i) Affiliation fees for 1978 and 1979 amounting to Rs. 12,284.05 at the rate of 5 Sw.Fr. per member was remitted to the MWIA.

Dr. DeSa Souza told the members that there is a proposal from the Birmingham Conference to the Executive Council of M.W.I.A. to reduce the International fees of the underdeveloped countries by 55% and the developed countries to be increased by 10%. This should bring our dues to 2.3 Sw. Fr. after the resolution is passed by the Executive Council in June 1981.

(ii) Office rent was paid at Rs. 30 per month.

(iii) The Secretary requested the Council to increase the monthly payment of the Part-time typist cum clerk from Rs. 50 to Rs. 75. This was unanimously passed.

(iv) The sixth all India Conference was held at Bombay on 2nd and 3rd December 1979. Three prizes were given for the best papers. The theme was 'Family Health'. Detailed report is given in the State Report.

(v) A receipt of the incidental expenses should be sent to the Secretary every year by each State treasurer.

5. Request for Increase in Incidental expenses of the States.

It was decided that the states should retain Rs. 5 per member for incidental expenses.

Life membership of Rs. 500 should remain with the State Branches but they should remit the yearly subscribed amount to the centre for each life member.

It was also decided that one copy of the membership list should be sent to each Secretary of State every year.

A request was made by the Secretary to increase the Association dues from Rs. 30 to Rs. 35 in view of the increase in Journal expenses and other incidental expenses. The members felt that if the international dues were decreased there was no necessity to increase our dues.

6 *Payment of subscription*

The Secretary requested that all branch subscriptions should be sent in by 31st January together with the list of members so as to facilitate the payment of international dues.

The President, Dr. Catchatoor here informed the members that the lady doctors of Madras are forming a branch with 27 members. She was requested by the Secretary to ask the Madras members to remit their yearly dues to the centre, together with the list of members and office bearers.

She was also requested by the members to revive the Delhi branch which had closed down.

7. *Next All India Conference*

It was decided that if the Madras Branch is confirmed, they should be requested to hold the next All India Conference in Madras sometime in November 1982. This Conference should precede the International Conference to be held at Manilla, Phillipines, so that International representative could attend our Conference on their way to Manilla. The International Conference is to be held from 22nd to 27th November 1982.

8. *Council Members of different Branches*

The following council members were appointed by the various State Branches for the year 1981.

(i) West Bengal no. of members 125, Council representatives

(1) Dr. Arti Roy
(2) Dr. Urmila Khanna
(3) Dr. Tulsi Basu
(4) Dr. Shobha Ghosh
(5) Dr. Shanti Indra

(ii) Latur Branch no. of members 12, Council Representation

(1) Dr. Lila Bajpai

(iii) Bombay Branch no. of members 250, Council representation

(1) Dr. C. Alwani
(2) Dr. A. Billimoria
(3) Dr. Tara Chinoy
(4) Dr. Saroj Jha
(5) Dr. Bansri Maniar
(6) Dr. Vandana Walwekar

9. *Nominations for All India Office bearers*

As different names were suggested by the different branches for the office-bearers, it was decided that a voting by ballot be carried out for the election. Only the following posts were uncontested.

(1) Treasurer	..	Dr. Dina Patel
(2) Editor	..	Dr. Dinoo Dalal
(3) Co-editor	..	Dr. Shobha Ghosh Dr. Swaran Arora
(4) National Corresponding Secretary	..	Dr. Juliet DeSa Souza

As per the constitution the President was to have a casting vote.

So far there was one post for the Secretary cum Treasurer. It was here decided to split this post and appoint a separate secretary and Treasurer as per the Constitution. The President also pointed out that as per the Constitution, we should have a Joint Secretary.

It was unanimously decided that the Jt. Secretary be appointed by the President in whichever State the President is, while the Secretary and the Treasurer should be at the centre.

10. The following Reports were read:

(i) Central
(ii) State
  (a) West Bengal
  (b) Bombay
  (c) Delhi
  (d) Latur
(iii) Editor's Report
(iv) M.W.I.A. News
(v) Dr. Jhirad's Library Report
(vi) Lady Hardinge Medical College Report

Reports

1. *Central Office*

Lady doctors of Madras, Akola and Amravati have been approached to form separate branches in their State. All other branches have been requested to have a membership drive.

As the Golden Jubilee Scholarship was not utilised for the year 1978 and 1979 it was given to Dr. Shanti Indra from West Bengal towards her expenses to present her paper at Barcelona. The amount was Rs. 2,400.

11. *State Report*

(a) *West Bengal*

Report of work done at the West Bengal Branch between 1978-1980.

The AMWI (WB) have been engaged in scientific work and also in social service. The activities of the West Bengal branch are as follows:

1. International Year of the Child—

(a) A qualified Pediatrician (honorary) was appointed to work at the Social Welfar and Cancer Detection Clinic twice a week.

(b) The International Year of the Child was celebrated together with the Anniversary Day function of Social Welfare and Cancer Detection Clinic. Miss Nirupama Chatterji, Minister of State, Department of Relief and Welfare, Government of West Bengal presided over the function and Dr. Moni Biswas, the well-known pediatrician was the Chief Guest. In the two-day programme special guidance was given to mothers in Child Care and health education. Immunisation of children was carried out on a large scale.

(c) Seminar on child health was organised by Dr. Shanti Indra under the Chairmanship of Dr. M. Konar. Importance of Breast feeding was highlighted by Dr. Sushil Madan. Interesting data on health of the

school children the immunisation programme and supplementary feeding programme was discussed by Dr. Sushila Kar while Dr. Arati Roy spoke on mother's influence on health of the child. Miscellaneous points were also discussed.

(d) Mr. Udayan Chatterji, husband of late Dr. Anjali Chatterji donated money for organising an Oration in her memory. The first memorial oration was delivered by Dr. S. Gupta, Subject of the oration was "Modern trends in treatment of Cancer". This was a very well attended function.

2. Health Delivery Service: The Association runs a Social Welfare and Cancer Detection Clinic twice a week while health care is delivered once a week to the dwellers of each of 6 slum areas in their own areas every week. During the last 2 years nearly 52868 patients have been treated. Of thes 27871 were children under the age of 10 years. Immunisation of children was an important feature. Family planning advice was given and aids provided to some. Education on community health was also given.

3. Hospital: The Association has wanted to have a hospital in order to be able to treat the seriously sick patients. The opportunity has come now. Dr. Catchatoor's efforts have borne fruit and the Baptist Mission has donated a house which is being repaired and will be converted into a hospital as soon as it is ready. The Government of West Bengal have been very helpful in getting the house vacated from its occupants, the Juvenile Count. The Association records deep appreciation of this gesture from the government.

4. Meetings: During this period we have had the following meetings

General Body	4
Executive	12
Scientific	4
Social get together	3

5. Members of our branch have done creditable work. Dr. Shanti Indra organised the programme for the children's day. Dr. Shobha Ghosh has been actively engaged in Cancer Research. Dr. Arati Roy has been devoting herself to research in methods for family planning. Dr. Swarup-Mitra delivered the Prof. J. B. Chatterjee Memorial Oration of Calcutta Medical Club in 1979. She delivered the Manorama Sapre Oration of Indian Society of Haematology in 1980.

(b) *Bombay Branch*

Report for the year 1979 *and* 1980

Bombay Branch

1979 was a busy year for the Bombay Branch with the organisation of the VI All India Conference.

Meetings

The following meetings were held:

5 Clinical Meetings

2 General Body Meetings

1 Special Meeting

1 Condolence Meeting

(i) First Clinical Meeting was held on 15th February 1979 when Dr. Lalit Ambani, spoke on "Genetics for Medical Practitioners' and Dr. Undevia, spoke in 'Interaction of Malaria and G6PD among the Paris'.

(ii) Second Meeting was held on 17th February 1980 when Dr. Veer spoke on 'Immune Thrombocytopenic Purpura".

(iii) The third clinical meeting was combined with a felicitation held to honour Dr. Homai DaCosta on having received the D.Sc. degree of the Bombay University. This was held on 14th June 1980. Dr. DaCosta is the first lady to receive this doctorate of Science in Nuclear Medicine, from the University. She spoke on 'A lady Doctor in India today—A La Seintigraphy."

(iv) Next meeting was held on 29th August 1980 on 'Leprosy to-day.' The speakers were Dr. S. S. Pandya, Dr. K. Ganapati and Dr. J. K. Maniar.

(v) The last meeting was held on 14th December 1980 when Session I was held on Cytology and the staff members of the Cytology Clinic were felicitated on having completed 10 years of fruitful service. Dr. Usha Sariaya spoke on "Human and Social relevance of cytology services'—A review of 10 year's experience. Session II was a symposium on "Malignancy in Women".

General Body Meetings were held on 29th March 1980 and 17th February 1980.

Social Meetings: A picnic was held on 25th February 1979 at Alibag. It was well attended and enjoyed.

All clinical meetings were followed by high tea or lunch.

Special Meeting

The Association of Medical Women Bombay Branch was registered with the Public Trust in 1977. The scheme in respect of the Trust was settled under Section 50A (1) of the Bombay Public Trust Act 1950, on 8th February 1979, by the Deputy Charity Commissioner, Maharashtra State Bombay.

A special meeting was held on 17th February 1980 to elect Seven Trustees for the Second Board of Trustees for the period ending 31st

December 1982 as per the rules and regulations of the Public Trust No. E.6358 (Bombay). The Trustees were:

Dr. Dina Patel—Chairman
Dr. Shirin Mehtaji—Vice-Chairman
Dr. Saroj Jha—Treasurer
Dr. Mehroo Pardiwala—Secretary
Dr. Sita Tilwani—Jt. Secretary
Dr. Mohini Garud—Members
Dr. Manju Mataliya— „

Because of the sad demise of Dr. Shirin Mehtaji soon after on 9th March 1980, Dr. Bansari Maniar was appointed Vice-Chairman in her place.

Condolence Meeting

A condolence meeting was held on 20th March 1980 to mourn the sudden and sad demise of Dr. Shirin Mehtaji, who passed away on 9th March 1980. A resolution was passed and a copy sent to her family.

Service Project—A medical check-up camp was held in the slum area at Turner Sanotorium Zopadpati. This camp was inaugurated by the then Health Minister Dr. Pramilabai Tople. 1,000 children were examined and were given treatment and tonics and clothes and biscuits. This camp was held in conjunction with N.W. Maternity Hospital and Zonta Club of Bombay II.

VI All India Conference

The VI All India Conference was held on 1st and 2nd December 1979 at Oberoi Towers Bombay. 151 delegates registered. Conference was inaugurated by the Hon. Minister of Health Maharashtra State, Dr. Pramilabai Tople.

Inauguration of Scientific session was done by Dr. Juliet DeSa Souza, and the Scientific Exhibition by Dr. Soman. Dr. Mrs. M. R. Chandrikapure, Dy. Director of Health & Medical Education gave the guest address and Dr. Marie Catchatoor the Presidential address. Dr. Padma Mehta, Bombay Chairman welcomed the guest and Dr. Aloo Billimoria, Secretary Bombay Branch gave the vote of thanks. The theme of the Conference was 'Family Health'. A souvenir was also taken out on the occasion. A panel discussion was held on 'Reaching the Disabled Child'.

The approximate amount of money collected was Rs. 19,600. Audited A/c. have not yet been received and the exact amount will be known later.

Cytology Clinic—A total of 3,433 patients were examined and 6,839 smears processed. Of these 1 had severe displasia, 4 C.I.S., 38 Invasine Ca and 17 unsatisfactory.

The Annual cytology course was conducted in March 1980 and 73 candidates participated. Two of our members Dr. U. Saraiya and Dr. M.

Garud attended the International Conference of Cytologists in Munich in May 1980.

Our Cytology clinic has been approved for accreditation by the Indian Academy of Cytologists Dr. U. Saraiya gave the Indian Academy of Cytology Oration at the 10th Annual Meeting at Hyderabad in October 1980.

The clinic has projects accepted and funded by ICMR and C.P.A.A.

Dr. Shirin Mehtaji, one of the pioneer's of the clinic left Rs. 20,000 in her 'Will' to be presented to the Cytology Clinic. One half of the interest from this amount will be presented to the guest speaker at the Annual Conference of the Indian Academy of Cytologists and the other half as prize awards for Technicians working in the cytology clinic of AMWI.

(c) *Delhi*

There is no report from Delhi as the branch is not functioning. It has been suggested to revive this branch.

(d) *Latur Branch*

Annual report of AMWI Latur for the year 1980

The members of our branch for the year 1980 were as follows:

(1) President: Dr. Mrs. Kuhade

(2) Secretary & Treasurer: Dr. Mrs. Kalka

(3) Members: Dr. Mrs. Bajpai, Dr. Mrs. Deshmukh, Dr. Mrs. Sonvane, Dr. Mrs. Ginolkar, Dr. Mrs. Chavan, Dr. Mrs. Jaju, Dr. Mrs. Asmat Fatima, Dr. Mrs. Shere.

Report

Monthly meeting on every second Wednesday of the month was regularly arranged by each one of us.

Cancer Detection camp was also arranged on 16-9-1980 and 237 cases of gynec. examined and 100 slides taken for cytology. 5 cases were detected as cancer and 6 cases of fibroids and all were operated in municipal hospital free of charge.

Polio and triple injection are carried out in 2 sub centre as before regularly once in a month and 300 doses were given in the last year.

Members of the association has helped 3 in each camp for gynec. examination arranged by Rotary Club, Lions Club, N.S.S. programmes by colleagus, nearly every month in the year 1980.

(iii) *Editor's Report* 1979

As usual all 3 issues for the year 1979 were published. But because

of the delay at the press we could not post the issues on time. The last issue of the year contained all pediatric subjects, as we wanted to make it a pediatric issue for the year of the child. Sorry we could not give it a special get-up because of the expense it would incur.

We have so far had a very poor response to our advertisement appeals and the amount of advertisement received does not even total upto 1/5th of the cost of the Journal. I would request the members of the Editorial Board to make a stronger effort to get more yearly advertise.

I take this opportunity to thank the contributors for their articles, especially some contributions from West Bengal, who regularly send their very interesting articles for our journal and thus make it possible for the Journal to be published on time, and make it interesting.

Thank you,

sd/- D. S. Dalal
Editor

(iv) *M.W.I.A. News*

April 26, 1981

N.C.S. Report

The last Annual Council Meeting of the AMWIA was held in Bombay on 30th April 1979.

The present meeting was to be held in Calcutta in July 1980, but because of difficulties has been postponed to this day.

At the meeting in Bombay held in April 1979, it was suggested to increase the corpus of the Golden Jubilee Fund by adding 10% of the profits of the All India Conference held every alternate year. The All India Conference was held in Bombay on 1st and 2nd December 1979 at the Oberoi Sheraton Hotel was a great success. 10% of the profits will be added to the Golden Jubilee corpus.

The Theme of the Conference was 'Family Health' and there was a panel discussion on 'Reaching the disabled child and a session on Nutrition.'

Three prizes were awarded to the best papers read at the conference to a member of 7 years standing since graduation.

(v) *Report on The Diamond Jubilee Conference of MWIA*

This Conference was held at the Metropole Hotel Complex Birmingham from 17th-23rd August 1980. About 600 delegates participated excluding those from U.K. There were were 76 from Japan and 53 from Korea. The opening ceremony was performed by the Duchess of Glouces-ter who came from her home to the hotel by helicopter.

Dr. Leela Mehra was the Guest Speaker. She is the Medical Officer for Maternity and Clinical Health, with was Dr. Fernandes read Dr. Dina Patel's paper on Laparoscopic Sterilization in Rural Camps and they were amazed at the number of sterilisations done in each camp.

Three general assembly meetings were held. The next Conference is to be held in Manila—November 22-27, 1982. Dr. Enverga Santos, was appointed Chairman of the organising committee. Dr. Carlos Dizon is Chairman of the organising committee and Dr. Lopez Chairman of the Scientific programme. "The theme will be Humane Management in Medicine" and abstracts should be sent on typed forms, obtained from the N.S.C. We have to fill in the nominations for 6 Vice-Presidents. Dr. Catchatoor for Central Asia and Dr. Sano for Western Pacific, are eligible for another term. We might consult Dr. Catchatoor to suggest names for the six Vice-presidents or atleast the country. The annual subscription has been fixed at 2.5 Sw.Fr. for underdeveloped countries and 5.50 Sw.Fr. for developed countries.

There were only 4 registered delegates at the Birmingham Conference from India. Drs. Catchatoor, Fernandes, Mukherjee and L. Sarasa Bharati from Madras who read a paper on 'Mental retardation and its priority in the Health Delivery Systems in India". Two Indian doctors Dr. Walvekar and Dr. L. Krishnaswami Paper's were read by title only.

Dr. Catchatoor presented the Bring and Buy Stall with some articles from Calcutta— and Dr. Fernandes offered Dr. Beryl Corner the President of MWIA with a silver coester on behalf of AMWIA. The Bring and Buy Stall brought in over £2200 for the MWIA.

However, there were very few young doctors probably because of the cost of travelling and hotel expenses. The U.K. doctors had their expenses paid by the Government.

Is it possible for us to start a fund to help sponsor young doctors to read papers at the Conference?

In this connection I received a questionnairs from Dr. Ute Ottem from Claudius Weg. 10, West Germany, who wants to know the following:

1. What is the percentage of members below 40 years of age in your National Medical Wowen's Association.

2. Did you already start activities to affiliate new members? If so, what kind of activities? Were you successful.

3. Which are the special problems and needs of the young, Medical Women in your Country? What kind of expectations exists towards MWIA?

The executive Council of MWIA will meet in Vienna on June 24, 25, 26, 1981.

We must send in our nominations for the elections and any suggestions which may be discussed at the meeting.

(vi) Dr. Jhirad Library—Annual Report 1980

The library is upto-date with most of the recent books. The maximum interest of the members was seen in obstetrics gynaecology and in perinatology. Hence during the year, the library was replenished with the recent books in the subjects. As in the previous years, the library is run without a librarian, though efficiently, Mrs, Suraiya Khan from cytology department helped in issuing the books and kept records.

The following books were purchased during the year.

(1) Post-graduate Obst. & Gynaec.—Krishna Menon et al.

(2) Recent Advances in Cynaec. & Obst.

(3) Year book in Obst. & Gynaec. 1980.

(4) Clinical gynaecological endocrinology—Sparoff.

(5) Perinatology.

Members who are post graduate students are greatly benefited and are taking full advantage of the most modern books available in the library.

Late Dr. Shirin Mehtaji's family has donated some Journals to the library. The books are sent for binding. AMWI is thankful to the family for the generous donation.

The accounts of the library are audited for the year 1980. The auditors report is attached.

I thank Mrs. Khan for helping me in day to day running of the library. I thank AMWI for giving me an opportunity to work for the library.

(vii) Lady Hardinge Medical College Report

Dr. Jyoti Trivedi had informed the President that the government has taken over the L.H.M.C. and the President should write to the governing body to have a representative of AMWI on their Board of management.

11. Statement of Accounts

The Statement of Accounts was not ready and the treasurer informed the members that the audited statement would be circulated and printed in the Journal as soon as it was received.

12. Appointment of Auditors

The same auditors Mama & Co. were to be re-appointed as the Association auditors. A resolution to this effect was proposed by Dr. Dinoo Dalal and seconded by Dr. Sen Gupta.

"Resolved that Mama & Co. be reappointed as auditors for the year 1981."

13. **Any other Business**

(i) It was pointed out that inspite of advertisement in the Journal none of the junior lady doctors were interested in the Golden Jubilee Scholarship award of Rs. 1200 per year. It was suggested that this amount be augmented by adding it to it the interest obtained from 10% of the profits of the conference and the Indian Conference amount be handed over to the centre.

According to one clause in the Golden Jubilee Scholarship award, if the Scholarship is not claimed, the amount of the scholarship may be used for sponsoring the travelling expenses of a delegate to the International Conference of MWIA. For this the following resolution was proposed by Dr. Juliet DeSa Souza and seconded by Dr. Shanti Indra.

"Resolved that the interest from the Golden Jubilee Scholarship Found if not utilised for the All India Scholarship should be used towards the expenses for sponsoring a delegate to the International Conference of the MWIA. The applicant must be a lady doctor under 10 years of standing after graduation and be a member of the AMWI for atleast 3 years and be ready to read a paper approved by the Association, at the Conference."

(ii) It was felt that our constitution was not very clear and as it had not been amended since 1959, it was decided to constitute a committee to go through the constitution and suggest amendments and bye-laws.

The names suggested for the costitution committee were:

Dr. Shobha Ghosh Dr. Shanti Indra	Calcutta
Dr. W. Fernandes Dr. Aloo Billimoria	Bombay
Dr. L. Bajpai	Latur

(iii) The President informed the members that she had applied for the All India Income-Tax Exemption and had received it for the year 1981 under the 80 A.T.G.I. T.A. Exemption Renewal of the exemption would be done end of the year.

The Meeting ended with a Vote of Thanks to the Chair.