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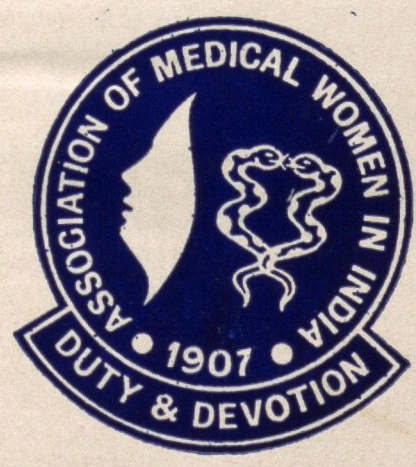
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# JOURNAL

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MEDICAL WOMEN  
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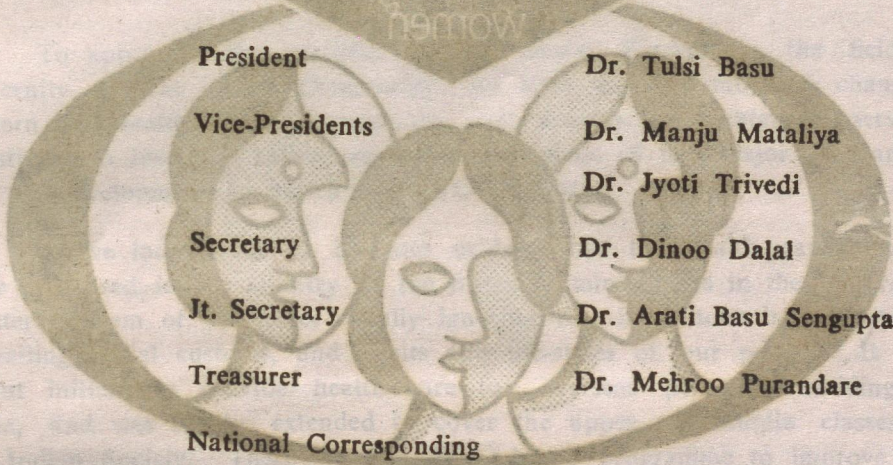
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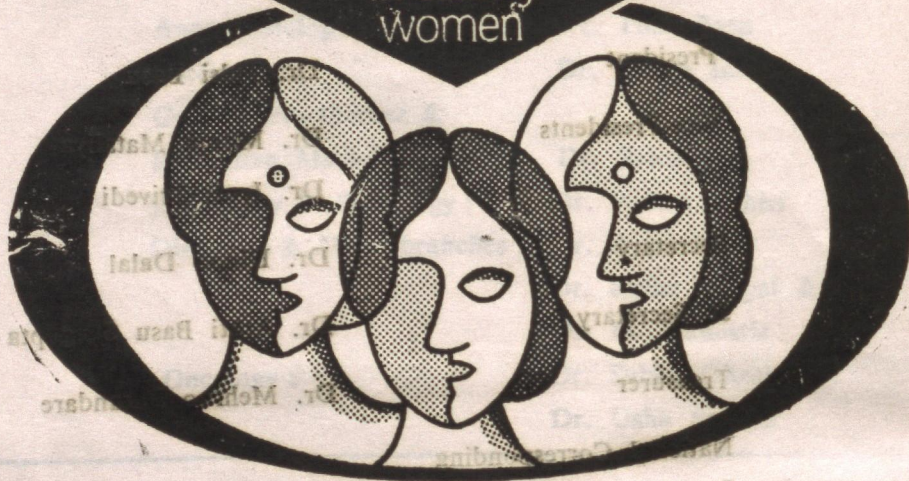
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
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ROLE OF SOCIAL WORKER IN "SAFE MOTHERHOOD"

DR. (MRS.) MADHURI BASU, M.B.B.S., D.P.H., Ph.D., FIAMS\*

To appreciate the possible role of Social Workers in the field of maternity services in the Community, we have to understand the changing pattern of Health Care Services in our country, as maternity services constitute an integral, rather essential component of any major programme for the development of health of the Community.

As we look back, it becomes evident that the health care services were organised in the country by the British administrators in the pattern of Western system of Medicine, totally ignoring the indigenous belief systems, prevailing social customs, and habits and life-styles of our people. It was meant initially to provide health care for overseas personnel residing in India, and was slowly extended to cover the upper and middle classes of the Indian Society. There was no broad-based programme to improve the health status of common people.

The urban-biased, top-down and elite-oriented health care system practised during pre-independence era continued to dominate in planning health care services and in their implementation even after independence. The health care services organised with curative bias led to expansion of existing hospital facilities. Measures to improve environmental sanitation in town and cities received some attention. Immunisation against communicable diseases was practised in areas. The bulk of facilities was enjoyed obviously by the Urban people; the poor, under privileged, rural people derived little benefit.

In this background of continued over-emphasis on Urban-Western oriented, essentially curative health care system, it was but natural that services of social workers would be utilised within the four corners of hospitals. In West Bengal curative and preventive services were integrated at the state level in mid-fifties.

Utilisation of services of Social Workers was thought of, but that was meant only for smooth running of hospital services. Their possible role in

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the delivery of health care in the community at large was not thought of at that stage. MCH services being only a part of the health care system, when the health services themselves are inadequate and fail to reach the periphery, we cannot expect that the underprivileged groups in the community will have the benefit of organised MCH services.

With the concept of Primary Health Care a new era has been ushered in. PHC approach constitutes a qualitative break with the past. It involves, first, the 'understanding' of the health problem, then use of certain policies to translate that understanding into practice, and finally the question of implementation of these policies. These three aspects of PHC approach imply a major social transformation. In the light of this altered strategy the social workers have, no doubt, a role in achieving 'Safe Motherhood'.

The four basic problems lying in our way to achieve this goal are—ignorance, lack of nutrition, ill-health and limited resources of a vast section of our population. To overcome these obstacles, we need a band of workers who are thoroughly conversant with the prevailing social setting and available to the community as friends and helpers in time of difficulties.

These workers may be Medical Social Workers specially trained in behavioural and social sciences, public health and social welfare techniques; or they may be enlisted volunteers, drawn from the community they are required to serve, with practical training of short durations; or they may be members of voluntary social organisations devoted to social work relating to well-being and advancement of women and children.

We must not forget that in the ultimate analysis, health is an individual responsibility, and so every individual has to be made health-conscious through health education. Social Workers can make a vital contribution by imparting health education to women at all levels in the community, by providing information, teaching skills and inculcating values.

We are aware of the valuable services rendered by workers under various community projects. Community Health volunteers under 'Multipurpose Workers' Scheme, Anganwadi Workers under I.C.D.S., Honorary Health Workers under CUDP are but a few examples where such workers have been recruited from the community to undertake many of the health functions previously performed by the medical and paramedical professions. In spite of limited educational qualification these workers acquire adequate skill after a few weeks or months of training. Their work is not merely a job but a social function. These workers have proved themselves effective not only because of their ready availability due to their location within the community,

but also for their cultural affinity with the people they serve. They can spread awareness and knowledge regarding physiology of pregnancy, nutrition, infant and child health, environmental hygiene; they can undertake immunisation and treatment of minor illness including oral rehydration therapy, they can motivate people for family planning to proper spacing of births and limitation of family which constitute a major step towards 'safe motherhood'. Sample surveys undertaken in ICDS project areas from time to time have shown effective MCH services and encouraging results have prompted the administration to open additional units year to year in rural, tribal and urban slum areas.

Before I conclude, I shall present before you a few data in respect of one unit of CUDP III with which I had the opportunity to be associated. The medical programme under the particular project was started in the year 1987-88 (April to March) to cover a population of 30,000 approximately residing within the jurisdiction of north Dum Dum Municipality, after a survey for collection of Base line data.

Services were rendered to the community through a group of social workers at the ratio of one worker per 1000 population, after making them conversant in MCH field work through training of 12 weeks duration.

Within 3 years the project had good impact. The Birth-rate declined from 17.7. to 14.7. The Infant Mortality Rate fell from 121.9 to as low as 26.7. Every expectant mother was immunised against tetanus, and there was no incidence of maternal or Neonatal Tetanus. Table I shows the fall in the Birth-rate during the 3 year period.

TABLE—I

	Birth Rate
Base-line	17.7
1987—88	18.5
1988—89	13.7
1989—90	14.7

Table II shows the fall in the Infant Mortality Rate during the same period.

TABLE—II

	IMR
Base-line	121.9
1987—88	65.2
1988—89	63.4
1989—90	26.7

Both the rates have subsequently more or less stabilised around the value in 1989-90.

In conclusion I may submit that we have found that the community not only takes active interest in the work of these social workers, but also extends full co-operation and support.

The intimacy with which these workers can approach people goes a long way to make them effective and useful for the fulfilment of the role assigned to them.

Before I conclude, I shall present before you a few data in respect of one unit of CUOP in which I had the opportunity to be associated. The medical programme under the partnership project was started in the year 1987-88 (April to March) to cover a population of 30,000 approximately residing within the jurisdiction of North Dam Municipality, after a survey for collection of base line data. Services were rendered to the community through a group of social workers at the rate of one worker per 1000 population after making them competent in MCH field work through training of 12 weeks duration. Within 3 years the project had good impact. The Birth-rate declined from 17.7 to 14.7. The Infant Mortality Rate fell from 121.9 to as low as 67.7. Every expectant mother was immunised against tetanus, and there was no incidence of neonatal or neonatal tetanus. Table I shows the fall in the birth-rate during the 3 year period.

TABLE-I

Year	Birth Rate
1987-88	17.7
1988-89	14.7
1989-90	14.7

Table II shows the fall in the Infant Mortality Rate during the same period.

TABLE-II

Year	IMR
1987-88	121.9
1988-89	67.7
1989-90	67.7

## ROLE OF MASS SCREENING FOR CARCINOMA CERVIX IN WOMENS HEALTH

DR. MEENAKSHI GHOSH *M.B., D.G.O., F.R.C.O.G.\**

### Introduction :

Women's health as part of health of population in general, had made marked improvement with time. Improved health care system, stress on preventive medicine and advanced therapeutics have played their part in this. But malignant diseases still pose a major health problem. There had been extensive research in this field and advancement of therapy but once the disease reaches advanced stage physician can do little to help the patient.

In women, Cancer of Breast and that of genital tract specially uterine cervix have become major killers.

### Incidence :

In Britain, incidence of cervical cancer has been estimated as 15 per 100000 women aged more than 20 years.

**Cancer of Breast**—In England & Wales 12000 deaths occur annually due to cancer breast. It is estimated 1 in 12 of all female children born, will develop the disease during life time.

Uterine cervix is unique in the fact that though it is an internal organ, it is accessible to visual examination and can be subjected to investigation without any invasive technique and this helps early detection.

As cancer is a silent disease at the earliest stage, mass screening would help its detection and minimise development of invasive carcinoma.

For effective control of the disease following measures help :

1. Education and motivation.
2. Setting up large number of clinics for screening.
3. Arrangement for screening by
  - a) Cytology with pap smear
  - b) Colposcopy
  - c) Colposcopy directed liopsy

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\* Senior Visiting Surgeon, Lohia Matri Seva Sadan, Calcutta .

4. Adequate treatment at precancerous, stage 0 and microinvasive stage.

**Education**—Has to be both general and specific.

General level of education is important. We see that women of higher strata of society with better education suffer less.

**Specific**—Women have to be made aware of predisposing conditions such as repeated child birth, and warning symptoms as—

- (i) Unusual discharge (ii) intermenstrual bleeding (iii) Contact bleeding  
(iv) Post menopausal bleeding (v) Menorrhagia and metrorrhagia.

Importance of screening programme has to be taught by propaganda through posters, Radio, T.V. and printed media.

**Motivation**—Health workers would be needed to reach the women extensively and motivate them to participate in screening programme.

**Setting up clinics for screening :**

Ideal would be to set up screening clinics to cover entire female population. As it is difficult to achieve, if all gynaecological & maternity patients attending all the major and minor hospitals are screened routinely and mobile camps are set up to reach women in remote places, a large section of population will be covered.

In a population thoroughly screened by cytology in British Columbia prevalence of invasive Ca Cx were following :

3.5 per 100000 women in screened population

24.1 per 100000 women in unscreened population.

Another study by Fiddler showed :

4.5 per 100000 in screened population

29 per 100000 in unscreened population

Screening had helped to reduce incidence of invasive carcinoma markedly.

1. Some cases may be missed due to false negative results due to :

Lesion being too small with exfoliation of few cells resulting in lack of diagnostic cells in slide—results improved with endocervical scraping.

2. Variation in collection or difference in cytologic expertise.

In a freshly screened population the following result had been recorded :

Ca in situ 2 to 4 per 1000

Invasive cancer 1 to 2 per 1000

Results of Smear are following :

1. Normal Smear
2. Inflammatory cells & metaplastic cells
3. Dysplasia
4. Dysplasia with malignant cells.

In a screening programme carried out by cancer screening centre conducted by Association of Medical Women in India (WB) results were following :

Total number of patients		882
Age	Parity	
Below 20 yrs. — 93	Upto 2	— 495
21 yrs. — 40 yrs. — 637	More than 2	— 387
41 yrs. + above — 152	Upto 12	

**Result of smear--**

Normal	—	357
Inflammatory	—	486
Dysplasia	—	27
Malignant cells	—	12

**Investigation on patients showing malignant cells revealed :**

- Cancer body of uterus — 3
- Cancer cervix — 6 lesions varied from stage I to stage III
- Failed to follow up — 3

Incidence of cancer in this series was pretty high. But this study was not carried out on population at large, but on women attending hospital with some complaint or other.

Rural screening programme carried out by our association showed following results ;

Total number	—	129
Normal	—	62
Inflammatory	—	61
Dysplasia	—	4
Unsatisfactory	—	2

For abnormal smears following routine is followed :

Inflammatory cells—treatment of inflammation—Smear repeated.

Dysplasia or doubtful smear — repeat smear — if doubt persist — biopsy.

Positive Smear — Confirmation by biopsy.

Ideally cytologic screening should be carried out in following manner :

All women — once every year

Abnormal lesion — 3 monthly — then two 6 monthly — subsequently yearly if smear continues to be negative.

If positive or becomes positive subsequently — biopsy followed by hysterectomy, where indicated :

#### Colposcopy—

Colposcopy evaluates the changes in terminal vascular network in cervix which reflect biochemical & metabolic changes in the tissue.

1. Pinpoint the area with neoplastic changes.
2. Evaluate extent of lesion & obtain directed biopsy.
3. Helps in differentiating between inflammatory atypia & neoplasm also indicates presence of invasion.
4. Helps establishing diagnosis in positive or doubtful smear.
5. Helps in selection of cases of Ca in Situ suitable for conservative management.
6. Helps in follow up of treated cases.

#### Findings on Colposcopy—

Normal — normal squamous epithelium and squamo columnar zone visualised.

Abnormal—Mosaic, punctate, white epithelium, keratosis or atypical blood vessels visualised.

Coppleson et al had positive results in 321 cases of preclinical Ca Cx as follows :

Colposcopy	—	92%
Cytology	—	93%
Combined	—	98%

#### Treatment—

1. Conservative surgery
2. Hysterectomy

**Conservative surgery :—**

Conservative surgery has a definite place in treatment of dysplasia or cervical intraepithelial neoplasm. Incidence of CIN in European women more than 25 years — 0.2 — 0.4%. Not more than 20 — 30% of these become invasive.

In another study by a panel of pathologist appointed by Royal College of obstetricians & gynaecologist, examined material from more than 700 cases on which firm diagnosis of CIN had already been made & acted upon in some of the best & experienced units in Britain, assessment of panel was :

No Ca in Situ — 30% Free of any lesion 17%

Varying degree of C.I.N. 17% Unsatisfactory 9%

It is not justified to go for radical surgery whenever C.I.N. is diagnosed.

Conservative surgery is indicated in younger women specially who are desirous of further child bearing.

**Methods**—Electrodiathermocautery — it has to be made sure whole of lesion including the margin is cauterised. Disadvantage—damage to healthy tissue.

Laser therapy — lesion is adequately treated without damage to surrounding tissue.

**Amputation or Conization of cervix**

Conization includes the whole area including endocervical canal. Disadvantage is that it is more traumatic and there is chance of cervical incompetence or cervical dystocia in future pregnancy.

In pregnant patients if colposcopy reveal the lesion to be strictly intraepithelial treatment can be deferred till six months after delivery.

**Hysterectomy :—**

**Indication—**

1. Older women after 40 yrs, specially where regular follow up is not guaranteed.
2. If smear becomes positive after conservative surgery.
3. If microinvasion is present.

Removal of vaginal cuff is not necessary unless there is intraepithelial neoplastic changes in the tissue of vaginal vault.

Follow up is most important in all form of treatment & it has to be interminable.

**Conclusion :—**

There is no doubt if ideal could be achieved and whole female population could be screened and adequately treated we would really be able to control invasive Ca Cx. Alternatively if stress is laid on screening programmes and practiced extensively incidence of invasive Ca Cx would be minimised.

**Reference :**

1. Baily. H & Love M. Short Practice of Surgery 21st edition. 805.
2. Feroze R. M. Integrated Obstetrics and Gynaecology 2nd edition 74, 741, 742.
3. Jeffcoate Sir N. Principles of Gynaecology 5th edition 398, 404.
4. Staff A and Wilkinson E. J. Recent advances in obstetrics & Gynaecology 13th edition 263, 265, 269.

## POLLUTION OF OPERATION THEATRE BY THE ANAESTHETIC GASES AND ITS HAZARDS

DR. SANDHYA SAHA, D.A., M.D.\*

The ambient atmosphere of an operation theatre is often filled with the anaesthetic effluent vapours and gases like ether, halothane, trichlorethylene nitrous oxide when it comes out through the expiratory heidbrink valve.

An anaesthetist who is sitting nearer to the source of contamination is mostly exposed to the chronic inhalation of trace amount of anaesthetic gases and vapours. The exit flow pattern of the expiratory valve is such that a fair amount also passes to the surgeon's nose. The E.N.T. and dental surgeons are affected most. The other persons working in the theatre like nurses, assistants even the recovery room nurses are also exposed to the polluted atmosphere. There is an increased global awareness about the environmental pollution. So in the fitness of the situation this subject has been chosen for discussion.

### *How Much Pollution is There ?*

It was estimated in two ways

- i) Measuring the exhaled air of anaesthetist
- ii) Measuring the O.T. atmospheric air, Corbet in 1973 was able to detect traces of halothane in the expired breath of anaesthetist for 7th to 64th hour and  $N_2O$  for 3 to 7 hours following occupational exposure.
- iii) Halothane concentration in the theatre air ranged from 4.9 PPM to 15 PPM at 0.2 to 1% Vapouriser setting,  $N_2O$  130 PPM and diethyl ether 20 to 500 PPM by open drop method. Even the corridors outside the theatre were found to contain 0 to 4 PPM of ether.

So to observe the effects, nationwide surveys were conducted. The earliest one was in Russia 1968, Others are Denmark 1970, U.S.A. 1971, U.K. 1972, Finland 1974, India 1973 and some other observations by other workers. The persons included were surgeons, anaesthetists, O.T. Nurses, physicians, wives of surgeons, Housewives, Intensive care unit nurses, other O.T. assistants, ward nurses. Study was done by sending questionnaire, measuring exhaled

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\* Professor, Department of Anaesthesiology, Medical College and Hospitals, Calcutta.

air from the nose, measuring operation theatre air and venous samples. Apart from gases other factors like O.T. environments, airconditioning, ventillation, scavenging and working hours were also included.

All the tables and surveys to be described in this article have been taken from National Survey India 1973 conducted by Dr. A. K. Badve and Dr. Mirakur from P.G.I. Chandigarh.

#### *What are the Effects of these Chronic Inhalation ?*

Possibility of the teratogenic effect of inhalational anaesthetics were first reported by Rector and Eastwood in 1964 which they proved on chick embryo by experimental method. The awareness of the fact that silently and artificially we are creating an polluted atmosphere and affecting ourselves are growing in Soviet Union, U.K., Denmark, U.S.A. and in our country also. A few surveys have been conducted in India and abroad. The observations were about the following factors :—

- (1) Professional performance
- (2) Cause of death
- (3) Incidence of chronic ailments
- (4) Reproduction.

#### *Professional Performance :*

Salvini and his co-workers selected six male student volunteers and they were exposed to 110 PPM of trilene for two period of 4 hours separated by an interval of 1½ hour in an air-conditioned theatre of 48 cm<sup>3</sup> capacity. The conc. of trilene was about the maximum that has been measured near the anaesthetist's nose during the administration. They observed the reduction in performance in tests of perception, memory, reaction time and manual dexterity.

Wertham observed same symptoms in anaesthetists, surgeons and nurses who worked for many years in operation theatre where ether was used. The symptoms were depression, fatigue, headache, anorexia, nausea and loss of memory. The Symptoms disappeared after six weeks vacation and did not reccur after installation of ventillatory equipment in the operation theatre.

#### *Cause of Death :*

In different retrospective and prospective studies of Bruce 1968, Adhoc committee of ASA 1974 a relatively high death rate due to malignancies of lymphoid tissue and reticuloendothelial tissues were found among anaesthetists.

Fig. I. Incidence of Systemic Diseases in Different Groups.

Systemic Disease	Anaesthetists	Surgeons	Physicians
Allergy	22.4%	16.0%	9.0%
Cardiac disease	6.4%	2.5%	2.0%
Respiratory disease	11.2%	3.5%	2.0%
Renal disease	8.0%	0	1.0%
Metabolic disease	2.4%	0	0
Jaundice	14.4%	7.5%	4.0%
Infective hepatitis	17.3%	9.5%	4.0%

Fig. II. Incidence of Chronic Ailments in Different Groups.

Chronic Ailments	Anaesthetists	Surgeons	Physicians
Backache	23.2%	13.5%	4.0%
Headache	25.6%	7.5%	3.0%
Hyperacidity	27.2%	3.5%	6.0%
Weakness	20.0%	1.5%	1.0%
Arthritis	3.2%	0	0
Insomnia	2.4%	0	0
Loss of appetite	4.8%	1.5%	0

A big and elaborate national survey was done by Late A. K. Badvo and Dr Mirakhur at P.G.I. Chandigarh in 1973. A portion of their observation is shown here. The incidence of chronic ailments in anaesthetists were compared with surgeons and physicians. They are all high specially allergy, infective hepatitis, backache headache, hyperacidity, weakness. From these observations we have strong reasons to believe that working in an atmosphere of pollution by anaesthetic gases and vapours in the O.T. could be hazardous to them and other theatre personnel. There are also other big surveys.

*Reproduction :*

Few big surveys were conducted about Obstetrical and Gynaecological problems amongst the lady anaesthetists, O.T. nurses, lady physicians, wives of anaesthetists and Housewives. The incidence of abortion, premature labour, nature of delivery, congenital anomalies and sex ratio of their children were studied.

In U.S.A. (1971) Gohen observed the incidence of spontaneous abortion rate was 29.7% in O.T. nurses 37.8% in anaesthetists whereas only 8.8% in general duty nurses and 10.3% in physicians.

Fig. III *Obsterical History :*

	Anaesthetists	Physicians	Housewives
No. of Pregnancies	73	86	169
Abortions	16.4%	5.8%	8.8%
Premature Labours	4.1%	1.1%	1.7%
Stillbirths	2.7%	0	1.7%
Toxaemias	10.8%	4.6%	8.9%
Placental insufficiency	2.7%	0	0

Our national survey shows the incidence of hyperemesis, toxaemia, placental insufficiency, abortion, premature labour, still birth is more in O.T. personnel as compared to others.

The purpose of this article is not to discourage us from practising the specialities of anaesthesiology but

- (1) To make the people conscious about its hazards.
- (2) To draw attention of the administrators about better ventilation and antipollution measures in the O.T. like gas traps and scavenging systems. Unhealthy environment will lead to fatigue with loss of efficiency and an increasing incidence of mistakes and errors of judgement.
- (3) Working hours of O.T. personnel should be limited, extra leave and compulsory vacation may be granted.
- (4) More use of closed circuits, regional blocks and less use of volatile agents are advocated.
- (5) Service of anaesthetist should be declared hazardous profession, risk allowance should be sought.

One more point to be noted, is that all these surveys were done long time before. Recent edition of text books have spoken softly about this complication. The reason may be that the Western world have taken up the suggestions and improved the situation. But in SARC Countries the situation is still bad. So, much campaigning is needed on this problem.

References :

1. Corbett, T. H. (1973)—Anaesth. Analg. Curr. Res. 52, 614.
2. Rector, G.H.M. Eastwood (1964)—Anaesthesiology 25, 109.
3. Salvini, M., Binaschi, S & Riv, M. (1971). Brit. J. Indust. Med. 28, 293.
4. Wertham—I.J.A. Edit. 1972 Vol. 20 No. 4.
5. Bruce, D. L. et al (1968) Anaesthesiology 29, 565.
6. Cohen, E. N. et al (1974)—Anaesthesiology 41, 321.
7. Badve, A. K. Mirakhur, R. H. (1973)—I. J. Anaesthesia, Vol. 21, No. 3, p. 308.
8. Cohen, E. N., Belville, J. W. & Brown, E. W. (1971), Anaesthesiology 35, 341.
9. Pramanik, S. (1973)—Edit. I. J. Anaesthesia, Vol. 21, No. 4, p. 305.
10. Mirakhur, R. K., Badve, A. K. (1973) Vol. 21, No. 4, p. 315.
11. Recent Adv. ; Churchill & Livingstone, Edinburgh, London, New York 1976, No. 12.

## WOMEN DOCTORS IN INDIA

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NITA BHOGILAL, *M.D.*

MEHROO S. PARDIWALLA, *M.B.B.S., D.C.H. (Lond.)*

Prior to 1880, there were no medical women in India except isolated Missionary workers who came to India and living under very strenuous condition rendered medical aid to women and children. The Purdah system was very strict not only among the Muslims but even among the high caste Hindu Families especially in the north. Women in child birth died by thousands refusing medical attendance by male doctors and were attended by untrained dais and ayahs and maternal and foetal mortality was very high.

With a view to uplift the status of women and improve their welfare, the Medical Women for India Fund was formed by influential philanthropists in 1883 in Bombay. An American businessman Mr. Kitredge, Mr. Sorabjee Bengalee, Mr. Suleman and several others.

The Objects of the fund were—

- (1) To get medical women from abroad to work in Bombay.
- (2) To open a Hospital for women and children staffed entirely by women.
- (3) To train Indian women at the local University on equal terms with men.

At the same time, Mr. Pestonji Cama offered a generous donation to build a Hospital for Women and children on condition that Government provided the site for the building and took over the maintenance and placed the hospital under the charge of women doctors. The present site of Cama Hospital was chosen and the foundation stone laid in November, 1883.

Dr. Edith Peechy Phipson, *M.D.* was the First British woman to be brought out to India with the purpose of setting up facilities for treating women and training Indian women to take over.

She started working in a dispensary at first, awaiting the opening of Cama Hospital and became the first Superintendent when the hospital was first opened in August, 1886. She was a woman of talent, education and experience and soon attracted patients from Bombay and surrounding areas.

About the same time 1885, the Countess of Dufferin Fund also known as the National Association for supplying aid by women to women came into existence. Queen Victoria on hearing the plight of Indian women who refused to be treated by male doctors requested Lady Dufferin to look into their needs. On arrival in India Lady Dufferin started the Countess of Dufferin Fund through which women's hospitals were opened in India to be staffed by women doctors only. These Hospitals were very isolated and medical women had to work under very unsatisfactory conditions. In these days, though Medical Colleges existed in Madras, Bombay, Calcutta, Agra, authorities were reluctant to take ladies, and hospitals for women were finding it difficult to increase their staff. In 1872, four woman students were admitted to the Madras Medical College for the first short certificate course. It was only in 1881 that the first woman was admitted for the L.M. & S. of Madras University. In 1885, Medical School was established at Agra and had a class for women with a separate women's department. In Bengal, medical education for women started later than in Bombay.

In Bombay, the first medical woman to join the Grant Medical College and pass L.R.C.P. in 1887 was Dr. Motibai Kapadia and one among the first few in Bombay to obtain F.R.C.S. Ireland (1891—92). Later she joined the Victoria Jubilee Hospital for Women and Children in Ahmedabad and gave forty years of meritorious medical and social service to the people of Ahmedabad, Gujarat and Kathiawad. She was the recipient of Kaiser Hind Silver Medal.

Others from the same group were Ratanbai Malabarwalla, Aimai Treasurywalla, Dhunbai Master and Miss Bradley. However, the first Indian woman to qualify as a doctor was Dr. Anandibai Joshi. She had been sent to Philadelphia School of Medicine through the help of Missionaries. She passed the M.D. degree in 1886 at the age of 21 years, but unfortunately she died of Pulmonary Tuberculosis soon after returning to India. Among the other earlier doctors were Rukhmabai and Dr. Emmeline de Cunha Da Costa. Dr. Rukhmabai was encouraged to go abroad and study at the London School of Medicine by Dr. Peechey Phipson, took M.D. degree from Brussels University in 1895. On her return to India, she did pioneer work at Surat and later at Rajkot encouraging young widows to come up for training in Nursing.

The hospitals opened by the Dufferin Fund were manned at first by medical women from abroad mostly from Britain and later by Indian doctors. These doctors felt isolated and the need to keep in touch with medical literature and other doctors was felt keenly and prompted them to form an association.

Thus, the A.M.W.I. was formed in Bombay under the Presidency of Dr. Anelle Benson, M.D. (London) at the Cama & Albless Hospital in 1907. India became the first country in the world to have an Association of Medical Women. The International Association was organised in 1919 in U.S.A., to which our Association is affiliated. Through the association, pressure was brought in the Dufferin Fund Committee to have a Medical woman as Co-Secretary to look into the grievances of the doctors working in the Dufferin Hospitals and by 1914 a scheme for starting the Women's Medical Services was presented. The W.M.S. was started in 1914 and thus the A.M.W.I. was able to help in providing a unique opportunity for women to work in organised service. Dr. Margaret Balfour was appointed the first Chief Medical Officer. After partition the W.M.S. was disbanded.

Our Association also sponsored the opening of the Lady Hardinge Medical College & Hospital at New Delhi in 1916. A residential college for women students only, staffed entirely by women and more women began to enter the field of Medicine. Dr. Hilda Lasarus was the first Indian woman to be appointed to the W.M.S. In 1940, she became the Principal of Lady Hardinge Medical College and about 3½ years later Chief Medical Officer of the Women's Medical Service of India and continued as C.M.O. till W.M.S. was disbanded. It was through her efforts that during the second World War medical women were accepted in the services and even sent to base hospital.

About the same time foundation of another famous college and hospital, Christian Medical College & Hospital of Vellore was laid by Dr. Ida Scudder, spurred by the plight of Indian women refusing medical aid from male doctors. She studied Medicine in U.S.A. and returned to India in 1900 and started practice in Vellore and nearby villages. In 1918, she started Lower grade Medical School for Women. Later a new 267 bedded Hospital started in Vellore Town, became the Vellore Branch of Madras Maternity and Children's Association in 1932. In 1947, was granted affiliation to Madras University with the admission of male students and patients. Today from a Medical School for Women only, it has developed into a co-educational medical college and hospital through the efforts of a great and noble doctor. She was an eminent Surgeon & specialised in repair of V.V.F.

The Women's Christian Medical College in Ludhiana came into existence in 1894 because of the efforts of another Missionary Doctor Dame Edith Brown, later it was made co-educational.

Keeping up with modern developments our Association took up seriously the promotion of Maternal and Child welfare by 1929 and later agitated for

the post of Professor of Maternity and Child Welfare at the All India Institute of Hygiene & Public Health at Calcutta to be chaired by senior women from W.M.S.

Investigations were also started on maternal mortality, anaemia, still births, neonatal deaths and functional uterine haemorrhage. In 1936, Dr. Bhatia was posted at the All India Institute of Public Health in Calcutta to conduct inquiry in to the causes of maternal deaths. Inquiry revealed sepsis and anaemia as the major contributing factors.

To mention some of our Indian doctors who have inspired us Dr. De Monte, Dr. Dossibai Dadabhoy, Dr. Awabai Mehta, Dr. Jerusha Jherad, Dr. Hilda Lazerus, Dr. Wadia. Dr. Dossibal Dadabhoy was the first Honorary Consultant to be appointed at Cama & Albless Hospital. She was the first woman doctor in Western India to possess and use radium and did pioneering work in malignancy and functional haemorrhage.

Dr. Jerusha Jhirad was born in 1891. She passed her L.M.L.S. in 1912 from Bombay and obtained her M.D. from London University in 1919 in Obstetrics and Gynecology. Her childhood dream of becoming a doctor and work in Cama and Albless Hospitals was realised when she was appointed as the first Indian Superintendent of the Hospital in 1929. She started Post-graduate teaching and was the first woman to become the examiner for M.D. in Ob. & Gy. of the Bombay University and it was during her time that Cama Hospital was recognised for the M.R.C.O.G., London. Students from all over India vied with each other for training at the Cama & Albless Hospital.

Her enquiry into maternal mortality, papers on puerperal sepsis, A.P.H., Pelvic disproportion, ectopic pregnancy, V.V.F., and Caesarian sections are still quoted as references. She was awarded the Padma Shree in 1966. The Association also owe deep debt of gratitude to our Past Presidents Dr. Desa Souza, Dr. W. Fernandes. The Cancer Detection Centre was started at Cama & Albless Hospitals because of their untiring efforts and guidance.

In 1981, the West Bengal Branch inaugurated their Mission Hospital of 50 beds in Calcutta. It was started because of the constant and untiring efforts of Dr. Marie Catchatoor (past President, A.M.W.I.) and the member of A.M.W.I. ( West Bengal Branch.)

The A.M.W.I. has contributed a great deal to the advancement of women in Medicine and maintaining the high status Indian women doctors enjoy today. Women doctors in India are distinctly in a better position

than Lady Doctors in developed countries. There is no discrimination against a well-qualified woman's appointment to the higher position. We have woman specialists in all branches of medicine. There does not seem to be a single branch which medical women have failed to enter. Women doctors are holding responsible administrative posts such as Health Ministers, Director of Health Services, Public Health, Medical Education & Research, Deans of Medical Colleges. Present Deans of all the three Municipal Hospitals & Colleges in Bombay are Women.

Our Present President of A.M.W.I., Dr. Dina Patel has been the first lady to be appointed Dean & Director of the Post-partum programme of Nowrosjee Wadia Maternity Hospital in Bombay.

In the scientific field, credit goes to Dr. Indira Hinduja, then working at K.E.M. Hospital, Bombay as the first Indian Lady Doctor for the birth of the first scientifically documented I.V.F. baby born on 6th August, 1986. The work on I.V.F. was started in 1982 in collaboration with Institute of Research & Reproduction (IRR), Bombay.

In the field of social work Dr. S. Reddy of Madras one of India's pioneer social workers was awarded the Padma Bhushan for her pioneering work in improving conditions for women and children.

Recently, Dr. Banoo Coyajee a Practising Gynecologist and Obstetrician of Poona and an eminent worker in the field of Public Health had been conferred the prestigious Magsaysay Award in Manila on 31st August, 1993. The award was in recognition of her life-long work to improve the lot of rural women in India.

To end, the achievements of women doctors in India bring to mind the following quotation of Sir William Oster—

"In the continuous remembrance of a glorious past individual and nation's find their noblest inspirations."

In 1931, the West Bengal Branch inaugurated their Mission Hospital of 50 beds in Calcutta. It was started because of the constant and unending efforts of Dr. Marie Cachator (past President, A.M.W.I.) and the member of A.M.W.I. (West Bengal Branch).

The A.M.W.I. has contributed a great deal to the advancement of women in Medicine and maintaining the high status Indian women doctors enjoy today. Women doctors in India are distinctly in a better position

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## ADOLESCENCE PSYCHOLOGICAL AND SOCIAL PROBLEMS

DR. AJITA CHAKRABORTY\*, *MBBS, DPM, FRCPE, FRCPsych*

The psychological transition period from childhood to adulthood, that is adolescence, may start from the physical dividing line of puberty but its end point is blurred. Our body knows the passage of time well, it develops, it grows, and then it decays. But mentally time is not perceived in relation to bodily changes. That one has grown old is often realised by seeing friends after some interval, as old! If that confusion can arise after such a long period, it will be understood—how confusing the transition from childhood to adolescence to adulthood can be. We all carry our childhood with us to a different extent. The child's mental format in the growing body causes problems and conflicts with the surroundings. Through these conflicts the child learns to adjust, and finds the limits. This horizon is flexible, it may expand or shrink, or remain static. To develop and adjust one's potentialities and capabilities with the world around may be called psychological growth.

The child starts with a limited horizon. She (or he) is lived and protected within the family, which she feels as under 'her command'. She is the centre of all attention, she can demand and get all she wants. She is helpless, at other people's mercy, yet at the same time powerful. Children have this sense of omnipotence. Outside world does not exist for them, they do not have to 'do' anything—just being there makes everybody happy. When school starts, siblings arrive, she is gradually made aware of others, but she is still merged with those around her, particularly mother. Puberty is a painful awakening from this bliss. She now has to share everything and is required to contribute—do something according to her capacity—be it helping the mother or singing in the school. She realises there are aspects of herself—which makes her appear in certain ways to others. Everybody may not appreciate or like her, as they do at home. She may start feeling nobody likes her. She may feel she is always at fault and everybody sit on judgement on her. The society's demand that she act as a separate person, makes her feel unhappy and lonely. All growing children have this feeling of loneliness in them. However, just the opposite may also happen. The

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\* *Retd. Professor of Psychiatry and Director of Postgraduate Medical Education and Research, Calcutta.*

omnipotent feeling, that she is the centre of the world may never disappear and adolescence may be approached in this queenly : (or princely : ) fashion, when she expects the world to be at her feet all the time. Such a child is likely to face great difficulties in later life.

With growth of the body, and advent of puberty, other disturbing feelings appear. Sex becomes an important, perhaps the overwhelming aspect of life. The urge to excel, do better than others, that is, competitive spirit and desire for success appear. Earlier these used to be encouraged in boys and suppressed in girls, but that is no longer the case. Feeling of being grown-up gives a sense of power and importance to self. The urge to establish oneself as a separate, independent and wilful person becomes very strong. In the old days girls did not have any option to conduct their own lives. They could only get married and raise a family. Post pubertal changes and personality formation did not have any social implication. But today, the situation is very different. The girls are growing up to be responsible persons, who are not second class beings.

To sum up, it can be said adolescence is the time frame in which the child comes out from being ensconced in the family's bosom and faces the outer world. Life will naturally depend on the way he or she is equipped or prepared. Family has its own set of rules and the child inspite of its self-centred ways blend with it. But the world outside has different rules, which is changing all the time. Unfortunately, the adolescent gets very little guidance either from the parents or teachers or other elders at this critical juncture. There is a deep seated desire to remain the child and be looked after, but at the same time they want independence. Most parents are equally confused and are unable to guide their children to achieve a stable personality, free of fears and anxieties.

The transition period is more difficult for the girl child. She has at this time an uncomfortable body. Breasts get into the way for games. Menstruation gives pain, headaches, discomfort and embarrassment. She feels everybody knows what is going on and shuns her (which is true for religious rituals). Irritation, moodiness and fatigue are complained of. For boys at puberty there is positive gain in strength and vigour. The girl feels she is on the losing side, she has become a woman and must wait for marriage to find her fulfillment: Fear, anxiety, and a sense of inferiority make the girl temperamental. She feels she can assert herself only by being negative, that is by saying 'No'. A thirteen year old has that as a fixed answer for everything, as all mothers of girls of that age know. She does not know

what she really wants, but it is definitely not what the parents want. Associated with this negativism there is a general moodiness and dissatisfaction which often hide deeper psychological problems. Mother and daughter are found to be at loggerhead with choice of friends, dress and (particularly) music. Some mothers refuse to accept that the world is changing and what was ideal in her days is not so in her daughter's. Peer group pressure meaning judgment of friends, are now much more than it used to be, when the family's opinion was all that mattered. Besides conflict on conduct, the other areas that give rise to constant battles are career and studies. Many mothers have their own career and aspiration frustrated which they try to fulfill through their daughters. Undue pressures are brought on the young girl to do everything perfectly, from studies to sports, to dancing to art. The girl may have no aptitude for these, but often tries hard to satisfy mother. The 'good and clever' girls are more vulnerable. They are usually highly pampered from childhood, and get unrealistic assessment of their qualities. When pushed to the limit by high expectations (of their own and of others) they become nervous wrecks before examinations. Examination phobias have reached an endemic proportion now a-days.

The question of morals and values are intimately related to the process of growing up. But this area has become confused and controversial. Today's parents of teenagers are around 'forty to fifty years in age, most of whose parents are alive and active. Conflict surrounding that generation gap is more acute than that of the next. Parents of adolescents are busy building their careers, adopting methods and means, which are not what can be taught to children, to say the least. Sexual permissiveness, unfair means, even if it is not called corruption, has become the norm of life. Who can say what is wrong or right? Added to this there is blatant commercialisation of life and onslaught on our sensibilities by naked display of destructiveness and violence. There is no doubt that TV is having a pernicious influence on the youngsters. Aggressive acts and violence had always been there, but the recent spate of senseless and bewildering crimes committed by innocent, middle class boys and girls are new and had not been experienced by the society before. In real life, unlike in Hindi cinemas, there is no triumph of the good over evil in the end. Permissiveness in the sexual area has brought on the scourge of AIDS. The very casual attitude to sex, abortion and divorce all contribute towards undermining of the family as a system. The Indian society has not gone as far as the West in this matter but the pressures are there. At this juncture we have to ponder whether the youngsters are going wrong or we the elders are :

## EARLY DETECTION AND DIAGNOSIS IN CANCER BREAST

PROF. URMILA KHANNA\*, M.S. (Cal), F.R.C.S. (Edn. & Eng.)

FICS, F.A.I.G.P., FAIMS, FAIS,

### Introduction :

Carcinoma of the breast is the most common site specific neoplasm in women and is the leading cause of death from cancer in female within 42-44 years of age. Breast Cancer comprise 26% of all female cancer and is responsible for 18% of cancer related death of women. Incidence of Cancer Cervix is highest in our country, next comes Breast. Mortality in breast cancer has remained stable, whereas the overall incidence of disease has gone up all over the world, so it is with India.

Breast Cancer is a common disease, nearly one out of every 1000 women suffers from this disease and 50% of them succumb to this. Although women recently report suspicious mass earlier to their physician, the mortality rate remains high and directly relates to the stage of disease as to the age of patients.

(1) For early detection of Breast Cancer women themselves have tremendous role. Intelligent women could definitely notice that slightest change in the Breast, particularly while washing or dressing themselves, thus a woman can notice the following :—

- (a) Presence of palpable lump in different quadrant of breast (known as self examination (A. C. S.))
- (b) Thickening of the part of the breast or axillary tail.
- (c) Presence of discharge per nipple other than lactating mothers—in the form of blood, serosanguinous, brown or greenish in colour.
- (d) Retraction of nipple or areola.
- (e) Shrinking or increase of girth of breast.
- (f) Presence of an abnormal swelling in the axilla of same side or opposite, presence of swelling in back, abdominal swelling etc.
- (g) Presence of intractable cough, haemoptysis, bone aches etc.

\* Prof. of Surgery, Calcutta National Medical College, Calcutta.

The women of any age particularly 25-35 years must carefully notice any change in the breast and inform the attending physician or surgeon for diagnosis, so that treatment could be done at the earliest.

**Role of Physician :**

Physician, particularly attending Family Physician have a very important role in detection of Cancer Breast at the earliest stage. Doctor concerned should notice the following :

(i) A female particularly between 25-35 years : a thorough history of Cancer in the family should be taken of either maternal or paternal side, as these patients are more vulnerable.

(ii) Thorough examination for the followings :

(a) Presence of retraction of nipple or areola of recent origin.

(b) Increase or decrease of the size of the breast.

(c) Presence of any ulcer or erosion in the nipple of the breast.

(d) Breast should be palpated thoroughly with the flat of the hand for presence of any lump or lumps and so also the opposite breast and axilla.

(e) Both breasts should be inspected and examined time to time for changes of the size, shape, moveability and its fixity with the superficial and deep structure.

(f) Physician should also note presence of any discharge per nipple particularly bloody in nature with or without presence of lumps underneath.

(g) All the women should be examined from time to time as a screening programme, at least once a year between the age of 40-49 and once in three years under the age of 40 to detect early changes of breast if any.

(h) Physician should also examine the patient thoroughly, as some times primary lesion may be very minute or occult and the patient may not be knowing, but can develop distal metastasis which can manifest as anaemia, chest pain, bone ache, pain abdomen enlarged liver and even lump in pelvis etc.

**Radiography and Imaging Diagnosis for Breast Cancer :**

(1) Mammography and Xero-mammography in a collaboration effort of American College of Cancer Society (A.C.S.) and the National Cancer Institute demonstrated the efficacy of mammography by a low dose x-ray examination to detect occult neoplasm otherwise un-identified even by

experienced doctors. The correct application of conventional mammographic technique, xero-mammography (XRM) represents the modality used to detect occult, non palpable lesion of breast. Both sides are done simultaneously in a cephalo caudal and medio lateral projections with reproduction of (XMM) pattern on a selenium plate in a positive or negative mode to accentuate tissue density. The most radio penetrable substance are fat and radiodense deposits are calcium salts, which are present in approximately 35%–45% of malignant and pre-malignant condition.

#### Indications :

Routine breast imaging is most useful in detecting Breast neoplasm prior to their clinical appearance. The large, fatty breast of post menopausal woman and the active dense breast of a young individual are difficult to examine by palpation. This helps in distinguishing between a Fibrocystic disease and malignancy. This is particularly valuable in detecting any unsuspected abnormality in the opposite breast of an individual with Breast Cancer. Thus the technique increases the diagnostic yield approximately two fold over physical examination alone.

Thermography, Sonography, X-Ray Chest and Skeletal X-ray also help in the diagnosis of Breast Cancer.

#### Hormone Receptors and Tumor Marker :

(A) Depends on the age of the patient and establishment of estrogen deficiency of the patient. This can be assessed by detecting estrogen receptor protein of the breast cancer patient and the reaction of the patient with ovarian ablation either by surgery, radiotherapy or by medical suppression.

The introduction of hormone, particularly estrogen, prolactin and androgen has got effect on the Breast Cancer treatments and its recurrences. So it can be used in many if not in all. The earlier the age more is the dependency on hormones. So with the menopausal and post menopausal patient can be assessed an androgen hormone. Thus the estrogen hormone detector not only help in the diagnosis of the breast Cancer but also in treatment and subsequent follow up of recurrent cases.

#### Tumour Marker :

There are various tumour markers available for the early detection & is of prognostic value in Breast Cancer. Though 100% surity for early detection is not established but still in majority Cancer of Breast can be diagnosed early even before it starts its clinical manifestations and also markers help in the diagnosis of systemic involvement which the other available

investigations like—Sonography, C.T. Scan, Radioassay etc. fails to diagnose—like the involvement of bone marrow. The common available markers are

- i) CEA ( Carcino Embryonic Antigen )
- ii) FERRITIN ( A iron binding protein )
- iii) CASIEN
- iv) LACTA ALBUMIN
- v) HCG ( Human Chorionic Ganodotropin )
- vi) SYALYL TRNBFERANCE & SYALIC ACID
- vii) XONOCLOMAL ANTIBIOTIC

#### Cytology & Histopathology of Breast Cancer

*Cytological Examination could be done from*

- a) Discharge from the nipple
- b) Aspiration of a Breast Lump ( FNAC )

This is done in same way as Papanicolau stain to detect the Cancer cell in Cervical Cancer.

#### Biopsy :

Biopsy could be done in the following manner and the material is collected by—

- a) Nipple aspiration for which the various needles are available
  - i) Vim-Silverman
  - ii) Menghiml
  - iii) Truent

This procedure is very simple and can be done under LA for superficial tumours. False positive result is rare and in 80% of cases diagnosis could be done. It can be performed even in the out patient department. But if the result is negative we can not say cancer is not there So open

Biopsy is a must.

#### Technique for Open Biopsy by—

- i) Excision
- ii) Wedge Section
- iii) Quadrectomy

These are the final procedure for confirmation of diagnosis either by paraffin section or frozen section. Malignancy of breast mostly are adenocarcinoma and rarely sarcoma.

### Mass Screening Programme

This is one of the best procedure for early detection of Cancer Breast which leads to

- i) Awareness of the patient regarding the gravity of the disease.
- ii) Teaching of Self Examination ( as suggested by A.C.S. ) by B.S.E.
- iii) Repeated and interval examination of the patient in the following manner by the doctor.

Physical Examination by the experienced Surgeon should be done  
(1) Every year for the patient above 40 years (2) Every once in three years for the patient between 20 -40 years.

### Investigations Like—Mammography

- a) Every year in Women above 50 years
- b) A mammography every one to two years in Women between 40—49 years.
- c) A base line mammography between 35—39 years of age of patient.

But one should not stick to the above procedure and this can be done even earlier or later according to the case depending on physical examination and findings of previous mammography.

Examination with Tumour Markers and hormone reseptors from time to time also help in the Mass Screening and early detection of Cancer breast.

All women should be assured and should not be apprehensive of the disease as many of them can develop psychological problem with the very thought of cancer. So this is the responsibility of Doctors to give proper assurance to the patient and make them aware about the benefit of early detection of the disease for better and good quality of life in future.

### References :

1. Degenshen G. A., Bloom N. et al. Estrogen and Progesterone receptor study as guide to the management of Advanced Breast Cancer—Breast P 329—334 ( 1977 ).
2. Haagensen D.E. Tumour Makers for Breast Cancer—Clinical Lab Med 2 P 543—565 ( 1902 ).
3. Ghosh, B. C., Ghosh, L.—Tumour Markers & Tumour Associated Antigen. Magrow Hill Book Co., P 1—9, P 17—97 (1987).
4. Kuhajda F. P., Mondelson G.—Distribution of Carcinoma Embroynic Antigen in Breast Carcinoma—Cancer 52—1257—1264 (1983).

5. Sobiston D. C.—Essential of Surgery W. B. Saunders Co. 282-318 (1987).
6. Stephen P. S., Ghosh B. G.—Biologic Markers in Breast Cancer 87—93 (1987).
7. Sloane J. P., Trotti P. H.—Biopsy Pathology of Breast, Chapman & Hall—254 (1985).
8. Toppin J. A., George W. D. et al—Effect of Surgery on Serum Feritin Concentration in patient with Breast Cancer—Breast Jr. Cancer 40—653 (1979).
9. Vaidya M. P., Suklaha—A Text Book of Breast Cancer, Vikash Publishing House (P) Ltd. (1983).
10. Waalks J. P., Enterlin J. P. et al—Biologic Markers for Breast Cancer—Cancer—53-644 651 (1984).

## M. W. I. A. NEWS

### *Election of Officers :*

- President** : Florence W. Manguyu, P.O. Box 41 307, Nairobi, Kenya.
- b) **President-Elect** : Lila Stein Kroser, 2855 Welsh Road, Philadelphia, PA 19152, USA
- c) **Secretary-General** : Carolyn Motzel, C/o. MWIA Secretariat, Herbert-Lewin Street, 1 50931 Cologne, Germany.

### **Future MWIA Meetings :**

20—23 March 1996

6th Western Pacific Regional Meeting of the Medical Women's International Association.

**Topic :** The Health and Well-Being of the Family

**Contact :** New Zealand Medical Women's Association, Goodfellow Unit, School of Medicine, Private Bag 92019 Auckland, NEW ZEALAND.

5-8 June 1996

12th Regional Congress Northern European Region.

**Topic :** The New Genetics—Friend or Foe. The Human genome research programme : Medical aspects and impact on society.

**Contact :** Danske Kvindelige Laegers Forening, c/o Sigbrit Christensen, Baunegaardsvej 56B, 2900 Hellerup, DENMARK.

1998

24th International Congress of the Medical Women's International Association.

**Venue :** Nairobi, Kenya.

**Contact :** Kenya Medical Women's Association, P.O. Box 49877, Nairobi, KENYA.

2001

25th International Congress of the Medical Women's International Association.

**Venue :** Sydney, Australia.

**Contact :** Dr. Jenny Thompson, Medical Women's Society NSW, 6 Lyndhurst Crescent, Hunters Hill NSW 2110, AUSTRALIA.

The International Association is in the process of preparing a Young Forum Newsletter and have invited young members to write about their activities and issues of interest in their country. Branches are requested to suggest names of young people who would want to form an Young Forum and send to Dr. Jyoti H. Trivedi who can then send their names to the International organization.

#### **United Nations Resolutions on Women :—**

##### *Resolutions Adopted on Women's Issues (at the 49th UN Assembly)*

The problems of violence against migrant women, Traffic in Women and Girls, Care of old women, the Commission on the status of women to address these and impact of technologies on women and give special attention to women in developing countries who suffer disproportionately from the effects of the global economic crisis and heavy debt burden. They should be made active participants in planning and implementing of sustainable development programmes, and governments be requested to consider nominating women representatives to the Commission on Sustainable Development.

International Women's Day was celebrated by mobilizing women and men to support positive change in women's lives.

The population explosion is very well known. The maternal mortality has doubled, especially in the developing countries.

##### *United Nations Population Fund—Important information :*

(1) The Catholic Church is still opposing alternate methods of family planning other than "natural." Even the argument that modern contraceptives would prevent Aids had no effect on the church dictats.

(2) Egypt has doubled its maternal mortality. It was stated that in 92% of cases death could have been avoided. The fundamental cause was delayed pre-natal, ante-natal and post-natal care. Non-cooperation of Egyptian women who insist on giving birth at home and only seek medical care at a very late stage. Constraints of medical training and educating the community. These are common to most developing countries, especially on rural areas.

(3) Research and development in Denmark have reported a discovery of a non-hormonal contraceptive pill for both men and women.

UN Conference on Human Settlements will be held in June 1996 in Istanbul. The themes of this Conference is important as it is shelter for all and urbanization. As we all know in India, most of the citizens live in slums causing immense problems of shelter, sanitation, health and the results of over-crowding. It is tragic to know that over one billion people, almost a

quarter of the global population are inadequately housed and more than a hundred million are absolutely homeless (according to the UN Centre for Human Settlements (HABITAT)).

*NGO Committee on the Family* : Organizing an International Seminar entitled "Focus on the Families—Action and Issues Beyond IYF". Any information on family related activities are welcome for their future Newsletter "Families International". This may be sent by members directly to the NGO Committee on the Family, Secretariat, An den Hulben 1/15, 1010 Vienna, Austria.

*WHO*—Recommends Forty-Eighth World Health Assembly-Resolutions on important public health issues :

- (a) Co-operation and assistance to the least developed countries.
- (b) Emphasis on reproductive health.
- (c) The problem of emerging and re-emerging infectious diseases.
- (d) Prevention of disability.
- (e) Integrated management of the sick child, especially in relation to control of diarrhoeal diseases and acute respiratory infections.
- (f) International strategy for Tobacco control.

*AIDS*—Aids is fast developing into a global problem. World Aids Day 1995 has high-lighted the problems of increasing Aids globally, has also invited global co-operation and support.

*Research*—There is an on-going research for making vaccines to prevent diarrhoea, pneumonia and malaria and develop other preventive measures, however, most of these deaths can be prevented today with available, simple and affordable interventions.

The long term solutions are obvious-improvement in economic status, education, infra-structure like sanitation, water supply, hygiene and an adequate nutrition made available at affordable cost.

#### **Fellowships for Women :**

The American Association of University Women Education Foundation has announced its 1996-97 International Fellowship for Women who are not citizens or permanent residents of the United States for graduate study or research in the United States. The memorandum is attached for your information ( annex 5 ).

## MEMORANDUM

**TO :** International Women's Centers  
**FROM :** Tanya Hilton  
 Director, AAUW Educational Foundation  
**DATE :** May 13, 1995  
**RE :** Announcement of AAUW Educational Foundation  
 International Fellowships for 1996-97

The American Association of University Women Educational Foundation is pleased to announce its 1996-97 International Fellowships for women who are not citizens or permanent residents of the United States for graduate study or research in the United States.

**STIPEND :** \$ 15,065.

### **CRITERIA FOR SELECTION :**

Strong preference for women :

- \* whose credentials prove prior commitment to the amelioration of the lives of other women and girls through civic, community, or professional work.
- \* whose study or research proposals show a continued interest in the advancement of women.
- \* who can verify that there is a definite position to which they will return in their home countries.

Applicants are judged on their professional potential and on the importance of their projects in their countries of origin.

### **ELIGIBILITY :**

- \* Previous and current recipients of AAUW fellowships are not eligible to apply.
- \* Applicants must hold a B.A. or its equivalent before December 1, 1995.
- \* Permanent residents and citizens of the U.S. will not be considered.

### **DEADLINES :**

- \* Completed application forms and supporting papers for 1996-97 fellowships must be postmarked no later than December 1, 1995 and sent in complete package.

- \* Please be aware that *applications are only available until November 15, 1995*
- \* TOEFL scores will be accepted separately *until February 15, 1996.*
- \* Applications submitted from overseas must be sent *by airmail.* We regret that incomplete applications or those postmarked after December 1, 1995 cannot be considered.

**FILING FEE :**

- \* A money order or dollar draft of \$ 20.00, payable to the AAUW Educational Foundation and drawn on a U.S. bank must accompany all applications.

Enclosed is an Order Form for the number of announcement flyers (sample enclosed) (maximum 20) and applications (maximum 5) you will need for the 1996-97 awards. Please return the Order Form by August 1 to allow ample time for the applications to reach you by October 1, 1995. We encourage the use of APO addresses because of the high cost of overseas postage. If an applicant requests an International Fellowships application after your supply has been exhausted, she should contact the Foundation directly at P.O. Box 4030, Iowa City, IA 52243-4030, stating her qualification to apply for the fellowship.

English Proficiency is of the utmost importance for those undertaking study or research in the United States. Thus, unless the applicant's native language is English, she is asked to submit a recent score on one of the following English tests : Test of English as a Foreign Languages (TOEFL), University of Michigan Examination for Proficiency in English, or American Language Institute Georgetown University (ALIGU).

**ELIGIBILITY :**

- \* Previous and current recipients of AAUW fellowships are not eligible to apply.
- \* Applicants must hold a B.A. or its equivalent before December 1, 1995.
- \* Permanent residents and citizens of the U.S. will not be considered.

**DEADLINES :**

- \* Completed application forms and supporting papers for 1996-97 fellowships must be postmarked no later than December 1, 1995 and sent in complete packages.

MWIA '98  
XXIV MWIA CONGRESS  
NAIROBI—KENYA  
NOVEMBER 1998

Kindly send me more information on the XXIV Congress.

Name : .....

Mailing Address : .....

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E Mail :

return to :

The Chairperson  
Congress Organizing Committee  
P.O. Box 49877  
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