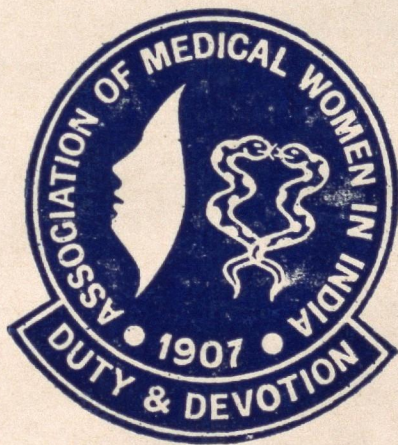


10-2-100
LC+1
Jal

JOURNAL

OF THE ASSOCIATION OF MEDICAL WOMEN IN INDIA



VOL. LXXVII

DECEMBER 1989

NO. 2

UNIVERSITY OF INDIA LIBRARY

ASSOCIATION OF MEDICAL WOMEN IN INDIA

- President : Dr. Winnifred Fernandes
M. D. F. C. P. S., F. R. C. O. G.
14, Kahun Road, Pune-411 007
- Vice-President : Dr. R. Tulsi Basu, Calcutta
Dr. R. Chako, Madras
- Secretary : Dr. Manju Mataliya
A-64, Flower Queen,
18, Veer Desai Road,
Bombay-400 058
- Treasurer : Dr. Mehroo Pardewalla
Sidhwa Building
Princess Street,
Bombay-400 002
- Secretary-Bombay : Dr. Dinoo Dalal
Neel Ganga, T. P. S. III Bandra
Bombay-400 050
- Calcutta : Dr. Ratna Sanyal
10A & B. K. K. Roy Choudhury Road,
Calcutta-700 008
- Madras : Dr. (Mrs.) Muthu Jaya Raman
Chief Nephrologist & Civil Surgeon
Govt. Stanley Hospital, Madras-1
- Vice-President Central Asia : Dr. Dina Patel
4/4, Rustam Baug.
Bombay-400 027
- National Corresponding Secretary : Dr. Tulsi Basu
10, Pratapaditya Road,
Calcutta-700 026

ASSOCIATION OF EDITORIAL BOARD IN INDIA

Dr. Winnifred Fernandes
M.D., F.R.C.P., F.R.C.O.G.
11, Kabur Road, Pune-411 007

Editor :

Dr. Meenakshi Ghosh

Dr. R. Tulsi Basu, Calcutta

Co-Editor :

Dr. Tara Rama Rao

Dr. Urmila Khanna

Dr. Manju Maniappa

Asst. Editor :

Dr. Manika Sen

A-64, Flower Road,
18, Veer Desai Road,
Bombay-400 028

Sub-Editors :

Anaesthesiology :

Dr. Tulsi Basu

Dr. Mehroob Parbewala

Paediatrics :

Dr. Shanti Indra

Princess Street,
Bombay-400 002

General Practitioner &

Preventive Medicine :

Dr. Saroj Jha

Dr. Dinoo Datta

Physiology & Pathology :

Dr. Padma Lahiri

104 & B. K. K. Roy Chowdhury Road,
Calcutta-700 003

Obstetrics & allied branches :

Dr. Arati Roy

Dr. Ratna Sanyal &

Dr. M. Honostia

Dr. Ratna Sanyal

Oncology :

Dr. Sobha Ghosh

Dr. Usha Suraiya

Dr. (Mrs.) Munda Jyoti Raman
Chief Nephrologist & Civil Surgeon
Govt. General Hospital, Madras-1

Surgery & allied branches :

Dr. Swaran Arora

Dr. Dina Patel

44, Rustam Bagh,
Bombay-400 022

Dr. Tulsi Basu

10, Parapadaya Road,
Calcutta-700 026

National Corresponding Secretary :

Dr. Tulsi Basu

10, Parapadaya Road,
Calcutta-700 026

Home Comforts
TENDER CARE
THE JOURNAL OF THE A. M. W. I.

Vol. LXXVII

December 1989

No. 2

PRINCE NURSING HOME
37/1B, HINDUSTHAN ROAD,
CONTENTS

Study of Psychosocial Impact on the Families of Thalassaemic Children by Dr. Rekha H. Udani, Dr. Vinit Shah, Dr. P. M. Pai	1
Pelvic Pain in Women by Dr. Urmila Khanna	6
Caesarian Sections—Practiced in Antiquity ? by Nozer Sheriar, Manju Mataliya	10
Humane Approach in Obstetrics by Dr. M. Ghosh	15
Progesterone in the Management of Dysfunctional Uterine Haemorrhage by Dr. Parveen Roshnawalla, Dr. Rina Goel Dr. Usha Saraiya	20
N. C. S.'s Report & MWIA Report	35

Central Calcutta Nursing Home
73A GANESH CHANDRA AVENUE
CALCUTTA-700013

Home Comforts

TENDER CARE

I. W. M. with all medical facilities

available at

No. 2

December 1980

Vol. LXXVII

PRINCE NURSING HOME

37/1B, HINDUSTHAN ROAD,

CALCUTTA-29

at moderate charges

WITH BEST WISHES

FROM

Central Calcutta Nursing Home

73A GANESH CHANDRA AVENUE

CALCUTTA-700013

THE JOURNAL OF THE A. M. W. F. 3

Discussion :

Forty-four (44.8%) mothers and 46 (47.4%) fathers accepted the diagnosis of thalassemia in their children. In other studies, the acceptance of diagnosis was found to be lower. Fathers expressed guilt and assumed personal responsibility for the child's illness whereas guilt was found in children.

STUDY OF PSYCHOSOCIAL IMPACT ON THE FAMILIES OF THALASSEMIC CHILDREN

REKHA H. UDANI, M.D.*

VINIT SHAH, M.D.

P. M. PAI, M.D., D.C.H.

Parent's reaction to hospitalization

A tremendous psychological impact on parents is associated with hospitalization of their child. Seven (7.1%) mothers and 4 (4.1%) fathers expressed anxiety regarding separation from their child upon hospitalization.

Introduction :

The life expectancy of thalassemic children has improved following development of newer techniques in its management. Psychosocial impact of the postponement of death is tremendous on the families of these children. It is therefore necessary for the attending physician to understand the psychosocial impact on the families of thalassemic children.

Aims and Objects :

To assess the emotional reactions of parents and changes in the family pattern due to chronic illness of the child.

Patients and Methods :

One hundred families of proved thalassemic children were studied to determine the reaction to diagnosis, hospitalization, procedures, long-term follow-up and possibility of death. The study was conducted at Nair Hospital, Rajawadi Hospital, St. George and Haffkine Institute, Bombay, between July '84 and November '85. Repeated interviews of both the parents (separately and combined) were conducted.

Observation :

Ninetyeight mothers and ninetyseven fathers were interviewed—mothers and fathers reacted in almost equal proportion to diagnosis, hospitalization, procedures and long-term follow-up (Table I & II). Feeling of defeat and acceptance to hospitalization were chief reactions (Table II). Fear of procedures were commonly seen in mothers (Table III). Defeat and inconvenience were chief reactions in long term follow-up (Table IV). Most of the parents (75%) were depressed when they were explained about the possibility of death.

* Professor of Pediatrics,
Department of Pediatrics T.N. Medical College & B.Y.L. Nair Ch.
Hospital, Bombay—400 008.

Discussion :

Forty four (44.8%) mothers and 46 (47.4%) fathers accepted the diagnosis. In other series¹ conducted on the parents of leukemic children, revealed acceptance of diagnosis in 75% of parents. Seven (7.1%) mothers and 6 (6.1%) fathers expressed guilt and assumed personal responsibility for the child's illness, whereas guilt was found in 8% of the parents of leukemic children.*

Parent's reaction to hospitalization :

A tremendous psychological impact on parents is associated with hospitalization of their child. Seven (7.1%) mothers and 4 (4.1%) fathers expressed anxiety regarding separation from their child whereas 50% parents showed anxiety in Gofman's² series. Only 15 (15.3%) mothers and 10 (10.3%) fathers expressed fear of chronicity and incurability as compared to 50% of parents in Gofman's study. This significant difference in two studies could be explained by the fact that 76% parents in the latter study were not explained properly about the tests, equipments and hospital set-up. Twenty one (21.6%) fathers and 21 (21.4%) mothers expressed inconvenience to repeated hospitalization for simple blood transfusions as they had great difficulty in managing other children at home.

Parent's reaction to procedures :

Thirtysix (36.7%) mothers and 29 (29.8%) fathers expressed fear and anxiety whereas it was noted in 57% parents in other study². Fortyfive (45.9%) mothers and 51 (51.5%) fathers accepted the procedures in the present series whereas 40% in the other series¹ also accepted the procedures without fear and anxiety.

Thirtysix (36.7%) mothers and 35 (36.6%) fathers accepted the regular follow-up as part of their duty towards child. Most of the parents had accepted the follow-up in order to prevent the 'threatened loss of child'³. Twentyone (21.4%) mothers and 21 (21.6%) fathers were feeling defeated about the fact they had to suffer so much for their child, who was ultimately going to die.

Parent's reaction to the possibility of death :

Each parent of an ill child must adjust in his own way, first to the threatened loss and then to the actual death of the child. An illness like thalassemia, extending over a long period, dilutes the grief experienced by parents. This reaction of grief was seen in 20 (20.6%) fathers and 21 (21.4%) mothers in the present study. This is similar to the reaction described by

Andre Lascare³. Twenty eight percent parents had reached the stage of acceptance. They were well adjusted to the possibility of terminal event of death. Parents who lag behind the course of illness in their basic reactions denial, anger, bargaining, depression and acceptance (as described by Ross)⁴ undergo a shattering impact.

Conclusions and Suggestions :

Procrastination in diagnosis often renders the future reaction between parents and doctors difficult. Because of the considerable anxiety that the parents face, it is advisable to communicate the diagnosis to both the parents at the same interview. Separation, anxiety, fear and defeat were seen commonly on hospitalization of child. This can be relieved by permitting the parents to verbalise their anxieties sufficiently. Group discussions with parents under the guidance of physician will help reducing tension, anxiety and ignorance. Anxiety and fear of procedures can be avoided by meaningful communication by the doctor about the procedure.

Defeat and inconvenience about regular follow-up can be relieved by continuing communication with parents at each step of the illness.

Since 50% parents had shown depression to the possibility of death and only 29.7% had reached the stage of acceptance, the physician's responsibility must include an effort to alleviate the pathetic reactions of parents and help them to reach the stage of acceptance.

The psychosocial impact on the families of thalassaemic children must receive proper attention from the physician caring for these children.

Table I ;—Parent's reaction to diagnosis

	Mother		Father	
	No.	%	No.	%
Anxiety	23	23.4	24	24.7
Defeat	21	21.4	18	18.5
Acceptance	44	44.8	46	47.4
Fear	3	3.06	1	1.03
Guilt	7	7.1	6	6.1
Denial	—	—	2	2.06

Table II :—*Parent's reaction to hospitalization*

	Mother		Father	
	No.	%	No.	%
Separation Anxiety	7	7.1	4	4.1
Fear of Chronicity	8	8.1	4	4.1
Incurability	6	6.1	3	3.09
Unknown	1	1.02	3	3.09
Defeat	24	24.4	20	20.6
Dislike	5	5.1	11	11.3
Inconvenience	21	21.4	21	21.6
Acceptance	26	26.5	21	21.6

Table III :—*Parent's reaction to procedure*

	Mother		Father	
	No.	%	No.	%
Acceptance	45	45.9	51	52.5
Appreciation	7	7.1	9	9.2
Dislike	10	10.2	8	8.2
Fear	21	21.4	12	12.3
Anxiety	15	15.3	17	17.5

Table IV :—*Parent's reaction to long-term follow-up*

	Mother		Father	
	No.	%	No.	%
Acceptance	36	36.7	35	36.08
Appreciation	6	6.1	6	6.1
Dislike	9	9.1	12	12.3
Defeat	21	21.4	21	21.6
Inconvenience	26	26.5	23	23.7

Table V :—Parent's reaction to the possibility of death in their children

	Mother		Father	
	No.	%	No.	%
Grief	21	21.4	20	20.6
Depression	43	43.8	54	55.6
Acceptance	28	28.5	26	26.8
Guilt	6	6.1	7	7.2

References :

1. Bozeman Metal : Psychosocial impact of cancer and its treatment. III Cancer 8 : 1—16, 1955.
2. Gofman and Wilma Buckman : Parent's emotional response to child's hospitalization. Am J Dis Child 93 : 629—631, 1957.
3. Andre Lascari. An evaluation of programme of emotional management. PCNA 23 : 27, 1976.
4. Elizabeth Ross : On death and dying. JAMA 221 : 174—184, 1972.

Table 7: Parent's reaction to the possibility of death in their children

PELVIC PAIN IN WOMEN

DR. URMILA KHANNA, M.B., F.R.C.S. (Eng. & Edin.)*

Introduction :

Pain is a subjective symptom and the tolerance of the pain depends upon individual's threshold. Women as a whole have more tolerance particularly to pain. So if women are complaining of pain, particularly of lower abdomen and pelvis, proper attention should be paid.

All women at some time experience pelvic pain associated with physiological events such as menstruation, ovulation, or sexual intercourse. Only a few women seek medical advice for such pain, yet it is the commonest reason for laparoscopy. In three quarters of cases no cause is found, but the reason for this is not clear. People's perception of pain varies, and women with unexplained pelvic pain have often been diagnosed as suffering from psychogenic pain. Certainly, the incidence of anxiety and depression is high in women with unexplained abdominal pain, but in some cases the pain may be due to genuine but unrecognised disease. For example, we and others have reported the consistent finding of pelvic varicosities in women who have often complained of a chronic dull ache in the pelvis. We have called this the pelvic pain syndrome. Many of these women have a history of serious disturbance to their normal emotional development in childhood, which may in some way underlie the subsequent development of varicosities. Whatever the cause, high levels of anxiety or depression certainly increase the severity of their pain.

Thus it is clear that the diagnosis and management of pelvic pain are not as simple as is sometimes believed. Severe pain is not necessarily caused by obvious organic disease just as women who complain little of pain may have serious disease. It therefore pays to investigate the patient fully before making a diagnosis.

Investigation

Further investigation may not be necessary if the diagnosis is obvious, but increasingly laparoscopy is being used before resorting to laparotomy.

* Professor of Surgery, Calcutta National Medical College, Calcutta.

This is particularly important with a diagnosis of pelvic inflammatory disease based on clinical findings as it is often disproved on laparoscopy. Pelvic varicosities with polycystic ovaries may be found in an otherwise normal pelvis. Polycystic ovaries can be confirmed with ultrasound scanning and varicosities in the broad ligament or the infundibulopelvic ligament with venography and ultrasound scanning.

We have recently described the routine use of pelvic venography in women with suspected pelvic pain syndrome. A normal venogram excludes pelvic pain syndrome as a cause of chronic pelvic pain and encourages the doctor to look for another cause. Skeletal survey is also important, to look for osteoporosis particularly in the menapausal age group.

Classification :

Many conditions cause pelvic pain, and a classification is of little practical use other than to remind the clinician of the possibilities to be considered.

Problems of Pregnancy—Abortion, ectopic pregnancy, round ligament pain, degeneration of fibroids, unexplained uterine pain.

Menstrual Cycle—Dysmenorrhoea, mittelschmerz.

Infection—Pelvic inflammatory disease.

Urinary tract—Cystitis, calculus, urethral syndrome.

Large Bowel—Carcinoma (rare), ulcerative colitis, diverticulitis, Irritable bowel syndrome.

Genital tract—Torsion, degeneration and haemorrhage into cyst, endometriosis, fibroids, prolapse, pelvic pain syndrome (varicosities).

Musculoskeletal—Prolapsed intervertebral disc, spondylolisthesis.

Site of tenderness in the pelvic pain syndrome is at the ovarian point which is located at the junction of the upper and middle thirds of a line drawn from the anterior superior iliac spine to the umbilicus.

Examination—Typically, women with pelvic pain syndrome look unhappy and they often resent questioning. In gynaecological emergencies abdominal examination is helpful when the site of tenderness is localised with or without rebound tenderness. With chronic pain the site of tenderness is more difficult to identify. In pelvic pain syndrome, however, pressure over the ovarian point produces pain in the pelvis identical to that

11/11/11
 11/11/11
 11/11/11

of which the patient complains. Pelvic venography shows that the reason for this is probably compression of the ovarian vein over the transverse processes of the lumbar vertebrae, which results in back pressure on the plexus of veins at the hilum of the ovary. Vaginal examination is essential to assess the size of the uterus and to detect pelvic disease. In pelvic pain syndrome the cervix is often blue due to engorgement, and the pelvic organs, particularly one or other of the ovaries, are tender on gentle pressure.

Diagnosis :

History—A clear history of the nature of the pain, its site, factors which exacerbate and alleviate it, and its timing should be obtained. Pain caused by bleeding from an ectopic pregnancy or torsion of an ovarian cyst is strikingly different from that due to more chronic conditions. The diagnosis of an acute abdominal incident necessitating laparotomy is not difficult. Occasionally, however, pelvic pain syndrome may present as severe lower abdominal pain mimicking an acute gynaecological emergency. The longstanding pain of endometriosis, recurrent pelvic inflammatory disease and pelvic varicosities is more difficult to diagnose, although the patient's history may be helpful. Unpublished data from our studies show that women suffering from pelvic pain syndrome have several symptoms, are more likely to admit to sexual problems which predate the onset of pain, are taking greater quantities of drugs, and have more hospital referrals than patients with proved organic disease.

Treatment :

In the management of women with pelvic pain, surgery is increasingly being replaced by medical treatment, even for conditions such as endometriotic "chocolate" cyst of the ovary. The treatment of pelvic pain syndrome is still in its infancy but the success of non-directive counselling and relaxation training suggests that psychotherapy is likely to remain a cornerstone of treatment. Recently preliminary results have suggested that suppression of ovarian activity with medroxyprogesterone acetate brings about complete relief of pelvic pain syndrome, but a prospective trial is needed to confirm this.

Results of surgery are disappointing. Surgery is also inappropriate in most cases, not only because most sufferers are in their reproductive years but also because removal of any pelvic organ tends to reinforce these women's feelings of inadequacy.

Conclusion :

Pain in the lower part of the abdomen particularly in women may be due to thousands of causes : it may be organic and sometimes it may be functional. But before stamping a patient as having a functional disorder one should meticulously examine the patient and thoroughly investigate including the internal genital organs. Sometimes patient might have pain in the back and lower abdomen in the menopausal and in the post-menopausal period due to osteoporosis which needs estrogen supplementation provided cancer is being completely excluded. Though sometimes it seems a minor problem to others but actually women are really in agony who suffer from and cannot express the gravity. So I feel this type of pain should not be neglected and be thoroughly looked into as far as practicable.

When you need more than a Haematinic

NEW

DEFERON CAPLETS

**Fortified Haematinic Caplet
with Iron, Vitamins and Minerals**

**Provides all the requirements for
the successful treatment of—**

Common Diverse Types of Anaemias

Also available—DEFERON LIQUID

**A highly palatable Haematinic Liquid containing—
IRON, B-VITAMINS, LIVER EXTRACT & GLYCEROPHOSPHATE—
that correct common types of anaemias and debility**

Presentations : Strip of 10 Caplets & Bottle of 112 ml.

Detailed information available on request.



Marketing Division
Day's Medical Stores (Mfg.) Ltd.
41 Chowringhee Road, Calcutta-700071

PX/DFN-2/83

CAESARIAN SECTIONS — PRACTISED IN ANTIQUITY? (A HISTORICAL SKETCH)

NOZER SHERIAR, MD, DNB, FCPS, DGO*

MANJU MATALIYA, MD, DGO, DFP**

Summary :

The Shah Namah, the Persian national epic, was written by Firdausi in the tenth century. It includes a detailed description of an abdominal delivery by which the hero, Rustam, is said to have been born. This and other references suggest that caesarian sections were performed by primitive people since antiquity, often with success.

Introduction :

“Despair the charm;
And let the angel whom thou hast served
Tell thee, Macduff was from his mother's womb
Untimely ripped.”

‘Macbeth’—William Shakespeare

From the time of the Talmud to Virgil's Aeneid to Shakespeare's Macbeth, writers have vaguely referred to persons delivered through abdominal incisions. Medical historians skeptically view these references as myths or fantasies (Pritchard and Macdonald). Susruta (600 B.C.) acknowledged for describing rhinoplasty is also said to have performed caesarian sections. Prehistoric man had many yet undiscovered skills. Archaeology has revealed a large number of trephined skulls confirming a basic surgical dexterity.

Presented here is a description of an abdominal delivery that predates all reported references by many centuries. It is found in the Persian National epic ‘The Shah Namah’ and is startling in some details recognisable to the modern obstetrician. It describes the birth of the famous Persian hero, Rustam.

Literary antecedents :

The Shah Namah was written by the Persian poet Firdausi (Abul

* Lecturer

** Hon. Obstetrician & Gynaecologist

Nowrosjee Wadia Maternity Hospital, Parel, Bombay

Kasim Mansur) c. 940-1020 A.D. It ranks with the world's great epics and is second only to the Mahabharata in size.

The epic spans thousands of years and six royal dynasties of Persia, from prehistoric times to the fall of the Sassanians in 641 A.D. The records of the earlier dynasties to which reference is made here are said to be meticulously based on oral tradition, while later records have been authenticated by historical facts (Surti).

Rustam is said to have lived soon after Zoroaster. According to the historians Diogenes Laertes and Pliny the Elder, Zoroaster is said to have lived sometime in the latter part of the 7th Millennium (Mirza). Hence the incident referred here may be dated an estimated 8000 years ago.

Relevant extracts :

The three passages quoted for perusal are literal english translations of the Shah Namah by A. G. Warner and E. Warner, Vol. I (London 1905-1925). The epic was translated when Caesarian sections were not in vogue to influence the translators.

- I. She wept blood for the burden that she bore.
Gone was her cerise-bloom, her cheeks were saffron.

Rudaba said—

“By night and day I cry for help. I lie
sleepless and withered like a living corpse.
My time hath come but not deliverance.”

Until that came she lacked both rest and sleep.

Unquestionably the lament of a disturbed parturient in difficulty.
A poetic description of a prolonged labour with dystocia, possibly postdated ?

- II. “His birth will not be natural,
So willeth he who giveth good, Bring thou
A blue steel dagger, seek a cunning man
Then let him ply his craft
And take the lion from its lair by piercing
Her waist while all unconscious, thus imbruing
Her side in blood, and then stitch up the gash.
Put trouble, care and fear aside.
Dress and anoint Rudaba's wound and watch her come to life.”

The advice to the expectant father Zal, by a mythical bird the Simurgh. Note the reference to the 'cunning man' whose craft it was to manage such cases and directions for making, suturing and caring for the incision in the post-operative period.

III. There came an archimage, one deft of hand,
 Who made the moon-faced dame mused with wine
 Then pierced her side while she was all unconscious,
 And having turned the infant's head aright
 Delivered her uninjured. None had seen
 A thing so strange. The babe was like a lion
 Tall and fair, none had ever heard of such an elephantine child.
 A day and night the mother lay asleep.
 They the while sewed up the wound
 And eased the anguish with the dressing.
 When she awoke they brought the babe to her
 She smiled upon the babe,
 "I am magnified" she said, "and grief
 Is over."

References to a deft surgeon, an 'all unconscious' inebriated patient, manipulation of the fetus, an 'uneventful extraction' and an 'elephantine child' (macrosomic?) are striking. Note again the emphasis on careful suturing and dressing of the wound and uneventful post-operative recovery.

Discussion :

It is important for a surgeon to fully understand the historical antecedents of any procedure to know it well. Nowhere are these more fascinating than in caesarian sections, undoubtedly the most frequently performed major surgery today.

Previous reports go back as far as 715 B.C. when Numa Pompilius codified the lex regia (later lex caesaria) ordering that the fetus of a woman dying far advanced in pregnancy, be buried separately. Passages in the Talmud refer to the operation on the living, and 'Jotze Dofan' was the name ancient Jews used for children delivered through the flanks of their mothers (Newell).

The significance of the Shah Namah passages was highlighted by Mirza and they probably predate all other references on the subject.

In spite of the fact that these descriptions were recorded by Firdausi from oral tradition and considering his poetic licence the obstetric significance of the poet's tale is obvious to us even today. It is, hence, likely that abdominal delivery may have been practised thousands of years ago in selected cases and we can positively conclude that the poet was reasonably aware of procedural details when he wrote the epic in the tenth century.

Stripping the story down to a few basic facts:—

Firdausi's description of the patient's prenatal condition, the preoperative advice to the father, the referral to a skilled surgeon, intoxicants used as anaesthetics, the abdominal incision and delivery of a large fetus, the wound closure and post-operative dressing are recognisable to any modern-day obstetrician.

Skeptics insist that uncivilized peoples were incapable of such surgical skills on living patients. Yet Felkin witnessed one such caesarian section in Uganda in 1879 before the West had scientifically recognised this as a justifiable procedure.

Felkin... 'The operator evidently possessed distinctly more knowledge of asepsis than civilized confreres of that period since he washed his hands and the field of operation with banana wine before operating, instead of deferring the cleansing of his hands until after the operation, as was the then civilized practice. The patient was anaesthetized by being made drunk with the same preparation. A rapid incision of the abdominal wall and uterus was done, the child removed and the cord cut. The placenta was then removed, the cervix dilated from above, and the uterus massaged and compressed to check haemorrhage. The peritoneal cavity was cleansed of liquor amnii and blood by raising up the patient and the abdomen was closed by means of pins and figure eight sutures. The wound was dressed with a paste of crushed herbs. The wound healed in eleven days and the convalescence was only slightly febrile' (Newell).

Now such a well developed technic suggests that the operation had been under development for a long time and was probably practised among certain barbaric races with success perhaps for centuries, while among civilized surgeons it remained an operation of greatest danger.

This leaves us with sobering thoughts on caesarian sections which we consider a recent operation just over a century old dating back to Porro in 1876. The possibility of ancient origins and its successful performance by primitive peoples is humbling and makes western medicine reflect upon the achievements it is so aggressively proud of.

Conclusion :

This has been an attempt to look back on our distant past as obstetricians. The paper concludes with pride that though a majority of obstetric work in antiquity was done by midwives (as in twentieth century India) ancient history suggests the existence of selected persons who practised difficult obstetric procedures with skill millennia ago.

References :

- Pritchard, J. A. and Macdonald, P. C. : Williams Obstetrics, 16th Edition, New York 1980, Appleton-Century-Crofts, p. 1100.
- Sarti, B. S. : Shah Namah of Firdausi, 1st Edition, Secunderabad 1986, Dr. Bahman S. Surti, Vol. I, p. 62.
- Mirza, H. D. K. : Outlines of Parsi History, 2nd Edition, Bombay 1987, Dastur Dr. Hormazdyar Dastur Kayaji Mirza, p. 31.
- Newell, F.S. : Caesarian Section, 1st Edition, New York 1931, D. Appleton and Company, p. 2.

HUMANE APPROACH IN OBSTETRICS**

Dr. M. Ghosh M.B., D.G.O., F.R.C.O.G.*

Introduction :

The word humane means having feelings proper to man ; compassionate ; tender. When we talk of humane behaviour we mean compassionate, tender behaviour which takes into consideration the effect it has on the most important part of a human being, namely the mind. Great influence of mind over the body is known. In ancient India, Yogis used to perform miracles by developing their mental power. They could completely control the body, even to the extent of controlling respiration and beating of heart. Such powers are encountered occassionally even in the present day. As medical science is advancing and new technology and more complicated laboratory investigations and highly specialised gadgets and techniques are evolving, the central point in human body, the mind, tends to be overlooked.

If we physicians have a humane approach and tend to the mind, as well as to the body of the patient, we are sure to get better results.

Material :

I would like to place before you two series of obstetric cases :—

- (a) One at the Kharberia Village Maternity Centre (K. V. M. C), a small village maternity unit with primitive facilities.
- (b) The other is of Lohia Matri Seva Sadan, Calcutta (L. M. S. S.), a fully equipped city hospital.

The village unit is a small eight-bedded maternity unit with a midwife and attendants looking after the patients. There is no facility for any operative treatment. Patients are transferred to city hospitals if any abnormality develops. Here, most of the patients are personally known to the midwife and the attendant, being residents of the nearby villages. The patients are familiar with both the surroundings and the personnel of the place. It is

* Head of the Dept. of Obstetrics & Gynaecology, Islamia Hospital, Calcutta, & Lohia Matri Seva Sadan, Calcutta.

** Paper presented at the International Congress of W.M.I.A. at Manila in 1982.

home away from home for them. There is no rush. Midwife can spare enough time to stand by the patient, explain things, reassure her and develop a rapport with her. Even though medical care leaves much to be desired, the human touch is there.

In the city hospital the patients get all the necessary medical care but they have to face the ordeal of labour in unfamiliar surroundings, in a detached clinical atmosphere.

The following are the results of the two series:—

Results of obstetric cases at Lohia Matri Seva Sadan (L. M. S. S) Calcutta and Kharberia Village Maternity Centre, (K. V. M. C).

TABLE—I

Total number of deliveries

Lohia Matri Seva Sadan	2028
From 1980-81	
Kharberia Village Maternity Centre	2064
From 1976-1982	

Figures for 6 years at the village centre have been taken and for one year at the City Hospital, to get comparable numbers.

TABLE—II

	Normal delivery		Abnormal delivery	
	Total	Percent	Total	Percent
L.M.S.S.	1681	83%	347	17%
K.V.M.C.	2026	98%	38	2%

In K.V.M.C. cases were taken as abnormal when they needed transfer to hospital. In L.M.S.S. abnormal cases include those who needed operative interference.

TABLE—III

Types of operative interference at L.M.S.S.

	No.
Caesarian Section	134
Low Forceps	185
Others	27

TABLE—IV

*Indications for interference at L.M.S.S.
Caesarian Section :*

Cephalo-pelvic disproportion	6	Abnormal presentation :	
Post Maturity	12	Transverse	— 8
		Brow	— 1
Toxaemia with foetal distress	6	Breech	— 9
		Face	— 1
Antepartum Haemorrhage	10	Cord prolapse	— 1
Elderly Primigravida	5	Previous history of C.S.	— 25
Uterine inertia leading to prolonged labour & foetal distress	35	Foetal distress due to other causes	— 15

Total — 134

Forceps :

Uterine inertia	100
Foetal distress	85

TABLE—V

Types of abnormality requiring transfer to Hospital from K. V. M. C.

Eclampsia	2	Prolonged labour due to inertia	6
Antepartum H'age	8	Abnormal presentation :	
Toxaemia with anaemia	8	Hand prolapse	1
		Brow	1
Cephalo-pelvic disproportion	4	Big baby with Breech	2
		P. P. H.	6
Total :		38	

TABLE—VI

Parity of patients :

	Primigravida		Multigravida	
	Total	Percent	Total	Percent
L.M.S.S.	676	33%	1352	67%
K.V.M.C.	840	40%	1224	60%

TABLE—VII

Age of Primigravid Patients

	L.M.S.S.	K.V.M.C.
Upto 24 yrs.	480	839
25 yrs. — 30 yrs.	186	nil
Above 30 yrs.	10	1

TABLE—VIII

	L.M.S.S.		K.V.M.C.	
	Total	Per thousand	Total	Per thousand
Maternal Mortality	nil	nil	nil	nil
Foetal Mortality	80	39	36	18

Foetal mortality at the village centre could be assessed only upto 3 days post partum after which patients are discharged.

Discussion :

From the above we find that the poorly equipped village unit gives results which compare favourably with the city hospital.

To my mind this is greatly due to the sympathetic and humane atmosphere of the village unit which helps the patients to be reassured and to relax.

We find much lesser number of abnormalities in the small unit in village and very few need of operative interference. Foetal mortality is not high. There are several factors which may be responsible for this :

1. The Village unit catering to a limited area of the population.
2. High-risk patients are screened ante-natally and advised to attend big hospitals. In reality such cases are very few.
3. Younger age-group of the primigravidae.

But taking into consideration all these factors we find patients requiring operative interference as the result of prolonged labour due to inertia is remarkably smaller than the city unit.

TABLE—IX

*Uterine Inertia leading to prolonged labour
and operative interference*

		Total
L. M. S. S.	C. S. - 35 + Forceps - 100 =	135
K. V. M. C.		6

All the cases of inertia in the hospital had not been included in these figures. Those who had syntocinon drip to enhance the pains and delivered normally had not been included. If these cases were taken into account the figures for inertia at the city hospital would have been much higher.

Surely humane approach can not have any influence on gross physical abnormalities as Placenta Praevia, Gross Pelvic Contraction, or Gross Malpresentation. But I do believe that among the three factors involved in labour, namely Power, Passage and Passenger, power is the one most important factor. Strong and effective uterine contraction is the most important factor for normal and easy labour. It can also overcome and correct mild degree of abnormality in the other two factors, such as borderline disproportion, rigidity of cervix, occipito-posterior position, etc. It is on the uterine contraction, mental condition of the patients has the greatest effect: if they are not tense and apprehensive they are more likely to develop good uterine contractions. It is my contention that, marked difference in the development of inertia during labour in the above two series goes to prove that a humane approach can help a patient to avoid tension and be relaxed which help development of good uterine contractions. It is this factor which has helped the village unit largely to produce good results in spite of poor medical facilities. The above two series go to show that a kind and sympathetic approach goes a long way to help get over physical ailments.

Acknowledgement :

I am grateful to the Superintendent, Lohia Matri Seva Sadan, Calcutta, & the Secretary, Y. W. C. A., Calcutta, to allow me to utilise the records of the patients of the institutions.

12

HUMAN APPROACH IN OBSTETRICS

PROGESTERONE IN THE MANAGEMENT OF DYSFUNCTIONAL
UTERINE HAEMORRHAGE*

** PARVEEN ROSHNAIWALLA M.D.

*** RINA GOEL M.D.

**** USHA SARAIYA

M.D. D.G.O. F.I.A.C. F.I.C.S. F.I.C.O.G.

It is estimated that at least 70% of women around the age of 42 suffer from periodic heavy menstrual flow, sufficient to lead to anaemia and debilitation. They are not able to cope with their daily routine and drop in Hb% leads to cardio-vascular complication. It is further known that in 70% of these women there is no organic pathology but the cause is a mere hormonal imbalance.

Careful clinical evaluation, investigation and treatment are simple in the hands of trained Gynaecologists, though laboratory facilities, surgery and the cost involved are not within the reach of all women.

Vast majority of Indian women live far away from the sophisticated medical facilities. Their only recourse for help is perhaps the General Practitioner or at best the local Gynaecologist. It is for this group of women and for the doctors attending to such women that this communication is intended.

The diagnosis of Dysfunctional uterine Haemorrhage is possible by a careful vagina internal examination and we feel we can offer a simple oral remedy that of oral progesterone therapy, at least as the first line of treatment. This will arrest the haemorrhage immediately and give a chance for Hb% to improve with haematinics. The next step would be to undertake simple investigations such as haematological profile, blood-sugar levels and perhaps cervico-vaginal cytology.

Adequate cycle control is possible in most cases. In those it is not possible, valuable time is gained to make arrangements for surgery either a

* Research Project carried out at Cama & Albles Hospitals Supported by Grant from Infar (India) Limited.

** House Surgeon

*** Registrar

**** Hon. Obstetrician Gynaecologist

UNIVERSITY OF HAWAII

D & C or a Hysterectomy. So this study was designed to outline a treatment modality for dysfunctional uterine bleeding in women who live in remote areas and for Doctors who practice in these areas and who need not feel handicapped by the non-availability of sophisticated equipment. This we feel is the need of the hour, if we are to modify our Medical Schedules to suit our patient population.

Material and Methods :

100 cases of dysfunctional uterine bleeding attending the OPD of a teaching hospital in Bombay were included in the study. The study was carried out in 1983-85.

The presenting symptoms were as follows :

Menorrhagia	...	56
Polymenorrhagia	...	20
Polymenorrhoea	...	7
Irregular Vaginal Bleeding	...	13
Continuous Bleeding	...	4
Total:		<u>100</u>

Age Group :

It was found that 90% of patients studied were between ages of 25 years and 40 years. Comparing with the original series of DUB reported by Sutherland in 1949, it is noted that we have a younger age group of patients. This is because our women marry young and complete their families early. It is also because of the high incidence of tubal sterilisation being done at relatively young age. We had only 10% of patients above the age of 40. Most patients and Doctors prefer Hysterectomy over hormonal therapy for this older age-group.

Progesterone was given orally as 5 mg tablets. Although individual adjustment in dosages was carried out, we tried to adhere to 3 different schedules :

- 1) 5 mg twice a day from day 15 to day 24 (10 days - 20 tablets). This was suitable for most cases on long term.
- 2) 5 mg twice a day from day 5 to day 24 (20 days - 40 tablets). This was suitable for those in whom there was evidence of hyperestrogenic pattern.
- 3) 5 mg three times a day for 10 days starting from any day of cycle for those who presented with bleeding and anaemia. On stopping the

medication a period was expected and one of the above regimes was started from day 5 of the period.

Further adjustments in dosage were made depending upon—

- 1) Quantity of haemorrhage.
- 2) Tolerance to the drug.
- 3) Degree of anaemia.
- 4) Response to treatment.

If patients continued to bleed even after 10 days of therapy, it was taken as a failure of therapy.

Results were very encouraging :

- (a) Out of 56 cases of menorrhagia, 45 responded completely and 5 partially.
- (b) Out of 20 cases of polymenorrhagia, 18 responded completely and 2 partially.
- (c) Out of 7 cases of polymenorrhoea, 6 responded favourably whereas one did not.
- (d) Out of 13 cases of irregular bleeding, 11 responded favourably whereas one did not and one was lost to follow-up.
- (e) Out of 4 cases of continuous bleeding, 3 responded and one did not.

On an average 80% of patients responded favourably to the therapy. Treatment was continued for 3—6 months during which time patients' general health and Hb% were improved and all the necessary investigations were completed.

81 patients had complained of dysmenorrhoea along with the bleeding episodes. It was gratifying to note that 46% had complete relief of pain with progesterone alone and did not need any other analgesics. 29 had partial relief but could bear the pain and did not need analgesic. Only 6 patients had no relief and needed analgesics.

On discontinuation of treatment, patients were further studied for another 3 months. It was expected that beneficial effect would last as hormone imbalance could get corrected. This, however, was not seen in all cases.

- (1) 72% cases showed favourable response.
- (2) 17% recurred and needed further hormone therapy.
- (3) 11% recurred and then were selected for surgery.

Surgery :

D & C being diagnostic and therapeutic, is considered an essential part of the treatment of DUB.

It was done in 35 cases prior to therapy

10 cases who did not respond satisfactorily

8 cases who had recurrence of symptoms

The cases whose endometrium shows proliferative phase or hyperplasia are likely to benefit most from this therapy. In most cases of DUB the endometrial pattern is uniphasic. Even in cases, where the endometrium is secretory, progesterone therapy helps substantially in improving the shedding of the endometrium.

Hysterectomy :

9 cases required Hysterectomy. 4 showed adenomyosis, 3 had small fibroids and in only 2 the histopathology was normal. Only 2 cases were lost to follow-up.

Pathophysiology :

Most cases of DUB are due to unopposed estrogen activity leading to endometrial hyperplasia. This condition is today considered precancerous and needs to be corrected. In those cases where secretory patterns are seen corpus luteal function is poor, with low progesterone levels leading to irregular ripening and irregular shedding of endometrium. Correction is needed with only cyclic progesterone therapy which will neutralise the estrogen effect at the endometrial level and at the ovarian level. At the pituitary level, it will suppress further production of FSH.

The combination pill with estrogen is not as suitable because the endogenous estrogen production is high. Besides, synthetic estrogens are potentially carcinogenic and are believed to lead to thromboembolic phenomena. Hence for the purpose of controlling haemorrhage pure progesterone is more suitable and allows flexibility in dosage so as to counterbalance the estrogen levels.

Unopposed high estrogen levels have deleterious effects on other target organs. Breasts in particular are sensitive and estrogen dependent breast cancers are a possibility. Obesity can be the cause and effect of hyperestrogenic syndrome. Hence the control of hyperestrogenic syndrome is advised for reasons other than just the menstrual disorders.

Conclusion :

This regime is, therefore, most suitable as a first line of management of patients in rural areas and those seen in peripheral hospitals. It gives prompt relief and prevents unnecessary hospitalisation.

In those needing surgery ultimately, it gives valuable time for investigations and for improving the general health.

Those with organic pathology will not respond. They can then be easily selected for surgery.

However, problems have been encountered with the hospital class of patients who cannot follow instructions, lose or forget to take the tablets and do not come for regular follow-up. Patient compliance is always a problem with any therapy: in this therapy it is even more perceived.

Most cases of DUB are due to hypoestrogenic activity leading to endometrial hyperplasia. This condition is today considered precancerous and needs to be corrected. In those cases where secretory patterns are seen, progesterone function is poor, with low progesterone levels leading to irregular shedding of endometrium. Correction is needed with cyclic progesterone therapy which will neutralise the estrogen effect at endometrial level and at the ovarian level. At the primary level, it will suppress follicular production.

The combination pill with estrogen is not as suitable because the progesterone component is high. Higher synthetic estrogen are probably carcinogenic and are known to lead to thromboembolic phenomena. For the purpose of controlling hypermenstrual pure progesterone is more suitable and allows flexibility in dosage so as to counterbalance the estrogen.

Unopposed high estrogen levels have deleterious effects on other target organs. Obesity in particular is sensitive and estrogen dependent. Hence the possibility of obesity can be the cause and effect of hyperestrogenic syndrome. Hence the control of hyperestrogenic syndrome is advised for

Paper read at 29th All India Congress of Obstetrics and Gynaecology in Bombay, December 1985.

OBITUARY



Dr. MUKULIKA KONAR, M.B., D.G.O., F.R.C.O.G.
1921—1989

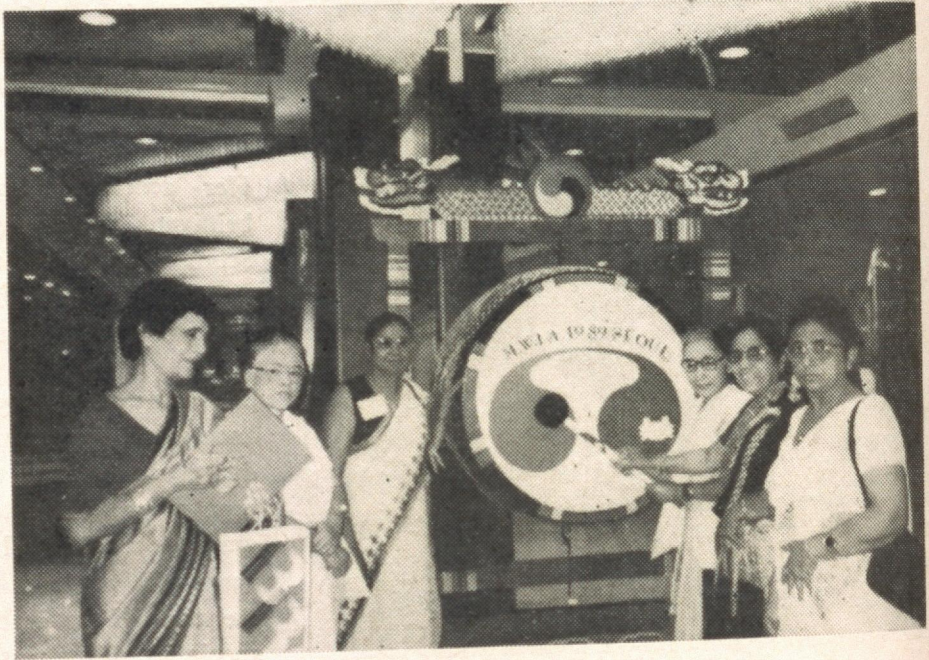
She had numerous papers to her credit and had given many prestigious orations. She initiated original work in the analysis of maternal morbidity & mortality in Eden Hospital, Calcutta, from 1972-1989 and made extensive studies on anaemias of pregnancy. She had a very even temper and a sweet smile which made her dear to every one who knew her. Her most important and rare quality was 'decision making'. She had the ability to deliver quick and precise judgments, based on clear logic, on any matter whether clinical or administrative. She was a surgeon of excellent skill and had helped many of her juniors in their careers.

She was married to the brilliant surgeon Dr. S. R. Konar and left behind a daughter and husband. She was a very good and efficient wife and mother, in spite of her wholehearted involvement in her profession.

Dr. Mukulika Konar was a past President of the Association of Medical Women in India (W.B.). Her untimely passing away had been deeply mourned by all our members and the medical profession of West Bengal. She had a brilliant career and retired as Head of the Department of Obstetrics & Gynaecology, Medical College, Calcutta.

Her academic career was brilliant, receiving many Scholarships & Gold Medals throughout her premedical and medical studentship.

She was a very good teacher and guide for any postgraduate work and she had been of great help to undergraduate students all through her career. She reached the top of the grade in her speciality, which was not easy at that time, competing with the men.



INDIAN DELEGATES AT XXIST CONGRESS OF M.W.I.A.
AT SEOUL, KOREA

... of Dr. Tulsi
... Correspondent

All the inter-
... various bran-
... Manju Mata
... M.W.I. (W.I.)

International
... national Assoc-
... (Korea). Over
... India has
... papers p-

Central As-
... Dr. W. Fe
... ship went t
... Both w

I think fo
... rral Roy a
... a sess
... her perso
... rish. The
... that max

Dr. Jhira
... at's Role
... State M
... ent Dr. F

Specificity
... presented t

A Welco
... and n
... Flat Par

On 5th
... and
... rman's D
... time Ind

Dr. D.
... but any

Report of Dr. Tulsi Basu,
National Corresponding Secretary

All the international news were either published in Journals or letters sent to various branches. I am grateful to Dr. Dina Patel, Dr. W. Fernandes, Dr. Manju Mataliya, Dr. J. Trivedi, Dr. Dalal and Executive Committee of A.M.W.I. (W.B.) for constant guidance.

International News. XXI International Congress of Medical Women International Association was held from 3rd to 8th Sept. 1989 at Seoul (S. Korea). Over 800 women from 33 countries participated. After Korea, Japan, India had largest number of delegates and maximum number of scientific papers presented.

Central Asia Vice-President and our Association President Dr. Dina Patel and Dr. W. Fernandes were very popular figures. Prestigious Lovejoy fellowship went to deserving Dr. Dina Patel and Young Forum to Dr. Rati Vajpay. Both worked very hard in their ways.

I think for the first time, two chairpersons were from India, namely Dr. Arati Roy and Dr. Dina Patel. Dr. Urmila Khanna was also asked to chair a session but she was presenting the paper during that time. Another person could have been recommended but our reflexes were not that brisk. The Calcuttans were asked to chair after it was pointed out by N.C.S. that maximum good papers came from India.

Dr. Jhirad Memorial was held on the day of the inauguration. Women's Role in International Development by Prof. Young Chung Kim, Second State Minister of Political Affairs. Plaque was presented by our President Dr. Fernandes.

Specicity of Cancer in Women by Dr. J. F. Bertaux of WHO. Plaque was presented by Dr. Tulsi Basu.

A Welcome Reception on 3rd evening allowed participants and guests to mix and renew old friendship. Next day was grand opening ceremony by a Flat Parade.

On 5th evening India took part in International Night. Delegates from Bombay and Calcutta came out in dresses of various states followed by Fisherman's Dance by Dr. C. Mukherjee. It was very much appreciated. First time India took part in all events.

Dr. D. Patel had made arrangements for registration fees on the spot without any fine. Even associates were given kits.



W.I.A.

M.W.I.A. Sale—All Indian goods were sold out. Dr. Arati Dutt had given some beautiful ivory goods.

In short our host Association produced rich and varied social programmes including music, dances, visits to museums, hospitals, Korean villages, and above all warm welcome of our Korean friends made the congress a memorable occasion.

We thank the Korean Medical Women's Association as Dr. Dina Dalal says Korea is such a mixture of East and West.

MWIA NEWS

Following is a summary of the discussions held and decisions taken in Seoul

Election of Officers

President	Dr. Il Ok Choo 90 Chebu Dong Chongro-Ku Seoul, Korea
Immediate Past President	Prof. Fernanda de Benedetti Venturini Via Fratelli Ferrari 32/5 I-16031 Genova Bogliasco, Italy
President-Elect	Dr. Dorothy Ward 3 Montgomery Drive, Giffnock Glasgow G46 6PY, United Kingdom
Treasurer	Dr. Lila Stein Kroser 2855 Welsh Road Philadelphia PA 19152, USA
Secretary General	Dr. Carolyn Motzel C/o Secretariat Herbert Levin Straße 5 5000 Koln 41 Federal Republic of Germany
Vice President Northern Europe	Dr. Vibeke Jorgensen Hegnsvej 37 DK-2850 Naerum, Denmark
Central Europe	Dr. Anjuta Lotsch Bartensteingasse 4 A-1010 Vienna, Austria

Southern Europe	Dr. Elvira Galluzzi Camozzi Via L. B. Alberti 5 I-20149 Milano, Italy
North America	Dr. Shelley Ross 7555 Morley Drive Burnaby, B. C. V5E 3Y2, Canada
Ibero America	Dr. Verna Alva Leon Arica 673, Miraflores Lima 18, Peru
Near East and Africa	Dr. Florence W. Manguyu P.O. Box 41307 Nairobi, Kenya
Central Asia	Dr. Dina N. Patel 4/4 Rustom Baug Bombay 400 027, India
Western Pacific	Dr. Virginia Yu-Chin Kuan 6th Floor 64, Lane 451 Tun HWA S. Road, Taiwan, R.O.C.

Committees

The Ad-Hoc Committee on the Re-Organization of Committee Structure after due consideration made the following recommendations which were presented and accepted by the Executive Committee in Seoul 1989 and presented to the General Assembly for ratification :

1. The formation of three Standing Committees

a. Finance

To consider Fund Raising, Scholarship, Lovejoy Fellowship and any other function allocated to it.

Committee Chairman :

Dr. Hannah-Reeve Sanders

329a Beach Road

Cape Town

8001

Republic of South Africa

b. **Scientific and Research**

To consider Education and Training, Research, Topic, Women's Issues and any other function allocated to it.

Committee Chairman

Dr. Maria Cornelia Ansink Schipper

Johan Braakensiekhof 12

1068 KK Amsterdam

Netherlands

c. **Ethics and Resolutions**

To consider ethical concepts and practices and receive all Resolutions other than those concerning membership dues.

Committee Chairman

Dr. Patricia Scrivenor

27 Laver St. Kew

3101 Victoria

Australia

2. **Other Committees:****Young Forum**

Committee Chairman

Dr. Else de Witt

330 Griffith Road

2641 Lavington

Australia

Vice-Chairman

Dr. Hilary Thomas

88 Ockendon Road

London N1 3NW

United Kingdom

Newsletter

Editor

Dr. Monica McWeeny

Knockoulart-Dublin Road

Shankill

Dublin, Ireland

The Public Relations and Publicity Committee of MWIA has been disbanded and the Editorship of the Newsletter will now be in the hands of Dr. Monica McWeeny. So please send any information that might be of interest for publication in MWIA's Newsletter to Dr. McWeeny.

It was requested that MWIA should make an effort to collect histories of the National Associations to have them on file in the Secretariat for future reference and to be published in the Newsletter. We therefore request you to please send such information to the Secretariat or to the Editor of the Newsletter Dr. McWeeny directly.

3. Past President's Advisory Council.

4. Ad-Hoc Committees—set up for a limited time and purpose.

Re-regionalization

It was discussed at the General Assembly to divide the Western Pacific Region into two regions :

1. East Asian Region with Japan, Korea, Taiwan.
2. Pacific Region with Australia, Philippines, New Zealand.

As some members of the Western Pacific Region did not agree to a division it was suggested that the region should take a referendum on splitting. That the Vice President of the Western Pacific Region should meet with the NCSs of the area and inform them that the Executive is willing to accept their wishes. That first the region must decide, second the General Assembly must approve and that the new Vice President would be elected in 1992.

Appendices to the statistical report and return them to the Secretariat as applicable (names of Jubilee Members, Members deceased).

May we kindly remind those National Associations, who have not submitted a report, to immediately send us the missing reports (narrative or statistical) for publication in the Seoul Congress report. We need this information urgently. This is our last reminder!

Committee Reports

All Committee Reports will be published as submitted in the Seoul Congress report.

Resolutions

The Executive Committee in Sorrento requested that the resolutions passed by MWIA since 1924 should be reviewed. On reviewing these resolutions it became obvious that resolutions must be updated to be effective. It would seem advantageous that the Resolutions Committee carry this out and that their observations be circulated to the Executive Committee for their comments and presented as updated resolutions by the Executive Committee to the General Assembly in Seoul for ratification.

UPDATING AND REWORDING OF PAST RESOLUTIONS AS SUGGESTED BY A CONSENSUS OPINION OF RESOLUTIONS COMMITTEE AND RATIFIED BY THE GENERAL ASSEMBLY, SEOUL, KOREA 1989

1984

"Be it resolved that the MWIA continue to send its historical records on file to the "Archive and Special Collections on Women in Medicine" of the Medical College of Pennsylvania, USA after 5 (five) years. Provisions to be made for the cost of this both in money and staffing."

C-84-R9

"The MWIA recommends to National Associations that health care providers be given the educational opportunities for dealing with sexual issues in the elderly as part of their total health care."

1982 Manila

Scientific Resolutions

No. 1

"Resolved that MWIA promote more effective information to patients concerning their health and what to expect from their doctors."

No. 2

"The MWIA expresses the need for the extension in remote areas of good medical and paramedical services."

No. 4.

"Whereas women are under-represented in some countries in obstetrics and gynaecology, resolved that in all countries where women are a minority of obstetric and gynaecology specialists MWIA requests National Associations to promote an increase in the number of women working in this speciality."

No. 6.

"The MWIA approved of the organization for Hospice Movement and urges National Associations to try to encourage the principle of Hospices in their own countries."

No. 7.

"Resolved that MWIA recommend to National Association the inclusion of rehabilitation medicine in all medical school curriculums."

No. 9.

"Resolved that MWIA recommend to National Associations to press for the Allocation of Adequate Public Funds within their country for the improvement of the condition of the handicapped."

No. 10.

"Resolved that MWIA support and that where possible National Associations implement the architectural barrier code to enable all those with physical and / or sensory handicaps to enjoy maximum access and the best quality of life in both the private and work sphere."

No. 12.

"MWIA advocates specific instruction in adequate communication to relatives for all health personnel in the humane management of sickness, especially of sick and abnormal newborn infants."

No. 14.

"MWIA recommends to National Associations that respect for the elderly and acknowledgement of their contribution over the years to the community should be emphasized in the profession, the family and throughout society."

No. 15.

"MWIA recommends that the training of the caring profession should include the study of Gerontology (the normal process of aging) and of Geriatrics (the pathology of aging) but as separate entities so that all elderly people are not treated as sickly, disabled or unfit people because of their chronological age."

1980 Melbourne

No. 2. (Health Education Session)

"It should be emphasized in programs of health education that an individual knowledge of their own bodies, information as to their diseases and sharing the responsibility for decision-making in their treatments will promote the health status of that individual."

No. 3.

"Resolved that MWIA supports all positive action to :

1. Educate women around the world on matters of health.
2. Protect women against unduly aggressive medical and surgical practices.
3. Defend women's rights in health matters.
4. Increase women's participation in decision making concerning their own care."

No. 4. (Community Health)

"It should be emphasized in medical education that the health-state of our patients should be considered in relation to their cultural background and that a solely technological approach should be avoided."

1978 Berlin

No. 2. (Health of Mother and Child Committee)

1. "We propose that MWIA requests the National Associations in all countries to encourage the use of the mass media to reduce maternal and infant mortality rates and to improve health education."
2. "We propose that MWIA views with great concern the persisting poor standards of maternal and child care and bring this to the attention of appropriate international and national organization."

No. 5.

"Mother and child care clinics should be expanded to reach the widest segment of the population. These clinics should stress the preventive care of mother and child with special regard to nutrition, immunization and family planning."

No. 6.

"The MWIA supports all efforts to improve and strengthen the means of dissemination of health information and stresses the proven value of radio and television for wide dissemination of health material."

1976 Tokyo

No. 2.

"MWIA requests all National Associations to affirm that the role of the doctor in the community is to care for the sick, to prevent and relieve suffering and that the health needs of the community are kept as a principle aim of professional and government planning."

No. 3.

"Whereas children are the world's greatest asset.

Whereas it has always been the responsibility of Parents to protect the health, safety and well-being of children.

Whereas there is much suffering among the world's children from abuse, neglect and deprivation.

Whereas children are powerless to speak for themselves and have no access to legal redress of wrongs, be it resolved that MWIA through its members representing National Associations and Individual Members all member countries urge each national government to be concerned with the interests and protection of children and co-ordinate efforts on behalf of children."

No. 4.

The MWIA wishes to encourage part-time positions for doctors so that their skills continue to be utilized as family needs or flexibility of life style arise and that part-time postgraduate training facilities be made available."

POLICY RESOLUTIONS

1. "That all nominated candidates be presented to the next General Assembly."
2. "That the technical problems of communication (typewriter, FAX, etc.) be returned to the Executive for consideration, and that the National Associations will be informed in a Circular Letter about the options and decisions of the Executive."

3. "To change item 8g in the Rules of Procedure from :
It attempts to change a resolution passed in the preceding 6 years to :
It attempts to change a resolution passed at the preceding Congress."
4. "That the recommendations of the Executive for the reorganization of the Committees of MWIA be accepted as presented and reviewed at the next General Assembly."
5. "That the updated resolutions of MWIA, approved by the Executive, be accepted by the General Assembly."
6. That the decision to divide the Western Pacific Region be delayed and allowed to lie on the table until the National Associations have taken a referendum in 1990 and have advised MWIA of their decision."
7. "That the recommendations from the Scientific Sessions be passed to the Resolutions Committee for evaluation and wording. The Executive Committee then considers their implications and funding. The recommendations of the Executive shall then be circulated to the National Corresponding Secretaries for comments. These recommendations shall then be presented to the next General Assembly as Resolutions. The Executive and the National Associations may use these recommendations for publicity and policy making as soon as possible."

SCIENTIFIC RECOMMENDATIONS

"It has been MWIA's privilege to meet in Seoul, Korea 3-8 Sept. 1989 discussing the "Incidence of Cancer in Women in Different Countries": finding cancer of the breast and cancer of the cervix to be the commonest cancer. It is MWIA's recommendation that education of women be as critical to allow women to present themselves for early detection, treatment, and care. MWIA would encourage governments to provide such centres for early detection of cancer."

FUND-RAISING

Dr. Park informed the General Assembly about the results of the fund-raising :

1. Sale=1,381,000 Korean Wong and 500 US \$
 2. Raffle=843,200 Korean Wong and 511 US \$
- total of : 2,224,200 Korean Wong and 1,011 US \$

YOUNG FORUM

The project of the Young Forum resulted in 2,114 English Pounds and two boxes of medical equipment which have been forwarded to the Eritrean Medical Association for distribution.

MWIA FINANCES

The Treasurer confirmed that the finances of MWIA are in sound fiscal health. Upon request the yearly financial statements of MWIA are available from the Secretariat.

The dues for the term 1989—1992 will not be increased.

XXIIInd MWIA Congress, 1992, Guatemala

1. Congress topic : HEALTH FOR ALL CHILDREN.
2. Date of Congress : March 1992 (at least 2 weeks before Easter).
3. Financial Management :
Registration fees will be paid in CHF or US dollars.
4. Congress fees must be divided :
 - a. social programme fees, which must be self supporting
 - b. scientific programme fees including of 35 CHF surcharge for MWIA. 350 US dollars plus or minus 20% depending on the 1992 economic situation, with the approval of the Executive.

Venue of the XXIIIrd MWIA Congress

The General Assembly voted to accept the invitation extended by the Dutch Medical Women's Association to host the XXIIIrd MWIA Congress 7-12 May, 1995 in The Hague, the Netherlands.

FUND-RAISING

Dr. Park informed the General Assembly about the results of the fund-raising:

1. Sale—1,381,000 Korean Won and 500 US \$
 2. Raffle—843,200 Korean Won and 211 US \$
- Total of : 2,224,200 Korean Won and 1,011 US \$

YOUNG FORUM

The project of the Young Forum resulted in 2,114 English Pounds and two boxes of medical equipment which have been forwarded to the African Medical Association for distribution.

STATEMENT REQUIRED UNDER RULES OF THE REGN.
OF NEWSPAPER CENTRAL RULES 1956

Statement about ownership and other particulars about newspaper to be published in the first issue every year after last day of February.

FORM—(IV)

(See Rule 8)

1. Place of publication : 22/26 Monoharpukur Road
Calcutta-700 029
2. Periodicity of publication : 2 Issues per year.
3. Printer's Name : Dr. M. Ghosh
(Whether citizen of India ?) Indian
(If foreigner, State the Country of origin)
Address : 22/26 Monoharpukur Road
Calcutta-700 029
4. Publishers Name : Dr. M. Ghosh
(whether citizen of India ?) Indian
(If foreigner state the Country of origin)
Address : 22/26 Monoharpukur Road
Calcutta-700 029
5. Editor's Name : Dr. M. Ghosh
(Whether citizen of India ?) Indian
(If foreigner, state the country of origin)
Address : 22/26 Monoharpukur Road
Calcutta-700 029
6. Name and Address of individuals who own the newspaper and partners or share-holders holding more than one percent of the total capital. The Association of Medical Women in India.

I, Dr. M. Ghosh, hereby declare that the particulars given above are true to the best of my knowledge and belief.

Dr. M. Ghosh
Signature of the Editor

Date 10th Feb. 1990

A complete haematinic

TONOFERON

satisfies principles of iron therapy

Assures prompt and predictable rise in haemoglobin concentration

Provides optimal daily iron supplementation

Ensures proper iron absorption

Offers little G.I. intolerance



COMPOSITION

Each 5 ml contains:
Colloidal Iron Hydroxide 0.5 gm
Folic Acid I.P. 0.5 mg
Vitamin B₁₂ I.P. 5 mcg
Syrup and flavour q.s.

Iron content:
Elemental iron:
250 mg per 5 ml

For therapeutic use.

DOSAGE

5 ml twice daily after meals or as directed by the physician.

Duration of Treatment: In order to replenish iron stores the therapy should continue for 2-3 months after the haemoglobin concentration has returned to normal level.

PACKING

Phials: 85 ml, 170 ml and 450 ml

Detailed prescribing information available on request.



EAST INDIA PHARMACEUTICAL WORKS LIMITED
6, Little Russell Street, Calcutta-700 071

Dr. M. Ghosh
Signature of the Editor

Date 10th Feb. 1990

20

PLACENTREX

AN ORIGINAL RESEARCH PRODUCT FROM THE
PIONEERS IN PLACENTAL EXTRACT THERAPY

ANAFLAM

IBUPROFEN 400 mg + PARACETAMOL 325 mg
THE SUPER ANTI-INFLAMMATORY

ALCORIM

CO-TRIMOXAZOLE FORTE TAB/SUSP

NEW ALAMIN-SE & ALAMIN-SN

THE PEERLESS PAIR OF NUTRITIVE INFUSION SOLUTIONS
OF PURE L-FORM CRYSTALLINE AMINO ACIDS

ALDEZOL IV^{100 ml.}

METRONIDAZOLE 5 mg/ml

& A WIDE RANGE OF EXCEPTIONAL QUALITY

INFUSION SOLUTIONS

AVAILABLE IN PLASTIC CONTAINERS AND GLASS BOTTLES.

GAMMA RAY IRRADIATED ADIV SETS

A RANGE OF QUALITY INFUSION ADMINISTRATION SETS

For Further information
Please Write to :

ALBERT DAVID LIMITED
15, CHITTARANJAN AVENUE
CALCUTTA - 700 072



10 001292420

UNIVERSITY OF HAWAII

R 97

.A8

V.77

1989

LIBRARY USE ONLY

N.B.