

14

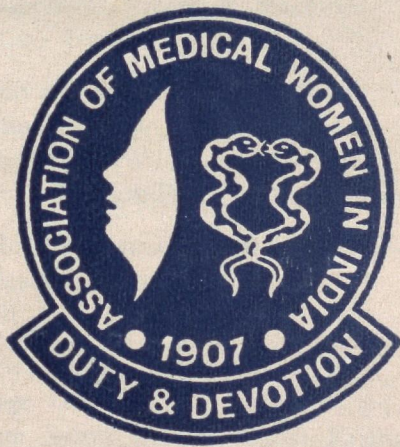
I-D-E-1466

LC+1

JOURNAL

OF THE
ASSOCIATION OF
MEDICAL WOMEN
IN INDIA

OCRe



VOL. LXXXIII

DECEMBER 1996

NO. 1

CONTENTS

H. R. T. and Women by Dr. (Mrs.) Manju V. Mataliya	1
Induction of Labour and its Impact on Safe Motherhood by Dr. Arati Roy	8
Antenatal Diagnosis of Congenital Adrenal Hyperplasia by R. H. Suchak and Z. M. Patel	13
Discharge from Nipple of Breast & Mastalgia by Prof. (Miss) Urmila	17
Obstetrical Outcome in One Year in a Small Hospital in Calcutta Run by Association of Medical Women in India (W. B.) by Dr. Bulbul Raichaudhuri & Dr. Sumana Sur	20
Improvement in Health Care of Female Prison Inmates : The Calcutta Experiment by Dr. Arati Basu Sengupta	25
Role of Psychosocial Stress Causing D. U. B. in Reoroductive Age Group by Dr. Ratna Sanyal & Dr. Gopal Krishna Das	30
MWIA News	36
Association News	38

EDITORIAL BOARD

Editor : Dr. Meenakshi Ghosh
Co-Editor : Dr. Tara Rama Rao
Dr. Urmila Khanna
Asstt. Editor : Dr. Manika Sen

No. 1 December 1998 Vol. LXXIII

Anaesthesiology : Dr. Tulsi Basu
Paediatrics : Dr. Shanti Indra
General Practitioner & Preventive Medicine : Dr. Saroj Jha
Physiology & Pathology : Dr. Padma Lahiri
Obstetrics & Allied branches : Dr. Arati Roy
Dr. Ratna Sanyal &
Dr. M. Hanostia
Oncology : Dr. Subha Ghosh
Dr. Usha Saraiya

With Best Compliments From :

PLAGENTREX

placental extract the original research product

SIOPLEX LYSINE

the novel B-Complex, Lysine, Lipotrope combination

FERROCHELATE SYRUP/

FERROCHELATE DROPS

the lysine powered multihæmatinic

GYP-L

the wonder combination that works wonders

ALCORIM SUSPENSION

the powerful antipyretic, anti-inflammatory, analgesic

ADLIV TONIC

Rational Herbal Formulation for the best protection against hepatobiliary disorders

For Further Information please write to :

Albert David Limited

15, Chittaranjan Avenue, Calcutta-700 072

EXECUTIVE COMMITTEE OF
ASSOCIATION OF MEDICAL WOMEN IN INDIA

President

Dr. Tulsi Basu

Vice-Presidents

Dr. Manju Mataliya

Dr. Jyoti Trivedi

Secretary

Dr. Dinoo Dalal

Jt. Secretary

Dr. Arati Basu Sengupta

Treasurer

Dr. Mehroo Purandare

National Corresponding
Secretary

Dr. Jyoti Trivedi

Vice-President

Central Area

Dr. Tulsi Basu

Helps
to prevent
urinary
incontinence

Restores
functional
vaginal
mucosa

Reduces
recurrent
urogenital
infections

For Consultation, Write to
President, Association of Medical Women in India,
17, Park Road, Calcutta - 700 017.

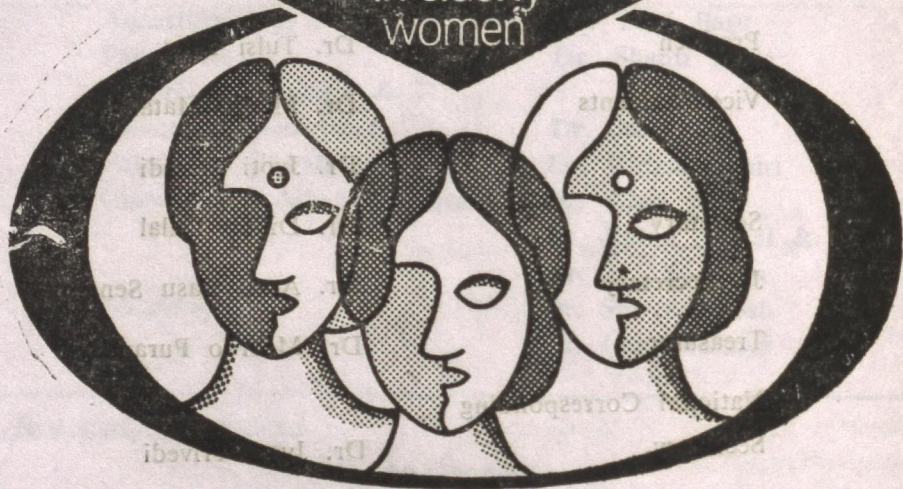
Manufactured under licence from
M.V. OGDON
HOLLAND

Further information
available on request from
REPAR (INDIA) LTD.
38, Connaught Place,
Calcutta - 700 017.

Composition: Each EVALON tablet
contains 1 mg. of natural
estrogen. It is a natural
estrogen, identical with the natural
estrogen produced in the body.
It is a natural estrogen, identical
with the natural estrogen
produced in the body.
It is a natural estrogen, identical
with the natural estrogen
produced in the body.



Recurrent
urogenital complaints
in elderly
women



Evalon

(The succinate ester of the natural estrogen, Estriol)

**Reduces
recurrent
urogenital
infections**

**Restores
functional
vaginal
mucosa**

**Helps
to prevent
urinary
incontinence**

89A113



Composition : Each EVALON tablet contains 2 mg estriol succinate.


Indications : Estrogen deficiency symptoms associated with the natural or surgical menopause, e.g., hot flushes, atrophy of the genito-urinary tract including urinary incontinence.

Dosage & Administration : 8-16 mg per day during the first week, followed by a gradual dose reduction during the next 2 weeks to reach the maintenance level of 2-4 mg per day.

N.B. : Dosage may be adjusted according to the requirements of the individual patient.

Presentation : 3 blister strips x 10 tablets.

For Contraindications, Warnings & Precautions, Interactions and Adverse Reactions—refer Pack Insert.

Manufactured under licence from
 **N.V. ORGANON
HOLLAND**

Further information
available on request from
INFAR (INDIA) LTD.
38, Chowringhee Road,
Calcutta - 700 071.





DR. MARIE CATCHATOOR

Members of Association of Medical Women in India deeply mourn the passing away Dr. Marie Catchatoor, late President of the Association and founder of the A.M.W.I. Mission Hospital.

Dr. Marie Catchatoor was an Armenian Indian, daughter of Mr. Catchatoor and Mrs Catherina Catchatoor. She was educated at La Martinere School for Girls, Calcutta and graduated from Lady Hardinge Medical College, Delhi. She joined "Womens Medical Service" later on, served as the Superintendent of the Lady Dufferin Hospital in Karachi, North West frontier Province in United India and then in Bihar and finally Calcutta. Dr. Marie Bennet Catchatoor became the first woman Presidency Surgeon in 1950 to 1967. She was a great disciplinarian and a very able administrator. She had dedicated Missionary Spirit and through all her career tried to relieve human suffering. She took a Special course in Family Planning and Cancer Detection at Hammersmith Hospital, London, taking a Norwegian Scholarship.

She was well known for her tireless work among the deprived and under-privileged women and children in rural areas and the City of Calcutta. She received the prestigious award from Ladies Study Group for her outstanding work in 1976.

She was one of the oldest members of the Association of Medical Women in India, and was responsible for its revival in West Bengal. She was past President of the National body as well as West Bengal branch and Vice-President Central Asia of the International body of Womens Medical Association.

She founded the A.M.W.I. Mission Hospital at Calcutta, from the association, an unique effort by a Medical Association. She worked tirelessly against great odds to establish this Hospital. She had great energy, which did not allow her advancing age to deter her.

Dr. Marie Catchatoor was the oldest Armenians in India.

The Armenians of India were proud of her and helped her in her work for humanity. She passed away peacefully on 6th November '96 at her own A.M,W.I. Mission Hospital at the age of 91 years. May her Soul rest in peace.

OBITUARY

DR. (MISS) ABUSHA BIBI MARIKAR, (M.B.B.S., D.G.O., M.D.)

Left for Heavenly Abode on 08. 08. 96 May. May her dear Soul rest in peace.

Dr. Marikar was first Woman doctor who was Director Medical Service. Madras and later Director Health and Family Welfare Tamil Nadu. She was born in 1912 and did her M.B.B.S. in 1937 from Madras Medical College. Joined W.M.S. in 1939 and worked at different Dufferin Hospitals and as lecturer in obstetrics and gynaecology at "Lady Atchison Hospital Lahore." She was recipient of Lazarus Gold Medal and worked as S.M.O. at Lady Dufferin Hospital Calcutta 1943-44. While in Service Dr. Marikar travelled a good deal visiting different states in U.S.A. and U.K. and attended the International Conference of Medical Women as a delegate from India. She published many scientific papers. After retirement worked with many associations particularly Association of Medical Women in India in Madras.

DR. (MRS.)
Major endocri
ge. There is marked
estrogen production.
known as menopause
sidered significant as
and postmenopausal p
of estrogen deficiency
a result of profound
to enormous decline i
menopause and years
women in developed
90% of women reach
average age of menop
her life time in po
women has increased
ous data). Number
estrogen due to estrog
the hot flashes, night
heat infections, prolap
the osteoporosis, increa
disease. All these lead
Women have
fertility free life sp
Although menopausa
replacement therapy i
infertility.
* Honorary Obstetric
Chairman, Clinic for
Novrojee Wallia M
Przel, Bombay.
Honorary Professor
Seth G. S. Medical

H. R. T. AND WOMEN

DR. (MRS.) MANJU V. MATALIYA, M.D., D.G.O., D.F.P.*

Major endocrine changes occur in a woman around 45-50 years of age. There is marked decline in the ovarian function, resulting in decreased estrogen production. This leads to series of changes in women, commonly known as menopausal changes. 50 years ago these changes were not considered significant as average life expectancy of women was only 60 years and postmenopausal population was small. Also short and long term sequelae of estrogen deficiency were not known at that time. However, at present as a result of profound changes in birth and mortality rates, and specially due to enormous decline in maternal mortality, many women are surviving to the menopause and years of active life beyond it. Average life expectancy of women in developed countries today is around 83 years and approximately 90% of women reach age of 65 years and 30% reach 80 years. If the average age of menopause is 50 years, most women will spend 1/3rd of their life time in postmenopausal life. In India also life expectancy of women has increased from 44 years in 1961-71 to 59 years in 1991 (91 census data). Number of women will experience menopausal changes and sequelae due to estrogen lack. Menopause is associated with acute symptoms like hot flushes, night perspiration, recurrent vaginal infections and urinary tract infections, prolapse and stress urinary incontinence and chronic sequelae like osteoporosis, increased risk for coronary artery disease and cerebrovascular disease. All these lead to increase in mortality and morbidity.

Women have become health conscious and want to have healthy, disability free life specially in their sixth and seventh decades of life. Although menopausal symptoms vary from woman to woman, hormone replacement therapy is useful to relieve symptoms related to estrogen deficiency.

* *Honorary Obstetrician & Gynaecologist and*

Chairman, Clinic for Elderly Women,

Nowrosjee Wadia Maternity Hospital,

Parel, Bombay.

Honorary Professor of Obstetrics & Gynaecology,

Seth G. S. Medical College, Parel, Bombay.

Hormone replacement therapy has become popular after 1960. Initially it was used to treat acute symptoms related to estrogen deficiency like hot flushes and night sweats and recurrent vaginal and urinary tract infections. From 1970 it was used to prevent long term sequelae resulting from estrogen deficiency like osteoporosis, and chronic backache. From 1980 it is used for prevention of cardio vascular diseases. Thus over the years use of H. R. T. has increased substantially. Menopause can be spontaneous & natural, or it can be due to surgical removal of the ovaries and premature.

Menopause produces following symptoms

I. Specific

Early

Late

True Hormone related symptoms

Hot-flushes, night sweats

Relate to metabolic changes in the target organ affected, like osteoporosis, vaginal and the urethral atrophy causing recurrent infections (Utian 1980)

II. Non-specific

Psycho-socio-cultural symptoms

These non-specific symptoms are determined by the woman's environment and the structure of her character like depression, irritability, insomnia, frigidity, headache and apprehension.

H. R. T. will take care of only the hormone related or specific symptoms. Some of the psychological symptoms like insomnia and irritability will be cured as a result of control of hot flushes and night sweats resulting in proper sleep.

Before prescribing H. R. T. to any woman potential risks and benefits must be kept in mind and explained to the woman in detail, as these prescriptions are apparently given to a healthy woman for prophylactic purposes and will have to be taken for a long period of time to be effective.

Potential Benefits

- 1) Relief of vasomotor symptoms—control of hot flushes and night sweats.
- 2) Relief of symptoms due to estrogen atrophy. Symptoms like recurrent vaginal infections and urinary tract infections respond well to short term H. R. T.
- 3) Relief of minor psychological symptoms like anxiety, agitation and irritability and depression. H. R. T. improves them due to control of hot flushes and night sweats. This leads to proper sleep and reduces irritability and mood disturbances. However full blown psychiatric symptoms and major depression will not be cured by H. R. T. Here

social factors like family problems should be considered and help from psychiatrist should be taken.

4) **Mental tonic effect**, postmenopausal women receiving estrogen therapy will feel better in terms of mental awareness and ability to perform their daily duties and generally have a sense of well being. This mental tonic effect improves symptoms like poor memory, anxiety and worry about old age, due to euphoria and improvement in mental state. This is a direct pharmacological effect as shown by Utian and is confirmed by placebo and double blind studies.

5) **Prevention of skin atrophy** : Estrogen prevents atrophy of skin and thus aging by improving collagen content of skin.

6) **Prevention of Osteoporosis**

Osteoporosis is characterized by low bone mass leading to an increased risk of fragility fractures, particularly in the femoral neck, vertebrae and radius. The association between osteoporosis and estrogen deficiency has been established since 1941. Estrogen deficiency is associated with calcitonin deficiency. Thus in postmenopausal women there is increase in bone loss resulting in increased incidence of fractures of the wrist, vertebral body and femoral neck. These fractures constitute major public health problem in the western world in terms of morbidity, mortality and cost. By age of 75 years 50% of women will sustain one or more of these fractures. Mortality from fracture of femur is around 16%. The efficacy of estrogen replacement therapy in preventing menopausal bone loss has been well documented by both prospective and retrospective studies. Estrogen are more effective than calcium supplementation, sodium fluoride Vitamin D and thiazide diuretics.

The great benefits are observed if the estrogen therapy is started shortly after the menopause (within 3 years) and if therapy is continued for more than 5 years. It is recommended to add progestogens to estrogen therapy (Oest + Proges) to reduce the risk of endometrial cancer. The estrogen replacement therapy is specially recommended for those women who are at increased risk of osteoporosis, like women with premature menopause, thyrotoxicosis. Hyperparathyroidism etc.

7) **Prevention of coronary artery disease**

Cardiovascular disease (C. V. D.) is the leading cause of death among women in industrialized countries. More than 50% of postmenopausal women will die of C. V. D. Estrogen therapy protect women against C. V. D. The greatest reduction in mortality were seen with long duration of estrogen. Use for more than 15 years of estrogen was associated with 40% reduction

in mortality. Estrogen also reduced mortality in groups of high risk women who smoked, had hypertension, history of angina or myocardial infarction. Risk of C. V. D. reduces by 25% following 5 years of use and by 50% with 10 years of use. The exogenous estrogens cause increase in H. D. C., decrease in L. D. L., also causes vasodilatation, thus prevents C. V. D. Other benefits of estrogen therapy are prevention of ageing and improvement of libido by preventing vaginal atrophy.

Protection against cerebrovascular disease :

It is found that there is approximately 30% reduction in deaths from stroke in postmenopausal women receiving estrogen therapy.

In spite of all these benefits estrogen therapy is not very safe, specially when given for larger duration for over 5 years. Certain risks have been observed following unopposed estrogen therapy.

Risks of estrogen therapy H. R. T. and cancer

The most important risk factor associated with estrogen therapy is increase in the incidence of genital cancers.

Uterine Cancer : A series of reports from 1975 have suggested that postmenopausal estrogen use increases the risk of uterine cancer. The risk increases with higher doses and when given for long duration. The risk is higher in obese patients. The cancer is usually of early stage and has good prognosis as it is diagnosed early and treated promptly. The risk of uterine cancer can be reduced by adding progestagens to the estrogen therapy.

Endometrial hyperplasia : Continuous unopposed estrogen stimulation can cause hyperplasia of the endometrium ranging from simple hyperplasia to a typical adenomatous hyperplasia. The incidence of endometrial hyperplasia with continuous estrogen use is about 15-30% (Whitehead et al 1979, Studd et al 1980), Cyclical use 12%. This can be reduced to 8% with 5 days course of progestagen and to 0% with 10 days of progestagens (Sturdee et al 1978) Whitehead (1978) has suggested that endometrial hyperplasia was dose related. 32% cystic glandular hyperplasia with higher dose and 16% with lower dose. Thus risk can be reduced by reducing the dose of estrogen. It is also shown that estrogen sulphate and estradiol preparations are associated with higher risk than estradiol preparations. The disadvantage of adding progestagens is occurrence of vaginal bleeding and increased risk of arterial thromboembolism.

Breast cancer : The relationship between estrogen therapy and risk of breast cancer is less clear. Some data shows that there was no increased risk. While others say that the risk for breast cancer is high specially

when high doses are taken or when estrogens are taken for more than 10 years. The risk is not there if estrogens are taken for 5 years or less. The risk increases with combined estrogen and progestagen therapy. Thus women receiving H. R. T. should undergo annual breast check up as well as mammography specially if they are high risk group

Ovarian cancer : This is also not clear. Some studies have shown increase in incidence of ovarian cancer with estrogen therapy (Hooper et al 1977), 2.5 fold.

Post-menopausal bleeding and unnecessary surgery :

This is the real disadvantage of postmenopausal estrogen therapy. The incidence varies with drug selection, dose and the patient response. Endometrial curettage is necessary to rule out endometrial cancer. Also incidence of hysterectomy will increase because of postmenopausal bleeding. It is assumed that there is 2-fold increase in risk of undergoing hysterectomy or D & C with estrogen alone and 25% increase with combined estrogen + progestogen therapy.

Deep vein thrombosis & throboembolism :

This is extremely important. There is definite evidence that risk increases with synthetic unconjugated estrogens like ethinyl estradiol and mestranal than with use of conjugated equine succinate. Use of natural estrogens will also avoid the risk. Also estrogens should be avoided in high risk women like obese, hypertensive or women who smoke and with previous history of thromboembolism. Other risks reported are slight increase in blood pressure, increase in incidence of gall stones and changes in glucose tolerance. Thus women should undergo medical checkup every 6 months and get G. T. C. done once in a year.

Balancing the risks and benefits :

Before prescribing estrogen therapy it is very important that risk and benefits are properly balanced. One must aim at minimising risk and maximize benefits.

Routes of replacement therapy :

- 1) **Oral :** This is the best and most convenient. Can be stopped abruptly and is well tolerated. High dose is required for relief of symptoms like hot flushes. 3-4% of women may get nausea and dyspepsia.
- 2) **Non-oral routes :** For those who cannot tolerate oral routes, various forms are available like injectables, implants and vaginal preparations.

Transdermal patches (T. T. S.) were developed in 1980 to overcome problems of poor absorption and hepatic first pass effect, permits easy adjustments of dose, can be stopped immediately when required. Must be changed twice weekly. Some women develop skin reactions.

Different regimens :

- 1) Estrogen only option used for postmenopausal women without uterus.
- 2) Estrogen & progestagens—For postmenopausal women with uterus to reduce the risk of uterine cancer.

Cyclical regimen ; Here estrogen is given first and progestogen added in last 10 or 12 days of therapy. Disadvantage is vaginal bleeding following withdrawal of progestogens. Occur in 50% of cases. Majority of women will not accept this.

Continuous regimens : Here both estrogen and progestogens are given orally in low doses daily. Incidence of vaginal bleeding is low—5%.

H. R. T. Prerequisites

- 1) An indication for treatment must exist.
- 2) There should not be any contra-indications.
- 3) Menopause should be confirmed.
- 4) Full general examination including B. P., C. V. S, and C. N. S. examination should be done and proper clinical history should be taken.
- 5) Breast palpation must be done.
- 6) Proper gynaecological examination.
- 7) Cervical and vaginal smears are essential prior to H. R. T,
- 8) Patient should be fully informed about the risks and should agree to come for regular follow-up.
- 9) Special and more frequent attention must be given to patients considered to be at risk.
- 10) Specific drug should be selected and given in smallest dose.

Annual follow up with following

- 1) B. P. and wt. checkup.
- 2) Breast palpation.
- 3) Pelvic examination.
- 4) Cytology smears.
- 5) Fasting and P. P. Sugar estimation.

- 6) Endometrial biopsy.
- 7) Mamography S. O. S.

Thus ideally H. R. T. should be prescribed by a Gynaecologist who is aware of all the risks and sequelae and is able to decide when to stop the therapy and how to manage the complications.

Contraindications of H. R. T.

- A) Absolute
- 1) Uterine cancer
 - 2) Breast cancer
- B) Relative contraindications

- 1) Abnormal genital bleeding
- 2) Previous or present thromboembolism
- 3) Liver disease
- 4) Hypertension
- 5) Varicose veins
- 6) Diabetes Mellitus
- 7) Hypercholesteraemia
- 8) Uterine fibroids

In conclusion. It is mandatory to keep an open mind and give therapy in such case where advantages are maximum and risks are minimal for each potential patient.

Statistical Method

This series consisted of collected patients who attended my private clinic from the year 1982-84 both years inclusive. From the year 1989-92 inductions of labour were done using I. V. Oxytocin drip only. For both type and unique cervix. From the year 1993 onwards PGT, intra cervical gel were used for ripening the cervix where cervical score was poor in addition to I. V. oxytocin drip.

* Ex-Professor of Obstetrics & Gynaecology, R. G. Kar Medical College, Calcutta

INDUCTION OF LABOUR AND ITS IMPACT ON SAFE MOTHERHOOD

DR. ARATI ROY, F. R. C. O. G.*

In Indian perspective safe motherhood is to lower the maternal mortality to 50% or below 200/100,000 births by the year 2000 A. D. Despite its modernisation drive and progress in high technology, maternal mortality as also perinatal mortality could not be reduced till to-day. The reason behind it is the very limited facilities in the rural areas of India where 80% of our population live. Therefore, the emphasis should be directed not to sophisticated management but to what can be achieved in the absence of modern facilities.

Induction of labour is an accepted procedure, for an obstetrician to deliver a patient by vaginal route. There are several methods of induction but I. V. oxytocin drip is considered to be the most effective. On the otherhand, cerviprime (PGF₂ gel) by intra cervical application helps in ripening of the cervix. In this series, 500 cases of induction of labour are presented of which 450 were induced by I. V. Oxytocin drip whereas 50 cases by oxytocin plus intra cervical prostaglandin gel where the cervical score was poor. No sophisticated gadgets were used to monitor the foetal condition during induction but constant vigilance by a trained doctor vis-a-vis the progress of labour and foetal well being. The purpose of this study is to prove that this easy procedure can be used in first referral hospital where facilities are limited but obstetricians are available who can manage the cases of failed induction by surgical procedure. Thus the rate of CS can be reduced and the mothers saved from the hazards of uterine scar in the subsequent pregnancies.

Materials and Method

This series consisted of collected patients who attended my private clinic from the year 1989-94 both years inclusive. From the year 1989-92 inductions of labour were done using I V. Oxytocin drip only. For both ripe and unripe cervix. From the year 1993 onwards PGF₂ intra cervical gel were used for ripening the cervix where cervical score was poor in addition to I. V. oxytocin drip.

* Ex. Profssor of Obstetrics & Gynaecology, R. G. Kar Medical College, Calcutta

INDUCTION OF LABOUR
All patients were
delivered by 1 week.
For I. V. Oxytocin
To begin with 5
given by I. V. route at the
Thereafter both
increased at an interval of
10 minutes and
clinical rupture of membranes
with cervical dilatation >
During the last 2
the cervix followed by uterine
contractions. In 50 cases we
noticed. To begin with
the 1 hour with Syntocinon
Clinically uterine
and foetal heart rates by
by descent of foetal head
physical examination with
induction of labour
a) Ineffective uterine
Syntocinon (80
b) Foetal distress (1
c) Poor or Failure of
d) Hyperstimulation
In these case labour
leads
Inc
Year Total No. of
1989 146
1990 135
1991 162
1992 169
1993 114
1994 127

All patients were primigravids who crossed their Expected date of delivery by 1 week.

For I. V. Oxytocin infusion the following schedule was used :

To begin with 5 units of Syntocinon in 5% Dextrose solution were given by I. V. route at the rate of 30 drops / min (i. e. 20 ml / min).

Thereafter both drip rate as well as concentration was gradually increased at an interval of 30 minutes till the desired result i. e., 3 contractions in 10 minutes and each contraction lasting for 40-60 seconds obtained. Artificial rupture of membrane was only done after the established labour with cervical dilatation > 5 cm.

During the last 2 years PGF₂ intra-cervical gel was used for ripening the cervix followed by usual induction with I. V. Oxytocin drip. Under this regime 50 cases were induced by a combination of cerviprime plus oxytocin. To begin with cerviprime was given at "O" hour. This was followed after 2 hour with Syntonin drip given at a schedule described above.

Clinically uterine contractions were monitored by palpatory methods and foetal heart rates by Stethoscope. Progress of labour was determined by descent of foetal head by abdominal palpation, cervical, dilatation, limited vaginal examination with proper asepsis.

Induction of labour was discontinued in the following conditions :

- i) Ineffective uterine contraction even after high concentration of Syntocinon (80 ml / min) drip.
- ii) Foetal distress (late deceleration).
- iii) Poor or Failure of effective cervical dilatation.
- iv) Hyperstimulation of uterus with foetal distress.

In these case labour was terminated by abdominal route by CS.

Results

TABLE—I

Incidence of Induction of Labour

Year	Total No. of delivery	No. of Cases induced	Percentage
1989	146	96	65.7
1990	135	76	56.2
1991	162	87	53.7
1992	169	99	58.5
1993	114	68	59.6
1994	127	74	55.9

TABLE—II

Criteria for Selection of Cases for Induction

- * Uncomplicated primigravidas who had crossed the E.D.D. (Expected date of delivery) within one week (within 41 weeks).
- * Cervix—ripe (Cervical Score > 6).
- * Cervix—unripe (Cervical Score 0—6).

TABLE—III

Cervical Score

Score	0	1	2
Position of Cx	Anterior	Axial	Posterior
Length of cervix	2 Cm	1 Cm	< 0.5 Cm
Dilatation of Cx	0 Cm	1 Cm	> 2 Cm
Consistency of Cervix	Firm	Soft	Soft and Stretchable
Station of Presenting part	- 2	- 1	0

TABLE—IV

Methods of Induction

Year	No. of cases induced	Induction by Syntocinon in ripe Cx (7-10 C. S.)	Induction by Syntocinon in unripe Cx (0-6)	PGE ₂ gel + Syntocinon in unripe Cx
89	96	66	30	—
90	76	50	26	—
91	87	60	27	—
92	99	69	30	—
93	68	38	—	30
94	74	50	—	24
		333 (60.7%)	167 (33.3)	

TABLE—V

Doses Schedule of Syntocinon Drip

- * 5 units Syntocinon in 5% Dextrose Soln. at a rate of 30 drops / min. (i. e. 20 mlu / min) by I. V. route as the Starting dose.
- * Then the drops and concentration of Syntocinon gradually increased till the desired results i. e.
- * 3 Contractions in 10 mins, and each contraction lasting for 40-60 Sec.
- * That concentration maintained till delivery.

TABLE—VI

Schedule of Induction by PGE₂ gel and Syntocinon Drip

- * Cerviprime (PGE₂ intra-cervical gel) was given at 'O' hour.
- * Syntocinon drip at a rate of 20 mlu / min. started after 2 hours of induction with Cerviprime.
- * Rate of drops and concentration of Syntocinon was increased till the desired results.

TABLE—VII

Clinical checks during Induction

- * Uterine Contractions were checked by abdominal palpation method.
- * Foetal heart rates were monitored by using stethoscope.
- * Progress of labour is determined by the descent of foetal head and cervical dilatation.
- * (Artificial rupture of membrane after established labour with cervical dilatation > 5 Cm).

TABLE—VIII

Indications of Termination of Induction of Labour and Discontinuation of Syntocinon Drip

- * Ineffective uterine contraction even after high doses of Syntocinon i. e. 80 mlu / min.
- * Foetal distress (Late deceleration).
- * Poor or ineffective cervical dilatation.
- * Hyperstimulation of uterus with in-co-ordinate contraction.

Results

(1)

Induction | Year | Vaginal delivery | C. S.

Year	No. of Cases	Vaginal delivery		C. S.
		Normal delivery	Forceps	
89	96	41	39	16
90	76	29	30	17
91	87	29	34	24
92	99	53	22	24
93	68	31	21	16
94	74	28	26	17
		386		114
		(77.2%)		(22.8%)

TABLE—VI
(2)

Induction—Delivery Interval

Methods	Average time taken in unripe Cx	Average time taken in ripe Cx
* Syntocinon	14 Hours	10 Hours
* PGE ₂ gel + Syntocinon	6-8 Hours	—

(3)

Success—Failure Rate

Methods	No. of Cases	Success rate	Failure rate
Syntocinon	446	77%	13%
PGE ₂ gel + Syntocinon	54	71.7%	28.3%

(4)

Indications of Caesarean Section

	No. of Cases	Percentage
* Causes Foetal distress	6	5%
* Cervical dystocia	51	45%
* Inefficient uterine Contraction	40	35%
* Hyper-stimulation	19	15%

Summary and Conclusion

In some obstetric conditions such as post dated pregnancy to deliver a patient safely Obstetrician has to accept either induction of Labour or Caesarean Section. To reduce the rate of Caesarean Section, successful induction of Labour by I. V. Oxytocin and endocervical PGE₂ wherever necessary for cervical ripening—gives encouraging results. In developing countries vaginal delivery has to be encouraged till now for safe motherhood.

ANTENATAL DIAGNOSIS OF CONGENITAL ADRENAL HYPERPLASIA

R. H. SUCHAK AND Z. M. PATEL*

Key Words :

Prenatal diagnosis, 17α OHP, CAH.

Summary :

The concentration of 17α -hydroxyprogesterone (17α OHP) was measured by RIA in second trimester amniotic fluid (AF) sample obtained from a mother at risk, having had earlier an infant with congenital adrenal hyperplasia. The concentration of 17α OHP was elevated in AF in this case. The mother delivered a male child at term after an uneventful gestation. It was noted that this child had a large phallus. Estimations of 17α OHP after 2 months of birth was 22ng / ml proving the diagnosis.

Congenital adrenal hyperplasia can now be diagnosed prenatally very accurately. A good clinical sign at birth in affected males is increased size of phallus.

Introduction :

Congenital adrenal hyperplasia (CAH) is a group of inborn errors of steroid metabolism inherited as autosomal recessive traits. In the commonest form due to 21-hydroxylase (21-OH) defect, the plasma concentration of the precursor steroid 17α OH progesterone (17α OHP), is markedly raised in untreated patients. Since the fetal adrenal is capable of synthesizing hormone by 8 weeks and because the fetus plays a role in the formation of amniotic fluid (AF), it is now seen that 17α OH in AF is raised in pregnancy associated with CAH.

This paper reports levels of 17α OHP in AF in a pregnancy at risk for CAH. For comparison, the steroid has been measured in 20 samples of AF collected at 16 weeks from women undergoing MTP.

* ICMR Genetic Research Centre.

(Indian Council of Medical Research)

Bai Jebral Wadia Hospital for Children,

Acharya Donde Marg, Parel, Bombay-400 012

Material and Methods :

The method of 17α OHP assay used was by radioimmunoassay Youssefnejadion et al. (1). Twenty samples of amniotic fluid from women undergoing MTP between 16-20 weeks were analysed for 17α OHP. They served as controls. The gestational ages were calculated from the dates of last menses, by ultrasonography dating. AF was collected from the pregnancy at risk described below and the supernatant was used for determining levels of 17α OHP by radioimmunoassay.

MS aged 4 years was referred to us for evaluation of ambiguous genitalia. He was a product of a consanguinous marriage. Examination of external genitalia revealed a phallus of 4.5 cm, urethral opening at the base, pigmented scrotal sacs but the gonads were not palpable.

Cytogenetic analysis of peripheral blood revealed a 46, XX karyotype with 17α OHP levels of 28ng / ml. The proband had CAH.

The mother attended our clinic when she was pregnant for the second time. Ultrasonography done at that time revealed a biparietal diameter and femur length equivalent to that gestation. Amniotic fluid 17α OHP was high (Fig. 1). This was conveyed to the couple but they opted to continue

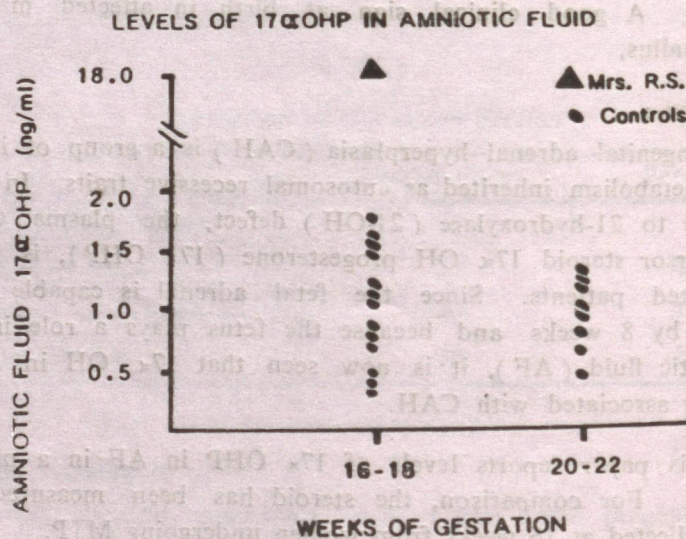


Fig I

pregnancy. A male child was born at term. Clinically he had a large phallus (4cm). Estimations of 17α OHP at two months of age was 22ng/ml. confirming the diagnosis. The child was put on steroids accordingly.

ANTENATAL DIAGNOSIS OF CONGENITAL ADRENAL HYPERPLASIA 15

Results :

Concentration of 17α OHP in AF collected from 16-20 weeks gestation from 20 MTP cases is shown in fig. 1. At 16-18 weeks the concentration of 17α OHP in AF ranged from 0.8-1.9ng/ml. The concentration of 17α OHP from our case at 16 weeks was 18ng/ml. This value was high. This was conveyed to the couple but they continued pregnancy till term.

Comments :

Successful antenatal diagnosis of CAH by estimation of 17α OHP in AF have been reported by Fraser (2), Milunsky (3) found a seven fold elevation of 17α OHP levels in AF obtained at 16 weeks in a affected pregnancy. Hughes (4, 5) noted that the concentration of 17α OHP was three times. Grosse and Wilde (6) estimated 17α OHP along with HLA typing to no greater advantage higher than normal in AF obtained at 16 weeks. In our case there was a 10 fold increase in levels of 17α OHP as compared to normals.

In India, data concerning antenatal diagnosis of CAH using 17α OHP levels in AF is scanty (7) more cases need to be monitored to generate meaningful data.

Although CAH is a treatable condition, most couples opt to have prenatal diagnosis, especially those who have lost children with salt losing variety, because even with regular therapy, normal life span cannot be guaranteed. Male patients of CAH can be missed because the clinical signs are minimal. In our case the child had a large phallus which prompted us to get 17α OHP levels done for diagnosis.

In conclusion we state that antenatal diagnosis of CAH can be accurately achieved by estimation of 17α OHP levels in AF. At birth the pediatrician should look out for good clinical signs in order to start adequate therapy in affected cases.

Acknowledgements :

The authors thank the ICMR for funding, the Dean Nowrosjee Wadia Maternity Hospital for amniocentesis, the Hon. Director ICMR GRC for continued support and Miss. Chavan for typing the manuscript.

References :

1. Youssefnejadion E, Florensa E, Collins WP and Sommerville IF : Radioimmunoassay of 17-Hydroxyprogesterone. *Steroids* 1972,20 : 773.
2. Frasier SD, Thorneycraft IH, Weiss BA and Horton R : Elevated amniotic fluid concentration of 17- α -OH progesterone in congenital adrenal hyperplasia. *J Pediatr* 1975,86 : 310.
3. Milunsky A and Tulchinsky D : Prenatal diagnosis of congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *Pediatrics* 1977,59 : 768.
4. Hughes IA and Laurence KM : Antenatal diagnosis of congenital adrenal hyperplasia. *Lancet* 1979, ii : 8132.
5. Hughes IA, Laurence KM : Prenatal diagnosis of congenital adrenal hyperplasia due to 21-hydroxylase deficiency by amniotic fluid. Steroid analysis. *Prenat Diagn*—1982,2 : 97-102.
6. Grosse-Wilde H, Valentine-Thon E et al. HLA-ABC, DR, Typing and 17 α OHP determination for second trimester prenatal diagnosis of 21-hydroxylase deficient CAH. *Prenat Diagn*—1988,8 : 131-143.
7. Patel ZM, Ambani LM et al : Antenatal Diagnosis of Congenital Adrenal Hyperplasia (9 case report) 1980, Vol. XVII—October.

Although CAH is a treatable condition, most couples opt to have prenatal diagnosis, especially those who have lost children with salt losing variety, because even with regular therapy, normal life span cannot be guaranteed. Male patients of CAH can be missed because the clinical signs are minimal. In our case the child had a large phallus which prompted us to get 17 α OHP levels done for diagnosis.

In conclusion we state that antenatal diagnosis of CAH can be accurately achieved by estimation of 17 α OHP levels in AF. At birth the pediatrician should look out for good clinical signs in order to start adequate therapy in affected cases.

Acknowledgements :

The authors thank the ICMR for funding the Dr. An. N. S. Wadia Maternity Hospital for amniocentesis, the Hon. Director ICMR, GRC for continued support and Mrs. Chavva for typing the manuscript.

DISCHARGE FROM NIPPLE OF BREAST & MASTALGIA

PROF. (MISS) URMILA KHANNA, MS. FRCS (EDIN. & ENG.)*

Nipple discharge occurs in 3 to 9% of patients as a result of alteration of physiological process due to secretion, normally. The pathological discharge is indication of the inflammatory proliferative or neoplastic changes in the breast. Discharge of pathological significance easily empties spontaneously from the ductal sinuses of nipple. Discharge coming out of milking of breast parenchyma or nipple areolar complex are most often from benign pathology.

Type of discharge :

A) Common.

B) Rare.

A) Common types are :—

1. **Bloody discharge**—is the most common type in reported series (50 to 55%) and it varies from bright red to brown in colour. In active breast clinics the most common type is dark green in colour. This is always being mistaken for blood. So a drop of discharge collected in a fine gauge can be identified as blood or not, and it can also be found by microscopic examination. The majority of blood discharge from breast are benign and result from epithelial proliferation, —occurs as a component of cystic disease or intraductal papiloma. This had to be differentiated from intraductal carcinoma where also blood discharge occurs. So every patient has to be examined very meticulously for presence of any associated lumps. On this basis programme has to be chalked out for the proper investigations and treatment of the individual case. A solitary mass in a post menopausal patient who presented with a bloody nipple discharge should be considered as malignant necessitating confirmation by biopsy and or papinicolau smear. In the spectram of diagnosis malignancy account for 9 to 14% of bloody nipple discharge, whereas intraductal papiloma is the most common diagnosis followed by cystic disease and duct ectasia. Haagansu reported that 11.5% of subcutaneous nipple discharge were all malignant in origin of which 55% were bloody in nature.

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

2. Milky discharge :—

Milky discharge is one of the normal physiological discharge from nipple which occurs during lactation, in pregnancy, in post caesarean and in post partum. Milky discharge does not have any relation with malignancy. The production and release of LTH can be inhibited by proper dosage of oestrogen, androgen and progesterone. Infrequently the milky discharge is a symptom of Acromegaly and also due to mammotrophic effect of growth hormone on breast tissue.

3. Serous discharge :—

This thin translucent straw colour fluid may occur spontaneously. As a result of menses, taking of cyclic oral contraceptives or any early pregnancy. Intraductal pathology or ductal atresia, fibro cystic disease and ductal papilomas. This could be confirmed by ductography prior to surgical interference.

4. Yellow or Green discharge :—

This is a characteristic of cystic disease of breast or galactocele. It is associated frequently with malignancy. Cytology of the discharge although desirable is rarely conclusive. It needs further investigations for confirmation of diagnosis.

B) Rare causes of discharge :—

This is due to circulating serum prolactin introduced by acedophilic, lactogenic cells of anterior pituitary. Elevated level has been noted in 25% of patients with nipple discharges of various etiology and occurs most commonly from normal physiological mechanism associated with nursing, intercourse, pregnancy and stress and strain. Also with the use of oral contraceptive, antihypertensive drugs and psychotropic drugs. About 1/3rd of the patients with secondary amenorrhoea, 1/4th with galactorrhea have elevated serum prolactin. These patients have to be investigated thoroughly by estimating multiple times of prolactin levels, X-ray of skull, CT Scan etc. to exclude pituitary growth which causes secondary amenorrhoea, libido, hirsutism, obesity etc. which need immediate attention.

Whatever may be the cause and type of discharge from the nipple every patient has to be investigated thoroughly. The following investigation are in our disposal: in every case a thorough history and meticulous clinical examination is most important and stress should be given on self examination of the breast by the patient which needs frequent and thorough

...ing so that they
...ography
...be done for conu
Last but not the
...considering the type
...investigation so tha
...through treatment could

References

- Amoradi J G 1979
Blicher-Toft M, A
Treatment of mast
study, British Medi
Bailey and Love's sh
Golinger R C 197
mastopathy, Surgery
Haagensen C D 19
W B Saunders and
Radfield G J 1960
disease of the breast
Hughes L E 1977
Smith (eds.) Operat
Prece P E, Fortt R
Some clinical aspect
Prece P E, Mansel
I H 1976 Clinical syn
Zeen B I, Gravelle
etnaia, British Jour
Strud-Ware R, Ster
Guzes, Part I; Ho
457-460.
The New Aird's Com
Edited by K. G. Bur
Churchill and Living

teaching so that they can do it themselves. Apart from that mammography, ductography, scanning, smear examination and biopsy of the lump should be done for confirmation of the diagnosis and treatment.

Last but not the least, final and thorough plan has to be worked out considering the type of discharge and presence of palpable pathology with investigation so that each and every case should be diagnosed and thorough treatment could be done according to credit of the individual case.

References

- Azzopardi J G 1979 Problems in breast pathology, Saunders, London.
- Bilchert-Toft M, Anderson A N, Henriksen O B, Mygind T 1979 Treatment of mastalgia with bromocriptine : a double blind crossover study. *British Medical Journal* 1 : 237.
- Bailey and Love's short practices of surgery, 21st Edition 1992.
- Golinger R C 1978 Hormones and the pathophysiology of fibrocystic mastopathy. *Surgery Gynaecology and Obstetrics* 146 : 273-283.
- Haagensen C D 1971 Disease of the breast, 2nd edition revised, W B Saunders and Co., Philadelphia.
- Hadfield G J 1960 Excision of the major duct system for benign disease of the breast. *British Journal of Surgery* 48 : 472-477.
- Hughes L E 1977 Operations for benign breast disease. In : Rob & Smith (eds.) *Operative Surgery*, Butterworths, London p. 64-71.
- Preece P E, Fortt R W, Gravelle I H, Baum M, Hughes L E 1979. Some clinical aspects of sclerosing adenosis. *Clinical Oncology* 5 : 192.
- Preece P E, Mansel R E, Bolton P M, Hughes L E, Baum M, Gravelle I H 1976 Clinical syndromes of mastalgia. *Lancet* 2 ; 670-673.
- Rees B I, Gravelle I H, Hughes L E 1977 Nipple retraction in duct ectasia. *British Journal of Surgery* 64 : 577-580.
- Sitruk-Ware R, Sterkers N, Mauvasia-Jarvis P 1979 Benign breast diseases. Part I ; Hormonal investigation. *Obstetrics Gynecology* 53 : 457-460.
- The New Aird's Companion in Surgical Study.
 Edited by K. G. Burnand and A. E. Young 1992.
 Churchill and Living Stone.

OBSTETRICAL OUTCOME IN ONE YEAR IN A SMALL HOSPITAL IN CALCUTTA RUN BY ASSOCIATION OF MEDICAL WOMEN IN INDIA (W. B.)

DR. BULBUL RAICHAUDHURI & DR. SUMANA SUR

Maternal and Foetal well being is the prime concern for an obstetrician. Every other day a new gadget or method is coming up to help obstetrician for safe delivery. But all facilities are not available in every maternity centre. There are small maternity units in the megacity of Calcutta. AMWI Mission hospital is one of them. It is a small 50 bedded hospital run by Medical Women only, catering to mainly women and children of low income group, having both free and paying beds, latter being on a very nominal charge. The visiting obstetricians render voluntary services. The medical Officers also work with spirit of service getting remuneration much below usual. The hospital is run mainly on donations and hence the hospital runs under strains, both on finance and manpower. One year obstetrical outcome of this hospital was reviewed. The period of study was from 1. 9. 94 to 25. 8. 95.

TABLE—1

Total no. of confinement : 467			
Religion :—	Hindu	96	20.6%
	Muslim	322	69.0%
	Christian	49	10.4%

This is because the area catered by the hospital is predominantly populated by Muslims.

It is seen Number of Muslim patients confined during the period were much higher than other communities.

TABLE—2

	Number	Percent
P ₀₊₀	215	46.1
P ₀₊₁	13	2.8
P ₁₊₀ —P ₂₊₀	114	24.4
P _{3+0+above}	125	26.7
Total	467	100.00

} 48.9

OBSTETRICAL OUTCOME
 Table 2. Shows prim
 89% (nearly 50%
 women prefer home
 process and illiteracy.
 contributing to lesser no. o
 The age group of p
 get an idea about teena
 Age in years
 15-20
 21-20
 20-above
 Total
 It will be evident
 girls were between th
 pregnancy was quite preva
 has risen to 18 years b
 women too. The perce
 because the people of p
 pregnancy.
 Anemia
 Post. C. S.
 Postdated
 P.E.T.
 B.O.H.
 Breech
 A.P.H.
 Twin
 Rh. Negative
 Pregnancy with Malaria
 Table 4 shows the
 ses. The hospital admits
 size iron and Calcium an
 to not follow the schedule
 require ANC had HB% mo
 of severe anaemia. There
 treated by L. S. C. S.

Table 2. Shows primi and virtually primigravids patients together comprise about 49.9% (nearly 50%) the possible reasons may be that the multipara sometimes prefer home delivery as they are scared of hospital due to their ignorance and illiteracy. Family Planning may have some role in contributing to lesser no. of multipara.

The age group of primi and virtually primi patients are scrutinised to get an idea about teenage pregnancies.

TABLE—3

Age in years	Number	Percent
15-20	122	53.5
21-28	98	39.9
29-above	15	6.6
Total	228	100.0

It will be evident from the Table—3 that about 53.5% of primigravids were between the age group of 15-20 years age. So teenage pregnancy was quite prevalent inspite of the fact that age of marriage has been raised to 18 years by law. In this group there were few unmarried mothers too. The percent age of elderly primi was quite low. This is because the people of poor community prefer early marriage and early pregnancy.

TABLE—4

Complicated Cases

Anaemia	50 (Cases below 9 gm. %)
Post. C. S.	13
Postdated	10
P. E. T.	48
B. O. H.	5
Breech	5
A. P. H.	1
Twin	5
Rh. Negative	2
Pregnancy with Malaria	1

Table 4 shows the no. of complicated cases in this series of 467 cases. The hospital admits only the booked cases. All patients are advised to take Iron and Calcium and two doses of Inj. TET-VAC. but all the cases do not follow the schedule of ANC properly. Those who have followed the regular ANC had HB% more than 9 gm.%. In this series there was no case of severe anaemia. There were 13 Post C. S. pregnancies. All of them were delivered by L. S. C. S.

There were 5 twin pregnancies of which 3 were very premature (500 to 800) gm. All of them had perinatal death. Though there were 48 cases of P. E. T. (about 11%), these are all mild P. E. T.. There was one case of severe essential hypertension, with IUGR which underwent L.S.C.S. with a living baby.

There were two cases of RH-negative mother with RH-positive baby who received anti D globulin after confinement. The case with malaria had high rise of temp. and had chloroquin and started spontaneous labour and was delivered by forceps. Baby was asphixiated but revived. The baby on follow up after 4 weeks was found to be healthy.

TABLE—5
Nature of Delivery

Mode	Number	Percent
Vaginal (noninstrumental)	401	85.9
Forceps	4	0.9
L. S. C. S.	60	12.8
Home Delivery	2	0.4
Total	467	100.00

Table 5 shows that noninstrumental vaginal delivery including, vertex, breech and twins were 85.9%. Forceps delivery in 4 cases, (0.9%). These two categories together shows that 86.8% were delivered vaginally. Whereas L.S.C.S. was done in 60 cases (12.8%). There were two cases who were delivered at home, but admitted with retained placenta. Manual removal were done in both the cases without any PPH.

TABLE—6
Different Types of V. Delivery
(Total 405 cases)

	Number	Percent
Normal Vaginal	392	96.8
Forceps	4	1.1
Face to Pubis	1	0.2
Breech	3	0.7
Twin	5	1.2
Total	405	100.00

The series show that 86.8% of the patients had vaginal delivery and 12.8% had L.S.C.S. One of the contributory factor in achieving higher percentage of vaginal delivery was the use of I. V. syntocinon and or Inj. Epidosin. After exclusion of any C.P.D. or other contraindications for vaginal delivery I.V. Syntocinon drip was used in most cases to augment labour, the dose varying from 2.5 to 5 units in 540 ml. of 5% Dextrose. Epidosin was used as I.M. injections and was often repeated at 1/2 to 1 hr. interval and maximum 3 injections were given. Of course in all such cases of augmentation of labour—labour was watched very closely. Induction of labour in suitable cases was also done with I. V. syntocinon.

Another striking feature in this series is that there was no case of P. P. H. due to uterine atonia. In addition to inj. mthergin 1 amp. at birth of anterior shoulder, 3rd stage was almost always aided in multi-gravida by additional syntocinon drip. There were two cases with perineal laceration, causing certain amount of P. P. H. from the laceration.

Review of LUCS Cases

Total case 60

Elective—30

Emergency—30

Age of patients—18-35 years

Profile of parity :

P0 + 0 32 more than 53%

P1 + 0 22

P0 + 1 1

P1 + 1 1

P2 + 0 2

P3 + 1 1

P1 + 3 1

Indications :-

1. Post CS
2. CPD
3. Non progress of labour
4. Foetal distress
5. Breech with big baby (Baby wt, 3 kg. to 3.6 kg.)
6. Post dated
7. B O H
8. Primi with PET with small for date baby
9. APH

Foetal outcome—all Live

Birth wt. 2.25 kg. to 4 kg.

Less than 2.4 kg. → 3

2.5 kg.—3 kg. → 29

3.1 kg.—3.5 kg. → 25

3.6 kg.—4 kg. → 3

Asphyxiated—2—revived. This is following **Emergency C. S.** for Foetal distress.

The overall picture revealed in this study is one of no maternal mortality and rare maternal morbidity.

Foetal outcome—The average foetal weight in full term babies varied from 2.25 kg. to 3 kg. There were 22 babies below the birth weight of 2 kg. at varying weeks of gestation. There was a perinatal loss of 14 babies, 7 were from premature twin deliveries some of whom were admitted with IUFD. This is due to the fact that these patients do not realise the value of rest in twin pregnancy. There was two cases who were admitted with IUFD after being manhandled at home by dais. Though all the cases were booked, the patients often come very late in labour as they are scared lest LSCS is done on them. There was one case of intranatal death of foetus during assisted breech delivery.

To reduce perinatal loss—special care for the premature, under weight and asphyxiated-babies is a must. This hospital being small had to send the very sick or very small babies to special centres. One of the reason for lower perinatal loss is institution of Breast feedings. Almost all babies are fed on breast.

When safe motherhood and Baby friendly hospital are the talk of the day the present study indicates that even with limited resources—proper supervision in antenatal and intranatal period can pull up the maternal and foetal salvage to a desirable level.

IMPROVEMENT IN HEALTH CARE OF FEMALE PRISON INMATES ; THE CALCUTTA EXPERIMENT

DR. ARATI BASU SENGUPTA, *B.Sc., MBBS, DGO, MD (Cal.)**

Abstract :

Health care of prison inmates is the responsibility of the jail authorities and medical services are available inside the prison. But the social outcasts seldom receive the medical attention they deserve. The female inmates are specially disadvantaged. Again out of them the Non-Criminal-Lunatics or the NCL's are the worst sufferers. Recognising this fact a leading judge of the Calcutta High Court, through a special order, instituted medical examination of female inmates of the largest State prison in Calcutta by outside specialists from NGO's. In the process it was found that some of the NCL's are perfectly normal. They were released and sent back to their own homes or in its absence, to homes run by Women organisations. Mother Teresa took the rest to her fold. This involvement of outside specialists helped in the diagnosis and treatment of the sick inmates and also the betterment of the overall living condition of the female wards of the prison by involving the prison officials. The district jails are now being taken up for similar improvements.

The author provides an account of her experience as a medical expert nominated by the Court in this unique initiative,

Introduction :

Prisons are well-guarded places where persons, proved or otherwise apprehended to be dangerous to the civilised societies, are kept in detention. Not always so. In jails are also kept victims of crimes like rape and stray wandering girls for their own 'safety'. There is another category of persons, those who are mentally unsound. In India, the Magistracy is empowered, by the Indian Lunacy Act, to cast mentally ill persons in the safe custody of the prison labelling them as Non-Criminal Lunatics (NCL's). Thus there lives in the harrowing conditions of the prison a number of

* *Consultant Gynaecologist and Obstetrician, Secretary, Association of Medical Women of India (W. B.) India.*

Paper presented at 23rd International Congress of the Medical Women's International Association, May 7th-12th, 1995. The Hague, The Netherlands.

people—some of them perfectly normal—because their existence has come to a nought to the outside world. The prison conditions are never ideal and seldom conform to even the rules laid down. In fact, there is not likely to be a large difference between the living conditions of convicts / criminals and non-criminals in jails, except for certain security measures. The misery of such ill-fated persons was not brought before the public eye till recently and through the efforts of a group of kind lawyers, the Supreme Court of India took cognizance of the illegality of the detention of mentally sick persons and the Mental Health Act of 1987 brought hope of a normal life to many NCL prison inmates. Along with theirs the case of the other inmates like rape victims, stray girls and under-trial prisoners has also drawn considerable attention. An Hon'ble Judge of the Calcutta High Court took all the initiative to invite the services of NGO's in improving the health-care services and also the general living condition of the female prison inmates. Since the case of the NCL's was the most glaring this was taken first. The Hon'ble Judge also succeeded in releasing, from the Presidency Jail, Calcutta, a good number of female NCL's, now normal, and they have been taken back to their own homes by their relatives or rehabilitation centres of reputed voluntary organisations, like the Missionaries of Charity of Mother Teresa. Amongst those released were a young medical doctor and a lady teacher with post-graduate degrees. Due to measures taken, the overall quality of life of the prison inmates in general has shown definite improvement with introduction of literacy, health awareness and other campaigns inside the prison. The Legal Aid Services of West Bengal, a social justice oriented organisation of eminent lawyers offering free legal counselling to the needy, has also come forward and provided commendable support. This Calcutta Experiment is spreading to other jails under the jurisdiction of the Calcutta High Court i. e. within the State of West Bengal.

Life in prison : Need for more care :

Prisons have to be different because of the special nature of the inmates. Largely criminals are kept in detention there as a form of punishment to rectify themselves. It is also necessary to keep those who are prone to commit crimes isolated from the rest of the society. Naturally, the rules are to be very strictly enforced and the many of these relate to the access to the inmates. Surrounded by high walls under the watchful eyes of armed guards the prisoners are required to live an isolated life, but whatever may be the degree of crime the fundamental human rights allow them to have food, clothing, shelter and medical services. Every prison has a physician attached to it and also hospital facility with outdoor clinics and indoor beds for treating the sick inmates. In serious

cases when the in-house facilities are proved inadequate the sick inmate is sent to outside government hospitals under strict security guard for treatment. The system is in vogue for many years in the jails of the country and there never arose any occasion to call for a change. But the NCL inmates who are psychiatric patients need not only regular monitoring but also care and special therapies besides the drugs. There should at least be a sympathetic approach if a cure is genuinely intended. Living in an unfriendly climate and often deserted by relatives such patients with hardly any light of hope, languish in the dark prisons year after year. They live a dreary deprived life.

The new initiative :

Moved by the pitiable conditions a group of lawyers appealed to the Supreme Court of India and the detention of NCL's in prison had been declared illegal. But the unfortunate victims, over the years, have lost contact with the outside world and even the 'cured' or the normal ones could not expect their relations eagerly waiting outside to take them back home. However, the Hon'ble Judge of the Calcutta High Court, through his special orders in 1993-94, first arranged the entry of teams of medical specialists into the jail and thorough examination of the female inmates of the NCL ward.

The Court through the appointment of Officers from lawyers, doctors and responsible people with social commitments monitored the pre-release and post-release exercises for the NCL's. The Special Officers prepared comprehensive data sheet of every NCL taking efforts in collecting the information from the jail records, from personal enquiry when possible and from other inmates. They also visited the relatives' homes to persuade the family members to take back the NCL into their fold. The efforts paid dividends and some of the NCL's, though few, returned to their homes, some others were taken to rehabilitation homes run by voluntary organisations, like the Missionaries of Charity of Mother Teresa. Out of the rest the seminormal ones were sent to government-run mental hospitals for admission on priority basis. A handful, old and with acute communication difficulties, for whom the outside worlds appeared more alien than inside, remained. The Special Officers were also empowered to visit the jail for monitoring the food distribution system. Health awareness campaigns were conducted for the inmates, the ward assistants and other support staff. A visible change could thus be created in the overall living condition inside the jail. The experience at this Central Jail was so encouraging that similar directives were issued to all other jails in the State and later visits have confirmed the desired improvements.

The rape victims and stray girls, deserted by their families, confined in the jail also live a life in squalor. The Court took up their case too and the jail authorities had been directed to segregate them from convicts and under trials. Thorough medical examination of these inmates have also been conducted by the specialist. Serious efforts are also being taken by the special Officers for their early release and rehabilitation.

Health examination of female prison inmates :

The order by the Hon'ble Judge also made a detailed health examination of the inmates possible. To begin with an eye specialist, a psychiatrist and a gynaecologist was authorised to examine the inmates. As the gynaecologist, the author had an experience which is both sad and rewarding. The living condition, crowded and squalid, speaks of the distressed existence. The inmates, specially the NCL's, were apprehensive and reluctant to undergo the examination. Personal histories were scanty and most of the informations were collected from other normal inmates, female ward assistants and jail records and often these were conflicting. The 298 inmates examined were from 18 to 65 year old and the education level from pure illiterate to post-graduate degree holder. The internal examinations revealed two interesting facts : (a) insertion and retention of foreign bodies, like steel bolts, slender vegetables, pieces of cloth, etc. inside the vaginal canal, and (b) healthy condition of cervix of almost all. The inmates living in the open space with no privacy had rather group sex habits than individual ones. The inmates did not take good care of their personal hygiene either because of ignorance or the circumstances. (A recent controversy has centred on the advocacy of hysterectomy for NCL's incapable of taking care of themselves during menstruation). The remedial measures suggested were : (i) Health Education and General Awareness Training Programmes for ward assistants, (ii) Medical advice and counselling to inmates on a regular basis, and (iii) creation of recreational and attractive vocational training facilities for mental diversion.

Besides the NCL's the health examination has also been extended to other inmates. The response has been very good and welcoming. A kind of familiarity has also been established and the sight of doctors and special Officers now brings in a sense of relief to the unfortunate souls. The programme has also met an equal success in other jails. The involvement of specialists with voluntary zeal has silenced the critics and the Special Officers appear to be determined to carry the mission motivated as they are by the kind-hearted Hon'ble Judges.

Conclusion :

The Human Rights movement has led to prison reforms everywhere but still the living condition inside the jail specially in developing countries needs further improvement. The jails are overcrowded, sanitary conditions poor and there is often the lack of due medical care. The plight of the Non-criminal Lunatics forced behind the bars and usually deserted by their families is indeed tragic. It is fortunate that moved by their deep silent sufferings a group of people with humane heart has initiated the improvement in Calcutta and this being extended to other prison inmates, both male and female, in all the jails in the State of West Bengal. Similar initiatives are also reported from other States of India. The NGOs can play a very important role in the implementation process and volunteers with professional backgrounds can bring in the healing touch most efficiently. Caring for others in societies, turning more and more indifferent, has a lasting impact and the Calcutta Experiment in improving the health care of the prison inmates, is going to be a success, setting an example of how love and care can restore hope in those thrown into misery. To the author, the experience will remain the most rewarding one.

Acknowledgement :

The author is grateful to her associates in the work at the Presidency Jail and specially to Hon'ble Justice D. K. Basu for his kind permission and alround support. She also expresses her gratitude to Mr. G. N. Ganguly, Sr. Advocate, Calcutta High Court for removing the legal obstacles, the Presidency Jail authorities for providing full co-operation and all the Special Officers for rendering constant help.

* Associate Professor Calcutta National Medical College, Page of 6 & 7.
 ** Principal & Professor G. O. Calcutta National Medical College, Calcutta.

ROLE OF PSYCHOSOCIAL STRESS CAUSING D. U. B. IN REORODUCTIVE AGE GROUP

DR. RATNA SANYAL & DR. GOPAL KRISHNA DAS

Introduction :

D. U. B. is defined as cases of menorrhagia in absence of organic disease of the genital tract (3). D. U. B. is not a singlar disease entity but a group of diseases with varied aetiology which result in abnormal uterine bleeding (7). Complaint of menorrhagia might reflect underlying problem not directly related to menstruation (1). In a large study greater number of women having menorrhagia had recent major life-events e. g. bereavement etc. compared to the matched group of women having normal menses (12). Progressive P. C. O. D. which might causes D. U. B. also, was clearly demonstrated to be associated with sustained emotional stress (2). It was also observed that history of psychiatric illness was significantly higher in patients undergoing hysterectomy, compared to matched controls (8).

Methods & materials :

50 cases of DUB in the reproductive age group were collected from GOPD of North Bengal Medical College, Siliguri West Bengal over a period of 1 yr. from 1.1.90-31.12.90 when both the authors were posted in that institute. All the patientt were entered into the study after taking detailed history, thorough clinical examination, routine investigations, endometrial biopsy and USG. Endoscopic examinations were performed when necessary. All the women and their husband were counselled and 30 women of primary DUB having normal endometrial pattern were not prescribed any hormone, instead they were repeatedly counselled and only Alprazolam 0.25 mg. was given at bed-time. Other patients of iatrogenic and secondary DUB were treated accordingly. All the 30 cases of primary DUB were called after 3 months. It was encouraging that 22 cases have shown much improvement, they were further counselled. their husbands had fully co-operated with us and they were asked to come back after 3 months. Rest of the patients were given hormonal therapy. After 6 months only 7 patients had persistant

*Associate Professor Calcutta National Medical College, Dept. of G & O.

**Principal & Prohessor G & O, Calcutta National Medical College, Calcutta.

OF PSYCHOSOCIAL
and they were
of 15 patients i.e. 30
Analysis :
Parity
0
1
2
3
It is evident that mos
TABLE-II
Inhabitants of Patien
No. Pa
35
15
90
It shows that 50%
From this table it
and above.

ROLE OF PSYCHOSOCIAL STRESS CAUSING D. U. B. AGE GROUP 31

menorrhagia and they were also treated by appropriate hormones. A total number of 15 patients i.e. 30% were completely relieved of their symptoms.

Result & Analysis :

TABLE—I
Distribution of parity

Parity	No.	Percentage
0	5	10
1	5	10
2	30	60
3	10	20
	50	100

It is evident that most of the patients are para 2 and above.

TABLE—II
Inhabitant of Patient

Residence	No.	Percentage
Urban	35	70
Rural	15	30
	50	100

TABLE—III
Educational Status

Education	No.	Percentage
Illiterate	25	50
Primary	18	36
Secondary	5	10
Higher	2	4
	50	100

It shows that 50% women were illiterate and 36% had primary schooling.

TABLE—IV
Family Income

Income	No.	Percentage
Upto Rs. 1000/-	10	20
1001 — 2000/-	25	50
2001 — 5000/-	15	30
	50	100

From this table it is clear that 80% of the total is middle income group and above.

TABLE—V
Occupation of wife

Occupation	No.	Percentage
Housewife	49	98
Service	1	2
	50	100

TABLE—VI
Occupation of husband

Occupation	No.	Percentage
Business	40	80
Police	8	16
Other Services	2	4
	50	100

Table V shows that 98% women were housewives.

It is very remarkable that 80% are businessmen and 16% are police or army men.

TABLE—VII
Endometrial Pathology

Type of end	No.	Percentage
Normal	30	60
Hyperplasia	15	30
Irreg ripening	2	4
Irreg shedding	1	2
Atrophy	1	2
	50	100

Our findings with endometrial picture tallies well with Sutherland Kistner (60% was normal).

TABLE—VIII
Types of D. U. B.

Type	No.	Percentage
Primary	40	80
Iatrogenic	9	18
Secondary	1	2
	50	100

We found 80% cases are of primary DUB. Out of this 18% are iatrogenic, 16% cases were due to intake of irregular O.C. and 1 case followed Cu-T insertion.

80% women suffered from primary DUB and there were 18% i.e. 9 cases of iatrogenic DUB. Out of these 9 cases, 8 cases occurred after irregular and / or prolonged use of steroidal contraceptive and one case followed introduction of Cu-T. (9). Only one case was secondary due to thrombocytopenia.

30 out of 40 cases of primary DUB have shown normal endometrium. These 30 women have expressed their underlying stress and we have evaluated psychosexual relation with their husband by 5 sets of questions mentioned above. The result was very remarkable—25/30 cases were not satisfied about their husbands physical presence. Most of these people used to stay out of their family for days together. 20/30 women were not satisfied with their husband regarding sharing of house-hold responsibility; they often complained that their husband never bothered to know or tried to solve their problem. 20/30 were dissatisfied regarding their husband's negative attitude to take part in child rearing. 25/30 women also complained about their husband's carelessness for their emotions. Role of psyche in regulating menstrual flow has been established by many authors (1,5). PCOD which is found in some cases of DUB is shown to be caused by psychological stress. 20/30 women were very unhappy as they could not fully enjoy their married life due to non-availability of their partner. Psychogenic menorrhagia is described to be caused by real or even imagined separation of a loved one. (1). DeSouza (5a) found 1/3rd of his patients complaining of unsatisfied sex relation. (5a) It was encouraging that at 3 months follow-up 22/30 patients of primary DUB have shown some improvement without any hormone or antiprostaglandin drug. These patients were only repeatedly counselled along with their husbands and only given Alprazolam 0.25 mg at bed time. After 6 months 15/30 cases were completely relieved of their symptoms. In this group we found full co-operation of their spouse who have supported these women and helped them overcome their stress. This study therefore confirms the idea that reassurance and sympathetic handling of psychologic and emotional problem has enormous role in treating cases of DUB(S).

References :

1. Abhayankar R, Bagadia V—Ind. J. of Psychiatry, 21. 328, 1979.
2. Chakravarty B. N., Gun K. M., Mukherjee S—Ind. J. of Psychosomatic O & G 1; 20, 1980.
3. Davy D. A.—Dewhurst's T. B. of G & O for PG, Whitefield C. R. Blackwell Scientific publ, Oxford 1995, 590.
4. Dawn CS, T. B. of Gyn. & contraception, 11th edn. 1992, Dawn Book Calcutta, 149-186.

ROLE OF PSYCHOSOCIAL STRESS CAUSING D. U. B. AGE GROUP 35

5. Dutta DC. T. B. of Gyn. 2nd. edn, 1994, New Central Book, Calcutta, 173-184.
- 5a. DeSouza A, Choudhury PC, Galverker H. J. of J. J. gr. of Hosp. & Grant Med Coll. XIX, Jan. 1974.
6. Kistner R. W. Principle & Practice of Gyn., Yr. Book Pub. Chicago, 1964, 238.
7. Novak E. R. Jones GS, Jones HW-Novak's T. B. G, n. Willium & Wilkins, Baltimore. 1971, 8th edn. 238.
8. Richard DH-Lancet, 2 : 430, 1973.
9. Slader R J, Laird E, Beynon G-Key Topic in O & G -R. W. Shaw Bios Sc. Publ. Oxford, 1993, 67-69.
10. Sutherland AM—Glasgow Med. J. 34 : 496-509.
11. Sarker B.—DUB-proceed of Int. meet on Safe Motherhood, Calcutta Modern Graphica, 1996, 216-216-220.
12. Smith & Haining—Paediatric and adolescent Gyn. Ed. Jones and Heller Willium Wilkins, Baltimore, 1st Edn. 1966, 484-500.
13. Taylor ES—Essentials of Gyn. Lee & Ferbigger, Philadelphia 3rd Edn. 1965, 429.
14. Wig N. Rustogi PK—O & G for PG, Ed. Krishna Menoh, M K. Devi P. K. Bhaskar Rao, K., Orient Longman, Bombay, Calcutta 1982, 484-498.

M. W. I. A. NEWS

MWIA News and Report of N.C.S.

NCS Dr. J. Trivedi has received the report of the Beijing Congress, which was attended by the International President Dr. Florence Manguyu. Details of the Regional Conference in Auckland N.Z. also was given. Some members from West Bengal Branch have gone for this conference to New Zealand, The next International Conference will be held at Nairobi in 1998.

Golden Jubilee Scholarship :

No applications have been received for the last 3 years and because of the accumulated interest the Scholarship has been enhanced from Rs. 1,200/- per annum to Rs. 1,900/- per annum. The corpus stands at Rs. 15,000/-.

International Congress :

The 23rd International Congress was held at the Hague Netherlands in May 1995. About 13 delegates from India attended. New President Dr. Florence Manguyu was installed. Dr. Lila Stein Kroser was elected President elect.

Beijing : Many MWIA members and other medical women in their official National delegations attended the 4th World X Conference on Women (FMCW) held at Beijing, China from 4th to 15th September, 1995. About 40 thousand people went to China to attend the Conference in different capacities.

MWIA President Dr. Florence Manguyu, Kenya has given short report of the same. In her report she says, that the U. N. Charter the first International instrument to establish the principle of equality for men and women was established in 1945. Since then a number of steps have been taken to improve the status of women.

Millions of individual women continue to face discrimination in social, economic, political and cultural aspects.

MWIA was quite visible at both the NGO Forum and at the Conference, as the forum members of MWIA organised an afternoon workshop on the theme "Women's Health in the changing World", as agreed during the 23rd MWIA Congress in the Hague. This was a very successful

workshop from which MWIA made a statement which was distributed to the heads of the national delegations. Also successful workshop was the health day at the African tent organised by the MWIA member from Africa on theme "Investing in Women's Health". Two members of the MWIA Executives also participated at the panel discussion organised by the WHO on the theme. "Health Security for Women".

To provide a basic for preparatory discussions and final negotiations at the Beijing Conference, the U.N. Commission on Status of Women has issued a draft platform for Action focussing on 12 "critical areas of concern", that have been indentified as obstacles to the advancement of women. These are, proverty, Education, Health, Violence. Armed conflicts, economic disparity, power-sparing Institutions, Human rights, Mass media, Environment, and girl child.

The International President feels that with the Conference over MWIA needs to see how we can contribute to the implementation of the programme for Action in the different countries where our members are. She feels that when the mid decade review of the conference comes in five year's time, we can look back with satisfaction and say that we have made some progress towards improving the health status and well being of women. And when the next Conference comes around in ten year's, we should be able to say that women have been rightly placed in the mainstream of human development. After all, women are not just half of the world's population, we produce the other half.

ASSOCIATION NEWS

Central Office : There was no Council Meeting in 1995. About 14 members attended the International Conference at the Hague in May 1995. India presented the Dr. J. Jhirad Oration to Dr. Cornelia at the Conference.

Bombay Branch : The 22nd Cytology course was held in April 1995. 54 doctors and technicians participated. The Shirin Mehtaji Competition for Junior doctors was held in November 1995. Indian Academy of Cyto-logists Silver Jubilee Conference was jointly hosted by AMWI Bombay Branch. The J. Jhirad oration for 1994 was given by Dr. Usha Luthra at the Conference. AMWI Bombay Branch also presented the Winified Fernandes Oration, the Dr. P. Daroowalla guest lecture and the Shirin Mehtaji Cytology Oration at the time of the Conference. Further 2 prizes were given by Bombay Branch for the best posters.

J Jhirad Oration : A very good file has been maintained with photographs and details of the orators through the years. The 1993 oration was given in 1995 at The International Conference at the Hague by Dr. Cornolia, and the 1994 oration given by Dr. Usha Luthra in November 1995. The 1995 oration will be given in February 1997 at Regional Congress.

Dr. J. Jhirad Library : Books worth Rs. 4,628/- were purchased in 1993. and books worth Rs 163/- in 1994. No purchases in 1995. The library is now maintained at the Cytology Clinic.

24th Annual Cytology Course was held between 8th and 18th April, 1996.

The Course was inaugurated by Dr. D. G. Dongaonkar, the Dean of Grant Medical College Dr. Prakash Bhatlamande, Joint Director of Public Health, Govt. of Maharashtra was the Guest of Honour.

The course was attended by 26 candidates many of whom had come from out of Mumbai.

Advani-Braganza Oration was given by Dr. Prakash Patil, Professor from J. N. Medical College, Belgaum. The Chief Guest on this occasion was Dr. Mehroo Hansotia, who awarded the certificates to the participants.

Dr. Rajam Jaishanker from Chemceh Laboratories personally attended the function and gave a donation of Rs. 5,000/- from Chemech Laboratories.

Cytology Clinic was the receipient of a munificent donation from Ishwardas Bhatia Trust to upgrade the Cytology Laboratory. One lakh was donated to renovate the Laboratory and install an airconditioner. One lakh was also donated to the Corpus Fund to maintain the same Laboratory.

West Bengal Branch :**Secretary's Report :**

The West Bengal Branch of the association is involved in the following activities as before :

Welfare Work :

Hospital—Patients treated at AMWI Mission Hospital from January to December 1995 :

Total No. of Patients treated ... 7349

No. of Operations ... 179

No. of Deliveries ... 494

Immunisation :

B.C.G.—244, Measles—133, DPT & Polio—851, on December 9, 1995 and June 20, 1996 Pulse Polio immunisation programme was undertaken at the Hospital with good response.

Dr. Hemprova McDonald Cancer detection centre screened 229 cases.

All India Radio made a special programme on the Hospital. It was broadcast on October, '95.

The free Clinic at Union Chapel is carrying on with treatment and free supply of medicine and also Cancer detection and immunisation.

Two health check up and Cancer screening camps were held at the outskirts of Calcutta during the year. The association also collaborated with I.M.A. Calcutta in Dr. Shibkumari Chatterjee Memorial Cancer Screening Programme.

Scientific :

Prof. Anjali Chatterjee Memorial Oration was delivered by Dr. Sandhya Ghosh, an eminent haematologist on 10th July, 1995. Prof Anjali Chatterjee memorial awards, for outstanding voluntary medical service and for Lady Medical Research worker in Biochemistry went to Dr. Urmila Khanna and Dr. Archana Chatterjee respectively.

Prof. Anjali Chatterjee Memorial Oration for 1996 was delivered by Dr. Tulsi Basu, Head of Anestheology, Ramkrishna Seva Pratistha.

Dr. Mukulika Konar Oration for 1995 was delivered by Prof. Dr. Mahamaya Sarkar. The same Oration for 1996 was delivered by Prof. Dr. Anila Sengupta. A Clinical meeting reviewing the obstetric cases at Mission Hospital was held. The speaker was Dr. Bulbul Raichaudhuri.

A discussion session was held with 'Paridhi', a womens group from Delhi on diaphragm as family planning device on March '95. Another Clinical meeting was held on 10th February, Dr. Adrija Sarkar was the speaker.

Social :

A get together was arranged at the Mission Hospital on 25th November, '95. Large number of members attended. Everybody enjoyed on the occassion. Armenian New year was celebrated on 6th January this year with ailing Dr. Marie Catchatoor as the central figure.

Eight members from West Bengal Branch attended M.W.I.A. International Conference at Hague, Netherlands. Several members from the branch attended the Western Pacific Regional Conference at Auckland New Zealand.

Number of Executive Committee Meeting during the year—7

Annual General Meeting—1

Association of Medical Women in India (West Bengal Branch) is grateful for following gifts for Mission Hospital.

- (1) Dr. Prof. YOKO HASHIMOTO. Vice-President M.W.I.A. fort Western Pacific, Dept. of Physiology, Tokyo Medical College for Women, Tokyo 162, Japan.
 - (a) Her gift of keidoscope a type of Stethoscope including for fetal heart.
 - (b) Baby clothes and fo1 children from her association members of Tokyo. All were sent by air mail at very high postage.
 - (2) Dr. G. Casper, Chairman, young forum MWIA unit 501 "Bibaringa" 349 New South Head Road, Australia 2028. For sending various items for patients of Mission Hospital through Dr. and Mrs. Brian Spurret who has promised further donations and training of young doctors in Australia. They were very pleased with services of Mission Hospital which they visited, and realised inspite of absenee of modern facilities good attention and treatment is given to under priviledged
- Thank you Please continue with your good work.

**Dates of Forthcoming International, Regional and
National Congress and Meetings**

MWIA and International Congresses

1997

13-24 January
99th Session of the WHO Executive Board, Geneva, Switzerland.

01-02 February
1st MWIA Central Asia Regional Congress, Bombay, India.

02-04 May
MWIA Executive Committee Meeting, Cologne, Germany.

17-19 May
3rd MWIA Southern European Regional Congress, Paris, France

15-19 September
WHO European Regional Committee Meeting, Istanbul, Turkey.

1998

14-18 September
WHO European Regional Committee Meeting, Copenhagen, Denmark.

October
1st MWIA Latin American Regional Congress, Sao Paulo, Brazil.

06-11 December
24th MWIA International Congress, Nairobi, Kenya.

1999

7th MWIA Western Pacific Regional Meeting, Seoul, Korea,

2001

April
25th MWIA International Congress, Sydney, Australia.

MWIA Executive Members and Committee Chairwomen 1995-1996

President : Dr. Florence W. Manguyu, P.O. Box 41307, Nairobi, Kenya

Immediate Past President : Dr. Dorothy Ward, Montgomery Drive Giffnock
Glasgow G46 6PY, United Kingdom.

President-Elect : Dr. Lila Stein Kroser, 2855 Welsh Road, Philadelphia,
PA 19152, U.S.A.

Treasurer : Dr. Hannah-Reeve Sanders, 14 Florentia, 329a Beach Road,
Bantay Bay 8001, South Africa

Postal Address : P.O. Box 154 Cape Town 8000, South Africa.

Secretary General / Secretariat : Dr. Carolyn Motzel, c/o MWIA Secretariat,
Herbert-Lewin Str. 1,50931 Cologne, Germany.

Assisant Secretary General : Dr. Waltraud Diekhaus, Füssmannstr, 21,
44265 Dortmund, Germany.

Vice-Presidents

Northern Europe : Dr. Anna-Maija Seppäläinen, Heinäsuontie 22, 00430,
Helsinki, Finland.

Central Europe : Dr. Gertrud Zickgraf, Matthias-Claudius-Str, 5, 65185,
Wiesbaden, Germany.

Southern Europe : Dr. Christine Pouliart, St. Laureisstraat 85, 2018
Antwerp, Belgium.

North America : Dr. Jean Swenerton, 1995 Sasamat Place, Vancouver, B. C.
V6R 4A3, Canada.

Latin America : Dr. Rebeca Kuniyoshi, Ricardo Palma 365, Miraflores,
Lima 18, Peru.

Near East and Africa : Dr. Mervat El Rafia, Professor Public Health, Faculty
of Medicine, Kasr El-Einie Hospital, Cairo University, Cairo, Egypt.

Central Asia : Dr. Tulsi Basu, 10, Protapaditya Road, Calcutta 700 026, India.

Western Pacific : Dr. Yoko Hashimoto, Department of Physiology, Tokyo
Women's Medical College, 8-1 Kawada-cho, Shinjuku-Ku, Tokyo 162, Japan.

142

UNIVERSITY OF HAWAII LIBRARY

107

ASSOCIATION OF
MEDICAL
IN



LXXXIV