

# Medical Journal of Basic and Applied Research

An Official Publication of Research Society of SKNMC, Pune

*Volume -3, No. 2, August 2022*

## CONTENTS

### Editorial

1. Narrative Medicine- Model of reflection and means to holistic care. 05-08

**Dr. Priya Mardikar**

### Original Articles

1. Comparison between various methods of management of uterine polyp and to find out the most effective and safe method. 09-11

**Dr. Poorva Patil, Dr. Sameer Darawade, Dr. Aparna Sasane**

2. A comparative study between total laparoscopic hysterectomy and non-descent vaginal hysterectomy for the treatment of benign diseases of the uterus 12-20

**Dr. Tanya Jha , Dr. Hitendrasingh Patil ,**

**Dr. Gulab Singh Shekhawat**

### Review Articles

1. Amended MTP Act 2021 : A critical review and the way ahead. 21-25

**Dr. G. S. Shekhawat , Dr. Shantanu Sembalkar,**

**Dr. Divya R. Meghrajani**

## **Case Reports**

1. Lupus Miliaris Disseminatus Faciei- A rare inflammatory dermatosis. 26-29  
**Dr. Gurman Singh Bhasin , Dr. Swapna Khatu**
2. Hysteroscopic Cu-T Removal: An Innovative Approach. 30-31  
**Dr Shivani Lasure, Dr Ketaki Junnare**
3. Case series of Gullain Barre Syndrome 32-36  
**Dr. Abhijit Chavan, Dr. Jitendra Ingole**

# Research Society of SKNMC, Pune

## Journal of Research Society SKNMC, Pune

### Author's Instructions

The manuscript must have separate documents

1. **Cover letter.**
2. Main document should contain abstract and original Research Article/ Review Article/ Case report / Letter to editor.
3. Figure /Tables /Graph /Flow charts.

#### 1. Cover Letter

A cover letter is a letter addressed to the Editor-in-Chief of the Journal of The Research Society of SKNMC stating why the article should be considered for publication. It should include source of funding and conflict of interest.

Main document should include Abstract & the research article

#### Abstract :

An abstract is a brief summary of a research article, A well written abstract is informative and completely self-explanatory. Abstract for original research article has to be structured and should be divided into the following section.(Objectives, Methods, Results and Conclusions )The abstract for Review article and case report may be unstructured and should not exceed 250 words.

#### 2. Main document.

Its contents vary with the type of Article.

#### Original Research Articles

Original Research Articles should include Introduction Methods, results, statistical analysis, discussion it should not exceed 2500 words.

#### Introduction

Introduction should include Aims & Objectives & should consist of 75-100 word.

#### Methods

Methods should mention IEC approval, CTRI registry if any. Study design should be specified Selection of participants along with inclusion/exclusion criteria and source of population must be mentioned.

#### Results

Results Maximum 6 tables/ graphs/ figures allowed . Tables should be labelled in Arabic (Not roman).

#### Discussion

Discussion should consist of summary of key findings, ( primary and secondary outcomes, results, hypothesis), confounding factors, ROI, Strengths and limitations of study should be mentioned here. Do not repeat results in discussion.

Maximum authors allowed-6 ( Others can be given acknowledgement).

Maximum 30 references.

---

## **Review article**

Review article it is a scholarly analysis of the latest trends or current state of a particular topic . No new data or personal experiences should be presented . An analysis of the advances in this field is based on a literature review on the subject.

## **Abstract**

Abstract – Upto 250 words (Unstructured)

Article ( Main document should not exceed 2500 words.) 6 figures, 30 References.

## **Case Report**

Interesting and rare cases can be presented. Cases with clinical significance & Implications will be given priority

Abstract-Should not exceed 150 words . Main document –upto 1000 words with maximum 2 tables/ figures allowed upto 10 references to be given .

## **Letter to editor**

Letter to editor should contain maximum 250 words excluding references and tables.

Maximum 5 references and 2 tables can be incorporated.

## **Writing instruction -**

While making presentation there should be single spacing. Font of 12 TNR, Page no. should be mentioned at bottom, references must be mentioned after punctuation as superscript without brackets, use UK English uniformly. Numerals at beginning of each sentence must be spelt out.

## **References**

References should be written in Vancouver style. Name of Authors ( Max 6 Followed by et al, if more). Name of the article. Name of the journal year of publication ; Issue : Page number. The citations should be in round brackets after fullstop.

\*\*\*

## **NARRATIVE MEDICINE - Model of Reflection and Means to Holistic Care**

**Dr. Priya Mardikar**

Professor & Head  
Department of Physiology  
SKNMC&GH, Pune

“The patient will not care how much a physician knows, until he knows that the physician cares”

### **Background**

A Physician-Patient relationship is sacrosanct, fiduciary and asymmetrical. It is sacrosanct because patient reposes trust in the physician to cure the illness. A fiduciary relation ensures ethical obligations at both ends to accept responsibility of treatment given and received. It is asymmetrical due to the tipping of balance of power in favour of physician in deciding the “what, how and when” of healthcare services.

Narratives have always been vital part of medicine. Narration of experiences of both, patients and physicians were a norm, which later got ignored in the favour of facts and findings. The past era of medicine was full of physician-patients anecdotes and served as means to add flavour to the medical education and practice. Advent of sophisticated technology driven tests and various investigations, practice of defensive medicine, contradictory objectives of clinical and financial targets, tremendous influence of social and electronic media and soaring of evidence based medicine obscured these anecdotes. Last decade

though has seen the return of narrativity in medicine and “Physician-ship curriculum” with physician as a healer and a professional has gained momentum once again.

Often the treatment is meted out to a system, organ or tissue, with less focus on patient as a whole person, wherein his/her despair, distress, desires and feelings take a backseat, mostly owing to emotional unavailability of the physician or ignorance of the patient to freely discuss, tell his/her story. The very element that defines this unimpeachable relationship can be engendered only through proper communication and empathy, focusing on shared model of doctor-patient relationship, all the while moving away from paternalistic approach of practice to patient-centered medicine. Physicians receive very limited formal training in the patient communication skills, despite the fact that throughout their professional span they encounter humungous sessions of patient interaction and thus act as hurdles for the core humane interaction between a clinician and the patient.

Medicine practised effectively is often accompanied by narrative competence. An ear lent faithfully, empathetically can direct a cognoscenti physician to treat the illness and the ill holistically,

---

paving way for mind body approach. Clinician who insightfully consumes the stories told by his/her patients and reflects on these with empathy, interprets and acts with humane practice, is better initiated for effective professional practice.

Narrative medicine is an emerging area of understanding and research in medicine referring to the training in interpreting literature and then applying that skill to understanding the accounts which patients tell. Its allied aspect is particularly applicable to the practice of family medicine as narrative based medicine. It uses stories as part of the process of understanding, diagnosing, and treating illness. It enables the physician to practice medicine with empathy, reflection, professionalism and trustworthiness. Narrative medicine is a stepping stone to Mind Body Medicine.

### **What is Narrative Medicine?**

Narrative Medicine is a practice of mindfully contextualizing the patients' lived experiences to better care for and treat them.

It is an approach to health care that not only considers physical, but also the mental and emotional aspects of persons' health enabling a more thorough exploration of the patient history, in-depth perspective of the patient as a person, as well as the ailments and the implications. By seeking out a patient's story, reflecting on it provides a deeper understanding to the clinician.

Narrative Medicine provides healthcare professionals with practical wisdom in comprehending what patients endure during sickness and what physicians themselves undergo in the care of the sick. A narrative has a finite and longitudinal sequence and doesn't restrict to a simple reporting, but is concerned with how the narrator feels and how the listener interprets. The narrative provides meaning, context, and perspective for the patient's predicament. Narrative Based Medicine is propagated to counteract the shortcomings of Evidence Based

Medicine and complement it.

Narrative Medicine encompasses different forms or genres of narrative depending on field of application. The insights of experiencing illness and experiencing the care for one and emerging natural mutual understanding out of it can lead to its 4 distinguishable genres.

- 1) **Your Story: Illness Narrative-** The classic biographical and social context of illness experienced by the patient. It is a set of events, recounted by patient in words and non verbal gestures and sometimes silences. The objectivity of information is often imbued with apprehensions and implications of the abnormal situation that the patient is in. Patient's story is therapeutically central act because it is difficult at times to find appropriate vocabulary to describe the disorder and its companion emotions in the form of anxiety or fear. At times through these narratives patients themselves can shed light on coping strategies and potential for personal growth.
- 2) **Our story: Physician-Patient empathetic engagement narrative-** Here the physician applies medical knowledge and expertise in deciphering the symptoms experienced by the patient culminating in the diagnosis and respective therapeutic intervention. The physician is seeking deeper understanding of patient and the patients' narrative then can be influenced and change as they start making sense of their sensations. Diagnostic and active listening or following the narrative threads of patient's story through close reading, alluding to associations allows the practitioner to establish therapeutic alliance and engage the patient in obtaining effective care.

A pitfall in this genre can occur if the patient feels devaluation of his existence due to neutral and strict compartmentalized medical judgements, generating a feeling of "not heard". Resultant

---

diagnostic workup will tend to ignore the other valuable aspects of the patient personality in the face of illness. It is these other aspects that can be leveraged upon to change the illness narrative into a whole person and holistic narrative.

- 3) **My story : Physician as Self** - The autobiographical accounts about life as a physician. Such stories contribute to rehumanization of medicine by reflection on consultation. Physicians' purpose of narrative can cultivate affirmation of human strength and at the same time acceptance of human weakness. "Physician's Self" attuned to patient through empathetic engagement, compassion and reflection can turn out to be the potent therapeutic instrument. Narratives by Reflective Practitioners present as an opportunity to address, explore and attempt to entangle complex gamut of emotions within self and exploration of his/her creative side of personality or at times as a means of catharsis.

On professional front, narratives imply to be a process of sharing experiences which others with similar situations can relate to and give a professional standing to the physician in his/her community. Reliance of professionals on one another as audience, witness, reader, critic, authority and hand holder works towards the knowing of each other and affirming their triumphs or sharing one another's grief.

A special shoot of the "Physician as Self" genre constitutes the physician as a patient, which shows how a physicians' experience of being ill and vulnerable can change their perspective of the professional role and relation with their patients. The self is referenced to gain insight into someone else's experience and is termed "reflexivity".

- 4) **Metanarratives: the background grand narratives** - these reflect more on the socio-

cultural fabric and its understanding of diseases and health, which can influence both, the physician and the patient. Physicians are conspicuous members of the society anointed as agents of cure and care in illness. Community as a whole expects benevolence from its health healers in form of tenderness in face of pain and courage or comfort in face of morbidity or mortality. The patients devoid of medicine practice knowledge still implicitly trust the judgements of the care givers. Sophisticated narratives in form of dialogues, interviews, articles and multiple interactive sources by the physicians and the patients, families, citizens together can have power to make responsible choices about pain, suffering, justice and prevention. This togetherness can work towards a compassionate and effective medical system.

### **Narrative skills, potential & challenges**

Narrative medicine requires a vast array of skills. Clinicians must be able to listen actively to, comprehend, come to implicit understanding and act upon a patient's story. A story that isn't clear cut needs to be navigated through its nuances. These set of skills is called narrative competence, which is "the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness". Clinicians can improve these skills towards creative expression with help of medical humanities, social sciences and art. The training in Narrative Medicine is a three tier process of close reading, reflective writing, and discussion. Close reading is careful, sustained interpretation of a brief passage of a text for the information, ambiguity, complexity, texture, and mood. Reflective writing is an analytical practice of describing a real or imaginary scene, event, interaction, passing thought, or memory through personal reflection on its meaning. Discussions add a dimension of explicit expression of creativity or

---

an emotion with right choice of words through speech act.

Narratives have a healing effect, both in terms of telling one's own story and listening to the stories of others. Several research studies have indicated improvement in lung functions in asthmatic patients, decline in diseases activity with rheumatic arthritis, or an increased immune response in vaccinations, due to the act of narratives about personal traumatic experiences and through expression of emotion carving a cathartic effect.

Illness of any sort is most often looked at by a physician as a phenomenon that needs quick medical intervention, while the context of illness for a patient can be altogether different as it can affect his/her life. Patient may feel neglected, invalidated or hesitant for subsequent follow up if feels disconnected during initial clinical visits. At times both the parties may not be comfortable in sharing/inquiring very personal details. The constraints may be obvious in view of lack of formal training in narrative skills, perseverance, and time management. The call for empathetic witnessing, all-encompassing attention and significant attitudinal change can be draining to the clinician, unless supported by narrative competence.

### **Current scenario & Road Ahead**

Several Interprofessional educational programmes are conducted in western parts of the world promoting training in narrative skills and several universities are mandating the incorporation of narrative medicine into undergraduate and postgraduate curricula.

Along similar lines and with major reforms in medical curricula of the country, National Medical

Commission of India has introduced the importance and inclusion of language skills in the foundation course for undergraduates as well as longitudinal spread of AETCOM modules through entire duration of the course. Basic premise of the AETCOM module is change in one's behavioural attitude with the help of cognitive and affective dimensions of the personality, through training in conducting interactive sessions, reflective writing and peer discussions. Successful institutional implementation of concepts of Attitude, Communication and Bioethics modules can play vital role as forerunners of Narrative Medicine that envisages the effective interpersonal communication between doctor and patient.

Incorporating literature classes along with medicine for medical students and professionals can serve as means to evolve analytical reasoning and develop respective sensitivity towards meaning-creating processes all the while emphasizing on the habit of daily reflection of clinical encounters to get a feel for narratives in action.

An era long notion of "detached concern" is dissolving and giving rise to a new knowledge of clinical practice with "engaged concern".

In the end, Narrative Medicine is a tool for mind body medicine practice and not a cure in itself, but then everyone has a unique story and every story matters. A patient is a complete person who needs to be treated and is no longer a therapeutically addressed organ or tissue. The scales of the balance are gradually becoming symmetrical with "What Way, How, Why the patient is ill".





## Comparison between various methods of management of uterine polyp and to find out the most effective and safe method.

**Dr Poorva Patil<sup>1</sup>, Dr Sameer Darawade<sup>2</sup>,  
Dr Aparna Sasane<sup>3</sup>**

1. Junior Resident, Department of Obstetrics & Gynaecology
2. Professor, Department of Obstetrics & Gynaecology
3. Asst. Prof, Department of Obstetrics & Gynaecology  
SKNMC&GH, Pune

Corresponding Author :

**Dr. Poorva Patil**, Junior Resident, Department of OBGY

Email: patilpoorva7@gmail.com Mobile: 9158248208

### Abstract:

Endometrial polyp are soft, fleshy intrauterine growths are composed of endometrial glands, fibrous stroma, and surface epithelium. Prevalence in the general population approximates 9 percent. Various modalities are available for the management of endometrial polyp. We conducted this study to compare between D & C, Hysteroscopic scissors and forceps, Monopolar Cautery with Glycine, Bipolar Cautery with normal saline as methods for polypectomy.

### Key Words :

Polyp, Monopolar, Bipolar, Hysteroscopy

### Introduction:

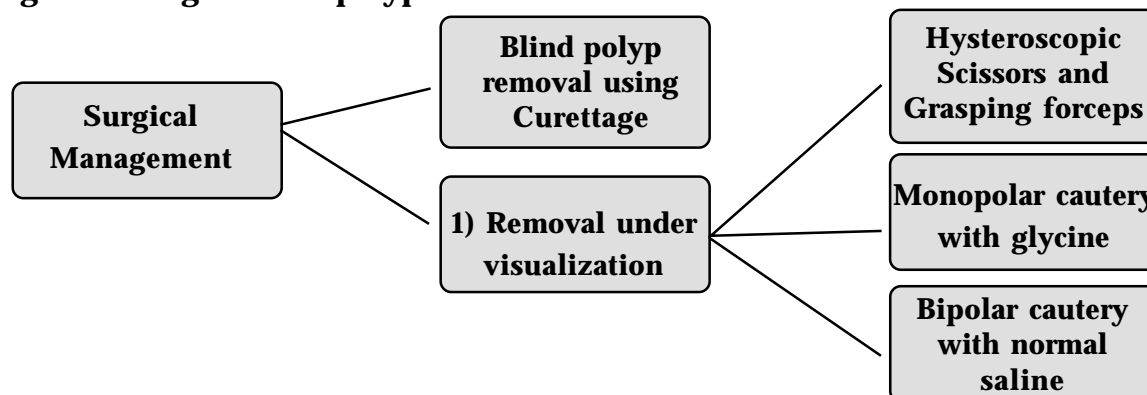
Uterine polyp is the overgrowth of cells in the endometrium that extends into uterine cavity. Polyps may be single or multiple, sessile or

pedunculated. Estrogen is implicated in their growth.

Incidence : 3-5 % infertility

10- 30 % : Abnormal Uterine Bleeding (AUB)

### Surgical Management of polyp includes :



### Materials & Methods :

This is a retrospective observational study. We have conducted polypectomy on women of age group 25- 45 years who came for gynecological consultation for the complaints of heavy menstrual or inter menstrual bleeding or infertility with either sonographic evidence of polyp or seen on diagnostic hysteroscopy.

### Procedures-

#### Diagnostic Curettage:

- Basic and blind procedure
- No fluids used
- Confirmation with hysteroscopy was required
- Repeated if incomplete resection occurs
- Less complications
- Done under local anesthesia.

#### Hysteroscopic scissors & forceps removal

- Direct visualization
- Fluid required 5 L normal saline
- No current used
- Minimal damage to endometrium
- Damage to instruments like scissor tip broken in uterine cavity
- Injury to vascular structure can hamper the visibility

#### Bipolar and NS

- Direct Visualization
- Fluid required 4-6 L NS

- Visibility less compared to monopolar
- Fluid Deficit 1-1.5 L

#### Monopolar and glycine

- Better visibility
- Fluid required 3-4 L of glycine
- Complications: 1.Perforation. 2. Fluid deficit <700ml
- Better suited for surgeon

#### Materials :

Sims Speculum, vulsellum, cervical dilators, Curette.

Hysteroscopic scissors, Hystero-mat, Light Source,

Irrigation Fluids- Glycine & NS, Monopolar Set and Bipolar set.

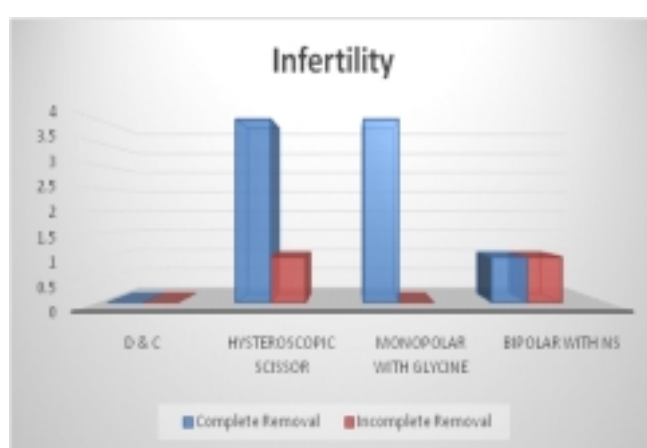
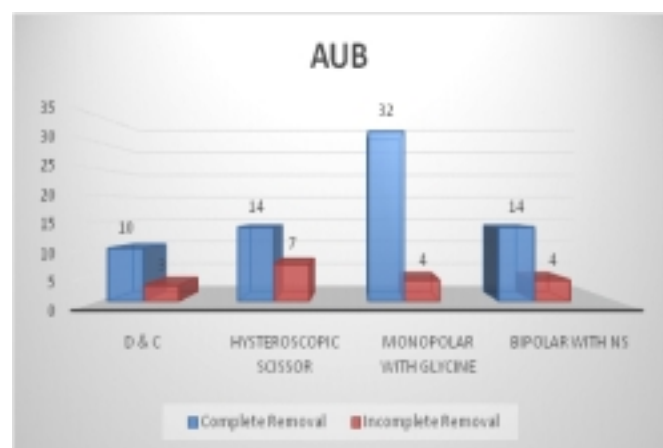
#### Discussion:

With increasing use of transvaginal ultrasound as imaging modality in the outpatient clinic, endometrial polyps are diagnosed easily. It typically appears as a hyperechoic lesion. Colour Doppler may delineate the feeding vessel. Saline infusion sonography improves the diagnostic accuracy. The improved diagnostic accuracy of polyp by various methods has led to the increased use of hysteroscopy that proves to be the best diagnostic and therapeutic approach.

## Results:

PROCEDURE		INFERTILITY	AUB
D & C	COMPLETE	-	10
	INCOMPLETE	-	3
SCISSORS	COMPLETE	4	14
	INCOMPLETE	1	7
MONOPOLAR WITH GLYCINE	COMPLETE	4	32
	INCOMPLETE	-	4
BIPOLAR WITH NS	COMPLETE	1	14
	INCOMPLETE	1	4

### Abnormal Uterine Bleeding (AUB)



## Observation and Results

- \* Total 11 out of 803 cases of Infertility and 88 out of 1507 cases of AUB presented with polyp at SKNMCC & GH Pune during January 2017 to December 2019.
- \* 13 cases of D & C, 26 of scissors, 40 of monopolar with glycine and 20 of bipolar and normal saline were operated.
- \* 54 cases operated by faculty and 43 case operated by residents and it was observed that procedure is equally effective in the hands of residents and expertise.
- \* Effectiveness of using monopolar with glycine were superior than any other methods.

## References :

- 1) Endometrial polyps: Pathogenesis, sequelae and treatment.  
Njume Peter Nijkang, 1, 2 Lyndal Anderson, 2, 3 Robert Markham, 1, 2 and Frank Manconi, 1, 2
- 2) Role of hysteroscopy in detection and extraction of endometrial polyps: results of a prospective study.  
G Gebauer 1, A Hafner, E Siebzehrübl, N Lang
- 3) Removal of endometrial polyps by use of grasping forceps and curettage after diagnostic hysteroscopy  
V Liberis 1, K Dafopoulos, P Tsikouras, G Galazios, N Koutlaki, P Anastasiadis, G Maroulis

\*\*\*

# A comparative study between total laparoscopic hysterectomy and non-descent vaginal hysterectomy for the treatment of benign diseases of the uterus

**Dr. Tanya Jha<sup>1</sup>, Dr. Hitendrasingh Patil<sup>2</sup>,  
Dr. Gulab Singh Shekhawat<sup>3</sup>**

1. Junior Resident, Department of Obstetrics & Gynecology
2. Senior Resident, Department of Obstetrics & Gynecology
3. Professor & HOD, Department of Obstetrics & Gynecology  
SKNMC&GH,Pune

Corresponding Author

**Dr. Tanya Jha**, Junior Resident, Department of OBGY

Contact : 8879172224

Email: jhatanya111@gmail.com,

## **Background :**

According to NCBI data, the prevalence of hysterectomy performed in married women is 17 per 1000 married women<sup>1</sup>. The number of women undergoing hysterectomy ranges from 2 to 63/1000 across different states. A little more than one-third of women who had undergone hysterectomy were under the age of 40 years<sup>2</sup>. We aim to compare between non-descent vaginal mode of hysterectomy and the total laparoscopic mode of hysterectomy in the treatment of Benign diseases of the uterus.

## **Methods :**

This was a Cross-sectional comparative study. Patients who underwent non-decent vaginal hysterectomy (NDVH) and Total laparoscopic hysterectomy (TLH) at our tertiary care Hospital during the study period were enrolled. 120 cases were randomized equally into two surgical procedure groups of NDVH and TLH with 60 cases in each group.

## **Results :**

The financial burden was less In the NDVH procedure. The length of hospital stay was significantly less in NDVH. Blood loss during surgery was significantly more in

---

NDVH. The mean drop in hemoglobin was significantly more in NDVH. Mean ambulation time was significantly less in TLH. The mean VAS score on different days was significantly less in TLH.

### **Conclusions :**

When both surgical approaches are feasible, VH should remain the surgery of choice for benign hysterectomy

### **Keywords :**

Laparoscopic hysterectomy, Vaginal hysterectomy

---

### **Introduction :**

According to NCBI data, the prevalence of hysterectomy performed in married women is 17 per 1000 married women<sup>1</sup>. The number of women undergoing hysterectomy ranges from 2 to 63/1000 across different states. A little more than one-third of women who had undergone hysterectomy were under the age of 40 years<sup>2</sup>. The proportion of women below 40 years of age who had had a hysterectomy was much higher in the southern states of Andhra Pradesh (42%) and Telangana (47%).

The vaginal approach greatly reduces complications, decreases hospital stay, lowers hospital charges and postoperative comfort is better.<sup>3</sup> Vaginal hysterectomy in the true sense is a scarless hysterectomy. As the awareness of simplicity and benefits involved with the vaginal route, that the vagina is the ideal and most natural route to approach the uterus along with the availability of good anesthesia, light, better suture material, electrosurgical technique, exploration of the uterus through vaginal route is becoming increasingly popular.

Factors that may influence the route of hysterectomy for benign diseases include, size, accessibility of uterus, the extent of extrauterine disease, need for the concurrent procedure, training of the surgeon, and experience<sup>4</sup>. A narrow subpubic arch, narrow vagina, an undescended

immobile uterus prior to caesarian delivery, and an enlarged uterus have been proposed by some authors as contra-indications for vaginal hysterectomy. However vaginal hysterectomy can be successfully done in the above conditions<sup>5</sup>.

Total laparoscopic hysterectomy is a modern concept. It is new to learn and the learning curve, requires modernized OT sections and special laparoscopic instruments which may not be available in all centers, especially in semi-urban and rural hospitals and it poses a greater financial burden for the patient when compared to vaginal hysterectomy. Non-decent vaginal hysterectomy is a viable alternative in such situations. Yet total laparoscopic hysterectomy is becoming popular because of its minimal invasiveness and overall better outcome<sup>6</sup>. Vaginal hysterectomy has been found to be associated with less febrile morbidity, less bleeding necessitating transfusion, shorter hospitalization, and faster post-operative recovery than total abdominal hysterectomy.

### **Material and Methods**

#### **Type of Study :**

Cross-sectional comparative study. Patients recruited from Obstetrics & Gynecology OPD to undergo non-decent vaginal hysterectomy (NDVH) and Total laparoscopic hysterectomy (TLH) during the study period.

---

**Inclusion Criteria :**

1. Patient with age >35 years.
2. Patient with a clinical uterine size of fewer than 12 weeks.
3. Patient having at least one live child.
4. Only benign cases such as Fibroid, Polyps, Adenomyosis, Endometriosis, and Abnormal Uterine Bleeding were enrolled,

**Exclusion Criteria :**

1. Patient with age <35 years.
2. Patient with a clinical uterine size of more than 12 weeks
3. Patient with no child

**Sampling technique :**

Simple random sampling.

**Data collection :**

Data was collected using a case record form which included basic demographic data of patients, like age, diagnosis, duration of surgery from the first incision to abdominal or vaginal closure, pathological specimen, estimated blood loss, drop in hemoglobin level, and length of hospital stay will be taken into consideration. Major and Minor complications were also observed.

**Methodology :**

All the patients were evaluated pre-operatively, and observed carefully during the intra-operative and post-operative periods for any complications. Hematoma requiring transfusion, surgical drainage, pulmonary embolism, injury to bowel, bladder, or ureter, unintended laparotomy, or any major anesthesia complications were taken under major complications. Minor complications included infection, fever of more than 38 °C on two occasions 6 hours apart, hematoma not requiring transfusion or drainage, deep vein thrombosis, or any minor anesthesia complication. After more than 24 hours of surgery, returning to the emergency room or hospital readmission was

recorded as a delayed postoperative complication. Overall expenditure by the patient was considered and recorded for both procedures. A visual analog score was calculated for postoperative pain assessment.

**Ethical Consideration :**

Institutional ethical committee clearance for the study was obtained.

**Statistical Analysis :**

The data were entered in a Microsoft Excel sheet and analyzed using SPSS version 26 and EPI Info version 7.2. Comparison of Categorical variables was done by using counts and percentages and a chi-square test for significance. The student's t-test (unpaired t-test) was used to compare the means of independent variables and data. A p-value of <0.05 was considered to be significant.

**Results:**

Table 1- Distribution of study subjects according to age

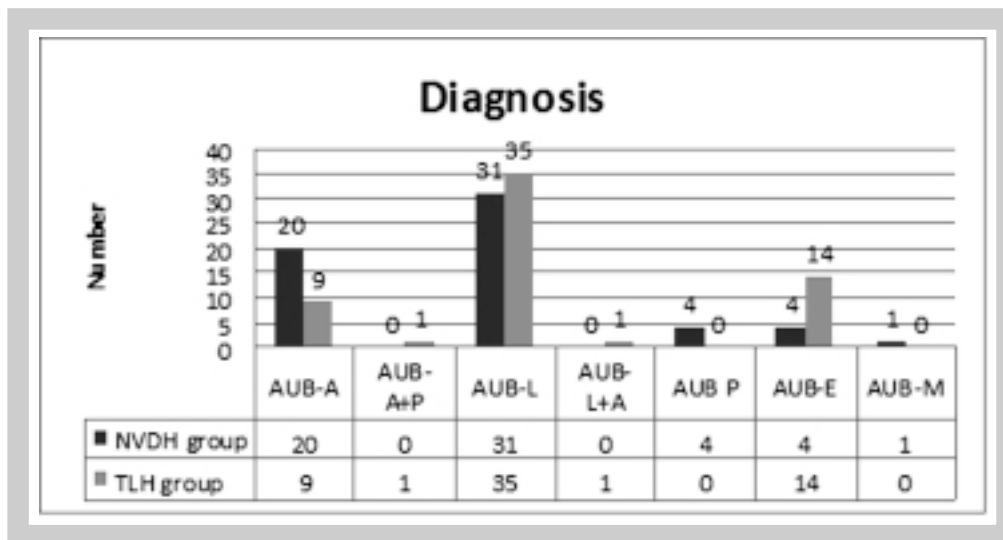
Age groups (In years)	NVDH Number (%)	TLH Number (%)
35-44	29(48.33%)	25(41.67%)
45-54	19(31.67%)	29(48.33%)
55-64	08(13.33%)	06(10.00%)
>64	04(6.67%)	00(00)
Total	60(100)	60(100)
Mean age	46.98 ±7.91	45.76 ± 5.81
Range	36-66	35-59

**Table-1**

show majority of 29 (48.33%) cases in the NVDH group were in the age group of 35-44 years followed by 19 (31.67%) cases in the age group of 45-54 years followed by 08 (13.33%) cases in the age group of 55-64 years. The mean age was 46.98 ±7.91 years ranging from 36-66 years in the NVDH

group. The majority of 29 (48.33%) cases in the TLH group were in the age group of 45-54 years followed by 25 (41.67%) cases in the age group of 35-44 years followed by 06 (10.00%) cases in the

age group of 55-64 years. The mean age was  $45.76 \pm 5.81$  years ranging from 35-59 years in the TLH group. Figure No1: Distribution of study subjects according to diagnosis



**Figure 1**

Shows the distribution of study subjects according to diagnosis. In the NVDH group, the majority of 31(51.67%) cases were diagnosed with AUB-L followed by 20(33.33%) cases diagnosed with AUB-A. In the TLH group, the maximum cases of 35(58.33%) were diagnosed with AUB-L followed by 14(23.33%) cases with AUB-E.

**Table-2 : Distribution of study subjects according to the type of surgery performed**

Type of surgery	Number	Percentage
TLH	60	50
NDVH	60	50
Total	120	100

Table no 2, shows the distribution of study subjects according to the type of surgery performed. A total of 60 cases each were included in both NVDH and TLH groups.

**Table-3:** Distribution of study subjects according to mean duration of surgery and type of surgery performed

Type of surgery performed	Duration of surgery (in minutes) Mean $\pm$ SD	Unpaired t-test p-value
NVDH	<b>164.50 <math>\pm</math>18.72</b>	<b>0.000*</b>
TLH	<b>185.50<math>\pm</math>2.38</b>	

**Table-4.** shows the distribution of study subjects according to mean duration of surgery and type of surgery performed. When the mean duration of surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.000).

**Table-5 :** Distribution of study subjects according to mean blood loss during surgery and type of surgery performed

Type of surgery performed	Blood loss (in ml) Mean ±SD	Unpaired t-test p-value
NVDH	<b>372.50±95.85</b>	<b>0.0006*</b>
TLH	<b>304.16 ±115.82</b>	

**Table 5,** shows the distribution of study subjects according to mean blood loss during surgery and type of surgery performed. When mean blood loss during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.0006).

**Table- 6 :** Distribution of study subjects according to mean hospital day during surgery and type of surgery performed

Type of surgery performed	Mean Postoperative hospital stay (in days)Mean ±SD	t-test Unpaired &p-value
NVDH	<b>5.21±1.12</b>	<b>0.001*</b>
TLH	<b>5.95±1.29</b>	

**Table 6,** shows the distribution of study subjects according to Mean postoperative hospital stay (in days) and type of surgery performed. When mean postoperative hospital stay (in days) was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.001).

**Table - 7 :** Distribution of study subjects according to mean expenditure during surgery and type of surgery performed

Type of surgery performed	Mean expenditure (In INR) Mean ±SD	Unpaired t test p value
NVDH	<b>3233 ±384.73</b>	<b>0.000*</b>
TLH	<b>6508±666.96</b>	

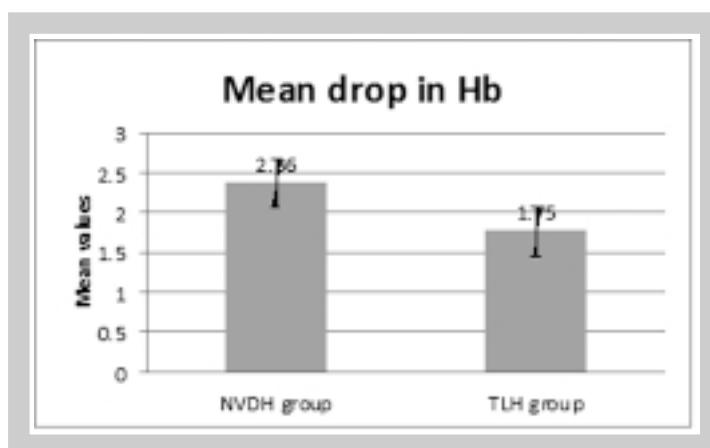
**Table 7** shows the distribution of study subjects according to Mean expenditure during surgery and type of surgery performed. When expenditure during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.00)



**Figure 2 :**

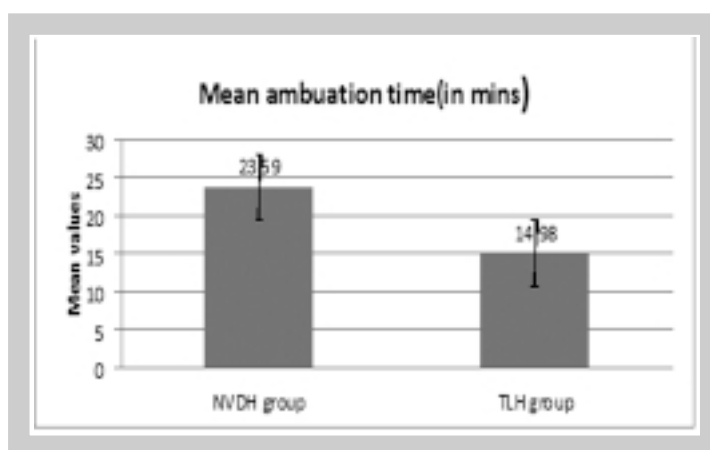
**Distribution of study subjects according to mean drop in hemoglobin during surgery and type of surgery performed.**

**Figure 2** shows the distribution of study subjects according to mean drop-in hemoglobin ring surgery and type of surgery performed. When the mean drop in hemoglobin during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.0001).

**Figure 3 :**

**Distribution of study subjects according to mean ambulation time and type of surgery performed.**

**Figure 3** shows the distribution of study subjects according to mean ambulation time and type of surgery performed. When mean ambulation time was compared in both groups using an unpaired ttest, it was found to be statistically significant. (p value=0.000).



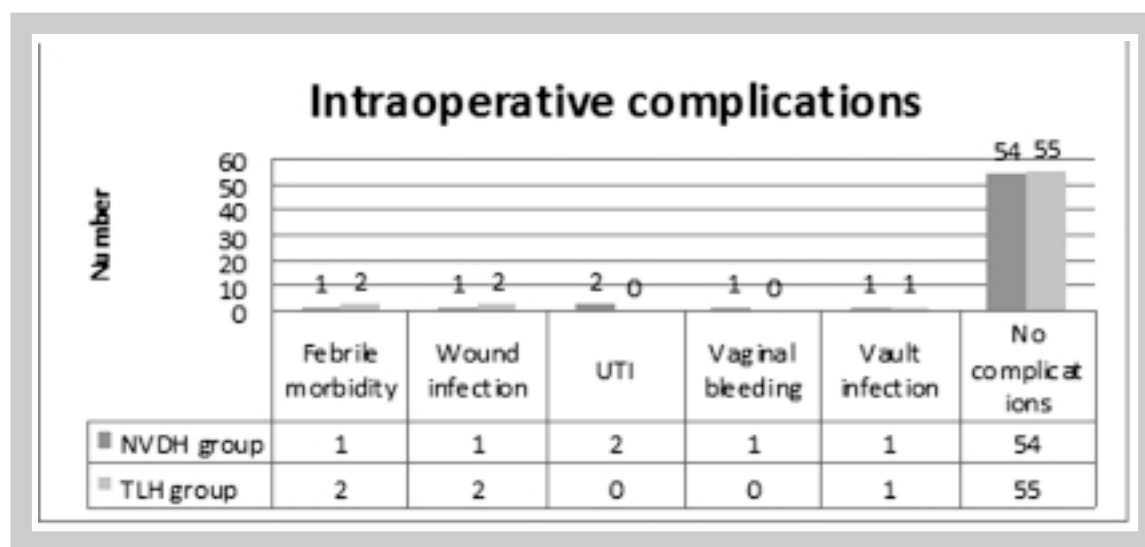
**Table 8 :** Distribution of study subjects according to mean VAS score at 3<sup>rd</sup> hour, day 1, and day 3 postoperatively and type of surgery performed

Type of surgery performed	Mean VAS score 3 <sup>rd</sup> hour post op Mean $\pm$ SD	Mean VAS score Day 1 post op Mean $\pm$ SD	Mean VAS score Day 3 post op Mean $\pm$ SD
TLH	4.81 $\pm$ 1.45	2.25 $\pm$ 1.21	0.45 $\pm$ 0.67
NVDH	2.35 $\pm$ 1.03	0.71 $\pm$ 0.76	0.18 $\pm$ 0.46
Unpaired t-test & p-value	0.000*	0.000*	0.01*

**Table 8** shows the distribution of study subjects according to mean VAS score at the 3<sup>rd</sup> hour, day 1, and day 3 post-operatively and type of surgery performed. When the mean VAS score was compared in both groups at 3<sup>rd</sup>-hour postop, it was found to be statistically significant. (p value=0.000). When the mean VAS score was compared in both groups at day 1 postop, it was found to be statistically significant. (p value=0.000). When the mean VAS score was compared in both groups at day 3 postop, it was found to be statistically significant. (p value=0.01).

**Figure-4 :**

**Distribution of study subjects according to intraoperative complications**



**Figure 4** shows the distribution of study subjects according to intraoperative complications. Out of 60 cases in NVDH, 54(93.33%) cases had no intraoperative complications and in TLH cases, 55(91.67%) cases had no intraoperative complications. There were 02(3.33%) cases with UTI in NVDH cases and no case of UTI in TLH cases. There was one case of febrile morbidity and wound infection in NVDH cases and two cases each of febrile morbidity and wound infection in TLH cases.

**Discussion**

The uterus has been removed by an abdominal route which gives the opportunity to inspect the ovaries and the vaginal route was reserved for

pelvic organ prolapse. Now emphasis on minimally invasive surgery has led to a resurgence of interest and importance of vaginal hysterectomy for nonprolapse indications, i.e., non-descent vaginal hysterectomy (NDVH) as the scarless hysterectomy. NDVH also gives us the option of minimal invasion with better access to ligaments of the uterus for surgery with less blood loss and minimal analgesic requirements post-surgery and under relatively safe spinal anesthesia rather than general anesthesia with its associated complications<sup>7</sup>.

However, laparoscopic hysterectomy has the advantage of visualization of pelvic structure from above and occasional dissection and adhesiolysis. High-tech instruments and sophisticated operation

---

theatre is required to perform TLH. Bowel preparation is also required. This is done under general anesthesia. It also increases the financial burden for the patient in comparison to vaginal hysterectomy. Vaginal hysterectomy descent or non-descent is a simple and effective technique for benign pathologies of the uterus. It can be a good alternative to trans-abdominal hysterectomy<sup>8</sup>.

The present study was conducted with the aim to study post-operative outcomes between NDVH and TLH. A total of 120 cases out of which 60 cases undergoing non-descent vaginal hysterectomy (NDVH) and 60 cases undergoing total laparoscopic hysterectomy (TLH) were included in the study.

In the present study, the majority of 29(48.33%) cases in the NVDH group were in the age group of 35-44 years followed by 19(31.67%) cases in the age group of 45-54 years. The mean age was  $46.98 \pm 7.91$  years ranging from 36-66 years in the NVDH group. The majority of 29(48.33%) cases in the TLH group were in the age group of 45-54 years followed by 25(41.67%) cases in the age group of 35-44 years. The mean age was  $45.76 \pm 5.81$  years ranging from 35-59 years in the TLH group. In a study by Nimbannwar et al<sup>8</sup>(2021) the age group was also similar

In the NVDH group, the majority of 31(51.67%) cases were diagnosed with AUB-L followed by 20(33.33%) cases diagnosed with AUB-A. In the TLH group, the maximum cases of 35(58.33%) were diagnosed with AUB-L followed by 14(23.33%) cases with AUB-E. Chattopadhyay S et al<sup>9</sup> also reported a similar trend in indications for surgeries. The mean duration of surgery was compared in both groups using an unpaired t-test, and it was found to be statistically significant (p value=0.000). Kansara v et al also had similar durations of surgery<sup>10</sup>. When mean blood loss during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.0006). It was also significant

in other similar studies.<sup>9,10</sup>

When mean postoperative hospital stay (in days) was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.001). When expenditure during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.000). Expenditure was less in NDVH procedure in our study. When the mean drop in hemoglobin during surgery was compared in both groups using an unpaired t-test, it was found to be statistically significant (p value=0.0001). When mean ambulation time was compared in both groups using an unpaired t-test, it was found to be statistically significant. (p value=0.000). Mean VAS score was compared in both groups at 3<sup>rd</sup>-hour postop, day 1 postop, and day 3 postop. It was found to be statistically significant. (p value=0.000,0.000,0.01 respectively). It was similarly significant in other studies by Aratipalli Jetal<sup>11</sup> and Tonge G et al.<sup>12</sup>

Out of 60 cases in NVDH, 54(93.33%) cases had no intraoperative complications and in TLH cases, 55(91.67%) cases had no intraoperative complications. There were 02(3.33%) cases with UTI in NVDH cases and no case of UTI in TLH cases. There was one case of febrile morbidity and wound infection in NVDH cases and two cases each of febrile morbidity and wound infection in TLH cases. Aarts JW et al also reported a low incidence of intraoperative injuries during hysterectomies in the Cochrane database review<sup>13</sup>.

**Conclusions:** When both surgical approaches are feasible, NDVH should remain the surgery of choice for benign hysterectomy. The results of this study suggest that VH should be the treatment of benign gynecologic disease when both operative methods are available. Large randomized controlled trials should be performed to identify differences in VH and LH outcomes for operation time, postoperative pain, perioperative complications, and effective cost.

---

## References :

1. Ghezzi F, Uccella S, Cromi A, Siesto G, Serati M, Bogani G, et al. Postoperative pain after laparoscopic and vaginal hysterectomy for benign gynecologic disease: a randomized trial. *Am J Obstet Gynecol.* 2010; 203(2) : 118 e1-8.
  2. Koike E, Kotani Y, Tobiume T, Tsuji I, Nakai H et al. Introduction of Total Laparoscopic Hysterectomy as a Substitute for Laparoscopic assisted vaginal hysterectomy Hysterectomy: A Comparison of the First 23 Cases. *Gynecol Obstet (Sunnyvale).* 2014; 4:211.
  3. Wilcox LS, Villard Mackintosh I, Epidemiology of hysterectomy. *Br. J. Obstet and Gynecol* 1992; 99:402-7.
  4. Patel R, Chakravarty N, Comparative study of Laparoscopic Hysterectomy versus Vaginal Hysterectomy. *International Journal of Medical Science and Public Health.* 2014; 3(3): 335-337.
  5. Shinde S et al. Non-descent vaginal hysterectomy (NDVH): Our experience at a tertiary care centre: *Indian Journal of Basic and Applied Medical Research.* 2015; 5(1): 132-137.
  6. Tohic AL, Dhainaut C. Hysterectomy for benign uterine pathology. *Obstet and Gynecol* 2008; 829-37.
  7. Meikle S F, Naugent S W complication and recovery of laparoscopic assisted vaginal hysterectomy compared with vaginal and abdominal hysterectomy. *Obstet and Gynecol* 1997;89;304-11.
  8. Nimbannavar H, Chugh A, Rama A, Bal H. Comparative study of non-descent vaginal hysterectomy and total laparoscopic hysterectomy performed for benign gynecological conditions. *Int J Reprod Contracept Obstet Gynecol* 2021;10:993-8.
  9. Chattopadhyay S, Patra KK, Halder M, Mandal A, Pal P, Bhattacharyya S. A comparative study of total laparoscopic hysterectomy and non-descent vaginal hysterectomy for treatment of benign diseases of uterus. *Int J Reprod Contraception, Obstet Gynecol.* 2017;6(3):1109.
  10. Kansara V, Chaudhari J, Desai A. A comparative study of non-descent vaginal hysterectomy and total laparoscopic hysterectomy. *Int J Reprod Contraception, Obstet Gynecol.* 2020;9(2):777.
  11. Aratipalli J, Bandi B. Comparison of outcome between total laparoscopic hysterectomy and vaginal hysterectomy in a non- descent uterus in a tertiary care hospital. 2018;4(12):197-201.
  12. Tondge G, Dasila PS, More N, Kale S, Shelke S. Comparison of intraoperative and postoperative outcomes of non descent vaginal hysterectomy and total laparoscopic hysterectomy. 2021;8:342-8.
- Aarts JW, Nieboer TE, Johnson N, Tavender E, Garry R, Mol BW, Kluivers KB. Surgical approach to hysterectomy for benign gynecological disease. *Cochrane Database Syst Rev.* 2015 Aug 12;(8):CD003677.

\*\*\*

**Amended MTP Act 2021 :  
A critical review and the way ahead**

**Dr. G.S. Shekhawat<sup>1</sup> , Dr. Shantanu Sembalkar<sup>2</sup>,  
Dr. Divya R. Meghrajani<sup>3</sup>**

1. Professor & HOD, Department of Obstetrics & Gynecology
2. Junior Resident, Department of Obstetrics & Gynecology
3. Junior Resident, Department of Obstetrics & Gynecology  
SKNMC&GH, Pune

Corresponding Author :

**Dr. G. S. Shekhawat**, Professor & HOD, Dept. of OBGY

Contact : 9372897090

Email: gsshekhawata@gmail.com

**Key Words :**

MTP amendment, POSCO, PCPNDT, Drug & Cosmetic act, Sexual Abuse, Section 375 IPC

**Abstract :**

The Medical Termination of Pregnancy Act 1971 has been met with the recent amendment in MTPA, 2021 after receiving the assent of the President of India on 25.03.2021. A new express provision relating to the protection of privacy of a woman who wants to avail MTP services has been introduced along with a penal provision of punishment for a violation to one year with a fine, or both. Recognition of live-in-relationship is evident from modification and addition/deletion. However, the composition and constitution of the medical board for termination of pregnancy beyond 24 weeks has been left to the discretion of concerned State Governments/UTs depending on the availability of experts by notification of Rules under the MTPA, 2021. This paper deals with a critical review of provisions of MTPA, 2021, and its overlapping grey areas related to POSCO, PCPNDT & Drugs acts. An attempt has been made by the author to present information in a simple and easily understandable manner to create awareness among all stakeholders, especially the medical fraternity.

---

**Table No.1**

Sr. No.	Old Provision	New provision	Remarks
1.	<b>Explanation 1 of MTPA, 2021, Explanation 2 of MTPA, 1971 :</b>		
	Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.	For the purposes of clause (a), where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of limiting the number of children or preventing pregnancy, the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.	The word “any married Pregnant Woman” was replaced by “any woman”, word married has been removed. This is done to cover those cases where pregnancy occurs outside marital wedlock, may be consensual, or as a result of sexual assault with an unmarried woman. Live-in-Relationship has been legally recognized. Other words “or preventing pregnancy” has been added. Word “her husband” has been replaced by “her partner”.
2.	<b>Explanation 2 of MTPA, 2021, Explanation 1 of MTPA, 1971:</b>		
	For the purposes of clauses (a) and (b), where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.	No Change	

The Medical Termination of Pregnancy, or MTP, (Amendment) Bill received the President’s assent and was notified by the Centre on March 25, 2021<sup>1</sup>. The amendment now allows abortions to be conducted within 20 weeks on one doctor’s advice and between 20 and 24 weeks on two doctors’ advice for specific categories of women, including victims of rape (although excluding marital rape). The Bill has also directed states and union territories to set up ‘medical boards’ to decide if pregnancy may be terminated after 24 weeks in

cases of substantial foetal abnormalities.

The amendment has introduced a change in Section 3 of the Act to cover unmarried women. As opposed to using the term “married woman and her husband”, the amendment uses the term “woman and her partner” [Table1]. Another addition to the Act is the introduction of Section 5A, which penalizes medical practitioners who fail to protect the privacy and confidentiality of women who wish to terminate their pregnancies.

---

## **Protection of Privacy of Woman availing MTP Services :**

A new section 5A has been inserted which reads as: “5A. (1) No registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act except to a person authorized by any law for the time being in force.” [Section 5A (1)]

## **Penal Provisions :**

Section 5A (2) further reads as: “Whoever contravenes the provisions of sub-section (1) shall be punishable with imprisonment which may extend to one year, or with fine, or with both.” [Section 5A (2)]

The MTP Act still overlaps with other Acts (Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT) Act 1994 and the Protection of Children from Sexual Offences (POCSO) Act 2012).

## **Constitution and Composition of Medical Board:**

Section (2D) of the MTPA, 2021 prescribed the constitution and composition of medical board for termination of pregnancy beyond 24 weeks, which reads as: “The Medical Board shall consist of the following, namely:

- A Gynaecologist;
- A Paediatrician;
- A Radiologist or Sonologist;
- And such other number of members as may be notified in the Official Gazette by the State Government or Union territory, as the case may be.”

Section 375 of the IPC prescribes the age of consent for sexual intercourse as 18 years. However, by virtue of exception 2 to Section 375 of the IPC, if a girl child between 15 and 18 years of age is married, her husband can have non-consensual sexual intercourse with her, without

being penalized under the IPC. The government of India enacted the Protection of Children from Sexual Offences [POCSO] Act,2012 to prevent and address sexual abuse in children less than 18yrs. The Medical Termination of Pregnancy [MTP] Act,1971 governs induced abortion services in India. It very clearly defines by whom, where, and when abortion services should be provided. These two acts overlap where the POCSO act requires medical providers to report sexual abuse among minors and the MTP act allows registered medical providers to terminate pregnancies on all indicated grounds. The intersection between the MTP act and the POCSO act creates confusion, delays, and sometimes denial of abortion services for young girls<sup>2</sup>. It is now mandatory for doctors to register a medico-legal case in all cases of child sexual abuse. Failure of reporting could result in **SIX MONTHS IMPRISONMENT AND /OR FINE** under sec 21 of the POCSO Act,2012.

The amended MTP law, though, largely guarantees privacy to the parties involved in abortion. Similarly, medical abortion pills are classified as Schedule H drugs for which a pharmacist must maintain a record of sales under the Drugs and Cosmetics Act. This violates the confidentiality promised by MTP Act 2021, Section 5a.

Though the PCPNDT act is aimed at tackling sex determination, it is tracked through abortion. For example, if a sex determination test shows up a male foetus and the parents decide to go ahead with the pregnancy, it counts as an offense under the act. But the crime will not be detected because the act only tracks violations through abortion.

These issues make medical providers nervous about undertaking abortions and it explains why they seek unnecessary consents and documents.

The law makes no mention of providing financial and logistical aid to pregnant women who want to access medical boards. Making a woman who is pregnant with a disabled fetus run to

---

medical boards where doctors and officials will decide for her “is extremely demeaning to her, is an invasion of her privacy & choice. Amendment Act is also silent on the availability of safe MTP services to every woman as in rural India, where 66% of the country’s population resides, reports a 70% shortfall in the number of obstetrician-gynaecologists, according to the 2019-20 Rural Health Statistics Report of the Ministry of Health and Family Welfare.

A pregnant woman cannot go to a certified provider and say I want you to terminate this pregnancy because that’s what I want. If the doctor says no, then that’s that,” Section 312 of the Indian Penal Code that labels “causing miscarriage” as an offense has not been scrapped yet. The MTP Act is seen as an exception to IPC; that is, abortion is available only under the conditions specified in it.

“The terminology that it (MTP Act 2021) uses is non-inclusive: only using the term ‘woman’ especially when we now have the Transgender Persons (Protection of Rights) Act, 2019. The MTP Act 2021 also contradicts the Supreme Court’s 2017 judgment (Justice K.S. Puttaswamy versus Union of India and others), which ruled that a woman’s right to make reproductive choices is a dimension of personal liberty as understood under Article 21 of the Constitution. Any law that restricts a person’s privacy must be “just, reasonable, and fair,” a test that India’s abortion law, if challenged, could fail.

This is because the law does not allow a woman to decide for her own pregnancy but gives her a narrow set of conditions where doctors and medical boards decide for her. A 2016 Bombay High Court judgement in a *suo motu* public interest litigation on the condition of a prison inmate emphasised the right of a woman to control her body and fertility—“the right to autonomy and to decide what to do with their own bodies, including whether or not to get pregnant and stay pregnant”.

In 2017, the Supreme Court said that a woman’s right to make reproductive choices is a constitutional right because it relates to her “right to privacy, dignity and bodily integrity”. Despite this, the amendment to the MTP act failed to incorporate a rights-based approach to abortion so that it still remains an exception.

Moreover, the POCSO and PCPNDT acts create grey areas of criminal liability for medical providers. Under section 19 of the POCSO act, doctors, who have knowledge of sexual activity between minors, with consent or otherwise, are required to mandatorily report the case to the police. Not doing so is punishable and can lead to imprisonment up to 6 months. Medical practitioners therefore end up turning away adolescents who seek abortion or any other kind of sexual and reproductive health service. “They say that if we provide you the service, we will have to report you to the police,”.

### **The road ahead**

While specific changes like extending gestational limits and including unmarried women are laudable, the amendment still leaves women with various conditionalities that in many cases impede access to safe abortion. With the overarching qualifier of “grave injury to her physical or mental health or severe physical or mental abnormality of the foetus”, the woman’s agency ends up taking a backseat, requiring validation from the law at every step. In *Justice K.S. Puttaswamy v. Union of India and Others* (2018), Justice Chandrachud stated that reproductive choice is a personal liberty guaranteed under Article 21 of the Indian Constitution. But the verdict, while laying a robust jurisprudence on reproductive rights and the privacy of a woman, didn’t fundamentally shift power from the doctor to a woman seeking abortion. Abortion thus remains tied to state-sanctioned conditions and not a woman’s rights.



---

The 2003 Rules to the MTP Act were amended to allow certified providers outside registered facilities to provide medical abortion services up to seven weeks (with some conditions), given that 81% of abortions in India take this route. Medical abortion is a safe and non-invasive method in which prescribed drugs are used to terminate a pregnancy. However, due to the lack of a regulatory framework and insufficient public healthcare facilities, most abortions are sought at private facilities, resulting in higher costs for marginalised groups. So, it would be interesting to see whether the Rules of the amendment address the specificities related to medical abortion, especially with respect to narrowing down the provisioners gap by allowing AYUSH practitioners, staff nurses, medical officers and auxiliary nurse and midwives to provide for medical abortions for up to 12 weeks.

As for terminations after 24 weeks – the Act doesn't reflect the urgency of the woman because it doesn't mention a time frame within which the medical boards will have to examine the pregnancy and share their opinions. The other issue with terminating pregnancy after 24 weeks has to do with medico-legal issues. That is, women who wish to terminate a pregnancy after 24 weeks but don't fall under the purview of "foetal abnormality" may have to knock on the doors of the courts, yet again. At this stage, specific provisions need to be clearer, and we can only hope that these issues will be addressed as and when the government promulgates the Rules.

## Conclusion

It is hoped that by creating awareness among all stakeholders to implement the provisions and aim of reducing maternal mortality and morbidity

can be achieved. It creates awareness regarding the primary duties and responsibilities of medical practitioners whenever a minor girl was brought with suspected sexual assault or pregnancy requesting for MTP. The POCSO Act is certainly a law which was very much helpful to prevent sexual assault against a child. The effective implementation of this Act would be a great tool in delivering of justice to the victim and punishment to culprits. All medical service providers should fulfill their reporting requirements and legal obligations under MTP Act and the POCSO Act after ensuring essential services.

## References

- The Medical Termination of Pregnancy Act, 1971.
- eGazette <https://egazette.nic.in> > 2021 THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT). ACT, 2021. NO. 8 OF 2021. [25th March, 2021.]
- Anil Kshetarpal, J. Mansi Through Her Mother/ Natural Guardian Krishna vs. State of Haryana and Others, CWP-6782-2021. Date of Judgment: 25.03.2021, 26.03.2021. Punjab and Haryana High Court.
- The Indian Penal Code, 1860, 312.313, 314, 315.
- The Medical Termination of Pregnancy (Amendment) Act, 1972, 1975, 1977, 2002, 2003 and 2014.
- Ipas Development Foundation (IDF) in close collaboration with Centre of Health Law, Ethics and Technology (CHLET), Jindal Global Law school, year 2017, [www.ipasdevelopmentfoundation.org](http://www.ipasdevelopmentfoundation.org) Author(s) : MS. Kerry MC Broom, MS Dipika Jain and MS. Medha Gandhi

\*\*\*

## **Lupus Miliaris Disseminatus Faciei - A rare inflammatory dermatosis.**

**Dr. Gurman Singh Bhasin<sup>1</sup> , Dr. Swapna Khatu<sup>2</sup>**

1. Junior Resident, Department of Dermatology

2. Professor , Department of Dermatology

SKNMC&GH, Pune

**Corresponding Author :**

**Dr. Gurman Singh Bhasin**, Junior Resident, Dept. of Dermatology

Contact No-8806665992,      Email Id- drgsbhasin@gmail.com

### **Abstract :**

Lupus miliaris disseminatus faciei is an uncommon inflammatory dermatosis of unknown etiology that primarily affects young adults. Its clinical presentation overlaps with that of granulomatous rosacea and hence can be misdiagnosed easily. Herewith we describe a case of a 14-year-old female with reddish papular eruptions localized on the central face with histopathological features suggestive of Lupus miliaris disseminatus faciei.

### **Keywords:**

Lupus miliaris disseminatus faciei, granulomatous rosacea.

---

### **Introduction:**

Lupus miliaris disseminatus faciei (LMDF) is a rarely seen, granulomatous disease of the face. Clinically, the disease is characterized by monomorphic, reddish-brown, dome-shaped papules symmetrically distributed on the face. Histopathologically, a perifollicular caseating granuloma is the hallmark <sup>(1)</sup>. Despite the

characteristic clinicopathological features, its etiopathogenesis remains to be elucidated and treatment is often unsatisfactory.

### **Case Report:**

A 14-year-old female presented with multiple asymptomatic yellow to red coloured lesions over face since 4 months with mild burning sensation

over lesions. She denied exacerbation of lesions on exposure to sunlight. The patient had been previously treated with antifungals and topical steroids with no improvement of the lesions.

Physical examination revealed multiple, discrete, erythematous, dome-shaped papules of size 1-3mm over eczematous skin distributed symmetrically over upper eyelids, nose and perioral region (Figure 1). On palpation, the lesions were firm and non-tender. There was accompanying oozing, scaling and crusting over nasolabial folds and angles of mouth. There was no cervical lymphadenopathy.

The differential diagnoses which were considered were LMDF, granulomatous rosacea, sarcoidosis and granulomatous perioral dermatitis.

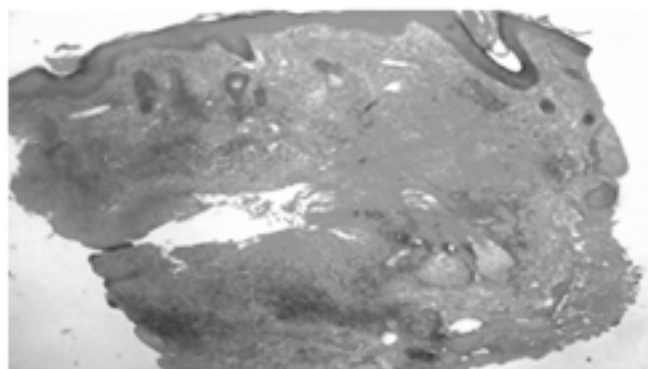


**Figure 1 :**

Pre-treatment clinical presentation shows multiple, discrete, erythematous, dome shaped papules of size 1-3mm over eczematous skin distributed symmetrically over upper eyelids, nose and perioral area associated with oozing, scaling and crusting over nasolabial folds and angles of mouth.

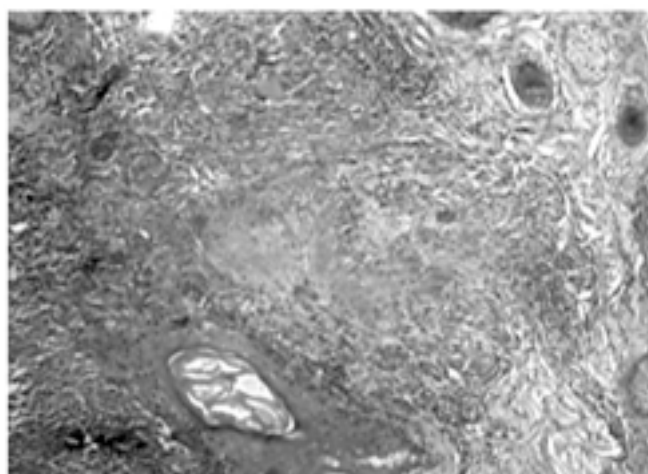
Routine investigations including hemogram, blood sugar levels, urine routine microscopy, renal function tests, liver function tests and thyroid function tests were within normal limits. Serum calcium levels and angiotension converting enzyme levels were also within normal limits. Tuberculin skin test was negative and no abnormality was detected on chest x-ray.

Histopathology of the papule showed the presence of dermal epithelioid granulomas with central caseous necrosis and multiple langhans giant cells (Figures 2 & 3). Special stains such as acid-fast bacillus (AFB) and periodic acid-Schiff (PAS) were both negative.



**Figure 2 :**

(H & E 10x) Periadnexal dermal epithelioid granulomas.



**Figure 3 :**

(H & E 40x) Caseating granulomas & Langerhans giant cells with lymphocytic infiltrate.

The diagnosis of LMDF was hence confirmed on clinical and histopathological examination. The patient was given oral doxycycline 100mg twice daily for 20 days without much improvement. She was then started on oral isotretinoin 10mg once daily along with application of tacrolimus 0.1% ointment once daily at night. On follow-up, flattening of papules was observed in one month and a moderate improvement in erythema was seen over a period of 3 months. No recurrence was noted for 6 months. She is currently under follow up period.



**Figure 4 :**  
Post treatment clinical presentation.

### Discussion :

Lupus miliaris disseminatus faciei is an enigmatic entity which was first described by Fox et al. in 1878<sup>(2)</sup>. The exact etiopathogenesis of LMDF remains unknown. Originally, it was classified as a tuberculid but repetitive failure to demonstrate *Mycobacterium tuberculosis* from the lesions led to this theory being no longer accepted<sup>(3)</sup>. Multiple theories of its pathogenesis have been proposed. While some of the studies suggested it to be a reaction to *Demodex folliculorum*, a few others also suggest

it to be an autoimmune reaction towards pilosebaceous units triggered by hair follicle damage or epidermal cyst rupture<sup>(4)</sup>. In 2000, Skowron et al. proposed a change of name from LMDF to facial idiopathic granulomas with regressive evolution (FIGURE); however, this name-change hasn't been widely accepted<sup>(5)</sup>. Sarcoidosis can also present similarly like LMDF. However, it may be associated with constitutional symptoms, cervical or mediastinal lymphadenopathy, lesions in the lung parenchyma or interstitium and increased levels of angiotensin-converting enzyme, features that are not seen in LMDF<sup>(6)</sup>.

LMDF has characteristic histopathological features. The early lesions show periadnexal lymphocytic infiltrates, while the developed lesions show dermal epithelioid granulomas with or without central necrosis. The late lesions reveal extensive perifollicular fibrosis<sup>(7)</sup>.

In clinical practice, however, LMDF can easily be misdiagnosed as granulomatous rosacea. Nevertheless, there are certain valuable clinical, symptomatic and histologic features which distinguish LMDF from granulomatous rosacea<sup>(8)</sup>. (Table 1) **(Table 1 on Next page)**

Therapy is difficult with variable efficacy. Although standard treatment is oral tetracycline, clinical improvement may take 3-6 months and a long-term maintenance therapy. Many other systemic therapies have been reported to be effective in some patients, including isotretinoin, dapsone, corticosteroids, clofazimine, tranilast, and metronidazole<sup>(9)</sup>.

A better understanding of the etiopathogenic mechanisms would improve the management of these patients and prevent permanent scarring in LMDF. Hence, we reported this case due to the younger age of onset seen in this patient and rarity of its presentation.

**Table 1 : Comparison of LMDF and granulomatous rosacea.**

	<b>LMDF</b>	<b>Granulomatous rosacea</b>
Age of onset	Adults	Adolescents
Background-Erythema	Absent	Present
Site- Upper eyelid, upper lip involvement	Common	Uncommon
Caseating granuloma	Present	Absent
Course	Self resolution	Recurrent episodes

**References :**

1. Esteves T, Faria A, Alves R, Marote J, Viana I, Vale E. Lupus miliaris disseminatus faciei: A case report. *Dermatol Online J.* 2010;16:10.
2. Van de Scheur MR, Van der Waal RI, Starink TM. Lupus miliaris disseminatus faciei: A distinctive rosacea-like syndrome and not a granulomatous form of rosacea. *Dermatology* 2003;206:120-3.
3. Sehgal VN, Srivastava G, Aggarwal AK, Belum VR, Reddy V, Sharma S. Lupus miliaris disseminatus faciei part II: an overview. *Skinmed.* 2005;4(4):234–8.
4. Makkar R, Ramesh V. On the diagnosis of facial granulomatous dermatoses of obscure origin. *Int. J Dermatol.* 2005;44(7):606–9.
5. Skowron F, Causeret AS, Pabion C, Viillard AM, Balme B, Thomas L. F.I.G.U.R.E.: Facial idiopathic granulomas with regressive evolution. Is ‘lupus miliaris disseminatus faciei’ still an acceptable diagnosis in the third millennium? *Dermatology* 2000;201:287-9.
6. Rocas D, Kanitakis J. Lupus Miliaris disseminatus faciei: Report of a new case and brief literature review. *Dermatology Online J* 2013;19:4.
7. Chougule A, Chatterjee D, Yadav R, Sethi S, De D, Saikia UN. Granulomatous rosacea versus lupus miliaris disseminatus faciei-2 faces of facial granulomatous disorder: a clinicohistological and molecular study. *Am J Dermatopathol.* 2018;40(11):819–23.
8. Kaur S, Kanwar AJ, Thami GP, Mohan H, Arya SK. Granulomatous Rosacea: Is it a variant of lupus miliaris disseminatus faciei? *Indian J Dermatol Venereol Leprol* 2003;69:58-60.
9. Koike Y, Hatamochi A, Koyano S, Namikawa H, Hamasaki Y, Yamazaki S. Lupus miliaris disseminatus faciei successfully treated with tranilast: Report of two cases. *J Dermatol.* 2011;38:588-92.

\*\*\*

## HYSTEROSCOPIC Cu-T REMOVAL : An Innovative Approach

**Dr Shivani Lasure<sup>1</sup>, Dr Ketaki Junnare<sup>2</sup>**

1. Junior Resident, Department of Obstetrics & Gynecology

2. Professor, Department of Obstetrics & Gynecology  
SKNMC&GH, Pune

Corresponding Author :

**Dr. Shivani Lasure**, Junior Resident, Dept. of OBGY

*Email: lasure.shivani@gmail.com (Mobile) 7038902562*

### Introduction-

The use of intrauterine contraceptive device (IUCD); Cu-T is a safe and effective method for long-term reversible contraception.

Missing CuT thread is not a very common phenomenon and warrants immediate concern by the patient.

### Case-

- A 28y/f P1L1A1 with prev LSCS was referred for hysteroscopic removal of an impacted intrauterine contraceptive device.
- Patient was referred from an outside private hospital with a misplaced CuT thread with a failed attempt to remove it hysteroscopically.
- Patient had chief complaints of heavy menstrual bleeding associated with passage of clots since 2 months.
- Menstrual history: LMP- 6/2/22.
- Obstetric history: P1L1A1
- A1- MTP done at 1.5 months of amenorrhea f/b surgical evacuation.
- P1L1- Female/6y/FT.LSCS in view of fetal distress/CuT inserted as history given by patient.
- On examination- Patient was vitally stable,
- Per abdomen- soft, no G/R/T, prev LSCS scar +/-healthy.
- Per speculum- cervix/ vagina healthy, CuT thread not seen.

- Per vaginam- uterus normal size, anteverted, b/l fornices free non tender, CuT thread could not be felt.
- Her laboratory routine investigations were normal.
- X-ray pelvis was done with uterine sound in-situ which confirmed CuT in-utero.
- TVS in OPD was done which confirmed intrauterine CuT.
- She underwent hysteroscopic CuT removal under SGA where the CuT was found to be deeply embedded in the myometrium. Attempt to pull CuT with a grasper was made but the CuT broke into half and only one half was removed. Bleeding was noted. Therefore procedure was abandoned after confirming hemostasis.

#### **Operative Procedure-**

- After referral at SKN, patient underwent hysteroscopic CuT removal under GA.
- 0degree hysteroscope was introduced.
- Hysteroscopic findings- embedded broken CuT was seen, rest findings normal.
- Hysteroscopic atraumatic grasper was introduced.
- Hydro dissection was done and CuT was loosened from both the ends.
- After attempts for removal with grasper, grasper broke with device still left in-situ.
- Further cervical dilatation was done.

- Maryland laparoscopic grasper was introduced alongside hysteroscope.
- Vertical limb of the IUCD was held under vision and pulled.
- CuT was removed.

#### **Conclusion-**

- Deeply impacted IUCD can safely be removed hysteroscopically.
- Vertical limb of CuT should be held and pulled.
- In case the hysteroscopic grasper fails to remove the embedded CuT, laparoscopic Maryland grasper can also be used for the same.

#### **References-**

1. Mohamed MA, Rachael KS, John C, Thoai DN, Iqbal HS. London: World Health Organization and Marie Stopes International; 2011. LongTerm Contraceptive Protection, Discontinuation and Switching Behaviour: Intrauterine Device (IUD) use Dynamics in 14 Developing Countries. [Google Scholar]
2. Crosignani PG ESHRE Capri Workshop Group. Intrauterine devices and intrauterine systems. Hum Reprod Update. 2008;14:197-208. [PubMed] [Google Scholar]
3. Fritz M, Speroff L. 8th ed. Philadelphia: Lippincott Williams & Wilkins; 2011. Clinical Gynecologic Endocrinology and Infertility. [Google Scholar]

\*\*\*

# Case series of Gullain Barre Syndrome

**Dr. Abhijit Chavan<sup>1</sup> Dr. Jitendra Ingole<sup>2</sup>**

1. Junior Resident, Department Of Medicine

2. Professor & Head of Department Of Medicine  
SKNMC& GH, Pune

Corresponding Author.

**Dr. Abhijit Chavan**, Junior Resident

Contact : -9028847750, Email: abhi.p.chavan@gmail.com

## **Background :**

Guillain-Barre Syndrome(GBS) is acute or subacute degenerative neurological disorder associated with inflammation and demyelination of peripheral nerves and spinal nerve roots. GBS is characterized by progressive weakness which begins distally to proximal fashion leading to flaccid muscle paralysis with decrease muscle stretch reflex.(1) Although etiology is not clear but immune mediated inflammatory nature of disease is well recognized.

The clinical spectrum of GBS comprises 5 types with variable severity of presentation: acute inflammatory demyelinating polyradiculoneuropathy (AIDP), acute motor axonal neuropathy (AMAN), acute motor and sensory axonal neuropathy (AMSAN), Miller – Fisher syndrome (MFS), Polyneuritis cranialis etc.

For diagnosis of GBS, clinical examination, increased protein content with cytoalbuminologic dissociation and electrophysiologic studies suggestive of demyelination are required. Plasmapheresis, Immunoglobulin's IVIG are mainstay of treatment with physiotherapy and airway management.(2)(3)

## **Abstract :**

GBS is an immune mediated inflammatory demyelinating disease of which exact mechanism is unexplained. Apheresis is widely used in management in which



intravascular, large molecules (antigen, antigen – antibody complex) are removed non selectively by adsorption and with centrifugation, plasma exchange done with fresh frozen plasma.(3)

### Case 1 :

23 year male came with history of fever since last 5 days along with sudden onset weakness of both lower limb began with difficulty in climbing stairs rapidly progress to inability to walk and weakness in left upper limb followed by right upper limb within next 2 days. After this patient noticed loss of neck holding and difficulty in swallowing and dyspnea on exertion. On examination, patient was vitally stable. Single breath count was 12. GCS was 11/15. Deep Tendon reflexes were absent. Gag reflex was absent. After admission, patient was intubated prophylactically i/v/o progressive

dyspnea, absent gag reflex and for prevention of aspiration. Later on tracheostomy was done for prolonged requirement of airway protection.

Patients' blood investigation complete blood count (CBC), Liver function test(LFT), Renal function test (RFT) etc. were normal. MRI brain with Whole spine screening (WSS)was without any abnormality. Nerve Conduction Velocity (NCV) studywas suggestive of pure motor axonal plus demyelinating polyradiculoneuropathy affecting upper limb & lower limb. Ach receptor antibodies and NMO antibodies were negative.

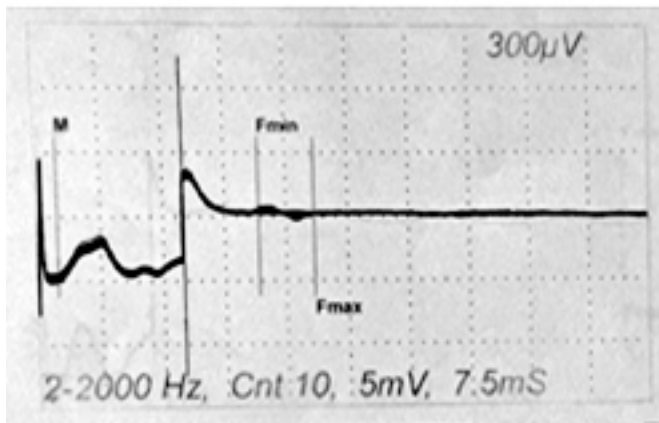
Clinical Examination		Before Apheresis	1 <sup>st</sup> Cycle (02/8/22)	2 <sup>nd</sup> Cycle (06/8/22)	3 <sup>rd</sup> Cycle (10/8/22)	4 <sup>th</sup> Cycle (17/8/22)	5 <sup>th</sup> Cycle (25/8/22)
<b>Neck Holding</b>		Absent	Absent	Minimal of neck+	Rotation	Holding +	Holding ++
<b>Single Breath Count</b>		12/min	14/min	16/min	16/min	20/min	18/min
<b>Power</b>	Shoulder	0/5	0/5	1/5	3/5	5/5	5/5
	Elbow	1/5	3/5	4/5	4/5	5/5	5/5
	Hip	0/5	0/5	0/5	2/5	2/5	3/5
	Knee	1/5	1/5	3/5	3/5	3/5	4/5
	Ankle	1/5	3/5	3/5	3/5	4/5	4/5
<b>Tone (in all 4 limbs)</b>		Hypotonia	Hypotonia	Hypotonia	Normotonic	Normotonic	Normotonic
<b>Gag Reflex</b>		Absent	Absent	Absent	Present	Present	Present
<b>Reflexes</b>	Biceps	Absent	Absent	Absent	Present	Present	Present
	Triceps	Absent	Absent	Present	Present	Present	Present
	Supinator	Absent	Absent	Absent	Present	Present	Present
	Knee	Absent	Absent	Absent	Present	Present	Present
	Ankle	Absent	Present	Present	Present	Present	Present



**Figure 1a :**  
Apheresis machine with Plasma exchange in patient of GBS.



**Figure 1c :**  
Case 1 patient after 4<sup>th</sup> cycle of apheresis standing with support



**Figure 1b :**  
NCV Report of Case 1

Possible diagnosis of GBS was suspected based on NCV & considering financial constraints a decision of apheresis was made.

Patient required 5 cycles of apheresis along with plasma exchange over a period of 1 month. Patient's power improved gradually and after 1.5 month of physiotherapy.

Patient also had severe critically illness related myopathy & muscle wasting, his BMI was 13.5 kg/m<sup>2</sup>. Hence he required high caloric, high protein nutrition. Patient started accepting orally without any difficulty after 1.5 month

Patient's breathlessness was decreased after 1 months and tracheostomy was closed.

## Case 2 :

68 year old Male patient, without any comorbidity presented to outside hospital with h/o Fever (High grade) associated with cough (dry) since 1 week. Patient started noticing weakness of both lower limb leading to imbalance while walking followed by weakness of both upper limb and difficulty in breathing. Vitally stable.

On investigation: CBC, RFT, LFT were within

normal range. NCV was done which was suggestive of sensory motor demyelinating symmetrical polyneuropathy affecting Lower limb more than upper limb. MRI was suggestive of C3-4, C6-7 disc hydration loss with bulging. L5S1 loss of disc height and hydration mild disc bulge traversing bilateral nerve roots and causing mild B/L neural foraminal stenosis.

Clinical Examination		At presentation	After IVIG	After 9 <sup>th</sup> cycle of plasmapheresis	After 1 month
<b>Neck Holding</b>		Absent	Absent	Minimal +	Present ++
<b>Single Breath Count</b>		12/min	14/min	16/min	16/min
<b>Power</b>	Shoulder	0/5	0/5	2/5	3/5
	Elbow	1/5	3/5	3/5	3/5
	Hip	0/5	0/5	0/5	2/5
	Knee	1/5	1/5	2/5	2/5
	Ankle	1/5	1/5	2/5	2/5
<b>Tone ( in all 4 limbs )</b>		Hypotonia	Hypotonia	Hypotonic	Normotonic
<b>Gag Reflex</b>		Absent	Absent	Absent	Present
<b>Reflexes</b>	Biceps	Absent	Absent	Absent	Present
	Triceps	Absent	Absent	Absent	Present
	Supinator	Absent	Absent	Absent	Present
	Knee	Absent	Absent	Absent	Present
	Ankle	Absent	Absent	Present	Present



**Figure 2.** a) Patient on mechanical ventilator



2b) Patient was shifted to T piece trial.

Patient received 1 cycle of IVIG (5 doses). Patient power didn't improve and neck holding was absent. Patient was suddenly deteriorated with low GCS and CXR s/o aspiration was intubated and later tracheostomy was done. After this patient was put on 9 cycles of plasmapheresis in outside hospital. Patient was continued on Mechanical ventilation and physiotherapy. Muscle weakness was slightly improved. Patient was then shifted to SKNMC for further management. Considering previous treatment of IVIG & multiple plasmapheresis cycle, patient was managed conservatively. Patient was managed in intensive care with extensive physiotherapy, nutrition. Later weaned off from ventilator. Power was further improved over 1.5 months of duration.

### **Conclusion:**

1. Earlier treatment with either plasmapheresis/ apheresis has good outcome.
2. If patient is not responding to 1 modality of therapy, other one may be tried for possible improvement.

3. Each therapy has its own advantages & disadvantages [IVIG therapy having ease of administration but costly; VS plasmapheresis cost effective but highly invasive.
4. Apheresis with plasma exchange as a therapeutic management in GBS patient has comparable outcome as compared to IVIG(2-4)

### **Reference :**

1. Pikula JR. Guillain-Barre syndrome: a case report. *J Can Chiropr Assoc.* 1995;39(2):80.
2. Hund EF, Borel CO, Cornblath DR, Hanley DF, McKhann GM. Intensive management and treatment of severe Guillain-Barré syndrome. *Crit Care Med* 1993;21(3):433-46.
3. Nagayama H, Katayama Y. Apheresis therapy in Guillain-Barré syndrome. *Nippon rinsho Japanese J Clin Med.* 2008;66(6):1195-9.
4. Haupt WF. Recent advances of therapeutic apheresis in Guillain-Barré syndrome. *Ther Apher* 2000;4(4):271-4.

\*\*\*