Clinical efficiency of TCM treatment of recurrent spontaneous abortion

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Aim: To compare the pregnancy outcome of RSA by treatment of nourishing kidney, promoting blood circulation and Aspirin combined with low molecular heparin, receptively.

Methods: We chose 639 patients compliant with the diagnostic and inclusion criteria, and divided them into two groups including experimental group (322 patients) and control group (317 patients). The experimental group was treated by decoctions of nourishing kidney and promoting blood circulation, while the control group by Aspirin combined with low molecular heparin.

Evaluation: Ongoing pregnancy rate at the end of 12 week and term delivery rate of two groups.

Results: In the experimental group, the ongoing pregnancy rate at the end of 12 weeks is 85.8%, and term delivery rate is 83.5%. In the control group, the ongoing pregnancy rate at the end of 12 weeks is 82.9%, and term delivery rate is 80.1%. The ongoing pregnancy rates at the end of 12 week and term delivery rate of two groups have no statistical difference (P > 0.05). The ongoing pregnancy rate at the end of 12 week and term delivery rate have statistically significant compared between experimental group and RSA patients in Shanghai.

Conclusion: Treating RSA by the therapy of nourishing kidney and promoting blood circulation can increase the ongoing pregnancy rate at the end of 12 weeks and improve pregnancy outcome.

Biography
Ji Li is the Director of Science and Technology Department of Longhua Hospital Shanghai University of TCM. He is the professor and mentor for graduate students in the field of TCM Gynecology. His clinical research mainly focused on the regulation of reproductive endocrine of Chinese herbal and treatment of endometriosis by TCM. His researches are funded by 12 different foundation grants, including Science and Technology Commission Shanghai Municipal, Shanghai Municipal Commission of Health and Family Planning. He has published more than 20 articles in various medical journals. He is the Executive Council Member of Specialty Committee of Gynecology and Obstetrics, China Society of Integrated Traditional Chinese and Western Medicine, etc.

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Development genetics of endometriosis

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Major recent advances in endometriosis (EM) should be addressed to wide application of new molecular technologies as well as to the systems genetic (omics -) view of EM development. We suggest the existence of specific endometriosis development program (EMDP) underlying EM pathogenesis. We hypothesize EMDP is switched on in the stem cells (SC) of endometrium or mesenchymal SC and provides their progression to full disease with at least three sensitive (critical) periods (SP) corresponding to their genome reprogramming. The origin of genetically and epigenetically modified embryonic SC destined to give rise to EM (SP1). Epithelial mesenchymal cell transition potentiated by unfavourable genetic and epigenetic factors (SP2). Invasion of EM prone cells in the peritoneum with their subsequent progression to endometriotic lesions (SPIII). The origin of EM directly from embryonic SC of muller ducts disseminated within pelvic cavity during embryogenesis is also suspected. The genes and affected metabolic pathways operative at each SP are already known. The unique genetic background, unpredictable “epigenetic landscape” of personal SC launch EMDP which soon after its start becomes canalized and proceeds to final EM disease, each with its own specific laboratory traits and clinical manifestations features. To our mind the EMDP as a whole and especially its SP should be used for elaboration of new strategies in prediction, prevention, and personalized treatment of EM.

Biography
Vladislav S. Baranov born in 1940 graduated Medical Institute in Lvov (Ukraina), postgraduate courses and PHD degree had at the Institute of Experimental Medicine, Saint-Petersburg (Russia). Since 1987 up to now- the Head of the laboratory for prenatal diagnosis of inherited and inborn disorders at the Ott’s Institute of Obstetrics, Gynecology & Reproductology. Professor in Genetics, Corresponding Member of Russian Academy of Sciences, Honorary Scientist of Russia, Chief City Expert in Medical Genetics, he is the author and co-author of 30 books and over 400 articles.

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Addressing maternal mortality in selected districts of Madhya Pradesh –human rights based approach

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Background: Maternal mortality is an indicator of state of maternal health services, status of women, women's health and above all development of nation. Realizing maternal health as one of the greatest impediments in human development, it has also been considered as a Human Rights Issue, affecting the rights to life, equality of women and right to health among other social and economic rights.

Objectives: of the study were to identify the patterns, medical as well as socio cultural causes of maternal death and to list out the rights realization perspective of the mothers and their immediate families and the community at large methodology- A cross sectional study was conducted in three districts of Madhya Pradesh, India for 1 year. 102 maternal deaths were traced and verbal autopsy was conducted using community based maternal death review questionnaire. Human right perspective was also assessed using human rights based questionnaire. Result- Majority (64.7%) of maternal deaths occurred between 18 to 25 years of age. 49% deaths occurred during postnatal period. 26 of 102 deaths were home death, 7 deaths occurred before reaching health facility; rest of deaths were institutional deaths either private or government. 50.9% were primigravida and PPH was the most common cause of death followed by hypertensive disorders of pregnancy. 53.9% had visited more than one facility before death.

Conclusion: Poor antenatal care, lack of human resources posed a major reason for death in all facilities. Rights realization among the beneficiaries was found to be very poor.

Biography
Manju Toppo is presently working as an associate professor in the department of Community Medicine, Gandhi Medical College, Bhopal (M P), India. She did her post-graduation in community medicine in year 1998 and employed as faculty in community medicine since then. She was awarded WHO fellowship in Community Health care and research in 2004 by (university). In the year in 2016 she was awarded fellowship in Indian Association of Adolescent and Health. She has published 23 papers in reputed journals and at present a reviewer in journal of Indian Association Community Medicine. She has given contribution in books related to community medicine. She has intense desire to work in areas of MCH, STI/ RTI and HIV/AIDS.

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How to address female sexual dysfunction (FSD) beyond menopause

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FSD is a, multidimensional, complex and challenging topic, which was not discussed before 1950. In last 20 years, explosion of research shaded much light on understanding of FSD. Starting from Kinsey (1960), Master & Jhoson (1966), Kalpan (1970-1979), Basson (2004) and many other researchers worked hard. Kalpan modified Master’s female sexual cycle in 3 phase model including desire, arousal, orgasm but recently reclassified (DMS-5) by AUAF. FSD are sexual interest disorder, arousal disorder, orgasmic disorder and painful sex.

Etiopathogenesis: FSD has tremendous effect in quality of women’s life, highly prevalent 20 %-40% (Lauman 99) in young and 48% in older women (Dinnestein 2003). Sexual behavior is controlled by a hormonally response neural network. Endocrine, neurological, psychiatric conditions, cancer medication and surgical procedures, local diseases, deficient estrogen- testosterone, biopsychosocial factors, relationship factor all are important beyond menopause. Nothing happens without desire again painful sex affects desire and all other domains of sexual cycle.

Diagnosis: Detailed history, General and pelvic examination and some Investigations need to be done. Therapy should be tailored according to the patient's need along with multidisciplinary team including psychosocial counselor / sexologist / therapist / and physician. Successful resolution of low interest and pain disorder ameliorate FSD. Evidences support the use of testosterone, tropical estrogen, DHEA. MHT does not have direct effect on FSD but ospemephene and laser therapy are promising ns for vaginal atrophy.

Conclusion: Who deals FSD should possess not only the necessary wide medical knowledge, but also need empathy& compassion.

Biography
Shaikh Zinnat Ara Nasreen is a Professor and Head of Obs/Gyne department at ZH Shikder Women's Medical College and Hospital, Dhaka. She is the Secretary General Bangladesh menopause society, Joint secretary Ob/Gyn society Bangladesh, Member Secretary, CPD, Committee, BCPS, CAMS Representative IMS, Treasurer RCOG Representative Bangladesh, Council member SASSM, Council member SAFOG, Council member SAFOMS, Member of IMS and Member of ISSM.

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Breast cancer - myth and facts

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Breast cancer is the most frequent cancer among women, impacting over 1.5 million women each year, and also causes the greatest number of cancer-related deaths among women. Myths on breast cancer: 1. only women with a family history of breast cancer are at risk. 2. Wearing an underwire bra increases your risk of getting breast cancer. 3. Most breast lumps are cancerous. 4. Breast implants can raise your cancer risk. 5. All women have a 1 in 8 chance of getting breast cancer. 6. Small-breasted women have less chance of getting breast cancer. 7. You can't get breast cancer after a mastectomy. 8. Your father's family history of breast cancer doesn't affect your risk as much as your mother's. 9. Annual mammograms expose you to so much radiation that they increase your risk of cancer. 10. Needle biopsies can disturb cancer cells and cause them to spread to other parts of the body. 11. If your mammography report is negative, there is nothing else to worry about. 12. Removing the entire breast gives you a better chance of surviving cancer than having a lumpectomy with radiation therapy. 13. Overweight women have the same breast cancer risk as other women. 14. Fertility treatments increase the risk of getting breast cancer. 15. Living near power lines can cause breast cancer. 16. Breast cancer is preventable.

Biography
Sankhari J has completed her M.Sc. Nursing (Dept of Community Health Nursing) at the age of 37 years from Pondicherry University. She is the Nursing Officer in Government General Hospital, Puducherry, India. She has published 1 paper in reputed journal and presented more than 10 concept paper in International and National conferences.

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Still birth in Bangladesh

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**Introductions:** The majority of clinically recognized pregnancies have no complications and result in the birth of a healthy child. However, 15-20% tragically end in loss. These fetal losses are devastating for expectant parents at any stage of pregnancy.

Facts and figures-(WHO)-stillbirths are invisible in policy and programs, yet constitute an enormous burden of deaths and disproportionately affect the poor.

2.6% stillbirths annually.1.3 million antepartum stillbirths. Worldwide SBR is 18.4 /1000 total births. 98% of the world’s stillbirths occur in low and middle income countries.

Stillbirths in Bangladesh. Around 1 in 200 pregnancies in Australia end in this devastating outcome but more common in developing countries like Bangladesh.

Study of singleton pregnancy from Nov 2008 to April 2009 in 34 slum areas in Dhaka. 231 women with stillbirths and 464 –live births. The stillbirth rate was 26 per 1000 total births of which 62% occurred during the intrapartum period (2.6 million 3rd trimester stillbirths occur worldwide every year).

46% of women living in rural Bangladesh report receiving ANC from medically trained personnel and only 18% having a TBA (doctor, nurse, midwife) being present at delivery.

About 83,100 babies were born dead in Bangladesh last year which is 50% decrease in stillbirths from 160,300 in 2000(lancet).

In 2001 –a study in Bangladesh of pregnancy outcome in 192 women –half in a village with high arsenic levels-found 17 stillbirths compared with 7 in a similar village with low level.

A total of 13,852 stillbirths were reported through death notification system to occur in 10 MPDR districts from Oct 2013 to Sep 2015-verbal autopsy has been done in 1059 cases.

**Conclusion:** Mortality targets by 2030 (included in every newborn action plan) 12 stillbirths or fewer per 1000 total births in every country. All countries set and meet targets to close equity gaps and use data to track and prevent stillbirths.

Universal health care coverage targets

Family planning-By 2030, universal access to SRH care services and integration of reproductive health into national strategies and programs.

Antenatal care; By 2030 universal quality of care and comprehensive ANC for all women. Care during labour and birth: By 2030, effective and respectful intrapartum care to all women in all countries.

**Biography**

Laila Arjumand Banu is the President of Obstetrical & Gynecological Society of Bangladesh (OGSB), Chief Consultant & Head of the Dept. of Obs & Gynae, Lab Aid Specialized Hospital, Dhaka, Bangladesh. She is the Vice President of South Asian Federation of Obstetrics & Gynecology (SAFOG), Secretary General-Bangladesh Perinatal Society, Secretary General- Gynecological Endoscopy Society of Bangladesh, Treasurer-Federation of Asia Oceania Perinatal Society-FAOPS Treasurer- Fertility & Sterility Society of Bangladesh and Treasurer- Bangladesh Menopause Society.

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Intervention strategies for successful breast feeding: Randomized clinical trial

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Breastfeeding is one of the most natural and beneficial acts a mother can do for her child. There are many possible nipple problems that breastfeeding mothers may encounter. The 7mm nipple length might be a possible screening indicator that would signal the clinician to provide more intensive breastfeeding monitoring (puapornpong, 2013)

Objectives: Comparison of selected nursing interventions like manual technique, rubber band and syringe method on successful breastfeeding pattern among the antenatal mothers.

Methodology: Randomized clinical trial study was conducted among 90 women having nipple problem, 30 in each group i.e. group I (manual technique), group II (rubber band) and group III (syringe method) in the selected government maternity hospital, Pondicherry, India. Samples were selected by simple random sampling. The outcome of study was evaluated by Descriptive and Inferential statistics.

Results: The demographic variables show that majority of the women 26(86.70%), 23(76.70%) and 23(76.70%) were in the age group of 19-25 in group I, II III respectively. 13(43.3%) women in group I, 13(43.3%) in group II and 18(60%) in gr III, ware studied up to High School level. Result on breast feeding pattern shows that there was improvement in feeding. Mothers not faced any difficulties for feeding the baby after delivery. Each intervention strategy shows equally good in case of nipple problem.

Conclusion and Recommendation: These intervention strategies are very simple and cost effective, so this can be practiced in all settings to correct the nipple problems.

Keywords: Nursing interventions, Successful breast feeding, Intervention strategies and Antenatal mothers

Biography
Manju Bala Dash has completed her PhD from Sri Ramachandra University, Chennai, Tamil Nadu. She has 20 years of teaching and research experience in the field of nursing. She is the National Trainer in IYCF (Infant and Young Child Feeding) Counseling Specialist course. She has published two books, contributed two chapters in two books published by the Nurses and Midwives Council, Tamil Nadu. She has published more than 20 papers in reputed journals and has been serving as an Editorial Board Member of repute.

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Our experience of prenatal diagnosis of congenital heart diseases for the planning of the delivery and the postnatal care

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Objective: Prenatal echocardiography is very important for diagnosis CHD, the management of affected fetuses, including parental counseling for the therapeutic options, the planning of the delivery and the postnatal care.

Methods: Multiple B- scan planes, Doppler color flow mapping and pulsed Doppler, 3-4 Dimensional Fetal Echocardiography. Methods of the echocardiographic identification of fetal CHD are: postnatal echocardiography, angiography, surgery, or autopsy.

Results: A total of 1698 fetal echocardiograms were obtained for 2 last years from which 221(13%) fetuses with a prenatal diagnosis of CHD were enrolled. CHD usually are diagnosed during the first echo. 34% of fetal echocardiograms were obtained before 14 weeks of gestation, 54% of fetal echocardiograms between 18- 21 weeks of gestation, 12% of fetal echocardiograms between 22- 38 weeks of gestation. The delivery through natural birth canals had took place at 76%.

Intrauterine fetal death took place about 0,7%( 2 cases).

Neonatal death soon after birth took place in 0,7% (2 cases). There were the preterm neonates with wide ductus arteriosus and neonatal pneumonia.

Fetal evolution of CHD took place at 59% (162 cases).

Fetal arrhythmias were successfully treated before the birth at 1,4% (4 cases).

In most live born infants, complete surgical repair can be achieved.

Surgical repair for 1 year were made in 23 % (51 cases). There were ductus-dependent CHD, radical correction of the coarctation of the Ao, AVC, TF.

Conclusion: Prenatal diagnosis of CHD was associated with improved preoperative clinical status of these infants and must include detailed extra-cardiac and intra-cardiac assessment to predict the risks of surgical treatment. Prenatal diagnosis of CHD may guide the timing and optimal location of delivery. The deliveries of patients with cardiac anomalies should be conducted in a tertiary obstetrics center with cardio vascular surgery department for optimal perinatal management.

Keywords: Prenatal diagnosis, fetal echocardiography, congenital heart diseases, delivery and postnatal care.

Biography

Elena Bespalova is 53 years old and she lives in Moscow. She is a professor, Doctor of Medical Sciences, cardiologist and ultrasonic diagnostic, head of department of perinatal cardiology in the Center of Motherhood and childhood. Her field of activity is ultrasound diagnostics of fetal and neonatal congenital heart diseases and arrhythmias, the treatment of organic complex arrhythmias in the fetus, counseling for babies and pregnant women. She has 389 articles, 7 monographs. She is a laureate of national prize “Vocation”.

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Ovarian hyperstimulation syndrome – OHSS – pathogenesis prevention and treatment

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Ovarian hyperstimulation syndrome (OHSS) is a serious and potentially fatal complication affecting ovulation induction. Its severest manifestation takes the form of massive ovarian enlargement and multiple cysts, hemoconcentration, and third-space accumulation of fluid. The full-blown clinical syndrome may be complicated by renal failure and oliguria, hypovolemic shock, thromboembolic episodes, adult respiratory distress syndrome (ARDS), and death. Although the pathophysiology of this syndrome has not been completely elucidated, it seems likely that the increased capillary permeability triggered by the release of vasoactive substance secreted by the ovaries under hCG stimulation plays a key role this syndrome. Several factors such as histamine, serotonin, prostaglandins, prolactin, and variety of other substances were implicated in this process in the past. At present factors belonging to the renin - angiotensin system, cytokines like the Interleukins, tumor necrosis factor alpha, endothelin-1, and vascular endothelial growth factor (VEGF) are thought as being involved in triggering increased vascular permeability after ovulation induction treatment.

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Social aspects in assisted reproduction

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In-vitro fertilization (IVF) and assisted reproductive techniques have become common practice in many countries today, regulated by established legislation, regulations or by committee-set ethical standards. The rapid evolution and progress of these techniques have revealed certain social issues that have to be addressed. The traditional heterosexual couple, nowadays, is not considered by many as the only ‘IVF appropriate patient’ since deviations from this pattern (single mother, lesbians) have also gained access to these treatments. Genetic material donation, age limitation, selective embryo reduction, preimplantation genetic diagnosis, surrogacy and cloning are interpreted differently in the various countries, as their definition and application are influenced by social factors, religion and law. Financial and emotional stresses are also often described in infertile couples. Information as deduced from the world literature regarding IVF regulation, as well as about the existing religious, cultural and social behaviours towards these new technologies, is presented in this article in relation to the social aspects of assisted reproduction.

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Reproductive health of women, child health, and common reproductive health concern for women

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A woman’s reproductive system is a delicate and complex system in the body. It is important to take steps to protect it from infections and injury, and prevent problems including some long-term health problems. Women were considered as means in the process of reproduction and as targets in the process of fertility control. Women benefited from the process but were not at the center of the process. The needs of women have been traditionally addressed within the concept of reproductive and child health (RCH). The needs of the woman were submerged in the needs of the mother. RCH programs and services have played and continue to play an important role in promotive, preventive and curative health care of mothers and children. Children represent the future and ensuring their healthy growth and development ought to be a prime concern of all societies. Newborns are particularly vulnerable and children are vulnerable to malnutrition and infectious diseases, many of which can be effectively prevented or treated. Issues in child health under five mortalities, Infant and young child feeding, Diarrheal diseases, Pneumonia, Child abuse, Malnutrition, etc. Common reproductive health issues of women are Female Sexual Dysfunction, Endometriosis, Cervical Cancer, HIV, Polycystic Ovary Syndrome (PCOS), Uterine Fibroids, Interstitial Cystitis (IC), Gonorrhea and Chlamydia, etc. Health systems interventions for women's health are:

1. Universal health coverage for key health interventions for women.
2. Inequities in access.
3. Quality of care, including supplies.
5. Monitoring and accountability.

Biography

Chozharajan Jeyamurthy has completed his M.Sc. Nursing (Dept. of Community Health Nursing) at the age of 26 years from Pondicherry University. He is the Nursing Instructor in WOISO, Navi Mumbai, India. He has published 1 paper in reputed journal and presented more than 10 concept paper in International and National conferences.

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