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EDITORIAL

ADOPTION : WHOSE BABY?

The practice of adoption goes back to the Indian mythological times. King Janak adopted Sita - a girl child abandoned in the field .. Not only was there no stigma to it, but she rose to the level of a goddess, whose name every Indian would know for ages. This was the directive to the whole of the subcontinent, irrespective of the religions, as the different religions did not exist then.

Adoption means establishing a bond between a couple and a child which is legally, socially and emotionally equivalent to that between parents and their biological children. What is it that makes human parentage? It is the raising of the child with parental love, guidance and tender care that makes the parent-hood. This has to be understood by the parents and has also to be engraved in the mind of the child. The biological parentage therefore becomes an important entity

only of the Animal World. Indeed, this is what separates humans from animals. Due to lack of this understanding, too much stress is given to biological parentage. Inability to produce one's own baby thus is taken as a serious disaster at personal and social levels. The possible alternative, i.e. Adoption is neither considered nor is it acceptable to the Indian society. It is for these reasons that the social workers and doctors should motivate the couple. In India, the adoption should be considered a National service, a Social service, and a Service to one's own family, as well as giving a good home to an orphan child. Adoption should be early enough, before the child develops the psychological trauma of an orphan. The Western society being more enlightened, among them adoption is found to be a self-motivated and spontaneous gesture. In India, overpopulation results in more orphans.

Hence there is greater need for adoption on the National scale. The childless couple must be convinced that adoption is not the last resort. It should be made a matter of choice, early in their quest of parenthood.

In spite of the political slogan : "Have one, adopt one" there are many legal hurdles. Most important is the lack of uniformity of application. The Hindu Adoption Maintenance Act (HAMA) of 1956, amended in 1960 and 1962 does not apply to non-Hindus. Only a Hindu husband can file the petition according to HAMA, while the wife is merely required to give her consent. The non-Hindus have to fall back on the Guardian and Ward Act (GWA) 1890 which is an antique. The guardianship lapses when the child attains majority. In the metropolitan cities, the incidence of adoption per year has risen to ten times over the past two decades (more than 250 per year in 1990). But in the rural areas, the incidence is very low. The role of Voluntary Coordinating Agencies (V.C.A.) is a crucial one. They play important part in providing homestudy, help to select the adoptee, supply child's background except names of the biological parents, even looking after the child till adoption. The VCAs are few and suffer from scarcity of branches especially in rural areas. Most are Government recognised, but require funds. The community plays a significant role in this respect. The doctors: Both general physicians and the gynec-obstetrician have additional responsibility to explain to the couple that Adoption is not competitive but complimentary to assisted reproduction. Owing to the paucity of voluntary organisations, all the medical colleges and teaching hospitals must have Adoption Promotion Department, preferably connected to the Dept. of Obstetrics and Gynaecology. It should be emphasised that the crucial role is played by the environment of the individual in building up his/her character. Thus the right opportunities will enable a child to develop its innate potential to the maximum regardless of the background it comes from. Risks of hereditary diseases can be

minimised by obtaining the detailed information as much as is possible about the medical background of the child's biological parents, and by consulting a paediatrician to examine the child for any serious medical problem and for milestones. This procedure is carried out by VCA prior to the adoption.

Our social workers and their leaders, mass medias, medical profession and all enlightened persons must educate the masses to erase the taboo against Adoption. The parents who adopt a child should be proud of their act rather than trying to conceal it. The child should be made to understand from an early age that the act of his being given up is not a rejection, but is an act to improve his environment. The adopter parents are the ones who really matter and not the biological ones. It is the experience of professionals who have promoted Adoption that the only complaint of these satisfied parents is : "Why were we not advised about adoption earlier?" - for this would have saved them several frustrating years of medical therapy failures.

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**THE 35TH ALL INDIA OBSTETRIC
&
GYNAECOLOGICAL CONGRESS, MADRAS**

27th - 30th December, 1991.

PRESIDENTIAL ADDRESS

by

DR.B. PALANIAPPAN, M.S., F.A.M.S., F.I.C.O.G., F.I.A.M.S.,

Friends, Colleagues, ladies and gentlemen,

I stand before you with a sense of pride and joy and this Congress is memorable one to me because it is unique in many ways. We are inaugurating the Congress during the pleasant evening which itself is a change. I am getting a rare chance as the President of the FOGSI to be installed in my home town itself. Not that I am only attached to this place: I have travelled to the nook and corner of our country and I love each and every place. More than 3000 years ago a Tamil Poet sang

'Every country is my country

Every man is my kinsman"

meaning

Har desh mera desh hain

Har aadmi mera aadmi hain

We have in our midst a professor of international repute, a pioneer who made history in his career, Prof. B. Ramamurthi. He is giving the inaugural address. He is the illustrious son of a noble father about whom also I want to say a few words. Dr. T.S. Balasubramaniam himself was a prize winning medico who once astonished his teacher and students 70 years ago in Madras Medical College by asking an embarrassing question, whether female breasts are reproductive organs or sexual organs? To this day there is no convincing answer.

The First All India OBSTETRIC & GYNAECOLOGICAL CONGRESS, saw Dr. Ida Scudder as the President in 1936 at Madras. She was a lady with great vision, a message and a mission. In 1983, in the 27th Congress it was Prof. C.S. Dawn, the walking encyclopedia nay a mobile university who gave the Presidential address here in Madras. I am proud to take his place now.

Tamil Nadu is the land of the trinity doctrines spreading out from the country of Voltaire and Dumas - 'LIBERTY, EQUALITY AND FRATERNITY'. To these have been added the virtuous qualities of way of life as described by Dr. ANNA, the late Chief Minister of Tamil Nadu - 'DUTY, DIGNITY AND DISCIPLINE'.

Now I have to mention about the sad incidents between the last congress and now. We have lost two great grandmasters of our time who were the renaissance men who placed our speciality and country in a notable spot in the international map. Dr. Krishnamenon and Dr. B.N. Purandare are the old guards who are keeping everlasting vigil on our activities. We in Southern India have been humbled in stature and status by the demise of Dr. Menon who raised the intellectual standard to great heights. Despite these setbacks I assure that I will do my best during the short period of one year. I take this opportunity to convey my heartfelt thanks to all of you for having elected me to this august chair. I am indebted to the organising committee from the Obstetric and Gynaecological Society of Southern India under the able stewardship of my teacher, Prof K. Bhasker Rao who has put tremendous efforts to make this congress a success. I promise that I have not taken up this prestigious post to aggrandize myself but to spread the message of safe motherhood, child health and family welfare. I wish to impress a few points upon the RCOG which has got the task of fulfilling the commonwealth commitments. I am glad Dr. Barns is here with us. He has great concern for the students from developing countries. He recently suggested to the RCOG to draw schemes give appropriate train-

ing for overseas students which will be of use to their respective countries in the third world, when they return.

W.H.O. has decided to spend 36 percent of its disease-specific budget for its war against Malaria which afflicts about 5 million people. The war should also continue against Infective hepatitis, anemia etc. which are the ferocious killers of pregnant women.

India now has the largest UNFPA supported population programme by getting approval for 90 million U.S. dollars. For the first time in the history of the programme, UNFPA is to involve the people and Non Governmental Organisations. It is heartening to note that they concentrate more on the MCH and health delivery systems.

As for the medical education, particularly the Post Graduate training, I emphasise the need for overhauling. There is inadequate staffing and the students are not getting sustained interest. The attendance at post graduate events are not-satisfactory and many are satisfied with doing a few hysterectomies and caesarean sections. We have to form a panel to discuss and decide the curriculum, teaching machinery and methods. Our responsibilities are great. The federation was founded more than fifty years ago and our accomplishments must be more than what they are. The remarkable achievement of Royal College in U.K. is well understood, e.g. there were 2500 maternal deaths in England & Wales in 1929 when the Royal College was founded and it is now less than 150. MMR is 8 per 1,00,000 in England and Wales whereas in India it is still, more than 300 per 100,000. Many maternity hospitals in western countries go without a single maternal death for two to three years. Over the last fifty years the maternal deaths in their country has been falling 50%, every ten years. The holocaust of maternal deaths in our country is not just due to the of-repeated complaints of lack of medical facilities alone in the remote areas. There are other challenges where agencies like Governments, economists, and planners have to contribute. We, the obstetricians and gynecologists are at the final leg. I am reminded of the message from recent Singapore Congress where Prof. Shan. Ratnam stressed to the members of maternal societies of obstetricians and gynecologists ev-

erywhere the importance of accepting our responsibility and also to deal with the causative factors prevailing outside the hospitals. I have given his complete message in the last page for you to go through later.

Of course as a part of the global strategies for achieving 'HEALTH FOR ALL' by the year 2000 A.D., member states of WHO are committed to extending the coverage of essential health care to all the peoples of the WORLD. One of the essential elements of primary Health Care is Maternal & Child Health Care which includes skilled help in child birth. Indeed one of the global indicators for monitoring progress in this regard is the availability of trained personnel for attending pregnancy and child birth. To this end much was expected by us from the hundreds of PHCs all over the country. But a recent survey of these PHCs indicates that there is a long way to go, much to be desired and some of the obstacles are insurmountable. We are sick of listening to the same old complaints regarding young doctors unwilling to go to remote areas. Now I wish to quote from the inaugural address of my esteemed friend Dr. Raman Nadkarni at CHANDIGARH during 1980 Congress.

"Indian tradition requires that the man should go to the forest after finishing his worldly responsibilities. Contrary to our tradition junior doctors are expected or even compelled to stay in villages. They are in a way expected to sacrifice, not only themselves, but the social life of their wives and education of their children."

In all seriousness he suggested that we owe so much to the society, that Government doctors; private practitioners, and teachers in medical colleges, should voluntarily go to villages say, after completing sixty years and Government should see that we get all the amenities in our errand. This has not materialised during the last ten years. Now the time is getting ripe to look for other ways and means. A restructuring of existing health services is the need of the hour. If an unbooked woman with arm prolapse dies after travelling 10 kilo metres in a bullock cart from her village to the hospital, lapses in a chain of events are collectively responsible for her demise and not just the obstructed labour. A major break through for this kind of problems will be to provide amenities like communication

and transportation to the High Risk cases and emergencies. The real service at the door step can be only by a van or ambulance at the doorstep to pick up the obstetric case for institutional care.

The safe motherhood initiative places special emphasis on the need for better and more widely available maternal health services, extension of Family Planning facilities and effective measures aimed at improving the status of the women. Time has come for us to realise that Family Planning Programme alone is not adequate. Population problem cannot be solved by technological advancements and innovative contraceptive methods alone. This is what we have been doing all along. Placing the entire reliance on cutting the Vas and blocking the tubes. Recently our Union Health Minister Honorable M.FOTEDAR admitted that the implementation of the Family Planning Programme has been faulty and announced that the revised strategy would induce a holistic approach to the problem which will take into account the importance of literacy, quality of health services and status of women in society. There had to be a total acceptance of the Family Welfare Programme if it has to succeed. While agreeing that the Health, Welfare and education of women were major factors in controlling population which will be of long term benefits, attention has to be given to Family Planning measures. He remarked that Family Planning Programme had been unevenly implemented in the four Northern States of U.P., Bihar, Rajasthan and Madhyapradesh. Ladies and Gentlemen, I wish to remind you that these states constitute nearly 40% of the country's population. My message to my dearest colleagues of these four states is to exploit the situation and try to get more and more finance for long term benefit schemes to the states in the way of improving the education, MCH facilities, job opportunities for women and their emancipation measures. Of course fertility control is the ultimate aim. The direct result of the above will be the reduction in maternal deaths as well. We in FOGSI will endeavour to fight for these goals, hand in hand with you.

Now I think it is time for us to quickly highlight some of the problems of our specialities.

CAESAREAN SECTION :

During the last few years there has been slight increase in the number of caesarean sections and it is heartening to note that despite the increase of caesarean sections the number of deaths following operative deliveries is falling. There are several reports about thousands of cases of caesarean sections with no mortality.

As for the incidence of the sections there is no uniformity and ofcourse it is something expected. It is around, 10% in our country. In U.K. incidence which was 5.2% during 1970-72 has doubled to 10.1% during 1982-84. There the fatality rates during the same period came down from 0.99/1000 to 0.37/1000. The situation may be slightly different in India. The incidence of C.S. varies from one city to another, and within the city from one hospital to other, and within the same hospital from one consultant to another. According to Dr. Menon, there is a lot of difference between day and night time obstetrics. There are differences in the type of anesthesia, the incisions and suture materials. Dr. B.N. Purandare used to say half seriously that whenever there is a traffic jam there are more normal deliveries !

The overall maternal mortality in caesarean section should not be more than two or three per thousand cases. Sometimes the deaths are more due to lack of ante-natal care, ante-partum hemorrhage and our blasted foe-infection. Among the caesarean deaths 40% occur within 24 hours of surgery and most of them are avoidable. We should all bear in mind that vaginal delivery is four times safer than abdominal delivery.

Now the question regarding ventouse or forceps. In many centres ventouse has been disregarded because of staff inexperience, technical difficulties such as inability to maintain a vacuum and leaks in the tubing. Other reasons - the concern about the chignon on the baby's scalp and the sporadic reports in the literature of infant damage after ventouse delivery. In a meta analysis of ventouse and forceps deliveries, from a number of countries, it was found that ventouse was more likely to fail to achieve the vaginal delivery. On the contrary the ventouse was associated with three fold decrease in the

incidence of maternal injury and maternal analgesic requirements. It was also seen with more babies with cephalhaematomas. But this excess was balanced by a greater number of facial injuries in the forceps delivered babies. There was no difference in the numbers of babies requiring phototherapy. But more babies in the ventouse group had retinal hemorrhage. Of course these are not thought to be of long term significance. The silicup made of silicon may less likely cause maternal trauma. But it has got greater failure rate. The evidence available suggests that the ventouse has a definite place in the modern labour ward. It should be an instrument of first choice by the experienced operator for operative vaginal deliveries. The role of forceps continues in other situation and in particular where the maternal efforts is impossible on contra indicated.

NAEGELE'S RULE :

More than 100 years old Naegele's rule is outmoded, and deserves to be given a goodbye. Naegele's algorithm is correct only in about 40% of cases. There are deviations due to irregularities in the cycles and the usage of O.C. Leap year intervening adds to the confusion. One must accept the time has come to replace Naegele's rule with a formula that takes into account the biological variability. Unnecessary distress is caused to pregnant women and their relatives when they are told a particular estimate date of delivery. Apart from the stress caused by going beyond dates or postdates, the possibility of induction is based solely on a date in the calendar which may ultimately lead to caesarean section. It is the duty of us to tell them that it is not like forecasting weather. We all know the story of the weather forecaster, the meteorologist who went with his wife for a long walk without an umbrella. In the evening they returned fully drenched in a heavy down pour and the weather expert received thunderous abuses from the lady. An alternative is to tell the patient a more accurate point estimate of due date plus calculation of confidence interval.

In prosperous places ultra sonography is widely used to predict expected date of delivery. B.P.D. is still the most commonly used index because it is the most easily obtained and a reproducible measurement. Including other

measurements like femur length and crown rump length may make a straightforward clinical work unwieldly. Of course alteration of EDD based on ultrasound are not necessarily correct particularly in those who are sure of their last menstrual period especially if they experienced early pregnancy symptoms and positive pregnancy test. We never ask the women when they thought they have conceived; many women know the date of conception and are rightly indignant when we say that the ultrasound machine is more reliable. So this question must form part of ante-natal history taking.

BIRTH ASPHYXIA :

One of the aims of obstetric and neonatal care is to reduce the number of children getting permanent brain damage resulting from asphyxia. Unfortunately there is no consensus between the professions regarding the question 'what is birth asphyxia'. Fetal heart abnormalities, meconium stained liquor and acidosis are the indicators of asphyxia to the obstetricians. The Neonatologist decides that a depressed Apgar score and delay in breathing define birth asphyxia, whereas the early onset of abnormal neurological behavior or encephalopathy decides its severity. The recent authors among developmental pediatricians believe that most cases of cerebral palsy and all cases of uncomplicated mental handicaps are not causally related to birth asphyxia. However they recognise a small group of children with spastic/dyskinetic cerebral palsy where birth asphyxia seems implicated. These different views of shifting scenes confuse the issue and a new irksome question emerges. What is BIRTH ASPHYXIA? Many new techniques to identify the unborn infants at the risk of suffering asphyxial brain damage with the hope of immediate delivery have come into use. Over the last 10 years fetal cardiotocography, and scalp blood sampling (abnormalities of fetal heart patterns such as decelerations) are thought to result from hypoxaemia and may lead to the development of acidosis. The false positive rate with CTG is disappointingly high so that even with severely abnormal tracing only about 50% of the babies have significant acidosis and so it has to be conceded that CTG provides inaccurate prediction of asphyxia at birth. The definition of birth

asphyxia has been a matter of controversy and a number of items other than acidosis have been described as better indicators of this situation. They include low Apgar score, late establishment of respiration and the need for active resuscitation. Unfortunately none of these is an accurate predictor of cerebral palsy. It is observed that although very low Apgar scores say less than three at five minutes, add an increased risk of cerebral palsy, most infants with low Apgar scores did not develop cerebral palsy, and 75% of children with cerebral palsy had Apgar scores of more than 7 at five minutes. Apgar score and other criteria reflect asphyxia at birth and are usefully best utilised to take active measures for energetic resuscitation but not to be used as predictors of good or bad outcome. In conclusion there is still no reliable indicator of birth asphyxia. The term birth asphyxia should be reserved to indicate calls for active resuscitation. Until agreement is reached between obstetricians and neonatologists on the definition, the loose term birth asphyxia should be avoided. This inference should bring cheer to us obstetricians because quite often our names are associated with the spastic children in very unfair measures. Many findings are consistent with reports that cerebral palsy rates have changed little over the past 30 years despite developments in perinatal care that have greatly reduced the risk of death. Obstetric practice is beset by worries about medical negligence. Many reports indicate that preventable intrapartum asphyxia is a much less common cause of cerebral palsy than is often supposed.

BREAST :

Even though in our country breasts belong to the realm of surgeons, we gynecologists have got a rightful claim and no examination is complete without history taking and palpation of the breasts. Patients with lump in the breast, mastodynia (mastalgia) not to speak of breast abscess and abnormalities of the nipple come to gynecologists first. Ovaries and endogenous or exogenously administered hormone estrogen are associated with CA breast. The incidence of CA breast is increasing all over the world but consolingly the mortality is not. Due to change of life styles, food habits, environment and other factors the prevalence is more. Unlike in

the past breast and breast cancer are widely discussed by the patients and the profession. In United States celebrity after celebrity volunteered to come forward to demystify the disease and soften its stigma. Famous Shirley Temple, Ingrid Bergman and wives of the successive Presidents Betty Ford and Nancy Reagan became the harbingers of good news that this menace is preventable and very much treatable. We as gynecologists have a great role to play in the early detection and advice regarding the treatment. Fact remains that it is very much hormone related. People who have their ovaries removed before 40 years of age, stand no risk of developing CA breast, Oral contraceptives administered in very young girls before 20 years of age are associated with the risk of developing CA breast; the much worse outcome being the cancer that develops may have the pathological features and prognosis which are less favourable. This is the same story with the older women exposed to HRT and OC.

The strong association between hormones and breast cancer is again revealed by an observation at Guy's Hospital. It is found that women who had surgery for breast cancer during the first two days or between day 13 and the last of day of menstrual cycle had an 84% chance of living more than 10 years. The women operated on from days 3 through 12 had a 54% chance of surviving 10 years. This outcome is regardless of the tumour size, type of involvement of the lymph glands. It is really amazing that the timing of the surgery holds the key to the remission of the disease. It is the duty of every gynaecologist to take up screening and impart health education regarding the high risk factors including obesity.

OTHER MALIGNANCIES :

Dramatic remissions are achieved with the modern chemotherapeutic measures and CIS-Platinum / carboplatin. Hydration and monitoring of the renal functions in these cases offer remarkable improvement even in recurring diseases. As for Cancer Cervix which is most commonly prevalent in our country, our attempts must continue with screening procedures and early diagnosis. Advanced Radio therapeutic modalities should be available to each and every patient poor and underprivileged all over

the country. I call upon the youngsters to generate interest in surgical oncology and develop versatility in the branch. I can recommend the interested youngsters to go to Calcutta where a doyen of our Profession Dr. N.N. ROY CHOUDHURY is operating. He will be glad to teach and train all the aspiring surgeons in radical vaginal surgery.

As we are talking about gynaec Surgery. I want to mention few words about the treatment of menorrhagia. Now endometrial resection is done with hysteroscopic electro diathemy. With a hysteroscopic resectoscope, the method is quicker than Laser ablation. Laser therapy is gaining popularity in many centres, but we have to take the warning from the American College of Surgeons who cautions that Laser should be used by highly experienced persons with great care because damages if any caused by the sophisticated technique is beyond repair.

Nevertheless more and more modern gadgets & innovations are bound to enter into our field and to replace human element. Already with the hard work of our efforts in the field of medically assisted conception we have started crossing the boundaries of heavenly borders. With the use of computers and the application of ARTIFICIAL INTELLIGENCE TECHNIQUE, an expert system is being introduced for foetal assessment. This system called 'FOETOS' will help clinical personnel to interpret several foetal assessment facts. 'FOETOS' has been built with the aid of the knowledge engineering tool 'GENIE'. Genie will simply tell us when to deliver and how to deliver the high risk baby,

Many thoughts are getting crowded in my mind because of the impending future shock of 2000 AD which is going to be a severe one. I want you to take a GRANDSTAND view of the Mega-trend of 21st Century will marvelous developments. Intensive Care-Units for healthy low birth weight and pre-term babies who will survive more and more will be a challenge to the neonatologists. Maternal deaths will have to be halved. Collaborative low dose aspirin studies in pregnancies (CLASP) will give the final verdict and we'll know whether low dose aspirin will reduce perinatal mortality in Preeclampsia by preventing hypertensive disorders and even eclampsia. Blind curettage will be replaced by

selective hysteroscopic endometrial biopsy. The uterus will become the operation theatre routinely when needed for foetal corrective surgery in utero. We may have to face more and more gynaec disorders which are hitherto found only in developed countries, because our life expectancy is rising. As all of you know there are going to be more than one billion Indians and many of the now available fertility control measures will become obsolete. Instant contraceptives, Post-coital contraception, the so called morning after pills will be popular. RU 486 and such drugs will become available if there are no cost constraints. On the legal side we have to face many more litigations sometimes from unexpected quarters. With all this we will survive, as we have in the past with the trials and tribulations and emerge victorious. Our dynamic, charming and endearing Chief Minister, Dr. J. JAYALALITHA has chalked out a plan to beautify Madras City with a scheme called "EZHIL MIGU CHENNAI 2000" (CITY BEAUTIFUL - 2000 AD). With her indomitable spirit, this will be accomplished and I welcome you all to Madras for the congress in year 2000 if approved by the FOGSI when you will see a more beautiful city with better amenities. We'll have a younger generation inviting you; people who will have tremendous adaptability and willingness to change. Like Japanese when situations change, they will change the bearings and set themselves on a new course. They will not argue about outmoded principles and convictions but concentrate on, what will work. By this way we shall also be reaching dazzling heights of excellence in health care systems, knowledge and research work in the 21st century.

Now the count down has started. We will march towards 21st century with courage & faith.

FORWARD, FOREVER FORWARD!
AT THE END OF THE TUNNEL IS THE LIGHT
AT THE END OF THE FIGHT IS THE VICTORY
 Come ... on.... let us move on - it is only walking distance!

Long live FOGSI!