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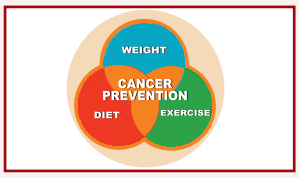
Newsletter

November 2018 | Issue 11



"PREVENTIVE ONCOLOGY"

President's Message

Dear FOGSIans
Greetings!

Here comes November and our issue dedicated to preventive oncology is on your table. There is no doubt that cancer as a whole has overtaken Non-communicable diseases as far as mortality is concerned and today cervical cancer and breast cancer are the most common cause of cancer deaths among women in India, but we also do understand that early detection and proper treatment can improve this prognosis and can make cancer curable.

A study conducted by EY and FICCI has reported that in India, 2,000 women are newly diagnosed with cancer every day. About 1,200 of these cases are detected in late stages, which reduces the 5-year survival rate by 3 to 17 times for breast and cervical cancer. This late detection also raises the cost of treatment by 1.5 to 2 times that for early-stage cancers.

So the major thrust in cancer control has to be on early detection and prevention. Mass screening for cancers is not possible, but unless we do that, how are we going to pick up cancers early and save lives. This requires great determination and political will, along with creating awareness. Also what is important is to spread information regarding the risk factors include smoking, excess body weight, physical inactivity and changes in reproductive patterns, such as a later age at first childbirth and fewer childbirths and improving our environment.

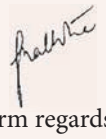
Cancer prevention efforts—including cancer screening, vaccination, tobacco control, healthy eating and physical activity—remain the key to reducing the effect of cancer and improving outcomes across communities worldwide. In fact, researchers estimate that 50% of cancer cases and deaths in the United States could be prevented if people adopted simple healthy lifestyle choices that include avoiding smoking and alcohol, maintaining a healthy weight and exercising regularly.

Along with this if we focus on two important preventive vaccines, one human papillomavirus (HPV) and second Hepatitis B, it will take care of two major malignancies. FOGSI this year took up project "Akshaya Jeevan" for cancer cervix screening and vaccination and also is working towards developing a module towards breast cancer screening with I-Breast along with Lions club and hope to sensitize populations towards universal screening. So dear friends, let us start a drive against rising trends in cancer and this has to be multi-pronged approach and work towards reducing incidence of cancer in our country.

"It's about focusing on the fight and not the fright."
~Robin Roberts

This month we have a YUVA conference dedicated towards Preventive Oncology and I hope many of our members will benefit from its deliberations.

Looking forward to seeing you all soon.



Warm regards
Lots of Love
Om Shanti
Jaideep Malhotra

UPCOMING

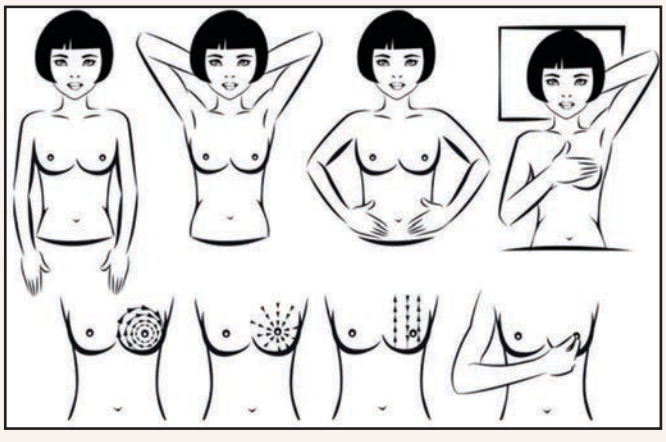
Preventive Oncology
"Stealing cancer's thunder"

Dr Ragini Singh

An ounce of prevention is worth a pound of cure

Preventive oncology is the study for preventing cancer to develop, rather counteract the advancement in progression. In many respects, it is a preventable disease and one half arises from modifiable risk factors or can be detected as precursor lesions. Prevention can be primary, addressing the cause or secondary which identifies the disease, before the onset of symptoms and keeps it from becoming more extensive. Risk assessment of an individual is the key, to identify modifiable and nonmodifiable risk factors.

Breast self examination (BSE) is recommended because of low cost and benefits of making the patient an active participant in her health. Beginning in the early 20's women must be taught the importance of prompt reporting of any new symptoms and their technique need to be monitored. Clinical breast examination (CBE) has greater sensitivity with mammography,



but has higher false positive rates than mammography alone. Studies show, since 1990, mammography accounts for 41% reduction in mortality rate in breast cancer. Film or digital mammograms are used. Digital is more accurate in dense breasts and in premenopausal women. Most experts agree that screening mammography is essential in women of 50–69 years and beyond 70 years who have a life expectancy of 10 years or more. Some express concern regarding radiation risk, but direct data associated with this level of exposure are lacking. Breast ultrasonography and magnetic resonance imaging are not used for routine screening in general population.

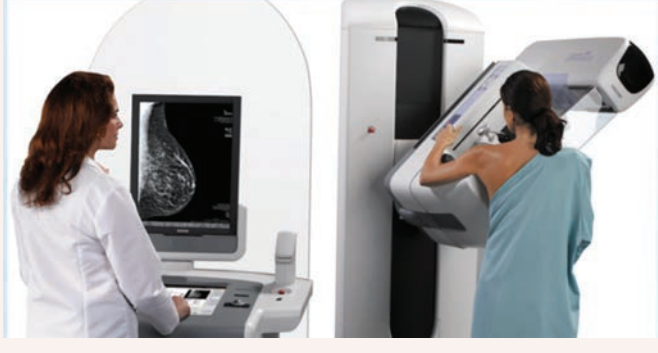
Human papillomavirus testing may be used along with conventional smear or liquid-based cytology (LBC) for cervical cancer screening. LBC is superior in picking up low grade, atypical squamous or glandular lesions. Primary HPV test is avoided before 30 years because of high false positive rates. The Pap smear is needed to follow a positive HPV test. Age-based screening after total hysterectomy with bilateral salpingo-oophorectomy (BSO) for cervical or uterine cancer must be continued for 20 years at least. Endometrial and ovarian cancer screening for general population is not recommended. Risk of malignancy index (RMI) is calculated based on menopausal status, CA-125 and transvaginal ultrasonography (TVS) findings.

Selective estrogen receptor modulators (SERMs) are available for primary prevention of breast cancer, but risks and benefits need to be assessed. HPV vaccines are available in three doses over 6 months. Adolescents need two doses. Catch-up vaccination can be given. Because of lack of study, it is not recommended in immune compromised. Pap smear must be continued even after vaccination. In individuals with high risk of cancer (hereditary and genetic predisposition) prophylactic surgical interventions provides another means of risk reduction. Hence, on a positive note there is more hope today then ever before.

Not only "Yuvraj" but lesser mortals have fought the dreaded disease and are still fighting its aftermath. The journey has been very traumatic for the so called "Survivors". If you are a health professional, it is all the more gruesome, because you know all about it. It is not easy for any one of us to sit on the other side of the table, to wait in the queue with other patients, to lie on the OT table again and again, to wait for the results of various investigations and biopsies. Above all if at the end of the treatment people discuss it with you saying it was not proper, it could be different, thinking you being a doctor are brave enough to digest everything. You are shattered.

It is human nature to surround and flock the powerful and discard, disown the needy and down under. Loneliness, disrespect and depression slowly ignites courage within you to stand up and face fear. Fear of death. Fear of uncertainities. Life starts moving, being soul conscious helps and so does focusing on your karma, without regrets.

Now most of the time I forget that I had cancer. Memory is a beautiful thing, but not always, sometimes so is a fading one.

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2018
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WORLD CONGRESS
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AND OBSTETRICS
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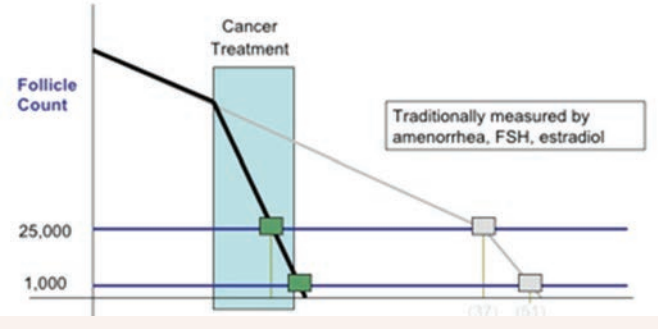
Cancer and Fertility

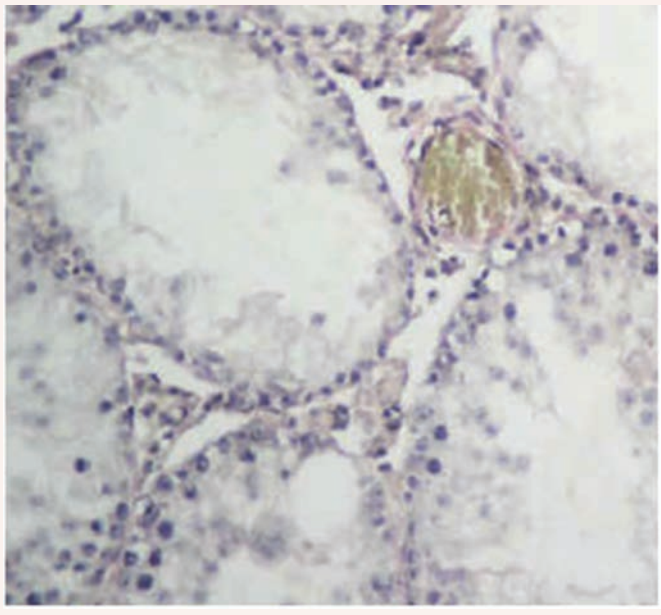
Dr Keshav Malhotra

Cancer therapy has advanced and with this it has increased the number of long-term cancer survivor worldwide. It had been suggested that by 2010, 1 in 250 adult would be a childhood cancer survivor. In India alone the number of patients who would develop cancer in their lifetime is set to go up from 9.79 lacs in 2010 to 11.4 lacs by 2020, out of these more than 140,000 would be diagnosed in their reproductive age.

Effect of cancer therapies on fertility

Chemotherapeutic agents produce a varied effect on fertility and it involves different pathophysiological pathways, which makes it difficult to predict the effect, also makes it difficult to understand and thus counsel. We have a basic understanding that the chemotherapeutic agents target proliferating cells like bone marrow and ovarian follicles etc. The reported rates of premature ovarian failure in such patients differs considerably. It is a known dilemma for oncologist that women are born with their full complement of eggs which decreases with time till they achieve menopause and both chemotherapy and radiotherapy accelerate that decline, if the eggs survive they might lose their functional competence as the DNA in such eggs might have been compromised due to the therapy and though this response varied in women, ovarian dysfunction post chemotherapy is quite common specially when using alkylating agents. Cancer survivors post chemotherapy can conceive naturally

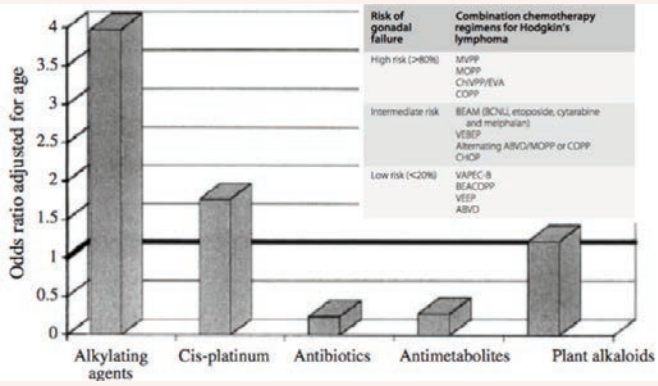




as there have been reports in literature regarding the same but we know that chemotherapeutic agents can be mutagenic and teratogenic and thus conception in such women should be delayed otherwise there is a risk of congenital malformations specially if conception happens within 3 months post treatment as suggested by animal models. However in humans the live birth rates in survivors are similar to their siblings, there has been no reports of significant increase in malformations, abortions, genetic defects when conception has taken place long after finishing therapy. Risk has been proposed to be maximum during oocyte maturation and not when they're dormant, therefore it is suggested that a woman should wait about 6 months after finishing treatment in order to conceive and even if preservation isn't done before treatment it should be done 6 months post treatment and not in between, the safety guidelines for this are yet to be established.

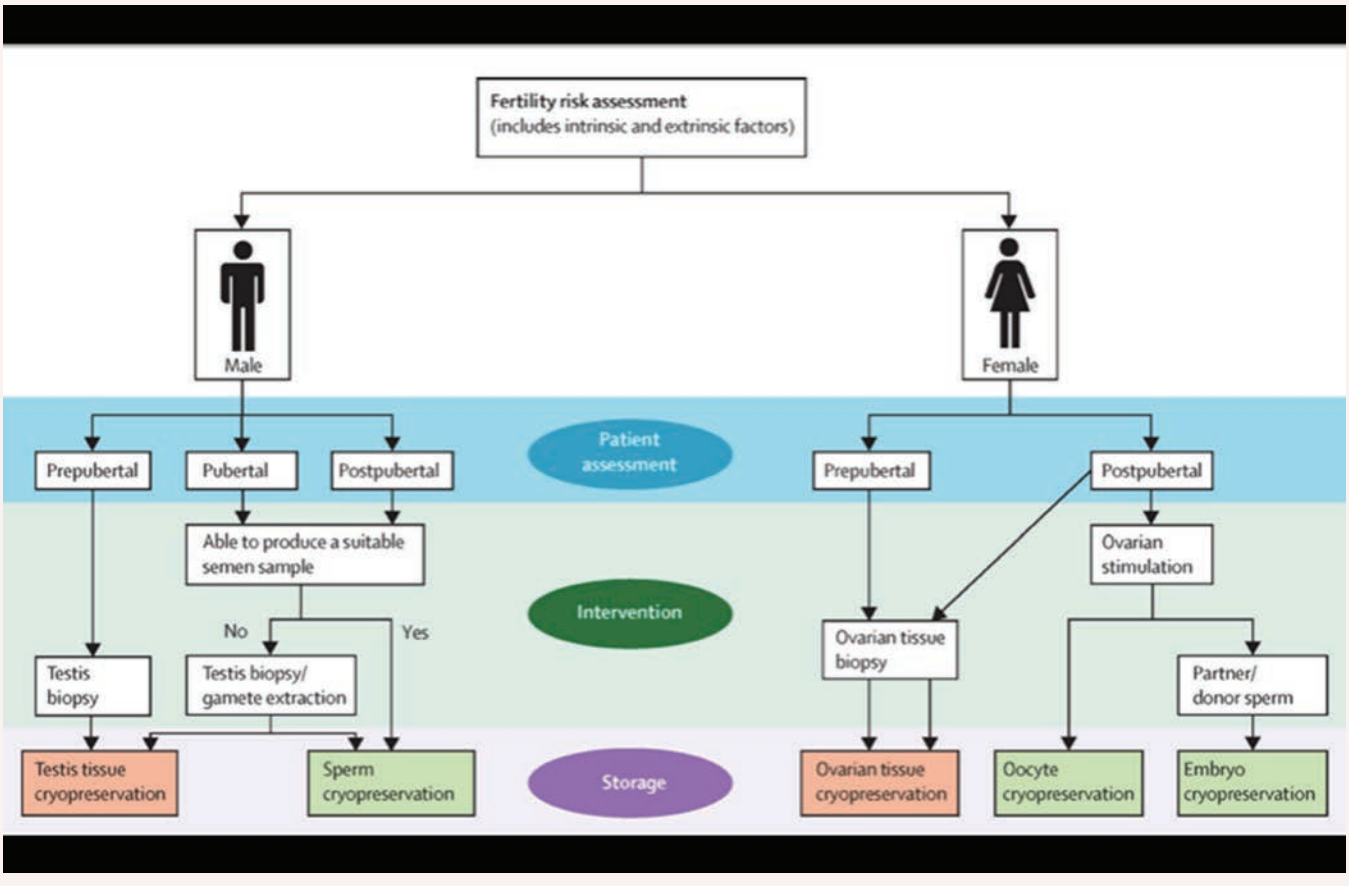
In men the chemotherapeutic agents have a profound effect on the seminiferous tissues, which is the crux of spermatogenesis but leydig cells tend to tolerate chemotherapy better and thus, post treatment, even though these men might be rendered as oligo-asthenozoospermic they still produce testosterone.

There have been various studies which have stated that gonads might be highly sensitive to irradiation



and the damage induced by radiotherapy depends on the field of exposure, the dosage and also the age of the patient at time of exposure. The human egg is highly susceptible to damage due to irradiation and the LD 50 which is the lethal dosage to kill half of the pool of oocytes has been shown to be <2 Gy (Wallace et al., 2003). Wallace (2005) also studied the sterilizing dosage which is when 97.5% of the oocytes are lost and this varies with age which is shown in the chart. It is not just the ovaries that are susceptible to damage, the uterus also undergoes changes post irradiation, and radiation can cause reduction in blood flow, fibrosis and even endometrial insufficiency and atrophy. A dosage of about 12 Gy can cause significant effects on the uterus, there have been studies which have reported an increase in miscarriage rate, intrauterine growth restriction (IUGR), preterm deliveries and even low weight at birth apart from an increase in the incidence of infertility within a year of irradiation. A radiation dosage of 25 Gy and above can cause permanent and irreversible uterine damage in childhood cases.

In men a radiation dosage of 0.1-1.2 Gy could result in detectable damage but a dosage of 4 Gy causes permanent damage. As far as pediatric oncology is concerned, post radiation testicular dysfunction is one of the commonest issues specially in common cancers like leukemia. Treatment for it includes irradiation with doses going as high as 24 Gy which can render the child as azoospermic. A total body irradiation dose for bone marrow conditioning before transplant is also 14.4 Gy and can cause permanent damage but leydig cell function might get spared. The various chemo and radiotherapy options and their effect on fertility both male and female are mentioned in the tables.



Update on Primary Prevention of Cancer Cervix

Dr Vaidehi Marathe

What is the current scenario of Ca Cx in India?

It is the commonest cancer in women in India.

India accounts for 25% of global burden of cervical cancer

Ca cervix is the most common cancer in India followed by breast cancer. According to a data in 2012, the crude incidence rate of Ca cervix 26.2 per 100,000 women per year to 16.5 per 100,000 women for breast cancer.

What causes cervical cancer?

There are multiple HPV genotypes, a subset of which infects the anogenital tract and cause cervical cancer. One group is responsible for most genital warts and are known as "low risk", contains closely related species HPV 6 and HPV 11.

There is another group of 30 oncogenic or "high risk" HPV which causes cervical cancer. Of these, HPV 16 and HPV 18 are responsible for 70% cases and along with HPV 31, 33 and 45 for more than 80% of cases.

What is the role of HPV in cervical cancer?

Human papillomavirus infects the transformation zone. In the cervix, persistent infection causes dysplastic changes, LSIL or HSIL on cytology and CIN 1 and CIN II and III on histopathology. These lesions may take 2 to 5 years to progress. Cervical cancer is a late consequence of 'persistent HPV infection' and may take 10-20 years to develop. Almost 80-90% of genital HPV infections resolve with time and the remaining 10-20% develop persistent infection.

What are the co factors responsible for persistent infection?

Early age at first intercourse, multiple sexual partner, multiple pregnancies, smoking, oral contraceptive use and male partner not circumcised.

How does HPV get transmitted?

Oncogenic HPV can spread via close skin to skin and sexual contact and does not necessarily require penetrative sex. Thus condoms cannot prevent HPV infection, unlike other STDs.

Non sexual routes

Vertical transmission (mother to baby), fomites (surgical gloves, undergarments, surgical instruments). These are hypothesized but not well documented.

What are the important serotypes responsible for cancer?

Human papillomavirus 16 and 18 are responsible for 70% of squamous cell carcinoma and high grade invasive cancer worldwide. Six other most common high risk serotypes are 31, 33, 35, 45, 52 and 58.

These eight serotypes together account for 90% of cervical cancers.

If cervical cancer a disease of middle-age, why catch them young?

The lag period of infection and cancer is 15-20 years. Since the protection is seen only when the vaccine is given before infection, the vaccine should be given prior to beginning of sexual activity.

Why natural infection doesn't give immunity? How does the vaccine provide protection?

Natural HPV infection induces weak immune response. So, the antibody response is quite poor after natural infection.However, HPV vaccine is immunologically a potent antigen hence immune response is robust, thereby providing protection.

Which vaccines are currently available?

Bivalent, quadrivalent and 9-valent vaccines are available and approved for girls aged 9–26 years. The 9-valent vaccine which covers five additional serotypes will soon replace the quadrivalent vaccine in India.

What is the recommended dose schedule?

The Advisory Committee on Immunization Practices (ACIP) recommends.

Quadrivalent vaccine (16, 18, 6, 11)

The administration schedule consists of a dose of 0.5 mL at 0, 2 and 6 months, administered intramuscularly in the deltoid muscle.

The 2-dose schedule recommendations—Advised for girls aged 9-14 years at '0 and 6-12 months'; for girls 15 years and older, current 3-dose schedule will continue. The interval between the first and second dose may be extended up to12 months.

However, for immunocompromised individuals, including HIV-infected, the 3-dose schedule is recommended, irrespective of age.

Bivalent vaccine (16, 18)

The 2-dose schedule remains the same for girls between 9–14 years.

Girls 15 years and above—3-dose schedule of 0, 1 and 6 months.

The vaccine is currently licensed for use between 9 years and 26 years of age, however bivalent vaccine can be given up to 45 years of age.

What are the adverse effects of the vaccine?

- *Minor*: Local area pain, swelling and erythema, fever on the day of vaccination
- *Major*: Anaphylaxis in subjects sensitive to yeast—S. cerevisiae, bronchospasm, gastroenteritis, and vaginal bleeding have been reported in isolated patients, their association with the vaccine is unclear. No vaccine-related deaths have been reported.

Is there anyone who should not get HPV vaccine?

Some people should not get HPV vaccine or should wait:

- Anyone who has ever had a life-threatening allergic reaction to any component of HPV vaccine, or to a previous dose of HPV vaccine, with severe allergies, including an allergy to yeast
- HPV vaccine is not recommended for pregnant women. Can be given during breastfeeding
- People with a moderate or severe illness should wait until they are better.

Are HPV vaccines safe?

Yes. The HPV vaccine was well studied in clinical trials and the vaccine safety monitoring studies showed that it was safe and effective.

Do HPV vaccines cause serious side effects?

Serious side effects to all vaccines, including HPV vaccines, are extremely rare.

The benefits of getting the HPV vaccine greatly outweigh the very small risks.

Do women still need Pap tests if they get the HPV vaccine?

Yes. Sexually active women of all ages will still need to get Pap tests after they've been vaccinated. This is important because HPV vaccines protects against most but not all cancers of the cervix.

Should women get the HPV vaccine if they are already sexually active?

A person should still get the vaccine even if they are already sexually active as they are unlikely to have been exposed to all of the types of HPV contained in the vaccine.

Can HPV vaccines cause premature menopause in young women, leading to infertility?

There is no current evidence that HPV vaccines cause reproductive problems in women.

Have HPV vaccines been linked to Guillain-Barré syndrome?

The studies provide evidence that the risk of getting Guillain-Barré syndrome following HPV vaccination is extremely rare.

Can HPV vaccines cause postural orthostatic tachycardia syndrome (POTS)?

Ongoing safety monitoring through VAERS (the Vaccine Adverse Event Reporting System) has not detected any safety concerns related to POTS following HPV vaccination.

Do HPV vaccines cause chronic regional pain syndrome (CRPS)?

The VAERS review concluded that CRPS following HPV vaccination is rare.

Do HPV vaccines cause chronic fatigue syndrome?

Centers for Disease Control and Prevention (CDC) is aware of reports of chronic fatigue syndrome following HPV vaccines and continues to monitor for any unusual or unexpected patterns among reported cases.

Has anyone died after receiving HPV vaccines?

After careful review of every reported case of death that has happened after HPV vaccination, CDC concluded , the evidence did not suggest a causal link.

Finally, what are the recommendations for males?

Human papillomavirus is responsible for genital warts and penile/anal cancers in males. Males can transmit HPV to their sexual partners. Therefore, 3-dose schedule from 9–26 years of age is recommended (CDC guidelines)

References

1. ACIP- advisory committee on Immunization Practices, US.
2. CDC guidelines.
3. ACVIP - advisory committee on vaccines and Immunization practices, India (IAP).
4. ACOG commitee opinion Number 704, june 2017.
5. IAP guidebook on vaccines and Immunization practices.

Humour of The Month

Malaria in Pregnancy

Ms Bhola Gunjan

Malaria infection in pregnant women is associated with high risks of both maternal and perinatal morbidity and mortality. Malaria infection during pregnancy can lead to maternal anemia and adverse pregnancy outcomes like spontaneous abortion, premature delivery, growth restriction/low birth weight, stillbirth, congenital infection and neonatal mortality.

Pregnant women are three times more likely to develop severe disease than nonpregnant women from the same geographical area. The mechanism behind this is poorly understood, one of the reasons being that pregnant women have a reduced immune response and therefore less effectively clear malaria infections. In addition, malaria parasites sequester and replicate in the placenta. This also disrupts nutritional exchange between mother and fetus and can lead to intrauterine growth retardation.

In early stages of the disease, it can present similar to any viral or flu-like illness. There are no specific symptoms and signs; if there is any suspicion of malaria, it should be confirmed by a blood film.

Microscopy and rapid diagnostic tests are the standard tools available. Rapid detection tests may miss low parasitemia, which is more likely in pregnant women and rapid detections tests are relatively insensitive in *P. vivax* malaria. Microscopic diagnosis allows species identification and estimation of parasitemia, so that appropriate antimalarials can be prescribed.

Women with malaria in pregnancy should have the severity of their condition assessed and documented as an aid to management. Severe/complicated malaria can present with impaired consciousness, respiratory distress, convulsions, circulatory collapse, abnormal bleeding or jaundice. The clinical condition is the most important indicator of severity and should be assessed promptly.

The severity of malaria determines the treatment and predicts the case fatality rate. In uncomplicated malaria, fatality rates are low–approximately 0.1% for *P. falciparum*. In severe malaria, particularly in pregnancy, fatality rates are high (15–20% in nonpregnant women compared with 50% in pregnancy).

For pregnant women diagnosed with uncomplicated malaria caused by *P. malariae, P. vivax, P. ovale*, or chloroquine-sensitive *P. falciparum* infection, prompt treatment with chloroquine (treatment schedule as with nonpregnant adult patients) is recommended. Alternatively, hydroxychloroquine, may be given instead.

For women in their second or third trimesters, artemether/lumefantrine is an additional option.

For pregnant women diagnosed with uncomplicated malaria caused by chloroquine-resistant *P. falciparum* infection, women in the second and third trimesters can be

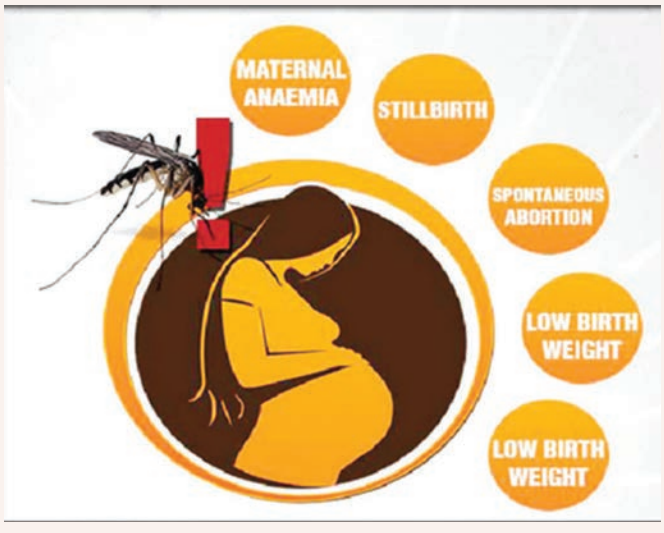
treated with artemether/lumefantrine, and for all trimesters, mefloquine or a combination of quinine sulfate and clindamycin is recommended.

Quinine treatment should continue for 7 days for infections acquired in Southeast Asia and for 3 days for infections acquired elsewhere; clindamycin treatment should continue for 7 days regardless of where the infection was acquired. For pregnant women diagnosed with uncomplicated malaria caused by chloroquine-resistant *P. vivax* infection, prompt treatment with artemether/lumefantrine (second and third trimesters) or mefloquine (all trimesters) is recommended.

Doxycycline and tetracycline are generally not indicated for use in pregnant women.

Pregnant women with complicated/severe malaria should be started with artesunate IV 2.4 mg/kg at 0, 12 and 24 hours, then daily thereafter. When the patient is well enough to take oral medication she can be switched to oral artesunate 2 mg/kg (or IM artesunate 2.4 mg/kg) once daily, plus clindamycin. If oral artesunate is not available, use a 3-day course of atovaquone-proguanil or a 7-day course of quinine and clindamycin at 450 mg three times a day 7 days.

Vertical transmission to the fetus can occur when there is infection at the time of birth and the placenta and the cord are blood film malaria positive. All neonates whose mother developed malaria in pregnancy should be screened for malaria with standard microscopy of thick and thin blood films at birth and weekly thereafter for 28 days.



President of India endorses FOGSI's initiative of H.E.R. (Health; Empowerment & Respect)

Special Appreciation to Dr Meera Agnihotri for organizing WWWCON

Few Important Links to Read

- https://www.memorialcare.org/events-education/live-healthy/gynecologic-cancers-signs-symptoms
- http://www.uchospitals.edu/specialties/cancer/gynecologic/prevention/index.html
- https://www.cdc.gov/cancer/gynecologic/basic_info/prevention.htm
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1891179/
- http://www.nccc-online.org/hpvcervical-cancer/gynecological-cancers/
- https://www.foundationforwomenscancer.org/about-gynecologic-cancers/
- https://journals.lww.com/ijgc/pages/default.aspx
- https://cancer.coloradowomenshealth.com/cancer-symptoms/index.html
- https://igcs.org/gynecologic-oncology-news-updates/
- https://www.ncbi.nlm.nih.gov/pubmed/29468855
- https://www.esmo.org/Guidelines/Gynaecological-Cancers
- https://www.webmd.com/children/vaccines/hpv-vaccine-what-you-need-know#1
- https://www.cdc.gov/hpv/parents/vaccine.html
- https://en.wikipedia.org/wiki/HPV_vaccine

Professor Dr S Sampathkumari

"Cancer Changes us, there's no doubt about that. But it's up to us to decide what that change will mean in our lives, and who we will become as a result"

Britta Aragon

FOGSI Initiative
AKSHAY JEEVAN

AKSHAYA JEEVAN Initiative of FOGSI: Screen The Mother: Vaccinate The Daughters

FOGSI under the leadership of its visionary President Dr. Jaideep Malhotra launched a unique Project at the FOGSI Fraternity Conclave in Feb 2018 at Varanasi.

Despite the documented evidence of Cervical cancer being preventable disease it is unfortunate to have one forth of global disease burden in India, with almost 67,000 women dying because of the disease

With the aboe background the aim of the project is to kill the disease before it kills our women both by Primary & Secondary Prevention.

Under the program various awareness activities were conducted to sensitize the women & adolescent girls for screening & vaccination respectively.

Tarot for November 2018

Aries: Good month for this sun sign, good phase to continue. Some celebrations in the family indicated. You will enjoy good health and mental peace.

Taurus: Gear up for hard work, you will face stiff competition this month, work related issues might stress you out and your health might be a cause for concern.

Gemini: Try not to take major decisions this month, take advise from your elders, be careful while driving. If wanting to start a family this is the right time. Fruitful for women wanting to get pregnant.

Cancer: Very good month for Cancerians, time for fulfilment of desires. Promotion on the cards, if planning to buy a new car this is the best time, you might be going on a holiday. All good things coming your way.

Leo: Money will go as soon as it comes, so try to be cautious with your expenses. You are likely to benefit in work and get accolades. Travel on the cards.

Virgo: Work will keep you on your toes, travel and lots happening around, try to stay focussed look after your health and try to relax.

Libra: Travel on the cards, work is likely to be demanding. Good month, fun with family and friends. Try not to overdo things and look after your health.

Scorpio: New relationships will be formed, work will be exciting and rewarding. Friends and colleagues will be supportive. Try to keep an eye on the expenses. Stressful and exciting month.

Sagittarius: Time to reap the fruits of your hard work, this month will be rewarding. Increase in income, promotion, financial gains indicated. Good family life, a happy and satisfying month.

Capricorn: Try not to hold on to the past, move ahead, forgive and forget. A month for self-cleansing and realisation. Try to relax yourself.

Aquarius: Changes in your attitude and thoughts for the better, a good month. You will get lots of attention from friends and colleagues. Good health is indicated.

Pisces: Travel on the cards. Work will be demanding. You might be confused and stressed out this month, do not make impulsive decisions. Think carefully before you speak.

Rest is in the hands of God, have a blessed November.

—Deepa Kochhar (Noida)
kochhar.deepa@gmail.com

Dear FOGSIans,

October has been a great travelling month for many of us and we are all back now refresh and recharged.

November is our month of festivities and I wish all of you a very Happy Diwali.

"May every Lamp which is lit bring in Happiness"

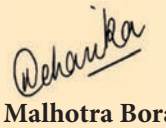
This month our focus is on preventive oncology and we hope to see you all in our last Yuva of year at Gangtok.

"Our Support to all Cancer Fighters
Our Admiration to all Cancer Survivors
Our Honor to all Cancer Lost."

Let us all help our women understand preventive oncology and screen them regularly.

We also must focus on working in improving the environment as endocrine disruptors are a huge underlying cause.

"Nothing ever goes away until it teaches us what we need to know"



Dr Neharika Malhotra Bora
Joint Secretary
FOGSI

29th NORTH - EAST OBSTETRIC & GYNAECOLOGICAL SOCIETIES CONFERENCE (NEOGSCON)

DATE
21st - 23rd December 2018

ORGANISED BY
Imphal Obstetrics & Gynaecological Society (IOGS), Manipur

VENUE :- JNIMS Auditorium, Imphal

Theme:
"High Risk Pregnancies - Early Detection, An Unmet Need"

Dr. Jaideep Malhotra
President, FOGSI

Dr Savana Chongtham
National Co-ordinator

Prof. Ngangom Indrakumar Singh
Organising Chairperson

Dr. James Elangbam
Organising Secretary

East zone Yuva FOGSI 2018

22, 23 & 24 November 2018

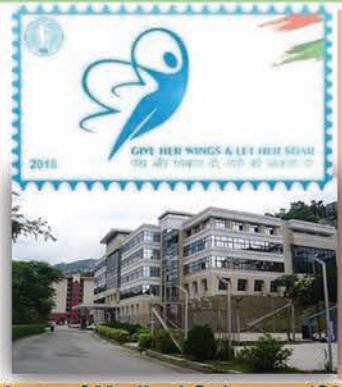
Organized by Gangtok Obstetrics & Gynaecological Society, Sikkim

Venue: Sikkim Manipal Institute of Medical Sciences (SMIMS) Gangtok, Sikkim, India

- Theme- Gynecologic Oncology

22nd November Pre congress workshop
- Gynecological endoscopy
- Imaging/Ultrasound
- Preventive Oncology/Colposcopy

23-24 November -Congress
- Dr Kamini Rao YUVA oration
- Senior Orations
- Keynote addresses & Symposiums
- Oral and poster presentations (award)
- Intercollege postgraduate Quiz (award)



23-24 November –Congress highlights
- Gynecologic malignancies : Indian Scenario
- Guide lines in Gynecologic malignancies
- Imaging in diagnosis and management of Gynecologic malignancies
- Gynecologic malignancies in Young women
- Fertility sparing management in Gynecological malignancies
- Updates on rare Gynecological malignancies
- Immunotherapy in Gynecologic oncology

Venue: Sikkim Manipal Institute of Medical Sciences (SMIMS) Gangtok, Sikkim, India

Getting to Gangtok
- By Air-Nearest airport Pakyong (20KM) / Bagdogra (120KM)
- By Train-Nearest station NJP
- By road-Bagdogra/ NJP/ Siliguri well connected by NH31 A to Gangtok and about 3 hour drive by taxi/bus.

Important dates

Abstract submission last date-31st Oct 2018
Author notification by -31st Octo 2018
Author registration deadline-1st Nov 2018
Regular registration by-1st November 2018
Online registration closes 15h Nov 2018

Registration Details [For detailed information or online registration log on to www.gangtokogs.in or mail at ezyf2018@gmail.com
- Payment by cheque or DD to be issued in favour of "East Zone Yuva FOGSI 2018" payable at Gangtok.
- **For NEFT or online transfer** A/C name-East Zone Yuva FOGSI 2018, A/C no-8676101009259, Canara Bank, Tadong branch, IFSC code-CNRB0008676, MICR code-737015003. Please send scanned copy of payment slip and registration form by e-mail or post.

Category	Regular up to 31st October 2018	1 November 2018 onward
Delegate/Faculty (INR)	6000	7000
*P.G Students (INR)	4000	5000
Accompanying Person (INR)	3500	4000
Banquet (INR)	2000	2500
Workshops (INR)	1500	2000

*PG students need certificate from HOD. Registration form/Cheque/DD or all communication should be addressed to: **Dr Hafizur Rahman, Organizing Secretary-East Zone Yuva FOGSI 2018, Professor of Obstetrics and Gynaecology,Sikkim Manipal Institute of Medical Sciences,5th Mile, Tadong, Gangtok-737102,Sikkim, India.(M)+919733400336.Email: ezyf2018@gmail.com**

For detailed information and registration form log on to Gangtok OBGYN Society website at www.gangtokogs.in or conference website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FOGSI President 2018


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Organizing Chairman


Dr R.N Deokota
Organizing Chairman


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Dr Hafizur Rahman
Organizing Secretary

PRINCIPLES
PROTOCOLS
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National Congress on Principles, Protocols and Practices in Obstetrics and Gynaecology

16th - 18th November 2018 | HICC, Hyderabad, Telangana

Get to know the Principles Protocols & Practices by the World Class Faculty

CONFERENCE HIGHLIGHTS

- Pre- Conference Workshops
- Orations
- Obstetric Critical Care Workshop
- Key Note Addresses
- Free Paper Presentations

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President FOGSI
Congress President

Dr. S. Shantha Kumari
Chairperson ICOG
Organizing Chairperson

Dr. Parag Biniwale
Secretary ICOG,
Organising Secretary

LAST DATES for ABSTRACT SUBMISSION on 15th October, 2018

AWARDED
20 Credit Points by ICOG
and
6 Credit Hrs. by TSMC

Conference Secretariat:
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