

KFOG JOURNAL

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Equity In
Maternal Healthcare



The Burning Issue
Of Teenage Pregnancy



Preventive
Urogynaecology



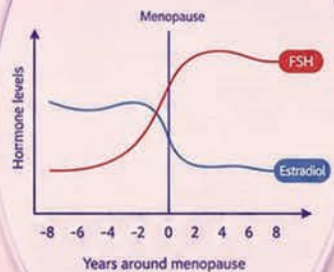
Laparoscopy
In Pregnancy



Recurrent
Endometriosis



Perimenopause:
The Midlife Drift



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PRESIDENT'S *message*

Dear Seniors and Friends,

It gives me immense pleasure to address you through this edition of the KFOG journal. This journal brings together a diverse collection of articles addressing important aspects of women's health across different stages of life. Women's healthcare continues to evolve with advances in science, technology, and a deeper understanding of the physical, emotional, and social dimensions of health. At the same time, persistent challenges such as inequities in access to care, reproductive health concerns, and chronic gynecological conditions remind us of the need for continued advocacy, research, and innovation. This journal renders the same message.

Also our academic committees are committed to organizing regular workshops, webinars and discussions, aimed at continuous learning and skill enhancement. I urge our members to actively participate in these academic endeavors.

Furthermore, "Synergy - Together For Better Care" is the core vision of our current tenure. We are dedicated not only to the welfare of our patients but also to the personal and professional well-being of every member.

I congratulate the editorial team and all contributing authors for their dedication to academic excellence and their commitment to evidence-based practice.

Let us blend the wisdom of our senior stalwarts with the energetic expertise of our younger generation to build a robust, united dawn in women's healthcare. Together, we can continue to achieve new milestones in our motto: "Save the Mother, Save Generations".

Yours in service,

Dr. Fessy Louis T.,
President, KFOG



Dr. Fessy Louis T
President,
KFOG 2026-27



SECRETARY'S

message

Dear seniors and Colleagues,

It gives me immense pleasure to present the latest issue of the KFOG Journal, which brings together a diverse and relevant collection of articles addressing some of the most important challenges and advances in women's health.

This issue features insightful contributions from Dr. B Presanakumari on Equity in Maternal Healthcare, Dr. S Sampathkumari on the burning issue of Teenage Pregnancy, Dr. Jayashree Vaman on Preventive Urogynecology, Dr. Ancy on Laparoscopy in Pregnancy, Dr. Reji on Recurrent Endometriosis, and Dr. Reshmy on Perimenopause : Midlife Drift.

The wide range of topics makes this edition a true "mixed bag," offering valuable learning opportunities for clinicians across all stages of practice. My sincere appreciation also goes to all the authors for sharing their expertise and enriching our academic community.

I congratulate Dr. Sangeetha D G, Editor of the KFOG Journal, for her dedication and hard work in bringing out another excellent issue.

HAPPY READING..

Dr Subhash Mallya,
Secretary, KFOG.



Dr. Subhash Mallya
President,
Secretary, KFOG

EDITOR'S

note

It is my immense pleasure to present the first printed version of the year 2026 encompassing the wide spectrum of issues affecting women's health. The topics featured in this issue reflect this breadth, highlighting critical areas that continue to shape clinical practice, research, and public health.

From the pursuit of Equity in maternal healthcare, to addressing the persistent challenge of Teenage Pregnancy, the articles in this issue underscore the importance of accessible, informed, and compassionate care. Advances in Preventive Urogynecology emphasize the value of preserving pelvic health and quality of life, while evolving evidence on Laparoscopy in Pregnancy, demonstrates how innovation can enhance maternal outcomes without compromising safety.

We also explore the complexities of Recurrent Endometriosis, a condition that continues to impact the physical, emotional, and social well-being of countless women. Finally, as women navigate the transition through Perimenopause, understanding the hormonal and physiological changes of midlife becomes essential to promoting healthy ageing and informed decision-making.

This issue serves as a reminder that women's health is not confined to a single stage of life, but is a continuum requiring awareness, advocacy, and evidence-based care.

I extend my heartfelt gratitude to all the authors of this edition and to KFOG President Dr Fessy Louis and Secretary Dr Subhash Mallya for their continuous support and encouragement in bringing out the issue.



Hope you enjoy reading the compilation.

Dr. Sangeetha D G,
Editor KFOG Journal.

01



**Prof
Dr. Presannakumari**
*Chairperson, Safe
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Equity In Maternal Healthcare

Equity in maternal health care means ensuring that every woman receives the care she needs during pregnancy, childbirth, and the postnatal period regardless of her income, education, social status, geography, demography, caste, ethnicity, age, disability or sexual orientation. Health is a fundamental human right. Health equity is achieved when every individual is able to attain their full potential for health and well-being. It is not merely about providing equal services to all, but about recognizing differences in needs and removing barriers so that outcomes are fair and just.

Maternal health remains a critical indicator of a nation's development. According to the World Health Organization, hundreds of thousands of women worldwide still die each year from preventable causes related to pregnancy and childbirth. These deaths are not distributed equally. In 2023, the global maternal mortality ratio (MMR) was 197 deaths per 100,000 live births. Despite a 40% reduction over the past two decades, approximately 260,000 women died from pregnancy-related causes in 2023—equating to one death every two minutes—with a maternal mortality ratio of 346 per 100,000 live births in low-income settings. Women living in rural areas, conflict zones, or marginalized communities face a much higher risk of complications and mortality. This disparity highlights the

importance of equity rather than simple equality.

In countries like India, significant progress has been made in reducing maternal mortality through national programs and improved institutional deliveries. According to the latest Sample Registration System (SRS) data for 2020–22, India's Maternal Mortality Ratio (MMR) has decreased significantly—from 130 per lakh live births in 2014–16 to 88 per lakh live births in 2020–22. However, wide variations persist between states, districts, and even communities. Maternal mortality exhibits a pronounced rural-urban divide, with rural populations facing a risk nearly 1.5 times higher than their urban counterparts.

As of early 2025, Kerala reports a Maternal Mortality Ratio (MMR) of 30 per 100,000 live births, according to the 2021–23 data from the Sample Registration System. Although increased from the previous estimate of 18, it remains among the lowest in India. The rise has been attributed to reduced total live births and the residual impact of COVID-19–related mortality. The state maintains a 99% institutional delivery rate, reflecting strong maternal healthcare access. Although the public health system is robust and widely accessible, nearly 68–72% of deliveries occur in the private sector, making private institutional care a major contributor to maternal outcomes. Many high-risk cases are

referred between sectors, with a considerable proportion of maternal deaths linked to referred cases.

Key challenges enumerated during the survey being; managing high-risk pregnancies, chronic illnesses, maternal suicides, and rising out-of-pocket expenses in private care. Kerala's low mortality rates are attributed to high female literacy, strong healthcare infrastructure, comprehensive antenatal and postnatal coverage, and improved access to emergency obstetric services.

Women from economically weaker sections or remote tribal areas may struggle with transportation, lack of nearby facilities, financial constraints, or social discrimination. An equitable maternal health system identifies these gaps and provides targeted interventions such as free antenatal care, skilled birth attendance, emergency obstetric services, and postnatal follow-up. Although Kerala's health infrastructure has significantly advanced over the years, there remains a crucial need to further strengthen available facilities and augment health care manpower to meet growing demands effectively.

To improve equity in maternal health care, the government should establish clearly defined, evidence-based protocols for the management of all obstetric conditions, ensuring standardized, high-quality care for every woman—regardless of whether she seeks treatment in the public or private sector. Equity also involves cultural sensitivity and respectful maternity care. Women should not face neglect, verbal abuse, or discrimination during childbirth. Respectful communication, informed consent, privacy, and emotional support are fundamental rights. When women feel safe and respected, they are more likely to seek timely care, which ultimately improves maternal and neonatal outcomes.

Measures proposed to achieve the goal:

- Emergency conditions such as postpartum hemorrhage, eclampsia, obstructed labor, and sepsis require prompt and skilled intervention.
- Strengthening referral systems, ensuring availability of blood banks, trained personnel, and functional operation theatres are essential.
- District-level hospitals must be strengthened to provide comprehensive, multidisciplinary care with all essential specialties available under one roof.
- Enhancing emergency obstetric and neonatal services, ensuring round-the-clock availability of skilled specialists, improving blood bank and crit-

ical care facilities, and integrating mental health and social support services are crucial steps.

- Equitable resource allocation, improved referral linkages, transport systems, and targeted support for vulnerable and high-risk populations will help reduce disparities and advance maternal health equity across regions.
- Financial protection through public health insurance or government schemes prevent families from falling into poverty due to medical expenses.
- Education and empowerment of women play a transformative role. When women are educated, economically independent, and aware of their health rights, they are more likely to access services early and consistently.
- Community engagement, involvement of male partners, and grassroots health workers further bridge the gap between facilities and families.

Equity in maternal health care is not only a medical issue but also a social justice concern. It demands coordinated efforts from governments, healthcare providers, communities, and international organizations. Robust data systems and well-defined processes for evidence-based decision-making are fundamental to designing programs and policies that advance health equity. Equally important is the disaggregation of data at both national and local levels. Breaking down data by geography, socioeconomic status, gender, age, and other relevant determinants helps uncover hidden disparities and inequities among different communities. Such granular analysis ensures that vulnerable and underserved populations are recognized, prioritized, and supported through targeted, context-specific strategies. Investing in maternal health is investing in families, communities, and future generations.

In conclusion, equity in maternal health care ensures that no woman is left behind during one of the most critical phases of her life. By addressing social determinants, strengthening health systems, and promoting respectful, accessible, and affordable care, societies can move closer to the goal of safe motherhood for all. Echoing the theme of United Nations for International Women's Day 2026 — **"Rights. Justice. Action. For All Women and Girls"**, advancing equity in maternal health demands a rights-based and justice-oriented approach that translates policy into meaningful action, ensuring every woman and girl—irrespective of geography, socioeconomic status, or vulnerability—has equitable access to respectful, high-quality, and life-saving maternal healthcare.

02



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Preventive Urogynaecology: Where Are We Now?

Pelvic floor disorders (PFDs), including urinary incontinence (UI), pelvic organ prolapse (POP), and defecatory dysfunction, represent a significant but often under-addressed public health concern. Traditionally managed after symptom onset, there is growing recognition that pelvic floor health should be preserved proactively across a woman's lifespan. Preventive urogynaecology encompasses early risk identification, lifestyle modification, pelvic floor muscle training (PFMT), obstetric optimization, and structured rehabilitation. Although evidence strongly supports PFMT and behavioural interventions, implementation

remains inconsistent. This review examines current evidence, clinical practice realities, gaps in implementation, and future directions in preventive urogynaecology, with particular relevance to routine obstetric and gynaecological care.

Introduction

Pelvic floor disorders affect a substantial proportion of women, with prevalence increasing with age, parity, obesity, and menopausal transition. While surgical and pharmacological treatments have advanced significantly, prevention has not received comparable attention.

In everyday practice, wom-

en frequently present with established prolapse or incontinence and ask whether earlier intervention could have altered the outcome. This question reflects an important shift in patient expectations: women are no longer satisfied with repair alone; they seek preservation. Preventive urogynaecology aims to move the discipline from reactive management to anticipatory care. It integrates risk assessment, behavioural modification, muscle conditioning, and life-stage-specific counselling into routine women's healthcare.

Conceptual Basis of Preventive Urogynaecology

Prevention may be understood at three levels:

- Primary prevention: Avoiding onset in asymptomatic women
- Secondary prevention: Early identification and halting progression
- Tertiary prevention: Preventing recurrence after intervention

At present, most evidence supports secondary prevention, particularly in early incontinence and mild prolapse. However, increasing data support structured preventive strategies beginning in pregnancy and extending through menopause.

The pelvic floor is influenced by cumulative stressors - mechanical, hormonal, metabolic, and behavioural across decades. Therefore, preventive strategies must be continuous rather than episodic.

Established Risk Factors: Opportunities for Intervention

Major risk factors for pelvic floor dysfunction include:

- Vaginal childbirth, especially prolonged second stage
- Instrumental delivery
- Increasing parity
- Obesity
- Chronic constipation and straining
- Chronic cough
- Advancing age and menopausal estrogen deficiency
- Genetic connective tissue vulnerability

While not all factors are modifiable, many are amenable to risk reduction strategies. Preventive urogynaecology begins with recognizing these risks during routine antenatal and gynaecologic consultations.

Pelvic Floor Muscle Training: The Cornerstone

Pelvic floor muscle training (PFMT) remains the most consistently supported preventive intervention.

Evidence demonstrates that structured PFMT:

- Reduces risk of postpartum urinary incontinence
- Improves early-stage prolapse symptoms
- Enhances pelvic floor strength and coordination
- Reduces severity of stress urinary incontinence

However, effectiveness depends on:

- Correct technique
- Adequate intensity and duration
- Supervised training when possible
- Long-term adherence

A major challenge is implementation. Women are often advised to do “Kegels” without demonstration or follow-up. Unsupervised and incorrectly performed exercises reduce effectiveness.

Incorporating structured PFMT into antenatal classes and postpartum visits should be considered standard preventive practice rather than optional counselling.

Obstetric Practice and Pelvic Floor Protection

Childbirth represents a pivotal event in pelvic floor health. Levator ani trauma, connective tissue stretch and pudendal nerve injury contribute to later dysfunction.

Preventive strategies in obstetrics include:

- Avoidance of unnecessary prolonged second stage
- Judicious use of instrumental delivery
- Appropriate episiotomy selection
- Perineal support during delivery
- Individualized intrapartum planning for high-risk women

While elective caesarean section may reduce certain pelvic floor injuries, it cannot be universally recommended solely for pelvic floor protection. Decision-making must balance maternal and neonatal outcomes.

More robust long-term studies are needed to clarify optimal obstetric preventive strategies.

Postpartum Rehabilitation: A Missed Opportunity

The postpartum period provides a critical window for secondary prevention.

Recommended strategies include:

- Early screening for urinary leakage
- Structured pelvic floor rehabilitation
- Gradual return to physical activity
- Education on bowel health
- Counselling regarding future pregnancies

In many healthcare settings, including parts of India, formal postpartum pelvic floor rehabilitation is not routinely integrated into care pathways. Establishing standardized postpartum pelvic health review clinics could substantially reduce long-term morbidity.

Lifestyle and Metabolic Factors

Lifestyle modification is frequently underestimated but essential.

-Weight Management

Increased body mass index correlates with greater intra-abdominal pressure and pelvic floor strain. Even moderate weight reduction improves urinary symptoms.

-Bowel Regulation

Chronic constipation contributes to repetitive pelvic floor strain. Preventive counselling regarding fibre intake, hydration, and correct defecatory posture is simple yet impactful.

-Physical Activity

High-impact exercise without pelvic floor conditioning may exacerbate symptoms. Conversely, structured core strengthening combined with PFMT is protective.

-Smoking Cessation

Reducing chronic cough minimizes repetitive pelvic strain.

These measures should be incorporated into routine gynaecological counselling.

Menopause and Ageing: Slowing Progression

Menopausal hormonal changes contribute to urogenital atrophy and weakening connective tissue support.

Preventive focus during this phase includes:

- Continued PFMT

- Weight control
- Management of constipation
- Local estrogen therapy when indicated
- Early conservative management of mild prolapse

In elderly women, goals shift toward maintaining continence, preventing falls, and preserving independence. Bladder training, mobility optimization, and appropriate continence aids become important components of preventive care.

Digital Health and Innovation

Emerging digital platforms offer opportunities to improve adherence to PFMT and behavioral interventions. Mobile applications, reminder systems, and tele-physiotherapy may increase engagement, particularly in regions with limited access to specialized pelvic floor therapists.

While promising, these technologies require validation and standardized protocols before widespread integration.

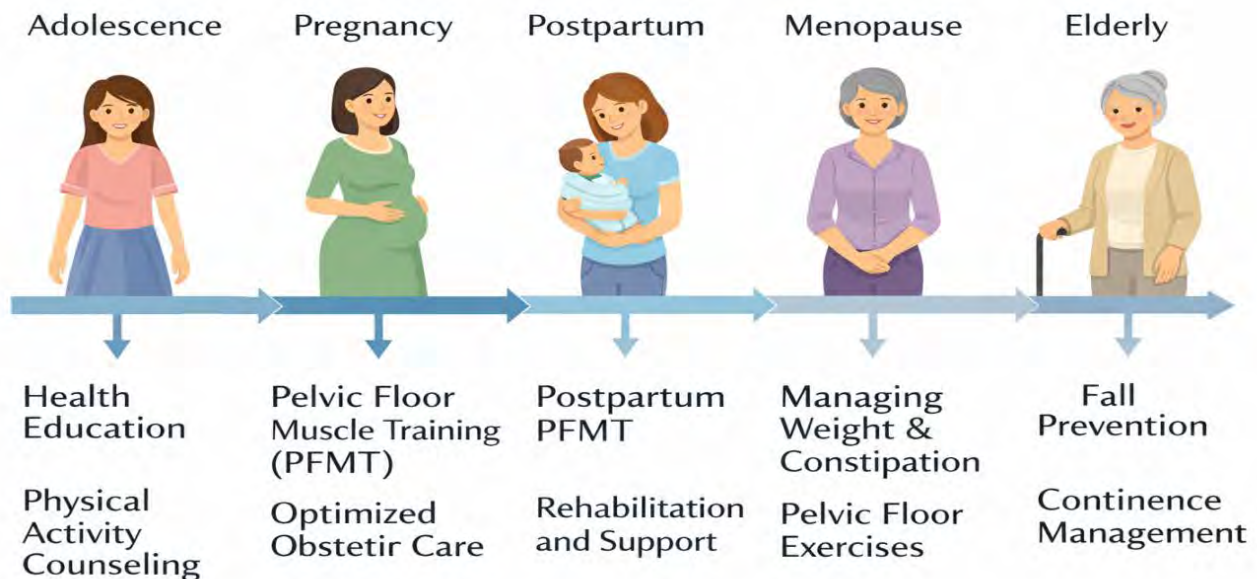
Barriers to Implementation

Despite growing awareness, preventive urogynaecology faces several challenges:

- Limited availability of trained pelvic floor physiotherapists
- Time constraints in busy outpatient clinics
- Lack of standardized preventive protocols
- Cultural hesitation in discussing incontinence
- Inadequate postpartum follow-up systems

Addressing these barriers requires institutional commitment and inclusion of pelvic health within broader women's health programs.

Life-Course Model of Preventive Urogynaecology



Preventive urogynecology is most effective when viewed as a continuum across life stages as a sustained process rather than a single intervention.

Where Are We Now?

We now possess:

- Strong evidence supporting PFMT
- Clear identification of modifiable risk factors
- Growing awareness among clinicians
- Emerging digital tools to enhance adherence

However, preventive urogynaecology remains inconsistently implemented. Most guidelines focus primarily on treatment rather than structured primary prevention. Systematic integration into routine care pathways is still evolving.

Future Directions

To advance preventive urogynaecology, we need:

- Standardized PFMT protocols for primary prevention
- Longitudinal life-course studies
- Cost-effectiveness analyses

- Integration of pelvic floor screening into primary care
- Structured postpartum pelvic health programs
- Public health initiatives to normalize discussion of incontinence

Preventive strategies must become embedded within routine obstetric and gynecological care rather than reserved for specialty referral.

Conclusion

Preventive urogynecology represents a necessary evolution in women's healthcare. While pelvic floor muscle training and lifestyle modification form the foundation, true progress requires systematic implementation across all stages of life.

The shift from repair to preservation demands clinician awareness, institutional support, and patient education. We are no longer asking whether pelvic floor disorders can be treated effectively — we are asking whether they can be prevented.

The answer increasingly appears to be yes — provided prevention becomes a priority.



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The Burning Issue of Teenage Pregnancy - India and Beyond?

Adolescence is a critical stage of human development, a transition from childhood to adulthood characterized by rapid physical, emotional, and social changes. The term itself derives from the Latin *adolescere*, meaning “to grow, to mature.” During this period, secondary sexual characteristics appear, identities are formed, and experimentation often begins. Yet, for millions of adolescents worldwide, this stage is overshadowed by the crisis of teenage pregnancy — a phenomenon with profound health, social, and economic consequences.

Global Burden

The World Health Organization (WHO) estimates that 16

million girls aged 15–19 years and 1 million girls under 15 give birth annually, predominantly in low- and middle-income countries (WHO, 2020). Complications during pregnancy and childbirth are the second leading cause of death among girls aged 15–19. Furthermore, around 3 million adolescents undergo unsafe abortions each year, exposing them to life-threatening risks (WHO, 2020). These figures highlight teenage pregnancy as a pressing global public health challenge, not merely an individual misfortune.

The Indian Context

India reflects this global crisis with alarming statistics. Teenage pregnancy constitutes

8–14% of total pregnancies nationwide (International Institute for Population Sciences [IIPS] & Ministry of Health and Family Welfare, 2021). Early marriage, poverty, and poor access to healthcare remain dominant drivers. Pregnancies outside wedlock often end in unsafe abortions performed by unqualified practitioners, further endangering adolescent lives. Moreover, teenage mothers are less likely to register pregnancies early or take essential supplements such as iron and folic acid, reflecting gaps in awareness and maturity.

Causes of Teenage Pregnancy

Teenage pregnancy arises



from a complex interplay of social, economic, and personal circumstances. Key contributing factors include:

- Poverty and unemployment
- Early marriage and school dropouts
- Early initiation of sexual activity
- Lack of comprehensive sexual education
- Limited access to contraception and lack of youth friendly health services
- Domestic violence, abuse, and rape
- Substance abuse, alcoholism, and peer/media influence
- Low self-esteem and social pressures
- Poor parent child communication and lack of proper parental supervision.

Together, these factors create a fertile ground for unintended pregnancies, trapping adolescents in cycles of deprivation and vulnerability.

Consequences: A Double Burden

For the Mother: Teenage mothers face biological immaturity, inadequate antenatal care, poor nutrition, and heightened stress. These conditions increase the risk of maternal mortality and long-term

health complications.

For the Baby: Neonates born to adolescent mothers are more likely to suffer from prematurity, low birth weight (LBW), intrauterine growth restriction (IUGR), and neonatal mortality. Inadequate breastfeeding and poor postnatal care further compromise survival and development.

The Socio-Economic Impact

Teenage pregnancy perpetuates the vicious cycle of poverty. Young mothers often drop out of school, limiting future opportunities and reinforcing socio-economic deprivation. Thus, adolescent pregnancy is both a cause and consequence of poverty.

Addressing the Crisis: Interventions

Recognizing the gravity of the issue, several initiatives have emerged:

- **Educational Programs:** Comprehensive sex education in schools to raise awareness about reproductive health, contraception, and safe practices.
- **Parent-Adolescent Relationship Education (PARE):** A program that strengthens family communication about sexual issues, helping prevent early pregnancies (National Campaign to Prevent Teen Pregnancy, 2019).
- **Access to Contraception:** Promoting adolescent-friendly contraceptive services that are safe, effective, and fertility-preserving.
- **Counselling:** Providing adolescents with information about pregnancy outcomes — abortion, adoption, and parenting — to enable informed choices.
- **Routine Screening:** Identifying substance abuse, violence, and sexually transmitted infections (STIs) among pregnant adolescents.
- **Nutritional Support:** Ensuring adequate supplementation to reduce anaemia and low birth weight.
- **Multidisciplinary Care Models:** Adolescent-friendly healthcare that integrates medical, psychological, and social support under one roof.

India launched the Adolescent Health Programme/ RKSK (Rashtriya Kishor Swasthya Karyakram) in 2014 under the National Health Mission to achieve the same goal.

Recommendations for Healthcare Providers

Healthcare professionals play a pivotal role in mitigating risks associated with adolescent pregnancy. Key recommendations include:

- Youth friendly health centres where safe pregnancy termination options are discussed with no judgement.
- Adapting prenatal care to adolescent needs and ensuring early access if pregnancy is decided to be continued.
- Recognizing adolescent pregnancies as high-risk and managing them accordingly.
- Routine testing for STIs and bacterial vaginosis, with appropriate treatment and follow-up.
- Nutritional assessments and supplementation to optimize maternal and neonatal outcomes.
- Sensitivity to the unique developmental needs of adolescents during pregnancy, childbirth, and postpartum care.

The Way Forward

Teenage pregnancy is not just a medical condition; it is a social and developmental crisis. Addressing it requires a multi-pronged approach:

1. **Education:** Comprehensive programs for children and adolescents.
2. **Contraception:** Improving access to safe and effective methods.
3. **Parental Involvement:** Educating families to support adolescents.
4. **Multi-component Programs:** Integrating health, education, and social support.
5. **Youth Development:** Empowering adolescents with skills, confidence, and opportunities.

Conclusion

The statistics are stark, the consequences severe, and the urgency undeniable. Teenage pregnancy contributes to maternal and infant mortality, perpetuates poverty, and undermines the potential of millions of young girls. Yet, with education, empowerment, healthcare access, and family involvement, this crisis can be addressed. By coupling awareness with routine antenatal, intrapartum, and postpartum care, society can break the vicious cycle and



give adolescents the chance to grow, mature, and thrive — as the word *adolescere* truly intends.

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Gallery

AKCOG 2026



Basic Laparoscopy workshop with hands on training at Trivandrum today by Endoscopy and Reproductive health committees.(07.06.2026)





CRMD 14.06.2026 at Kottakal



CRMD Calicut (15.03.2026)



Kannur PPMD for staff nurses



PPMD TOT program at Trivandrum



04



Dr. Ancy T Jacob
Chairperson,
Endoscopy
Committee, KFOG



Laparoscopy in pregnancy and lactation - Current guidelines

Laparoscopy in pregnancy is a challenging option in certain unavoidable non obstetric and obstetric emergencies. Though challenging it is considered as a better choice compared to laparotomy due to less postoperative pain, less hospital stay and better cosmesis. It is challenging because of the increased uterine size and inherent risk of injury to the uterus and the fetus. Also CO₂ pneumoperitoneum can adversely affect the venous return to the heart and the cardiac output, compromising the fetoplacental circulation. But with proper precautions and supported by guidelines from SAGES, SOGC, BSGE and recent studies showing safety across all trimesters, laparoscopy has to be considered as the

choice of surgical intervention in centers where facilities and expertise are available.

Indications:

Gynecological:

The most common gynecological condition in pregnancy is an ovarian torsion. Most adnexal masses are diagnosed by ultrasound examination. Sometimes MRI may be needed which is considered safe during pregnancy. Most of the adnexal masses can be managed conservatively during pregnancy. But surgery is indicated in case of ovarian accidents like torsion or rupture or adnexal masses with high suspicion of malignancy. Randomized controlled trial by Chen et al. showed laparoscopy

superior to laparotomy (less blood loss, less postoperative pain and shorter hospital stay).

Non-gynecological:

Appendicitis is the most common indication which requires surgery during pregnancy. The incidence of acute appendicitis is 0.05 - 0.1 % during all trimesters of pregnancy. Cholelithiasis is also common in pregnancy, in 1.2- 12 % of all pregnancies. Appendicitis and cholecystitis carry significant risk in pregnancy due to generalized peritonitis and maternal sepsis which in turn may cause miscarriage, preterm delivery and stillbirth.

Obstetric:

Recurrent pregnancy loss

due to weak cervix with prior failed vaginal cerclage or cervical surgery. Though it can be done pre conceptionally, studies have shown the same outcome when done post conceptionally in the first trimester.

Management of heterotopic pregnancy with viable pregnancy in utero and ectopic pregnancy. Management lies in the lines of excision of ectopic site with minimal manipulation of uterus.

Timing

Laparoscopy is best done in early second trimester of pregnancy though it can be done in first and third trimester depending on the indication. During second trimester the uterine size is optimal for primary and secondary port placements. The risk of miscarriage and preterm delivery is less during the second trimester. Recent studies have shown that laparoscopy can be safely performed even in the third trimesters.

Anaesthesia

Preoperative anaesthetic assessment should include the gestational age, any co morbidities in pregnancy along with routine anaesthetic history and examination. General anaesthesia with endotracheal intubation is preferred. Aspiration prophylaxis is considered.

Technique

Patient positioning

SAGES and SOGC recommend left lateral or par-

tial decubitus position in advanced pregnancy as it will improve the venous return by reducing the venacaval compression.

Port placements

Primary port placement varies and is dependent on the height of the uterine fundus according to the gestational age of pregnancy. When the size is lesser as in the first trimester primary port can be at the umbilicus. As pregnancy advances the primary port has to go at least ≥ 5 cm above the uterine fundus or Palmer's point being the ideal primary port site. BSGE mentions that given the absence of randomised controlled trials, the choice of primary port position including umbilical, sub / xiphoid or Palmer's point is based on operator's expertise. Insertion of a nasogastric tube is preferable for gastric decompression during Palmer's point entry.

Verres needle or open (Hasson's) entry is ideal for primary port placement especially as pregnancy advances as it will avoid uterine trauma and spillage of ovarian cysts. Direct entry can be an alternative in experienced hands, though not recommended in advanced gestation.

Secondary ports need to be placed under direct vision and the site of entry depends on the uterine size, the pathology and the operative approach. Secondary ports need to be placed ipsilateral to the identified pathology avoiding gravid uterus crossing.

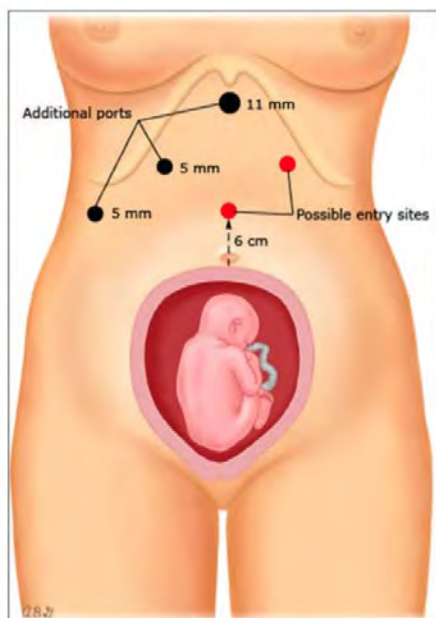
Pneumoperitoneum

Current evidence supports the use of an intra abdominal pressure of 12 mm Hg. Various studies have shown that no adverse effects to foeto maternal perfusion or adverse pregnancy outcome were recorded at operating pressure of less than 12 mm hg.

Energy use

The surgeon can choose ultrasound, unipolar or bipolar energy which are considered safe in pregnancy, but the surgeon should be mindful of the principles of safe energy use in laparoscopy.

Specimen retrieval method is again the surgeon's preference, though infected and suspicious specimens are better contained in an endobag. Usage of drain at the end of the procedure depends on the individual case. For appendicitis, drain can be considered, but may not be an option for cholecystitis or adnexal pathology.



Perioperative care

BSGE guidelines suggest pre and post-operative fetal heart monitoring in laparoscopic surgery rather than intraoperative monitoring to establish the fetal wellbeing. Uterine activity should be monitored in viable pregnancies.

Thromboprophylaxis can be considered postoperatively after thrombotic risk assessment as pregnancy is a hypercoagulable state. Some recommend only intra and post-operative pneumatic compression and early ambulation as the preventive measures.

Routine use of tocolytics is not recommended unless warranted with signs of preterm labour. Regarding Anti D prophylaxis, routine administration is not recommended as laparoscopic surgery is not considered as a sensitising event. Corticosteroid and magnesium sulphate use can be used when the fetus is at viable and preterm gestational age (< 34 weeks). But in case of sepsis, corticosteroids should be given with caution after evaluating the risk - benefit ratio.

Lactation

Laparoscopy is safe during lactation period. All emergency gynec and non gynec laparoscopy procedures can be done. Interval sterilization via laparoscopy remains the most common procedure during this period. There is no need to interrupt breast feeding unless specific contraindicated anaesthetic medications are given.

Conclusion

With the technological refinements in laparoscopy over the years, it has become a safer choice in pregnancy with less morbidity and less hospital stay. Thorough preoperative assessment and planning of management is important for a successful outcome. The management has to be done by a multi-disciplinary team including a skilled surgeon with proper training in advanced laparoscopy, an anaesthetist and a fetal medicine specialist or a neonatologist in case of advanced gestation.



NEWER INSIGHTS INTO RECURRENT ENDOMETRIOSIS

Introduction

Endometriosis is a chronic, estrogen-dependent inflammatory disorder affecting nearly 10% of women of reproductive age. It manifests with pelvic pain, infertility, and fatigue, profoundly impacting physical, reproductive, and emotional health. Despite its prevalence, the disease remains poorly understood, and current treatments—surgical excision or hormonal suppression—are symptomatic rather than curative. Postoperative recurrence, whether as pain relapse or lesion reappearance, complicates long-term management and remains a major clinical challenge. Reported recurrence rates vary widely (0–89.6%), reflecting heterogeneity in definitions, disease stage, surgical technique, and postoperative therapy. At five years, recurrence rates may reach 40–50% in conservative management settings (Ceccaroni et al., 2019).

Defining and Measuring Recurrence

Recurrence in endometriosis lacks a standardized definition. It may refer to:

- Symptom recurrence: relapse of dysmenorrhea, dyspareunia, or pelvic pain after a symptom-free interval.
- Lesion recurrence: radiologic or surgical confirmation of new or regrown lesions.
- Biochemical recurrence: rise in CA-125 after surgery.
- Histologically proven recurrence: visually and histologically confirmed disease.

The International Working Group (AAGL/ESGE/ESHRE/WES) proposed four subtypes: symptom-based suspected recurrence, imaging-based suspected recurrence, laparoscopically proven recurrence, and histologically proven recurrence. Pain recurrence rates are typically higher than lesion recurrence. For example, in deep infiltrating endometriosis, pain relapse at five years was 43.5%, while lesion recurrence was 28% (Vignali et al., 2002). Conversely, imaging-confirmed endometriomas may recur without



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symptoms in up to 30% of patients. Assessment methods include imaging (TVUS, MRI), histology, patient-reported outcomes, and management proxies such as reoperation. Meta-analyses report endometrioma recurrence rates ranging from 4% at 3 months to 27% at 24 months post-surgery without hormonal therapy (Veth et al., 2021). The absence of validated non-invasive biomarkers remains a critical gap.

Pathophysiology of Recurrence

Recurrence is multifactorial, reflecting both biological regrowth and pain mechanisms. Contributing factors include:

- Residual microscopic disease after incomplete excision.
- Re-implantation of endometrial cells during surgery.
- Ongoing estrogenic stimulation of ectopic tissue.
- Genetic predisposition and immune dysregulation.
- Aberrant angiogenesis and stem-cell involvement.
- Central sensitization driving pain independent of lesions.
- Progesterone resistance limiting hormonal therapy efficacy.

Thus, recurrence should not be viewed solely as surgical failure but as a biological phenomenon offering insights into disease progression and heterogeneity.

Risk Factors and Clinical Predictors

Patient-related

- Younger age at surgery and younger age at menarche.
- Positive family history.
- Preoperative pain symptoms (dysmenorrhea, chronic pelvic pain).

Disease-related

- Extensive adhesions and larger cysts (>5 cm).
- Coexistent adenomyosis and deep infiltrating lesions.
- High rASRM staging scores.
- Bowel lesions and fibrotic nodules.

Management-related

- Conservative surgery linked to earlier recurrence compared to radical excision.
- Absence or poor adherence to postoperative hormonal therapy.
- Repeat surgery significantly reduces ovarian reserve (Muzii et al., 2015).
- Pregnancy and breastfeeding confer protective effects via prolonged ovarian suppression.

Secondary Prevention Strategies

Surgical Technique

For ovarian endometriomas ≥ 3 cm, cystectomy is superior to drainage/coagulation, reducing recurrence of lesions and pain while improving spontaneous pregnancy rates (Hart et al., 2005; 2008). However, repeat surgery significantly lowers ovarian reserve, necessitating careful patient selection.

Postoperative Hormonal Suppression

Hormonal therapy is central to recurrence prevention. Meta-analyses show:

- Lesion recurrence reduction: 59–70% with postoperative hormonal therapy (Chen et al., 2020).

- Symptom recurrence reduction: ~30% after 12 months compared to surgery alone.
- OCPs: strongest protective effect, with recurrence reduced from 40% to 10% (Vercellini et al., 2010). Continuous regimens may be superior to cyclic ones (Seracchioli et al., 2009).
- Progestogens: LNG-IUS reduces recurrence (RR 0.40) and improves pain scores (Song et al., 2018). Dienogest is equivalent to leuprolide acetate for recurrent pain and reduces endometrioma size (Lee et al., 2018).
- GnRH agonists/antagonists: effective but limited by hypoestrogenic side effects; add-back therapy improves tolerability. Newer oral antagonists (elagolix, linzagolix, relugolix) show promise but require long-term data.

ART and Recurrence

Assisted reproductive technologies (ART) do not increase recurrence risk. Ovarian stimulation has mild or negligible impact, and ART should not be withheld (Somigliana et al., 2019).

Management of Established Recurrence

Medical Therapy

Hormonal re-suppression remains first-line unless severe symptoms or obstruction exist. Comparative studies show similar efficacy among dienogest, leuprolide, desogestrel, and continuous OCPs (Abdou et al., 2018; Razzi et al., 2007).

Repeat Surgery

Reserved for refractory pain, suspicion of malignancy, or bowel/ureteric obstruction. Pain recurrence after second surgery is 17–19%, with third surgery required in 14% (Candiani et al., 1991). Repeat cystectomy significantly lowers ovarian reserve.

Advanced Techniques

Robotic-assisted surgery and nerve-sparing approaches enable precision excision of deep and recurrent lesions, reducing morbidity and improving functional outcomes.

Emerging Predictive Models and Biomarkers

Clinical models using rASRM scores and

inflammatory parameters achieve moderate accuracy (AUC up to 0.895; Su & Xie, 2019). Exploratory biomarkers include: LncRNAs (Long non coding RNAs) like UCA1, LINC01465, H19, miRNAs like miR-20a, Stemness (stem cell marker) markers like NANOG, Inflammatory proteins like COX2, NF- κ B-p65, S100A8/A9 and Proliferation/adhesion markers: Ki-67, E-cadherin, MMP9.

None are validated in independent cohorts. A reliable non-invasive biomarker would revolutionize recurrence monitoring and personalized management.

Future Directions

To improve long-term outcomes, future research should focus on:

1. Standardizing recurrence definitions across clinical trials.
2. Developing validated biomarkers for non-invasive monitoring.
3. Integrating predictive models with molecular, imaging, and electronic health record data.
4. Exploring novel therapies targeting central pain pathways, immune modulation, and progesterone resistance.
5. Personalized management strategies tailored to patient risk profiles and reproductive goals.
6. AI-assisted imaging for improved early detection of residual disease.
7. Combined modality therapy (medical + surgical) to maximize disease control.

Conclusion

Endometriosis recurrence remains a major clinical challenge, complicating long-term management and patient quality of life. Current evidence highlights the multidimensional nature of recurrence, involving both lesion regrowth and pain mechanisms. While postoperative hormonal therapy reduces recurrence, its suppressive nature and limitations necessitate new strategies. Emerging biomarkers and predictive models hold promise but require validation. Reframing recurrence as a biological opportunity may unlock insights into disease mechanisms, paving the way for personalized, mechanism-based care.

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Midlife Drift:Navigating The Silent Transition

Menopausal transition or Midlife drift is the transitional period before menopause, starting in a woman in her 40s. Age of menopause is an important marker of not only loss of fertility but also concordant rise of various midlife diseases and various distressing symptoms due to the hormonal changes. The transition usually lasts for up to about 10 years. Perimenopause which is a pre runner to menopause occurs due to natural age-related decline of ovarian function and steroidogenesis, hence less estrogen and progesterone which in turn causes fluctuations in pituitary hormones FSH and LH.

Around 5-10% women experience premature menopause. The causes may be genetics, autoimmune diseases like SLE, Rheumatoid Arthritis or Hashimoto's thyroiditis, Cancer chemotherapy or radiotherapy and due to surgical intervention (surgical menopause) i.e. removal of both ovaries. For women who undergo premature menopause or surgical menopause, the menopausal transition symptoms are exaggerated than the natural menopause. Premature menopause is also associated with increased risk for cardiovascular diseases, osteoporosis and breast cancer.

Average age of menopause in India is 46.2 years, which is much lesser than our western counterparts which is 51 years. Due to this, the intervention to make the menopausal transition smoother should be started earlier for Indian women. Hormonal changes in menopause especially decreased estrogen can affect the physical, mental and emotional well-being of a woman. Different woman experiences different symptoms at different magnitudes.

The most common symptoms of menopausal transition are;

1. Hot flashes and night sweats: refer to sudden feeling of heat in face and neck accompanied by flushing, perspiration and palpitation lasting several minutes. It is due to resetting of the thermoregulatory system in association with fluctuations in the estrogen level.
2. Irregular periods followed by cessation of periods.
3. Vaginal dryness and dyspareunia: This is mainly due to the falling levels of estrogen.
4. Weight Gain and difficulty in losing weight.
5. Insomnia/ Mood changes /Cognitive impairment: Women experience insomnia twice as much as men along with day time fatigue and sleepiness.
6. Increased Cardiovascular Risk:
7. Osteoporosis and fractures.



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Menopause accelerates bone loss and increased osteoporosis risk. Vertebral compression fractures are the most common fractures followed by hip and wrist fractures.

Treatment of common symptoms of perimenopausal transition:

Life style modifications stand as the first line and consistent mode of management with dietary changes and exercise. Symptom based treatment options are:

1. Vasomotor symptoms: Various hormonal and non-hormonal treatment options are available as oral preparations, patches, gels or sprays. The common preparations are Conjugated equine estrogen (0.3-1.25mg daily), 17 B Estradiol (1-2mg PO daily) and Ethinyl estradiol (0.02-0.05ng 1-3 times daily). Combinations of estrogen and progesterone are available. Effective non hormonal options are Fluoxetine, Venlafaxine, Gabapentin and Citalopram.
2. Genitourinary syndrome of menopause: Vaginal moisturizers and water-based lubricants can be options to reduce discomfort. Low dose vaginal estrogen (creams, rings or tablets) can restore moisture and improves tissue health. Laser therapy is a newer option to enhance moisture and elasticity.
3. Treatment of Insomnia: Cognitive behavioral therapy is the highly recommended first line treatment .Sleep Apnea is treated by CPAP (Continuous Positive Airway Pressure) devices. Benzodiazepines, Gabapentins and Zolpidems are medical treatment options.
4. Treatment of depression: Although estrogen is often the recommended treatment modality for most of menopausal symptoms, women with depression with onset in perimenopausal transition are not likely to respond to estrogen therapy. Hence estrogen should be avoided in treating depression in menopause.

Psychotherapy, antidepressants or a combination treatment is recommended. SSRIs like Fluoxetine and Citalopram are the first line treatment modality.

Though all women go through this phase, the symptoms can be distressing for many and severe for few. Around 130 million Indian women are expected to live beyond menopause. Hence apt recognition of symptoms along with directed and compassionate treatment is the need of the hour enabling the women make this a journey of change, resilience and rediscovery.



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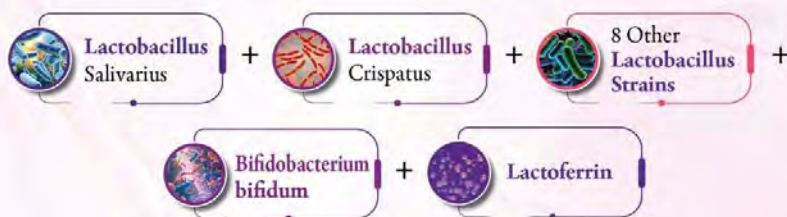
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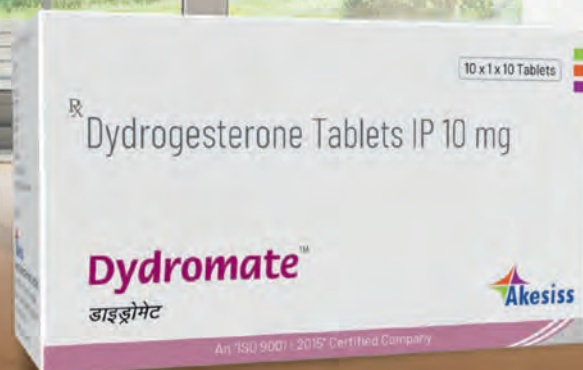
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