Sri Lanka College
of
Obstetricians & Gynaecologists

50th Anniversary

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in collaboration with
FIGO, AOFOG & SAFOG

"Women's Health: Past Experiences; Future Agenda"

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CONFERENCE PROCEEDINGS

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FIGO
INTERNATIONAL FEDERATION OF GYNECOLOGY & OBSTETRICS

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SAFOG
1996

The reduction in the use of forceps deliveries is multifactorial and often related to departures from practicing guidelines. These trends may be due to concerns over neonatal and maternal safety and lack of clinical skills in forceps delivery.4 A recent Cochrane review of 32 studies concluded that forceps was a better instrument in terms of achieving successful delivery with associated higher rates of complications to the mother.5 Kielland's forceps are very effective instrument to achieve vaginal delivery in a malpositioned fetus and the "art" of obstetrics is well demonstrated with the use of this instrument.6 The use of modern technology in training like simulator training, increasing number of courses aiming at teaching skills of instrumental delivery like ALSO/ MOET and 24 hours residential consultant supervision can increase the uptake of forceps delivery and reduce its complication rates.

165. Allowing a labour companion Should we? Could we?

Hemantha Senanayake

Sri Lanka has reached a pre eminent position in maternal and newborn care by emphasizing safety at childbirth. This laid the emphasis on procedural aspects of care. Emotional aspects of childbirth, such as companionship were forgotten.

Research has shown that allowing a female labour companion is one of the most effective intervention. It results in a shorter labour, lesser requirement for analgesia, lesser requirement of instrumental deliveries and cesarean section, improved breastfeeding and greater maternal satisfaction.

Our own research has shown that the above benefits could be replicated by allowing a female labour companion. In a study on the attitudes of care providers, we learnt that they view companionship as a concept that helps in their work and the mother's experience of labour. An online survey among obstetricians in Sri Lanka, in which 68 (48%) participated, showed that the knowledge regarding the benefits was unsatisfactory among those who did not allow a companion compared to those who did ($p<0.001$). The main reasons quoted for not allowing a companion were inadequate space in the labour ward and that it was too busy. The units that handled more than 300 births per month tended not to allow a companion ($p<0001$). More than 25% believed the population they were serving was not capable of handling such a facility.

Allowing a female companion in labour is a highly effective intervention, which has been demonstrated to be feasible in many Sri Lankan Units. The Sri Lanka College of Obstetricians & Gynaecologists should spearhead its wider usage.

Symposium 42

Improving the standard of care in Obstetrics and Gynaecology

166. The concept of PID

Per-Anders Mårdh

167. Improving antenatal screening for infections

Otilia Mårdh

168. Antibiotic and antifungal resistance of global concern

Per-Anders Mardh

169. Decreasing maternal mortality related to adverse obstetric events

Mehmet Genc

Symposium 43

Issues of adolescent reproductive health

170. Teenage pregnancy and child bearing: Trend in the world and in Sri Lanka

Ramya Pathiraja

Teenage pregnancy remains a major contributor to maternal and child mortality, and to the cycle of ill-health and poverty. Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally and the babies born to teenage mothers face a substantially higher risk of dying than those born to women aged 20 to 24 years

The average global birth rate among 15 to 19 year olds is 49 per 1000 girls. About 16 million girls aged 15 to 19 and 1 million girls under 15 give birth every year mostly (95%) in low and middle-income countries. There has been a marked, although uneven, decrease in the birth rates among teenage girls since 1990, but some 11% of all births worldwide are still to girls aged 15 to 19 years old. Country rates range from 1 to 299 births per 1000 girls, with the highest rates in sub-Saharan Africa.

Compare to South East Asian Countries, teenage pregnancy in Sri Lanka is relatively low. There are more than 20,780 girl children aged 12- 17 years in Sri Lanka have children before they reach 18 years of

age. Over the past decade there has been a significant progress with a steady decline in national teenage pregnancy rate with a wide variation in progress between districts but also missed opportunities and disappointments.

Broad societal changes, crosscutting socioeconomic, political and cultural characteristics of individual countries play an important role in explaining recent trends. Increased motivation to delay pregnancy and childbearing to achieve higher education and to gain job skills before forming a family and improvements in knowledge and access to the means of preventing unplanned pregnancy are some of the factors.

Country-specific estimates of pregnancy and birth among teenagers can motivate policy and programmatic responses to help and monitor progress toward reducing their incidence. Countries with low levels of teen pregnancy might serve as references or models for efforts to reduce levels elsewhere. Even where incidence is low, data on teen pregnancies can highlight remaining unmet needs for information and services to help teenagers to prevent unintended pregnancies.

171. Caring for teenage pregnant mothers, Social aspects

Charika Marasinghe

172. Teenage Pregnancy- Issues within the legal framework of Sri Lanka

Janaki Karunasinghe

Despite Sri Lanka having a much lower teenage pregnancy rate (5.1%) compared to the worldwide average (11%) and the highest rate in USA, there are several legal issues that need attention. All cases of teens pregnant due

to rape are brought to the courts, and mothers age<16 are considered rape cases regardless of consent. As the upper guardian, courts can order a teen mother to a probation home during pregnancy and thereafter, or

separate the baby from its natural mother. No legal barriers exist to attend the court case or school during pregnancy, or stop breast feeding the baby. However, the system typically does not allow probationary facilities to let mothers' education continue. Rather than separating the unwanted baby from its teen mother soon

after birth, facilities continue to house them until the court case is over thereby further delaying the return to school. The juvenile court hearings could be expedited to minimize the probationary length of stay to facilitate continued education and exam completion, and their role expanded to include an aspect of carrier guidance.

173. Management of PCOS in childhood

Farzana Tasmin

Polycystic ovary syndrome (PCOS) is recognized as the most common endocrinopathy in reproductive aged women. The symptoms of PCOS vary with age, race, weight and medications, adding to the challenges of accurate diagnosis. It is difficult to make a diagnosis of PCOS in adolescent patient because characteristics of normal puberty often overlap with signs and symptoms of PCOS. Several adolescent specific criteria have been proposed. In adolescents, presence of oligomenorrhea or amenorrhea beyond two years of menarche should be considered an early clinical signs of PCOS followed by Rotterdam criteria (of adults) for diagnosis of PCOS. The pathophysiology of PCOS is still uncertain, although there is evidence that both genetic and environmental factors may play a role, resulting in ovarian heperandrogenism and, impaired insulin sensitivity. In adolescent the most common presenting features of PCOS include, menstrual irregularity (amenorrhea, oligoammenorrhea) and or androgen excess (hirsutism, alopecia).Acanthosis nigricans and abdominal obesity are clinical surrogates for insulin resistance.Elevated risk of premature cardio-vascular dysfunction, cardio-vascular disease, lipid abnormalities have also been reported in PCOS. Adolescent PCOS should be investigated by total & free testosterone, LH FSH ratio, serum prolactin, fasting lipid profile, OGTTtwo hours after 75 g glucose load and USG. For exclusion of other disease, thyroid function test, DHEA-S, 17 hydroxy progesterone for exclusion of CAH should be done. Management of adolescent PCOS should be directed to –life style modification including diet, exercise and weight loss. Evidence suggest that a reduction of as little as 5% of total body weight has been shown to reduce insulin resistance and testosterone level as well as improving body composition and cardiovascular risk markers. Daily strict physical activity sessions for at least 30 min/day or 150 min/ week are recommended. A multidisciplinary team approach including psychologist and dieticiansis advocated. Insulin sensitizers such as metformin can be used in selective cases, myo-inositol and dichiroinositolcan be safely used in adolescent obese PCOS. Menstrual irregularities should be treated by cyclic administration of micronized progesterone or low dose COCs containing drospirenone, desogestrel. For andogen excess- low dose COCs, anti androgen like spironolactone, cryptorene acetate with low dose COCs are useful. Flutamide, finisteride may be prescribed. Acne can be treated by benzoyl peroxide, topical retinoids and topical antibiotics and low dose COCs. PCOS is an important emergent health problem. The current epidemic of childhood obesity