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India North
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Committed to Women's Health

E- Newsletter

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Welcome Address by Our Chair

Dr Ranjana Sharma
Chairperson

Dear Friends

It is a great relief to see COVID becoming milder and allowing us all to move towards some form of normalcy again. It was a delight to see so many of you at our long-awaited GBM get-together on March 24th. The unbridled enthusiasm of our group continues to motivate me! It was heartening to have the ever-vibrant and inspiring Dr Urmil Sharma join us at the event, and we thoroughly missed those who could not join us.

Our April 2022 newsletter, the third one in the making, is centred on the theme of Preventive Gynae Oncology. It is packed with pertinent updates regarding prevention and risk reduction of malignancies of the cervix, ovaries, breasts, vulva and the endometrium. I trust you will find the articles thoroughly informative and enjoy the quiz that follows.

As you know, we ran a very successful course for the MRCOG-Part II, from August to December 2021. A big thank you to Drs Shelly Arora, Priyata Lal and Shweta Gupta for their immense dedication. I thank you all for the grand success of our 2021 Annual Conference, which was held on 12th December 2021, and was much appreciated for the scientific content shared by the renowned faculty. We will soon begin preparation for our next Annual conference, which will be held virtually again, on 10th& 11th September, 2022. I look forward to your continued support and participation, without which we would never be able to make it a successful endeavour.

I am so happy to see the long list of volunteers for the upcoming MRCOG Part 3 revision course on April 30 and May 1, 2022 at the Indraprastha Apollo Hospital Auditorium. Our North Zone has always been at the forefront of training candidates for the MRCOG examination and I hope it will stay that way.

Finally, last but not the least, it is a pleasure to include Dr MamtaDagar and Dr Vidhi Chaudhary into our AICC RCOG-NZ Executive Committee.

As always, if you are interested in contributing to our upcoming issues of our newsletter kindly contact Dr Chanchal at chanchalsngh@gmail.com.

I wish you all a safe, healthy and fulfilling summer and hope to see you in person soon.

Kind regards

Ranjana

From the Editor's Desk

Dr Chanchal
Member Representative
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Dear friends, life seems to be slowly coming back to the pre-COVID era with the reopening of schools, travel, and our physical meetings.March was the month when the world celebrated Women's Day. The editorial team of the newsletter thought of dedicating this issue to 'Preventive Oncology'. To put it in Atul Gawande's words: 'Our ultimate goal, after all, is not a good death but a good life to the very end.'

I'm grateful to all our contributing authors, my co-editors and Dr DivyaSehra, our guest editor for this edition for all their hard work. Hope you enjoy reading through the articles and I look forward to receiving more and more write-ups from all our members for the next newsletters.

Best wishes,

Dr Chanchal

Welcome Address by Secretary

Dr Shelly Arora
Secretary

Dear Friends and Colleagues
Warm Greetings to all of you!

It gives me immense pleasure to present our third e-Newsletter. It covers yet another important topic of "Preventive Oncology". Non-communicable diseases including cancer are emerging as major public health problems in India. The burden of Cancer is not only that they kill people, but that they cause suffering to people who live with them.

Preventive Oncology focuses on key measures that can prevent cancer development or delay the progression of the malignant process. This can include maintaining a healthy lifestyle, avoiding exposure to known cancer-causing substances, and taking medicines or vaccines that can prevent cancer from developing. This Newsletter includes preventive aspects of all gynecological cancers.

I am sure this issue will assist practitioners to advance their day to day practice.

We hope you enjoy the hard work put in by all the authors and our editorial team led by Dr Chanchal.

Happy Reading !!

Dr Shelly Arora

Welcome Address by Guest Editor

Dr Divya Sehra
Guest Editor

"Prevention is the most cost effective and long-term strategy for controlling cancer." Since nearly 30-50% of all cancers are preventable, it is only prudent that the clinician's thorough knowledge must be translated into best efforts to target the right subset of population for screening, early diagnosis and timely treatment. In addition, patient awareness of modifiable risk factors, applicability of available screening methods and simple measures like HPV vaccination and regular breast examination are the grounds on which preventive strategies will succeed. In this issue, we focussed on collating the evidence based management of most common cancers, and aimed at establishing algorithms which can easily be put into practice by point of care clinicians.

Dr Divya Sehra

Over-View of Preventive Gynecological Oncology with focus on Vulva

Dr Vinita Kumar Jaggi
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Lifespan of a cell involves three stages comprising of growth, division and programmed death by apoptosis. Factors that alter genetic codes through promoter and suppressor agents disrupting normal cell cycle result in cell-immortality causing cancer, which is thus a genetic disease.

Comprehensive cancer control is applied at primary, secondary and tertiary levels, and is defined as "Integrated and coordinated approach, to reduce cancer incidence, morbidity, and mortality through emphasizing primary prevention, supporting early detection and treatment activities, promoting rehabilitation and health needs of cancer survivors, and addressing palliation".

This is achieved by collaboration, between communities and their partners to combine, share, and coordinate resources to reduce cancer burden at different ages: early childhood, adolescence, early adulthood, midlife, older adulthood, and demonstrating outcomes through evaluation. (Centers for Disease Control and Prevention)

India has a national program for prevention and control of cancer ,combined with life style disorders like diabetes, cardio-vascular diseases and strokes (NPCDCS). Cancer etiology and risk factors are defined through clinic and community-based studies in targeted populations. Effects of harmful exposures and health behaviors often start appearing in midlife (45-64 years of age). Through IEC (information, education and counselling)one must make positive changes to reduce cancer risk.

Primary prevention focuses on limiting the risk, by identification and modification of high-risk lifestyles and environmental factors. Secondary and tertiary prevention focus on control measures, to limit the serious consequences of cancer by detection and treatment at pre-clinical, and clinical stages especially earlier treatable ones. (Table)

PROMOTE HEALTHY BEHAVIOR	REDUCE HARMFUL FACTORS/CONTROL
A. General	
Regular Physical Activity	Indolent life
Diet rich in fruits and vegetables	Fatty diet
Healthy Body Weight	overweight
Breast Feeding	Excessive unprotected Sun exposure when outdoors
Empowerment of women	Multiple sex partners and Multiparity
	Early age at first sexual activity or first pregnancy
	Cancer causing substances and chemicals
	Stress
	Inadequate sleep
	UV Rays
	Tobacco, Smoking, Alcohol, Sugar sweetened drinks,
	Illiteracy
B. Medical Management	
Control of Chronic diseases like diabetes, Obesity, Hypertension, PCOD.	Prevention and Treatment of sexually transmitted infections (HPV infection, chlamydia infection, HIV infection, HSV2 infection)
Use of combined oral contraceptives	Long term usage of pills

Treatment of Skin Disorders: candida, lichen planus, Lichen sclerosis, chronic inflammation and cell mediated immune disorders.	Radiation dose limitation during Imaging procedures
	Degree of immunosuppression eg. steroids, HIV or AIDS
C. Vaccine Prophylaxis	
Promote HPV vaccination programs for cancer cervix and other HPV related cancers	
Hepatitis B vaccination to prevent Hepatobiliary cancer	
D. Genetic counselling in view of family history	
Know family genetics, and about inherited or acquired gene changes for prophylactic treatment accordingly (Cancer is Inherited in 5%)	
E. Focus on Organization of Screening Tests applied to appropriate, accessible sites (breast, cervix, colorectal, ovarian etc.)- Either community based or Hospital based	
F. Organizing an information, education and communication (IEC) session	

VULVA CANCER PREVENTION: Key messages

1. No evidence to support screening an unselected population,
2. Self-examination is recommended.
3. Vulvar Intra-epithelial Lesion (VIN) in younger women is HPV related, being multifocal in 30-40%.
4. VIN in older women, is HPV negative related to vulvar dermatoses,
5. Approximately 40% of invasive vulval cancers are HPV positive, and 85% are attributable to HPV-16.
6. Prophylactic HPV vaccines, could decrease incidence by one-third, in younger women.
7. Do not ignore vulval itching, irritation, pruritus, pain, lump, bleeding or discharge.

ADDRESS RISK FACTORS FOR PREVENTION:

1. Age, as elderly women are affected predominantly
2. Lichen sclerosis has approximately 4% risk of invasive cancer.
3. Behavioral risk as in STD and cancer cervix may co-exist.
4. Vulva is common site of clinically evident HPV infection, and vulval warts has relative risk from 15-23.
5. Basaloid and warty carcinomas, are onco-HPV linked, hence these VIN must be treated with ablation or excision.
6. Multifocal genital lesions: condyloma acuminatum, and Lichen planus must be treated.
7. Immuno-suppressed states, like diabetes, chronic steroids, HIV, irritable bowel, organ transplantation, pregnancy, cause rapid growth of lesions.
8. Invasive sq cell ca occurs in untreated lichen simplex chronicus, squamous cell hyperplasia, and lichen sclerosis, hence ensure treatment with topical corticosteroids while ruling out VIN if not responding.
9. Bowens disease occurs as a solitary plaque in older women, and has high (26%) risk of invasive cancer.

SCREENING AND PRE-REQUISITES FOR PREVENTION OF VULVAL CANCER

1. Inspect vulval and perianal area in good light or colposcopically to characterize morphology and extent of lesion, (cornified vulvar epithelium, may not reveal specific vessel patterns, contour alterations, and epithelial changes)
2. Thorough evaluation of vulva is must as 15% of VIN lesions involve both hair and non-hair bearing areas while 75-85% involve non-hair bearing areas.
3. HPV testing is not a proven screening tool.

4. Abnormal Paps smear, must be carefully evaluated, to rule out vulvo-vaginal diseases.
5. Toluidine blue, exfoliative cytology with scrapings, aid diagnosis.
6. Signs are non-specific, and biopsy of suspicious lesions (occasionally multiple), needed to rule out invasion,
7. High grade VIN, multicentric disease, or immunocompromised status, must be referred to gynae oncologists.
8. Manage pre-malignant diseases like, Pagets, adenocarcinoma in situ, melanoma in situ in gyn-oncology clinics
9. Follow up pre-existing vulval diseases eg; Lichen sclerosis, or VIN.
10. Vulvar condylomata must be confirmed by visual inspection, colposcopy, and directed biopsy, so as not to miss verrucous carcinoma before therapeutic intervention. (Small warty growths coalesce into large confluent masses).
11. Persistent VIN in areas of dermatoses, is treated with topical steroids, or with local excision if steroids fail.
12. Understand that immunocompromised status, smoking, or pregnancy, cause multifocal disease and are at high risk of persistence and recurrence of VIN-3, or invasion.

"Be careful about reading health books. Some fine day you'll die of a misprint."

-Markus Herz

HPV Vaccination - Preventing the Preventable

Dr Pakhee Aggarwal
MS, FICOG, MRCOG, MIPHA, PGDMRCH

Worldwide, cervical cancer is the fourth most frequent cancer in women, with an estimated 5,70,000 new cases in 2018. However, among women in India, cervical cancer is the most common cancer. Nearly 99% of cervical cancer cases are linked to high-risk HPV infection. The WHO recently declared three targets to eliminate cervical cancer by 20301. These pertain to HPV vaccination, screening and early treatment. For HPV vaccination target to be met, 90% of the girls below 15 years of age should be fully vaccinated[2].

Two high-risk HPV types (16 and 18) cause 70% of cervical cancers. Other high risk HPV types are 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68. HPV types 6 and 11 cause 85-95% of anogenital warts, and are considered low-risk HPV. Cervical cancer is the most common HPV-associated cancer, others being and vulval & vaginal cancer in women, penile & anal cancer in men, and oropharyngeal cancer[3].

There are 3 types of prophylactic HPV vaccines available (Table 1). Trials have found that they are 93%–100% effective.

Table 1: HPV vaccines

	Bivalent/2vHPV (Cervarix)	**Quadrivalent/4vHPV (Gardasil)**	**9-valent/9vHPV (Gardasil 9)**
Manufacturer	GlaxoSmithKline	Merck	Merck
Year Licensed	October 2009 - females	June 2006 - females; October 2009 - males	December 2014 - males and females June 2020 – approval for oropharangeal cancers
HPV types in vaccine	16 and 18	6, 11, 16, and 18	6, 11, 16, 18, 31, 33, 45, 52, and 58
Adjuvant in vaccine	AS04: 500 µg aluminum hydroxide 50 µg 3-O-desacyl-4′-monophosphoryl lipid A	AAHS: 225 µg amorphous aluminum hydroxyphosphate sulfate	AAHS: 500 µg amorphous aluminum hydroxyphosphate sulfate
Recommended age group	• Females aged 11-12 (can start at age 9 years) • Females aged 13-26 who were not adequately vaccinated previously	• Females and males aged 11-12 (can start at age 9 years) • Females aged 13-26 and males aged 13-21 who were not adequately vaccinated previously • Males aged 22-26 with certain immunocompromising conditions; gay, bisexual, and other men who have sex with men (MSM); and transgender persons who were not adequately vaccinated previously	• Females and males aged 11-12 (can start at age 9 years) • Females aged 13-26 and males aged 13-21 who were not adequately vaccinated previously • Males aged 22-26 with certain immunocompromising conditions; gay, bisexual, and other men who have sex with men (MSM); and transgender persons who were not adequately vaccinated previously
Contraindicated in	People with anaphylaxis caused by latex	People with immediate hypersensitivity to yeast	People with immediate hypersensitivity to yeast

All three vaccines have been approved for administration in a 3-dose series at intervals of 0, 1 or 2, and 6 months. In 2014, the WHO- SAGE review recommended a two-dose regimen for individuals less than 15 years. Adolescents aged 9-14 years who have received two doses less than five months apart require a third dose. The third dose should be given 6–12 months after the first dose to complete the series. A three-dose

schedule is recommended for teens and young adults who start the series between 15- 26 years. Under this schedule, the second dose of HPV vaccine is given 1–2 months after the first dose, and the third dose 6 months after the first dose. In case the schedule is interrupted, it does not need to be restarted[4]. Three doses are recommended for people aged 9–26 years with certain immunocompromising conditions[5].

Vaccination is not recommended in pregnant women. If inadvertently vaccinated in pregnancy, remaining doses are deferred to post-partum. No intervention is needed for the pregnancy and termination should not be offered for this reason alone. Equally, pregnancy testing is not recommended prior to vaccination[6].

HPV vaccine can be co-administered with other non-live and live vaccines using separate syringes and different injection sites. In ideality, the same vaccine should be administered for all doses. However, if the vaccine used for prior dose is not known or not available, either of the HPV vaccines can be given to complete the schedule.

The Indian Academy of Pediatrics Committee on Immunization recommends offering HPV vaccine to all girls/women who can afford the vaccine (Category 2 of IAP categorization of vaccines) before sexual debut[7]. Currently, bivalent and quadrivalent HPV vaccines are available in India, although the nonavalent vaccine was also licensed in 2018[8].

As of June 2020, 107 (55%) of the 194 WHO Member States but only 41% of the LMICs (most of them with GAVI support) have introduced HPV vaccination in their national program[9]. There is a large geographical divergence in the uptake of vaccination, with the LMICs lagging behind HICs.

Vaccination could have an adverse effect upon the uptake of screening if women believe themselves to be protected from cervical cancer. An HPV16/18 vaccine can potentially reduce the incidence of cervical cancer by 70%, whereas well organised cervical screening programmes have decreased the incidence by up to 80%. The delay of ten or more years before the effects of vaccination start to be realised will mean that cervical screening in countries with low and intermediate resources will impact upon the incidence of cervical cancer faster than vaccination programmes. HPV vaccines should be introduced as part of a coordinated and comprehensive strategy to prevent cervical cancer and other diseases caused by HPV. Recently in 2020 US-FDA gave approval for the nonavalent vaccine to be used for prevention of oropharyngeal and other head and neck cancers.

Given the current scenario of high cancer load and resource limitations in developing countries an effective HPV vaccine is a must. The current vaccine candidates are not ideal for use in low resource settings since they are expensive to manufacture, entail a cold chain as well as two or three intramuscular injections, and only protect against two high risk HPV genotypes. Second generation HPV vaccines are required that can be produced more cheaply, be administered as a single dose without the use of a needle and prevent infection by many oncogenic genotypes over a long duration. The recent evidence review (2020) of the Single dose HPV vaccine evaluation consortium supports single dose HPV vaccination based on systematic review of available clinical trials and may be the way forward[10].

Abbreviations: HIC - High income countries, LMIC - Low and middle-income countries, SAGE - Strategic Advisory Group of Experts (SAGE) on Immunization

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Women's day celebration

Dr Sweta Gupta
Regional Clinical Lead & Sr Consultant Reproductive med. & IVF, Apollo Fertility, Lajpat Nagar Delhi/NCR
MD, FRCOG, MSc, Fellowship in Reproductive medicine & ART (London, UK)

International women's day is celebrated world while on 8th March. A focussed panel discussion was organized to raise awareness and to discuss practical holistic approach for the common yet complex gynaecological problems under the banner of "RCOG north zone" and "Forum of south Delhi of obstetrics and gynaecology". Topic was "Understanding the epochs of women's life" with case discussion on various clinical scenarios likemenorrhagia in adolescence, PCOD with acne, subfertility in diabetes and hot flushes in menopausal life. Experts were Dr Ranjana Sharma, Dr Nirmala Aggarwal, Dr Sadhna Kala, Dr Anita Sabarwal, moderated by Dr Sweta Gupta. Panelists were Dr MamtaSahu, Dr Monika Bhatia, Dr YuvakshiJuneja, Dr induBala, Dr Mita Verma. This was followed by fun activities like cake cutting, ramp walking, music, tambola etc.

Screening for Breast Cancer

Dr Jasmine
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Consultant Obstetrician & Gynaecologist
Hindu Rao Hospital & NDMC Medical college
Delhi

Female breast cancer has now surpassed lung cancer as the leading cause of global cancer incidence in 2020, with an estimated 2.3 million new cases, representing 11.7% of all cancer cases. Among women, breast cancer accounts for 1 in 4 cancer cases and for 1 in 6 cancer deaths[1].

Guidelines for cancer breast screening are based on risk stratification with women being divided into average risk and high risk through risk assessment tools. A number of validated breast cancer risk assessment tools e.g. the Gail model, BRCAPRO, Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm, IBIS, or Claus model are available online (www.cancer.gov/bcrisktool). While there are various guidelines to screen for average risk women, the strategies to screen high risk remains controversial[3].

Tools available for screening :

1. Self-breast examination (SBE)
2. Clinical breast examination (CBE)
3. Conventional mammography
4. Digital mammography
5. Ultrasound breasts
6. MRI breasts

SELF BREAST EXAMINATION / SELF BREAST AWARENESS

As per ACG Research or ACOG Guidelines [4] Breast self-examination is not recommended in average-risk women because there is a risk of harm from false-positive test results and a lack of evidence of benefit. There is very little evidence that these tests help find breast cancer early when women also get screening mammograms. However, **Women should be familiar with how their breasts normally look and feel (known as 'BREAST AWARENESS') and should report any changes to a health care provider immediately.** Approximately 50% of cases of breast cancer in women 50 years and older and 71% of cases of breast cancer in women younger than 50 years are detected by women themselves

CLINICAL BREAST EXAMINATION The clinical breast examination use varies amongst different guidelines among average-risk women (table 2). It continues to be a recommended part of the evaluation of high-risk women and women with symptoms.

Mammography

It is the process of using low-energy X-rays (usually around 30 kVp) to examine the human breast for diagnosis and screening typically through detection of characteristic masses or microcalcifications. This has been shown through various studies to be associated with decreased Breast Cancer mortality rates[6,7].

TABLE 1: MAMMOGRAPHIC SCREENING AND BREAST CANCER SPECIFIC MORTALITY REDUCTION BY AGE GROUP[8]

Age range (yrs)	Relative risk (95 % confidence interval)
39-49	0.92 (0.75-1.02)
50-59	0.86 (0.68-0.97)
60-69	0.67 (0.54-0.83)
70-74	0.80 (0.51-1.28)

The reporting of BREAST Imaging is standardized and follows the BIRADS system.

TABLE 2: BREAST IMAGING – REPORTING AND DATABASE SYSTEM (BI-RADS)

Category	**ASSESSMENT**	**FOLLOW UP**
0	Need additional imaging evaluation	Additional imaging needed before a category can be assigned
1	Negative	Continue regular screening mammograms
2	Benign (non cancerous) finding	Continue regular screening mammograms
3	Probably benign	Receive a 6 month follow up mammogram
4	Suspicious abnormality	May require biopsy
5	Highly suggestive of malignancy (cancer)	Requires biopsy
6	Known biopsy proven malignancy (cancer)	Biopsy confirms presence of cancer before treatment begins

BREAST ULTRASOUND :

Ultrasound is typically used as an adjunct to mammographic imaging. The main indications include palpable mass, dense fibro-glandular breast tissue, and pregnant/lactating women.[9]

BREAST MRI

Important in screening high risk younger women with typically denser breast tissue or with specific tumor phenotypes (e.g BRCA 1/ BRCA 2 gene mutation carriers etc.) If MRI is used, it should be in addition to, not instead of, a screening mammogram as MRI alone has high sensitivity for detecting breast cancers, but lower specificity leading to increased false-positive rates.[3]

SCREENING IN INDIA

As per the latest reports by National Cancer registry published in 2020, it is the most common cancer amongst women in India accounting for 27.7 % of all cancers in 2018 with the incidence of Ca Breast rising and Ca cervix decreasing.[10]

India has a population based screening programme aimed for NCD (non-communicable disease including breast cancer) launched in 2017 with a strategy to involve 1st line health workers (ASHA/ ANMS) in screening all women 30 years and referring to nearest health centres if suspected.

Table 2: COMPARISON of GUIDELINES FOR AVERAGE RISK WOMEN[5]

	American College Of Obstericians And Gynaecologists	**Us Preventive Services Task Force**	**American Cancer Society**	**National Comprehensive Cancer Network**
Clinical Breast Examination	May be offered every 1-3 years for women aged 25-39 years and annually for women 40 years and older	Insufficient evidence to recommend for or against	Does not recommend	Recommend every 1-3 years for women aged 25-39 years and annually for women 40 years and older
Mammography initiation age	Offer starting at age 40 years Initiate at ages 40-49 years after counselling , if patient desires. Recommend by no later than age 50 years if patient has not already initiated	Recommend at age 50 years . Age 40-49: individual choice	Offer at ages 40-45 years Recommend at age 45 years	Recommend at age 40 years
Mammography screening interval	Annual or biennial	Biennial	Annual for women aged 40-54 years Biennial with the option to continue annual screening for women 55 years or older	Annual

Mammography stop age	Continue until age 75 yrs . Beyond age 75 , the decision to continue should be based on a shared decision making process that includes a discussion of the womans health status and longevity	The current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years and older	When life expectancy is less than 10 years	When severe comorbidities limit life expectancy to 10 yrs or less

Table 4. Summary Of The Resource Stratified Clinical Practice Guideline For Secondary Prevention Of Breast Cancer : NCG INDIA 2019[11]

		Essential / Limited Resource	**Optimal / Enhanced Resource**	**Optional / High Resource**
1	Primary screening methods	Clinical Breast Examination (CBE)	Clinical Breast Examination (CBE)	Clinical Breast Examination (CBE)+ Conventional Digital Mammography
2	Where : place for screening	Health & Wellness centre Primary Health Centre (PHC) Community Health Centre (CHC)	Health & Wellness centre Primary Health Centre (PHC) Community Health Centre (CHC)	Health & Wellness centre if Primary Health Centre mammography available Community Health Centre District Hospital (DH) Tertiary Health Settings Private Health Care facilities
3	By whom	Trained Primary Care Workers Trained Nurse	Trained Nurse Physician	Trained Nurse Physician/ Breast Surgeon
4	Target screening ages	40 – 65 years	40 – 65 years	40 -49 yrs : CBE + Mammography based on risk assessment and advice of physician >50 -75 years : CBE + conventional Mammography
5	Frequency of screening	1-3 times in a life time	2 years	2 years

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Epidemic of Uterine Cancer: How Shall We Modify Risk Factors

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Endometrial cancer (EC) is the most common gynaecological cancer in developed countries with an increasing incidence over the years. From 1990 to 2017, the age-standardized incidence and prevalence rate of EC increased globally by 0.58% and 0.89% per year respectively and it is estimated to increase by more than 50% worldwide by 2040[1].

RISK FACTORS

Lifestyle

Obesity is by far the most important risk factor in the causation of endometrial cancer. Worldwide, the prevalence of obesity (BMI > 30 kg/m2) has doubled in the last three decades.[2] Prevalence of obesity in India is 40.3% with obesity being more common in women as compared to men.[3] It is estimated that around 60 % of endometrial cancers are related to obesity. The World Cancer Research Fund has concluded that the risk of endometrial cancer is reduced by moderate physical activity and maintaining a healthy weight.[4]

Lifestyle modification can result in 4–6% weight reduction over 2 to 4 years, and anti-obesity drugs can lead to 7–10% weight reduction; however, only bariatric surgery produces significant and, crucially, durable results. Over 18-year median follow-up, the prospective, non- randomised SOS Study has demonstrated that bariatric surgery significantly reduces the risk of EC (hazard ratio (HR) 0.56, 95% CI 0.35–0.89, p = 0.014).[5]

Caffeine is associated with increased levels of sex hormone-binding globulin (SHBG) and, as a consequence, levels of bioavailable oestrogen and testosterone may be reduced which may play a beneficial role. Both coffee and tea, have been seen to reduce the risk EC[6].

Arthur et al. developed a Healthy Lifestyle Index (HLI) which includes low body mass index, sufficient physical activity, non-smoking, low alcohol consumption, and sufficient fruit and vegetable consumption and reported that for every unit increase in HLI, there was a 5% reduction in EC risk[7].

MEDICATIONS

Aspirin Mixed results are available with the use of aspirin, with 2018 meta-analysis showing an inverse relationship between use of aspirin and endometrial cancer.[8]

Metformin has shown anti-tumor effects in invitro studies, however, there are no trials to support its use at present.[9]

Biphosphonates Various studies have shown beneficial effect of biphophonates in reducing the risk of EC.[10]

Hormones Combined oral contraception have shown to reduce the incidence of endometrial cancer and the protective effect lasts for many years after it has been stopped. However, they cannot be used in obese (UKMEC 3).[11] Progesterone in any form tends to reduce the risk of EC. The most widely used has been LNG-IUS for endometrial protection and reduces the risk by 78%. Sequential Hormone Replacement Therapy may increase the risk, however, continuous tends to reduce the risk EC but micronized progesterone if used in continuous hormone replacement tends to increase the risk[15]. Bezodoxifene is a new compound (SERM) used menopausal hormone treatment tends to be promising with minimal effects on endometrium[16].

Use of Intrauterine devices- not only those containing progesterone but plain ones have been seen to decrease the risk of endometrial cancer[17].

TABLE 1: RISK FACTORS FOR ENDOMETRIAL CANCER AND RISK REDUCING STRATEGIES [18]

SN	RISK FACTOR	RELATIVE RISK	RISK REDUCING STRATEGY
1	Prolonged estrogen exposure	2-10	Progesterone supplementation
2	Estrogen-only hormonal therapy	1.5-2.0	Progesterone supplementation
3	Early menarche	2-3	Non - modifiable
4	Late menopause	2.0	Non- modifiable
5	Nulliparity	2.0	
6	Anovulation (Polycystic Ovarian Syndrome		Induce regular withdrawl Metformin Hormonal contraception
7	Increasing age (> 55 years)	1.4	Non – modifiable.
8	High socioeconomic status 1.3	1.3	Introducing Healthy lifestyle
9	Family history of uterine malignancy (Lynch syndrome)	22-50% life time risk	Risk reducing surgery ?Aspirin
10	Obesity For type I endometrial cancer: 1. BMI 25.0 to 30.0 2. BMI 30 to 39.9 3. >40	 2-4 OR 1.5 OR 1.5-4.5 OR 7.1	 Weight reduction Physical activity Bariatric surgery LNG –IUS
	Obesity For type 2 endometrial cancer: 1. BMI 25.0 to 30.0 2. BMI 30 to 39.9 3. >40	 OR 1.2 OR 1.7-2.2 OR 3	 Weight reduction Physical activity Bariatric surgery LNG –IUS
11	Hypertension	1.5	
12	Prior pelvic RT	8	Low threshold for investigation
13	Tamoxifen	2	Low threshold for investigation LNG-IUS
14.	Diabetes	2.0	Modulation of insulin resistance

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"We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being."

-Atul Gawande

Strategies for reducing ovarian cancer in high-risk women

Dr Divya Sehra
MS (Obs & Gynae), MRCOG (UK), Mch Trainee, Gynaecology Oncology, AIIMS, New Delhi

Ovarian cancer (OC) is the leading cause of death among gynaecological malignancies[1] with 10-year survival rates at around 30%. In the absence of robust screening tools, risk reducing bilateral salpingo-oophorectomy (rrBSO) is currently the most effective method for preventing ovarian cancers in high risk women. However, it is associated with both economic and physiological sequelae. Hence, clear understanding of identification of women who will benefit most from this procedure, and how to care for them during and post-surgery is of utmost importance.

1. Should routine screening be done for ovarian cancer?

Unlike screening for breast and cervical cancers, there is no proven effective method of screening for ovarian cancer. Routine annual pelvic examination is ineffective and current ovarian cancer screening options of Cancer antigen 125 (CA-125) and transvaginal ultrasonography (TVS) have not proven to be effective in improving survival or detection in either the normal or high-risk population, as evidenced by the United Kingdom Collaborative Trial of Ovarian cancer (UK-CTOCS)[2] and the United Kingdom Familial Ovarian cancer screening (UK-FOCS)[3].

2. In which women should risk reducing surgery be done?

The life time risk of ovarian cancer in the general population is 1.4%, and it increases substantially when associated with hereditary ovarian cancer syndromes (13-50%), defined as having at least two first degree relatives with epithelial ovarian cancers[4]. Up to a quarter of women with ovarian cancers harbour a deleterious germ line mutation, the most common being in BRCA tumor suppressor genes, but other genes like BRIP 1, Lynch associated genes, RAD51C, RAD51D and STK 11 are also implicated[5]. The cumulative risk of OC and breast cancer (BC) by age 70 years is upto 48.3% and 72 for BRCA 1 mutation carriers while it is 20% and 69% for BRCA 2 mutation carriers, respectively[6]. For patients with Lynch syndrome, there's a life time risk of 40-60% of developing endometrial cancer and 6 – 12% risk of OC.

In clinical practice, Risk reducing bilateral salpingo-oophorectomy (rrBSO) is offered to all women with BRCA 1 or 2, BRIP 1, BARD, RAD 50, RAD 51 C/D mutations diagnosed either due to personal history of premenopausal breast cancer or positive family history of breast and ovarian cancers. In the UK, broader criteria are taken into consideration such that any woman with an estimated life time risk of OC greater than 10% should be offered rrBSO[7]. Moreover, now there is an expanding role for rrBSO for women at intermediate risk (5-10% lifetime risk) as well. Family history clinics and regional genetics centre use detailed pedigree analysis and risk assessment tools to calculate a woman's chance of having an inherited gene mutation and life time risk of breast and ovarian cancer, e.g. CanRisk and Manchester scoring system. Hence, detailed personal and family history and involvement of a geneticist is imperative in patients at high risk of OC.

3. What is the right time to offer Risk reducing surgery?

Women with BRCA1 mutations should be offered rrBSO typically between 35- 40 years, and upon childbearing. For BRCA2 mutated women, it is reasonable to delay the procedure until 40- 50 years, since onset of OC is delayed by 8- 10 years in such patients[6].

Since chances of occult malignancy at the time of rrBSO is 4-8%[4], a TVS and CA 125 should be performed pre-operatively. Intra operative finding of malignancy necessitates full surgical staging and counselling regarding additional surgery should be done beforehand. See Table 1 for the surgical protocol.

Concurrent hysterectomy should be offered to all patients with Lynch syndrome because of 40-60% lifetime incidence of endometrial cancer, in patients planned to receive tamoxifen for breast cancer, and also in

select patients with fibroids and adenomyosis.

Evidence suggests an 80% reduction in incidence of ovarian and fallopian tube carcinomas, and a substantial reduction in OC specific as well as all-cause mortality to age 70 years. There is additional benefit of reducing risk of BC by 30-75%[8].

Table 1: Best Practice Recommendations for Risk-reducing Bilateral Salpingo-oophorectomy

RRSO PROTOCOL
• Minimally invasive laparoscopic surgery • Survey upper abdomen, bowel, omentum and appendix • Biopsy suspicious peritoneal findings • Obtain peritoneal washings (50 cc normal saline and aspirate immediately) • All ovarian tissue including ovarian adhesions should be removed • Perform total BSO, remove 2 cm of proximal IP ligament, all tube upto cornua along with surrounding peritoneum • Gentle tissue handling, avoid traumatic cellular exfoliation • Place both tubes and ovaries in an endobag for retrieval • Tubes and ovaries should be processed by SEE FIM protocol (Sectioning and Extensively Examining the FIMbriated End of the Fallopian Tube) • If occult malignancy or STIC lesion (Serous tubular intra epithelial carcinoma is identified, refer to gynaecologic oncologist

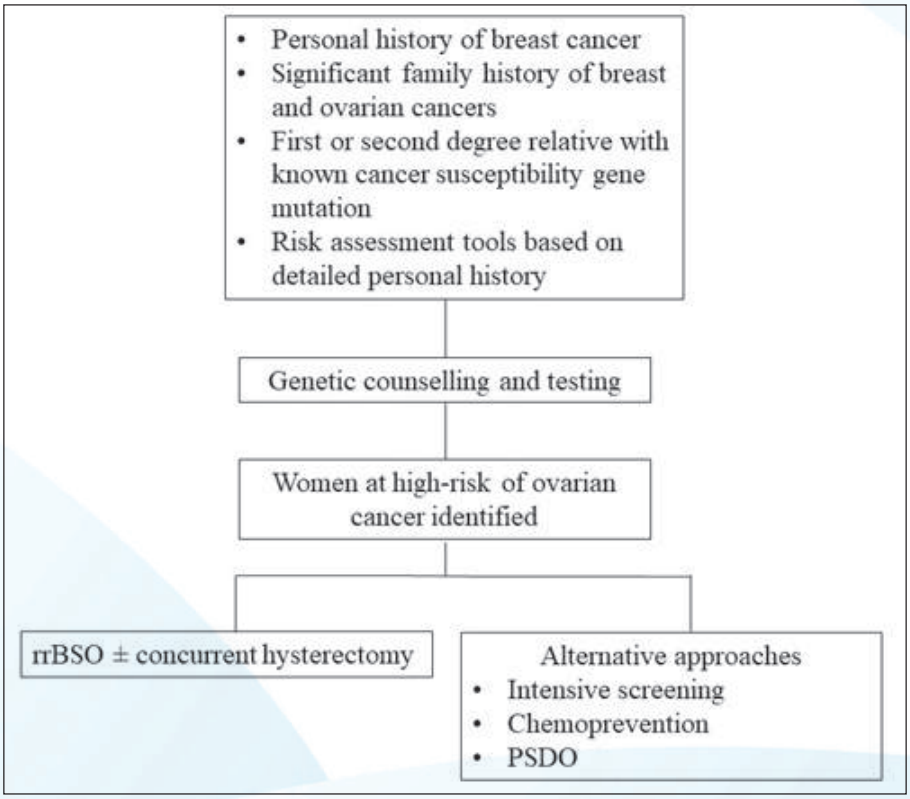

Figure 1: Evaluation and management of women developing high risk of OC

4. What is the Morbidity associated with rrBSO?

It is important to remember that rrBSO does not confer risk reduction in developing primary peritoneal carcinoma (0.8-10.7%) and appropriate pre-operative counselling should be done.

Iatrogenic menopause owing to rrBSO can compromise immediate QoL with vasomotor changes, mood disturbances, sleep disruption, and poor sexual functioning in the form of low libido and vaginal dryness. Long term health implications stemming from hypoestrogenism include increased risk of coronary artery disease, osteoporosis and neuro-cognitive impairment. Unless contra indicated, hormone replacement therapy (HRT) should be offered starting immediately post-surgery and continued until the age of natural

menopause following rrBSO even in BRCA mutation carriers[7]. The type of HRT mainly depends on whether the uterus has been retained, and also on the specific symptoms experienced.

5. For women declining premature oophorectomy, what are the alternative strategies?

Owing to concerns regarding childbearing, and various health implications following rrBSO, it has not shown to be widely acceptable in spite of clear-cut benefit. In such individuals, three main alternatives are intensive screening, chemoprevention and prophylactic salpingectomy and delayed oophorectomy (PSDO).

5.1 Intensive screening

BRCA carriers not electing rrBSO should undergo periodic screening by TVS combined with CA-125 starting at 30-35 years, although of uncertain benefit[6].

5.2 Chemoprevention

Oral contraceptives (OCP) reduce the risk of OC by as high as 40-50% and the effect is increased with longer duration of use. Even though there are speculations regarding increased risk of breast cancer, studies haven't demonstrated a statistical higher risk of breast cancers in users of post 1975 OCP formulations (reduced estrogen concentrations) or in the first 10 years following discontinuation of use[9]. NCCN recommends OCP use in BRCA mutated carriers who are not trying to conceive and not electing rrBSO[6].

5.3 Prophylactic salpingectomy with delayed oophorectomy (PSDO)

Since STIC is the probable precursor lesion in serous carcinomas, prophylactic salpingectomy may confer sufficient risk reduction until oophorectomy can be completed. Evidence suggests that PSDO may be offered as a viable alternative substitute to rrBSO in the setting of a clinical trial. The Dutch "TUBA" study is ongoing[10], which will compare rrBSO will PSDO in terms of QoL and OC mortality.

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RCOG North Zone Members' Achievements

Congratulations!

Newly passed Members of Royal College of Obstetricians and Gynecologists (MRCOG)

November 2021
1. Dr Seema Sehgal
2. Dr Tulika Sinha

Feb 2022
1. Dr Deepshikha
2. Dr Vijay Lakshmi Rawat
3. Dr Ridhi Narang
4. Dr Sabina Sanan
5. Dr Shefali Sood

April 2022
1. Dr Harshiba
2. Dr Rhythm
3. Dr Ananya Basu
4. Dr Kavita

Newly passed Fellows of Royal College of Obstetricians and Gynecologists (FRCOG)
1. Dr Mamta Mishra
2. Dr Usha M Kumar
3. Dr Jyoti Bhaskar
4. Dr Puneet Kochhar
5. Dr Pooja Chaudhry Thukral

Fellow ad eundem: Dr Neerja Bhatla
Fellow honoriscausa: Dr Pratima Mittal

Dr Vidhi Chaudhary was awarded the FOGSI Karan Gupta Memorial Prize for the best poster in miscellaneous group at the 64th AICOG held at Indore from 9-13th Jan, 2022

Dr Vidhi Chaudhary was awarded the FOGSI-Karan Gupta Memorial Prize for best poster presentation in the miscellaneous group for her poster titled "Introducing patient feedback through QI initiative, knowing patient perception and improving patient satisfaction in an obstetric facility" at the 64th AICOG held at Indore from 4th-8th April, 2022.

Dr Chanchal was awarded the FOGSI - Dr Rajat Ray Award in Fetal Medicine for her papare titled 'Natural History of Monchorionic Twins' at the 64th AICOG held at Indore from 9th-13th January, 2022

"Excellence is never an accident. It is always the result of high intention, sincere effort, and intelligent execution; It represents the wise choice of many alternatives - choice, not chance, determines your destiny."

-Aristotle

QUIZ: Preventive Oncology

Dr Jharna Behura
MD, FRCOG, WHO Fellowship in High Risk Pregnancy,
Senior Consultant
Kasturba Hospital, Delhi

A) With regard to infection with HPV

1. less than 40% will clear within 1 year. T/ F
2. the risk of developing squamous cell carcinoma of the cervix is about 400 times higher following infection with serotype16 compared with the risk in uninfected women. T/F

B) With regard to HPV testing,

3. self-obtained vaginal samples (for analysis of HPV DNA) have been shown to have the same sensitivity in detecting high-grade cervical lesions and invasive cancer as the Papanicolaou smear. T / F

C) With regard to cervical glandular intra-epithelial neoplasia (CGIN),

4. women who undergo treatment for CGIN have a greater risk of recurrence than those treated for CIN. T / F
5. there must be glandular cells within the cytology for adequate diagnosis. T /F

D) With regard to combining HPV testing in cervical screening, triage and test of cure,

6. the stable double-stranded DNA genome is obtained from exfoliated cells. T / F
7. HPV primary screening has been shown to reduce the frequency of screening episodes. T/ F
8. the test for cure after treatment offers a more accurate prediction of residual/ recurrent CIN than conventional cytology-based follow-up. T / F

E) With regard to the diagnostic pathway for women with postmenopausal bleeding

9. Those with endometrial thickness less than 4 mm and a normal ultrasound and speculum examination should be reassured. T / F
10. A heterogenous appearance of endometrium and increased vascularity on transvaginal scan are features associated with endometrial cancer T/ F
11. those with an endometrial thickness of 8 mm but no other irregularities should be offered hysteroscopy and endometrial biopsy as first-line investigations. T/ F
12. those presenting with class III obesity and an irregular, thickened endometrium (20 mm) should be offered hysteroscopy and endometrial biopsy. T/F

F) With regard to endometrial cancer,

13. Over 95% of cases occur in women over the age of 55 T / F
14. Every 5 kg/m2 increase in body mass index increases the risk by 60%. T/ F
15. Women with Lynch syndrome have a 25–60% life time risk T / F
16. late menarche increases the risk. T / F

G) With regard to risk-reducing strategies for women with Lynch syndrome

17. hysterectomy is strongly recommended for all those with the syndrome. T/ F
18. the timing of risk-reducing surgery depends on the syndrome gene. T/F
19. where possible, a laparoscopic approach is recommended. T/F
20. aspirin is not recommended as a means of reducing their overall cancer risk. T/F

H) **Concerning hereditary breast and/or ovarian cancer**

21. BRCA1 and BRCA2 germline mutations are inherited in an autosomal recessive fashion. T /F
22. The reported prevalence of BRCA1 and BRCA2germline mutations in the UK is approximately 1%. T/F
23. A woman carrying a mutation in the BRCA2 gene has a lifetime risk of ovarian cancer inthe region of 30%.T/F
24. .RAD51D mutation carriers have an approximately 10% cumulative life time risk of ovarian cancer. T/F

I) **Concerning hereditary non-polyposis colon cancer syndrome (Lynch Syndrome)**

25. Endometrial carcinomas that present on a background of Lynch Syndrome have a predilection for arising from the lower uterine segment. T/F
26. The prevalence of lynch syndrome in endometrial cancer patients is less than 1%. T / F
27. MLH1 and MSH2 account for the majority (90%) of all identified hereditary non-polyposis colon cancer syndrome alterations. T/ F
28. germline mutations in MSH6 have greater penetrance for endometrial than for colorectal carcinomas. T/F

J) **Concerning Peutz-Jeghers syndrome,**

29. the associated risk of malignancy is elevated 10–18 fold over the general population. T/F

K) **With regard to Cowden syndrome,**

30. 80% of patients have an identifiable germline mutation in PTEN.

L) **Endometrial cancer**

31. is more likely in premenopausal women with heavy or irregular bleeding if they have a history of polycystic ovary syndrome. T/ F
32. Risk is reduced by physical activity in obese patients. T / F
33. Risk is reduced by bariatic surgery . T / F
34. Risk is reduced by the levonorgestrel-releasing intrauterine system. T / F

Answers

A)1. F	2. T			**G)**17 .T	18. T	19. T	20. F
B) 3. T				**H)**21. F	22. T	23. T	24. T.
C) 4. T	5. T			**I)** 25. T	26. F	27. T	28. T.
D) 6. T	7. T	8. T		**J)** 29. T			
E)9. T	10. T	11. F	12. T	**K)** 30. T			
F) 13. F	14. T.	15. T	16. F	**L)** 31. T	32. T	33. T	34. T

(Compiled from the journal, The Obstetrician and Gynaecologist (TOG))

Shradhanjali

Forever
IN OUR HEARTS

Dr Sanjeev, You will remain in our memories & hearts forever

All India Co-ordinating Committee (AICC)
RCOG North Zone Family 2022

Forever
IN OUR HEARTS

Dr Sanjeev, You will remain in our memories & hearts forever

"Sanjeev was an amazing human being, packed with knowledge, humility, and dignity. He was a friend to everyone who met him. Sanjeev was an integral part of our AICC RCOG North Zone family and the backbone of our MRCOG courses. His passion for teaching shone through! We will always be indebted to him for his contribution to AICC RCOG NZ. We are truly lucky to have known him and worked with him. It is devastating to lose a dear friend so prematurely but he will always remain in our hearts and thoughts."

- Dr Ranjana Sharma
(On behalf of AICC RCOG NZ Family)

It's a huge loss for RCOG NZ. Remember his key support in the initial phase when We started part 2 courses in CR Park and trained all of us. Very humble and helpful person. He will always live in our memories. Heartfelt condolences and prayers.

-Dr Asmita Rathore

******

I have known Dr Sanjeev Sharma as a colleague and friend. Had the opportunity of interacting with him at many courses in Delhi. He was an academician but more than that a warm and caring human being. His love for his country and family was evident as also his concern for his students. In him we have lost a dear friend indeed

- Dr Mala Arora

******

I met Dr Sanjeev Sharma for the first time as a candidate preparing for the exam ..he was such a gentle soul instilling so much positivity and confidence in candidates and later got the opportunity to work as faculty with Sanjeev sir. His teachings and guidance continued both academically and in real life.
Knowing he is no more with us is painful to accept! But the soul immortal.....May he rests in peace with the blessings of Supreme soul Parmatma Shiv. Om Shanti.

- Dr Mamta Sahu

******

I remember Urvashi introduced Sanjeev to us. His smile and his mannerisms won everyone's heart. He was so passionate about teaching and always wanted to do so much for North Zone. I remember under his guidance I along with other colleagues started with "Advanced Obstetrics Skill Course " and he was so happy about it. We all are going to miss him. It's an irreparable loss. May God give peace to the departed soul and request God to take care of him up there in heaven

- Dr Anjila Aneja

******

Dr Sanjeev Sharma was a very gentle and lively human being .he was like family for all of us in NZ RCOG. His loss is irreparable .he will always live in our memories. May his soul rest in peace. Om Shanti

- Dr Meena Naik

******

Dr Sanjeev Sharma was a very committed, sincere, softhearted, and gentle personality. He did wonders for the RCOG organization and his loss is irreplaceable. I wish his soul "sadgati" and place at Lotus feet of Lord Himself.

- Dr Vinita Kumar Jaggi

******

A man of knowledge dedication teamwork always a giver. Cherish the chats we have had in between during courses. The icing on the cake was his simplicity and helpfulness.
Adieu Sanjeev till we meet again

- Dr Jayasree Sundar

******

I remember Dr. Sanjiv Sharma as a very soft-spoken humble and knowledgeable person. His untimely demise is a huge loss to our fraternity. He will be deeply missed.

- Dr Kaberi Banerjee

******

Dear Dr Sanjeev,
Your life was truly a blessing & your memories a treasure,
You will always be remembered beyond words & missed beyond measure.

-Dr Mamta Dagar

******

I met Dr Sanjeev for the first time in Dr Urvashi Jha's place in 2008 I think when he agreed to teach regularly at the RCOGNZ courses.
Since then he was coming down twice a year to Delhi spending at least a week teaching on the MRCOG and the Basic Skills courses. He would start at about 8:30 sharp and go on till 5 pm every day, only having beverages in the breaks. He taught with passion, was absolutely down to earth, with no ego or airs about himself. He would share his email with all the students and would guide them till the exam. Whilst in Delhi, he would help his family and friends with any medical advice.
We all remember how fondly he celebrated his beloved daughter's wedding in Delhi with Bollywood dancing and street food Delhi.
I visited them with my friend in England a few years ago. They warmly welcomed us and Deepali fed us delicious home-cooked food.
He was an integral part of the RCOGNZ family and helped RCOGNZ grow over the years. Thank you Dr Sanjeev for being there for us. I am sure the almighty God has reserved a special place for you in heaven.
We pray to God to give strength to Deepali, Lona, and his family to bear his loss.
Rest in peace Dr Sanjeev

-Dr Saritha Shamsunder

******

I met Dr Sanjeev Sharma during the RCOG courses. He was always helpful, full of positive ideas and encouragement. We wrote a book together for the RCOG exam which was published in 2015. During the course of its writing, editing and publication we corresponded several times and I got to know him more closely as a person. I remember he was not a tea person. He was always professional and full of practical tips for the exam. May his soul rest in peace.

-Dr Pakhee Aggarwal

******

Dr. Sanjeev, through his humility, humbleness, and humanity, commanded respect from all he came in contact with.
He taught me through his conduct and actions, it is not one position but one's behavior as a human being, that leaves lasting memories.
He was so easy to talk to, so approachable, so compassionate that I always considered him as a friend.
He will spread happiness wherever he is.
He will be happy in his new abode.

-Dr Jyoti Bhaskar

******

I know Dr Sanjeev Sharma since 1995,I was introduced to him by my Consultant in Liverpool Mr Charles Kingsland in the department of Reproductive medicine of Royal Liverpool University hospital. From the very first day i found him friendly and cordial with a keen interest in academics.He always talked to me about India during the coffee time and desperately wanted to return as if his soul was left here, and look at the destiny that he took his last breath here only.Met him multiple times when he visited for the courses and then he would update me about the friends in Liverpool.

I don't remember how many cups of coffee he made for me during my posting in Reproductive medicine department.I learnt a lot from him.

Rest in peace Dr Sharma.

-Dr Sushma Sinha

******

Dr sanjeev
I first met dr sanjeev in 2009 when i attended the basic surgical skills course as a delegate . He came across as somebody completely dedicated to his work and with immense amount of postive energy . A year later I was the convenor of the same course and in this capacity interacted very frequently with dr sanjeev. He was one of the warmest people i have met with a genuine interest in people around him. I always found him to be very kind with a warm gentle smile and ever willing to help everyone around him. For so many years , the numerous rcog courses always meant meeting up with dr sanjeev and learning something new. He will really bemissed.May his departed soul find peace . Om shanti .

-Dr Jasmine Chawla

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Dr Sanjeev Sharma had a great passion for teaching.We met so often during our MRCOG Courses and exams.I had the opportunity to drop him near Connaught place after the courses on a few occasions. Remember him fondly. I always admired his intelligence, kindness and most of all his straightforwardness. He was loved, respected and sought after by the students who came for the courses.He had an instant connect with them because of his gentle nature.His radiant smile exuding warmth, confidence and simplicity is etched in my memory.Heaven certainly gained a beautiful soul and left a huge personal void for all of us.May you find eternal peace and may your affection continue to bind us forever.

-Dr Jharna Behura

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Dear Dr Sanjeev it's extremely sad to say goodbye to you! You will always remain in my heart as a wonderful colleague & friend with a lovely cheerful smile always! Your passion for teaching was most amazing and truly inspiring. Will miss you forever! May God bless your soul with moksha and give courage to your family to cope with this irreparable loss. Om Shanti

-Dr Sohani Verma

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Deeply Saddened by Dr Sanjeev's Demise
I have know him, ever sure I've know RCOG –NZ. Having spent sometimewith him during the course easier on and while dropping him back to his home on few occasions, we have together reflected on how different it was working here than in the NHS.
I've always valued his commitment to RCOG, to teaching with emphasis on practising communication and amazed at how he could just survive on 'Coca Cola'. I have learnt a lot from him – his humbleness, the accuracy of his teaching techniques the patience to be there all throughout and to take each of us on board.
Dr Sanjeev, you would surely, be missed
May you rest in peace!

-Dr Poonam Tara

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It saddened my heart hearing about his loss. He was an amazing human being, an amazing teacher and an amazing mentor who motivated many during our RCOG Courses. May his soul rest in peace

-Dr Neema Sharma

All India Co-ordinating Committee (AICC)
RCOG North Zone Family 2022

Jab we met..!

What is a friend? A single soul dwelling in two bodies."

-Aristotle

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- Hippocrates

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