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In association with

55th Annual Scientific Conference 2022

30th September to 2nd October 2022

"Enhancing Women's Health with Regional & Global Partnership"

Abstracts

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CONTENTS

ORAL PRESENTATIONS - OBSTETRICS

OP/O – 01
ASSESSMENT OF KNOWLEDGE AND ATTITUDES OF SRI LANKAN PRE-INTERN DOCTORS ON OBSTETRICS AND GYNAECOLOGICAL EMERGENCIES

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Objective
To study and assess the knowledge and attitudes of Sri Lankan Pre-intern doctors on obstetrics and gynecological emergencies.

Method
Descriptive cross-sectional study was conducted using a self-administered close ended questionnaire based on RCOG guidelines. The study was conducted among 182 randomly selected volunteer Pre-intern doctors graduated from state and non-state sector medical faculties recognized by the Sri Lanka Medical Council. Data was collected and analyzed using Beta version of SSPS

Results
Of 182 pre-intern doctors, 15.9% (n=29) don't like to think or speak about obstetric and gynaecological emergencies. An adequate knowledge on gynaecological emergencies is shown by 88.5% (n=155) participants and for obstetric emergencies it is 85.2% (n=115). During undergraduate training 92 (50.5%) of participants, have faced postpartum hemorrhage (PPH), while 89 (48.9%) and 80 (44%) of them experienced antepartum hemorrhage (APH) and pre-eclampsia (PE) respectively. From those exposed, only 7 (3.8%), 7 (3.8%), 2 (1.1%) have actively participated to manage PPH, APH and PE respectively. Most commonly encountered gynaecological emergency was miscarriage 145 (77.7%), while 121 (66.8%) actively participated for the management of those miscarriages. Only 74.2% (n=135) participants have practiced emergency maneuvers using mannequins during undergraduate training and 90% (n=164) knew basic drugs on obstetric and gynaecological emergencies. Competency of communication (63.8%) and skills of handling the situation (57.7%) were low among pre-intern doctors. 173 (95%) requested modified teaching methods while 178 (97.8%) requested to involve them in emergency situations and 181 (99.5%) requested skills development programmes on emergencies.

Conclusion
Pre-interns show adequate theoretical knowledge on management and use of drugs in obstetric and gynaecological emergencies but lack active participation, positive attitudes, competency in communication and skills of handling emergencies. Most commonly encountered obstetric and gynaecological emergencies by the participants are miscarriage and postpartum hemorrhage respectively. Active involvement in managing emergencies, modified teaching methods and skills development programmes are suggested to improve skills and attitudes of pre-interns in managing emergencies in order to improve the quality of Sri Lankan healthcare.

OP/O – 02
"LAPAROSCOPIC ABDOMINAL CERCLAGE DURING PREGNANCY- A GAME CHANGER"

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Introduction
Cervical insufficiency with a previous history of failed cervical cerclage, need placement of stitch a little higher on the cervix. Thus, providing a better outcome for the pregnancy by providing better integrity of the cervix.

Objective
The objective of this procedure, though it's challenging as compared to interval abdominal cerclage, is the demonstration of the laparoscopic placement of the transabdominal cerclage in cases of pregnancy with prior failed vaginal cerclage for a better outcome.

Methods
Laparoscopic method of placement of abdominal cerclage during pregnancy is a challenging task owing to the presence of gravid uterus that needs minimal manipulation and also the increased vascularity of the gravid uterus. Surgical procedural demonstration (video) of a G5A4 at 14 weeks GA with cervical insufficiency and previous two failed vaginal cerclages. Suture Material used – 5 mm MERSILENE polyester Fiber Ligature (30 cm).

Results
The Operating time was 20 mins and duration of hospital stay for the patient was less than 24 hours (day care). The pain post-surgery was very minimal with requirement of the analgesics for 2 days and the associated blood loss was approximately <100 ml. With minimal manipulation of the uterus the surgery was accomplished, and the pregnancy was pulled till term safely without any associated complications.

Conclusion
Laparoscopic abdominal cerclage offers benefit over vaginal cerclage in previous history of one failed cervical cerclage, especially in cases of refractory cervical insufficiency. Minimally invasive approach has an added advantage of better visualization of pelvic anatomy, hence avoidance of damage to uterine vessels, lesser morbidity and shorter recovery time with fewer wound complications. Placement of cerclage more challenging during pregnancy than as an interval procedure, and hence the experienced team should handle the procedure.

OP/O – 03

THE EFFECT OF ULTRASOUND SCANNING ON THE PSYCHOSOCIAL ADAPTATION TO PREGNANCY AMONG EXPECTANT MOTHERS IN THEIR FIRST TRIMESTER AND PREDICTORS OF PSYCHOSOCIAL ADAPTATION IN PREGNANCY

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Introduction
The psychosocial adaption of a woman during pregnancy may influence the period of pregnancy, labour and delivery, and postpartum period. Evidence suggests undergoing USS during the first trimester has improved identification with the motherhood role and attachment between mother and the unborn baby. The present study aimed to explore the impact of first trimester USS on the psychosocial adaptation and identifying its predictors among expectant mothers during first trimester.

Objectives
To understand how the first trimester Ultrasound scanning can impact psychosocial adaptation to pregnancy and to determine predictors of psychosocial adaptation to pregnancy among first trimester expecting mothers in Sri Lanka.

Methods
A repeated measure design study was conducted in maternity clinics of University Hospital KDU, Ninewells care hospital and Navy General hospital over four months with hundred and fifteen (N= 115) expectant mothers. Participants first completed a demographic questionnaire. Predictors considered in this studywere age, highest educational qualification, partner's support, parity and Miscarriage history. Prenatal Self Evaluation Questionnaire (PSEQ)was administered immediately before and after undergoing the USS. Mean age of the participants was 28.84 ±3.68.

Results
The Wilcoxon Signed Rank test showed that the level of psychosocial adaptation to pregnancy was slightly increased after the USS, $z = -2.261$, $p < 0.05$, with an effect size of $r = 0.149$. None of the predictors were able to significantly predict the psychosocial adaptation of the participants.

Conclusion
Findings suggest that undergoing the first trimester USS improves psychosocial adaptation to pregnancy. Based on the present study, future studies can focus on how USS can contribute towards psychosocial adaptation of expecting mothers in second and third trimesters of pregnancy.

OP/O – 04
FETAL ANOMALIES AND MULTIDISCIPLINARY CONSULTATION – AN INTERGRATED APPROACH

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Introduction & Objectives
Fetal anomaly increases the risk of infant death as well as causes great pain to the family. We aimed to investigate the frequency of different types of fetal anomalies and their outcome after a multidisciplinary consultation by a team consisting of Obstetricians, Pediatricians and Clinical Geneticists.

Methods
A retrospective study was conducted in pregnant women who were diagnosed with fetal anomaly by ultrasound between April 2021 and September 2021. Patient's information and the ultrasound findings were obtained from the database at the centre and outcome and follow up details were obtained by contacting the patients over the phone.

Results
There were 33 women.The anomalies affected central nervous system (n=9, 27.27%), genitourinary system (n=8, 24.24%),multiple malformations (n=7, 21.21%), cardiovascular system (n=4, 11.42%), gastrointestinal system (n=3, 9.09%), and musculoskeletal system (n=2, 6.06).The detection rates of fetal anomalies were 15.15% (n=5), 9.09% (n=3), and 75.75% (n=25) during gestational age of <18 weeks, 18–22 weeks, and >22 weeks respectively. In addition, when considering the maternal age 3.03% (n= 1), 39.39% (n=13), 18.18% (n=6), 21.21% (n=7), 12.12% (n=4) and 6.06% (n=2) fetal anomalies were detected in pregnant women in the <20, 21–25, 26-30, 31-35, 36-40 and >45 year age groups respectively.

24 (72.72%)of pregnancies were carried to the third trimester. Of them12 (50%) were normal deliveries and 12 (50%) were caesarean sections. The outcome was a stillbirth(16.66%, n=4), neonatal death (37.5%, n=9), live with CNS anomalies(20.83%, n=5), live with renal anomalies (8.33%, n=2), or live with minor abnormalities(16.66 %, n=4). The neonatal deaths were due to renal anomalies (33.33%, n=3), congenital diaphragmatic hernia (22.22%, n=2),cardiac abnormalities (22.22%, n=2)gastrointestinal abnormalities (11.11%, n=1), and skeletal dysplasia (11.11%, n=1). The still births were due to heart diseases (50%, n=2), CNS anomalies (25%, n=1), and renal abnormalities (25%, n=1).Of the babies delivered by Caesarean Section,50% (n=6)were alive. Of those delivered normally 33.33% (n=4) were still births, 25%, (n=3) were neonatal deaths, and 41.66 % (n=5)were alive. Of the babies who were alive only 5 (45.45%) were developmentally normal or near normal.

Conclusion
Fetal anomalies are associated with poor pregnancy as well as poor long-term outcomes for surviving babies. The establishment of a multidisciplinary consultation team is necessary to manage and support these families.

OP/O – 05
PRETERM PRELABOR RUPTURE OF MEMBRANE: A ONE YEAR STUDY IN DHAKA MEDICAL COLLEGE HOSPITAL, BANGLADESH

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Background
Preterm prelabour rupture of membrane (PPROM) is one of the common obstetric complications in tertiary hospitals. It is caused by some maternal as well as some fetal complications. The fetal outcome in PPROM is affected mainly by prematurity and neonetal complications like early onset neonatal sepsis, respiratory distress syndrome, necrotizing enterocolitis, neonatal jaundice mainly.

Methods
A retrospective study was done on the admitted patients of Maternal Fetal Medicine Unit, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Bangladesh, during the year 2020. With due permission from Department of Obstetrics and Gynaecology and ethical clearance from appropriate committee, records of admitted patients with PPROM were reviewed and analyzed for evaluation of their underlying etiologies and subsequent outcome of these pregnancies.

Results
Among total 656 admitted patients 103 (15.7%) had PPROM.16.5% of PPROM was between 34 to 37 weeks, 36.9% was between 32 to below 34 weeks, 37.9% was between 28 to below 32 weeks and 8.7% was below 28 weeks. 23.3% of patient had H/O previous caesarian section. Among PPROM patients 9.71% had diabetic disorders in pregnancy, 6.8% had preterm labor, 5.8% had multiple pregnancy, 3.9% had Fetal growth restriction, 2.9% had anomalous fetus. 62.1% patients were delivered in this hospital and 37.8% were discharged after conservative management. Among delivered babies 87.5% was alive, 10.9% was still birth and 1.5% was old intrauterine death.

Discussion
PPROM is one of the frequent complications that we meet in hospital. So many factors are associated with PPROM, some of which are maternal, and some are fetal. Early detection and appropriate management can reduce its incidence and improve outcome.

Conclusion
It is important to give regular antenatal care in appropriate protocol can improve the current situation associated with PPROM.

OP/O – 06
PROPER DOCUMENTATION OF INTRAPARTUM CARDIOTOCOGRAPHY: COMPLETE AUDIT CYCLE IN TEACHING HOSPITAL RATHNAPURA

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Introduction
Cardio Toco Graph (CTG) is used to assess intrapartum fetal wellbeing in almost all obstetric units. Continuous CTG has reduced the rate of neonatal seizures, but no significant reduction is demonstrated in perinatal mortality or cerebral palsy. Pathological CTG has a high positive predictive value identifying fetal acidosis which does not apply to suspicious traces. Although robust evidence is lacking, guidelines recommend CTG for high-risk pregnancies. CTG interpretation is prone to significant intra-and inter-observer disagreement even when experienced obstetricians are involved, and international guidelines are followed. Proper documentation of CTG can minimize this discrepancy and will aid clinical decision-making. The objective of this audit is to evaluate the completeness of documentation of intrapartum CTG.

Methods
A complete audit cycle was conducted in labour ward 2B Teaching Hospital, Rathnapura in 2021. NICE guideline CG190 was used as the standard review tool. Intrapartum 1st stage CTG traces of singleton pregnancies at term was included and CTG of fetuses with known structural anomalies were excluded. Retrospectively selected intrapartum CTG traces were included in the preliminary audit. A new documentation tool was introduced as a seal and a lecture on CTG interpretation was organized. The re-audit was conducted 3 months following implementations. Descriptive statistics were used to summarize the data and the Chi-square test was used for analysis.

Results
In the preliminary audit 389 CTG traces and the re-audit 302 CTG traces were included. Documentation of all the CTG parameters has improved. Documentation of date, time, and patient information was 93%, 97%, and 82% respectively which has improved up to 99%. Documentation of maternal pulse rate and maternal contractions information has improved from none to 86% and 1.2% to 90% respectively. CTG features (FHR, variability, accelerations, and decelerations) were documented in 96.5% of CTGs which initially was at 77.3%. In the preliminary audit, CTG was classified in 66.53% instances and 38.8% had an action plan written. In re-audit, both parameters were documented in 88.7% of CTG and the responsible medical officer has signed 99% CTG which was initially 90.2%. There was a statistically significant difference in proper documentation after the introduction of the new protocol (P-value < 0.05).

Conclusion
There was a significant improvement after the introduction of the new protocol which even can be used for antenatal CTG. Maintaining an acceptable level of clinical accuracy in documenting CTG features according to a protocol will lead to proper CTG categorization and timely identification of fetal hypoxia.

OP/O – 07
RARE COMPLICATION OF HYPERTENSIVE DISORDERS IN PREGNANCY: POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME - 2 CASE REPOTS

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Introduction

Hypertensive disorders in pregnancy are one of the leading causes for the maternal and foetal morbidity and mortality. One of the rarest complications of preeclampsia and eclampsia is Posterior Reversible Encephalopathy syndrome (PRES). Approximately 20% of eclamptic patients and less commonly patients with neurological symptoms of preeclampsia experience PRES. We are reporting 2 cases of PRES in preeclamptic and eclamptic patients in Sri Lanka.

Case Presentation

Case No 1

A 37-year-old woman in her first pregnancy presented with a period of gestation (POG) of 25 weeks experienced blurring of vision and scotomas. On the following day she developed occipital headache and denied any convulsions. Patient was grossly oedematous, found to have high blood pressure, exaggerated reflexes but no clonus. She had 4+ of protein urea and blood investigations were normal. Her blood pressure was controlled, and corticosteroids were given. $MgSO_4$ was commenced and emergency hysterotomy was performed. MRI of the brain revealed high intensity signals in the white matter of bilateral occipital lobes and in the right cerebellar hemisphere. There are no evidence of infarctions or other abnormalities, and diagnosis of PRES was made. Ophthalmologic evaluation was done, and the patient had hypertensive retinopathy and optic disc haemorrhages. Her blood pressure was controlled with nifedipine, and her visual symptoms were reversed after 4 weeks from delivery. Her baby's birth weight was 680 g and after 68 days of neonatal care the baby was discharged.

Case No 2

A 39-year-old lady in her second pregnancy with a POG of 34 weeks presented with signs and symptoms of preeclampsia. Her first pregnancy had also been complicated with hypertensive disorders and she was started on a low dose of aspirin. At 26 weeks of POG, she developed hypertension for which she was started on nifedipine. At 34 weeks she was admitted with blaring of vision, generalised tonic clonicconvulsion and hypertension with 4+ of proteinuria. Her blood pressure was controlled, and convulsion was controlled with $MgSO_4$. Emergency Caesarean delivery was performed, and MRI revealed high intensity signals in bilateral occipital and parental lobes without evidence of infarction or thrombosis and a diagnosis of PRES was made. Gradually her visual impairment improved, and blood pressure was controlled with nifedipine. She delivered a 2.2 kg baby, both mother and baby were discharged after 12 days of inward care without major complications.

Discussion

PRES also known as reversibleposteriorleukoencephalopathy was first described by Hinchey et al. in 1996 describing a neurological disorder with characteristic imaging findings in the brain with occipito-parietal predominate vasogenic oedema without infarction. PRES is associated with many clinical entities including eclampsia, pre-eclampsia, renal failure and blood pressure fluctuations. Two theories describe the pathophysiology of PRES. The first theory describes the rapid rising of arterial blood pressure above the level of cerebral auto regulation leading to cerebral hyper perfusion and subsequently causing fluid leakage and vasogenic oedema. The second theory describes that the syndrome is triggered by endothelial dysfunction caused by endogenous or exogenous factors. In preeclampsia both endothelial dysfunction and hypertensive crisis can occur.

PRES presents with a wide array of symptoms including headache, visual disturbances, seizures, encephalopathy and focal neurological deficits. Visual disturbances have been reported in 39% of patients and typically presents as cortical blindness, visual field defects and visual blurring. Ocular examination may reveal papilledema, haemorrhages and exudate. Seizures are associated with 81% patients and are generally tonic-clonic in nature. In PRES almost always involves the occipital and parietal lobes and the

white matter vasogenic oedema is typically symmetrically and bilateral. CT scan of the brain is the often first line imaging modality and shows white matter hypoattenuation. Digital subtraction angiography (DSA) demonstrates signs of arterial vasospasms and MRI of the brain will reveal characteristic signs of vasogenic oedema. The main strategies of management include control of blood pressure, consider delivery, control of seizures, securing the airway and other supportive care. Nicardipine, labetalol and hydralazine can be used as first line antihypertensives while sodium nitroprusside, enalapril can be used as second line agents. Although it was initially described as completely reversible, patients may still have residual effects. In literature maternal mortality rate associated with PRES is described between 6 - 27%.

Conclusion

One of the rarest complications of preeclampsia and eclampsia is PRES also known as reversible posterior leukoencephalopathy syndrome. PRES typically presents with high blood pressure and symptoms such as visual disturbances, headache, seizures and encephalopathy. Radiologically neuroimaging characteristically reveals bilateral occipito-parietal lobe white matter vasogenic oedema without infarction. The main strategies of management include control of blood pressure and seizures with supportive care and delivery. Majority of the patients will have complete recovery but can have recurrences in subsequent pregnancies.

OP/O – 08

PHYSICAL ACTIVITY & LOW BACK PAIN DISABILITY: A DESCRIPTIVE AMONG PRIMIGRAVIDA

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Introduction & Objectives

Physical activity (PA) is not optimal during pregnancy and most of the mothers affect by lower back pain (LBP). Physical inactivity correlates with LBP. LBP usually starts around 18th week of gestation and causes functional disability (LBPD). The connection between PA & LBPD is controversial & not well understood. So, this study was designed to investigate the relationship between PA & LBPD among primiparous mothers.

Methods

Adescriptive cross-sectional study was conducted in the ante-natal clinic, Teaching hospital, Peradeniya from September'2019 to March'2020. Primiparous mothers who were in second (n_2=225) and third (n_3=178) trimesters were recruited (N=403) using systematic random sampling. Validated, self-administered pregnancy physical activity questionnaire & modified Oswestry low back pain disability questionnaire were used for data collection. PA and LBPD scores were estimated with corresponding criteria of questionnaires. Pearson chi-square test and Pearson correlation test were adopted in data analysis using SPSS version 25.0.

Results

Mean age & pre-pregnancy BMI of participants were 26.13±3.21 years and 22.19 ± 4.12 kg/m^2 respectively. PA level was determined based on international PA recommendation for pregnant mothers (moderate intensity PA for ≥150 minutes per week).Accordingly, mothers who fulfilled current recommendation considered as active and others considered as inactive. From the total, 69.5% (280) mothers were in the active group. According to LBPD level, 37.5% presented with minimal disability (LBP score 0 <20%), 48% moderate disability (LBP score 20 <40%) and 11% severe disability (LBP score 40 <60%) in the total study sample. A significant association was found between PA level and LBPD level in the total

study sample ($\chi 2$=10.49, p=0.01, df =3) by Chi-square test. It is revealed that, inactive mothers presented with higher proportion of disability levels compared to active mothers. Similarly, a significant association was seen in second trimester also, showing higher LBPD levels in inactive group ($\chi 2$=11.44, p=0.01, df =3). Weak positive correlations were identified between LBPD score and sedentary PA score (p=0.02, r= +0.12) by Pearson correlation test presenting disability score slightly increase with sedentary PA. Further, significant weak negative correlations were observed between LBPD score and total PA duration (p=0.04, r= -0.11) & vigorous PA score (p=0.04, r= -0.10).

Conclusion

PA & LBPD are interrelated.Physically inactive pregnant mothers presented with relatively higher LBPD levels & sedentary PA improves the disability. Therefore, structured PA programs which comprise LBP preventive measures are recommended through comprehensive PA & LBPD assessments adjusted with gestational age for pregnant mothers.

OP/O – 09

A RARE CASE OF AGNATHIA OTOCEPHALY SYNDROME COMPLICATED WITH SEVERE POLYHYDRAMNIOS DURING PREGNANCY: CASE REPORT.

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Background

Agnathia-otocephaly complex (AOC) is a rare and complex craniofacial malformation characterized by mandibular hypoplasia or agnathia, auricular fusion (synotia), and microstomia with oroglossal hypoplasia or aglossia. It can occur alone or in combination with forebrain anomalies and cardiac malformations and has an extremely poor prognosis due to breathing difficulty at birth. Here, we report a case of AOC presented with severe polyhydramnios at 34weeks of gestation.

Case Presentation

Mrs.I.K is a 32-year-old mother who presented to us for the first time in her fifth pregnancy at 32 weeks of gestation with severe abdominal pain and shortness of breath. She had one live healthy baby girl (birth weight 2.8 kg) in her first pregnancy and the other 3 pregnancies were miscarriages that were not further investigated. Also, there is no consanguinity or congenital abnormalities in her family history. She was not diagnosed to have any chronic disease like diabetes mellitus. She had uncomplicated first and second trimesters and didn't undergo a detailed anomaly scan during the first or second trimester. She was not diagnosed to have Gestational diabetes mellitus or febrile illness during this pregnancy. She complained of shortness of breathing and abdominal discomfort due to gross distension of the abdomen with a symphysio-fundal height of 49 cm.Ultrasound scan(2D) of the abdomen showed severe polyhydramnios (AFI - 38 cm)with a single live fetus and normal appearance of the gastrointestinal tract with normal growth of the baby and other anomalies couldn't be detected due to gross distension of the abdomen. She underwent amnioreduction which failed. After completion of the Dexamethasone, she underwent cesarean section at 34 weeks of gestation due to worsening of her symptoms and persistent transverse lie of the baby.

She delivered a dysmorphic baby girl who didn't cry at birth and died soon after birth despite resuscitation. Autopsy findings revealed a female fetus weighing 1820 g, having a crown to heel length of 42 cm, with an abdominal circumference of 24 cm, and occipitofrontal circumference of 32 cm with severe craniofacial anomalies – microstomia, aglossia, agnathia and synotia suggestive of Agnathia-otocephaly complex and no other gross anomalies. During surgery and the postpartum period, all the measures were taken to prevent postpartum hemorrhage in the mother which can arise as a complication of severe polyhydramnios. Mother was discharged on postpartum day 2 after counseling with family planning advice.

Discussion

The agnathia otocephaly syndrome often called agnathia otocephaly complex is a rare lethal condition affecting less than 1 newborn in 70,000 live births. The term 'oto" refers to the relationship of the ears to the face. Otocephaly, with associated anomalies, is considered lethal due to severe respiratory dysfunction. The infants show absence or hypoplasia of the mandible (agnathia), ventromedial malposition of the ears with or without auricular fusion (synotia), and microstomia with hypoplasia or absence of the tongue (aglossia). AOC anomalies occur between 4 and 7 weeks of gestation. Facial structures affected by AOC are mainly derived from the first pharyngeal arch.

AOC etiology is not clear; however, it has been related to genetic factors such as mutations in the PRRX1 gene or unbalanced translocation, and few proposed teratogenic effects as the cause for otocephaly such as exposure to theophylline. Previous studies classified AOC into four groups: (i) agnathia alone; (ii) agnathia with holoprosencephaly; (iii) agnathia with situs inversus and visceral anomalies; and (iv) agnathia with holoprosencephaly, situs inversus, and visceral anomalies. Due to swallowing difficulties of the baby their amniotic fluid will accumulate and ultimately lead to Polyhydramnios during pregnancy. Prenatal diagnosis of otocephaly is extremely rare however it had been reported on several occasions. Prenatal diagnosis of otocephaly depends mostly on 2-dimensional and 3-dimensional ultrasounds. Key to diagnosis is low set or midline position of ears but visualization of this feature is difficult using 2D ultrasound. AOC is probably one of the diagnoses where 3D ultrasound helps in demonstrating the position and shape of ears in addition to facial features.

Conclusion

Otocephaly is usually incompatible with life, so it is important to diagnose on routine antenatal radiological checkups when the mandible cannot be visualized, and fetal ears are noted to be abnormally placed. First-trimester screening with a demonstration of fetal profile for facial anomalies and evidence of severe polyhydramnios with the use of 3D ultrasound will contribute in the future.

OP/O – 10

A VERY RARE CASE OF PSEUDO-HYPOALDESTERONISM TYPE 2 (GORDON SYNDROME) IN A 24-YEAR-OLD MOTHER WITH DICHORIONIC DIAMNIOTIC (DCDA) TWIN PREGNANCY

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Background

A Rare case of Gordon syndrome (hyperkalemichyperchloremic acidosis, and chronic hypertension) complicating twin pregnancy is presented. In the literature, this is the first case report of a twin pregnancy complicated by this rare syndrome.

Introduction

Pseudo hypoaldosteronism (PHA) comprises aheterogeneous group of disorders of electrolyte metabolism characterized by an apparent state of renal tubular unresponsiveness or resistance to the action of aldosterone. It is manifested by hyperkalemia, metabolic acidosis, and a normal glomerular filtration rate (GFR). Since primary PHA was first described, it has been further subclassified into PHA type I (PHA-I), which is the classic form, and PHA type II (PHA-II), which is also referred to as Gordon syndrome. PHA-II is a rare Autosomal dominant renal tubular defect characterized by hypertension and hyperkalemic metabolic acidosis in the presence of low renin and aldosterone levels.

During the literature survey we found that there are only a few case reports regarding Gordon syndrome complicated pregnancy and there were no reports that complicated with DCDA twin pregnancy and Gordon syndrome. Here we present a case of Gordon syndrome in a 24-year-old primi mother with DCDA twin pregnancy.

Case Presentation

Mrs. S.M. is a 24-year-old lady who had congenital heart disease (Atrial septal defect) in her early childhood at age of 4 years and underwent successful ASD device closure. A few years after cardiac surgery she developed hypertension and hyperkalemia with normal renal function tests. Then she was diagnosed to have Pseudo-Hypoaldosteronism Type 2 (Gordon syndrome) at the age of 11 years.

At the age of 24 years, she presented to the antenatal clinic with unplanned pregnancy. During her booking visit her blood pressure was 140/80 mmHg and further examination revealed short stature (145 cm) with defective dentition which is associated with some cases of Gordon syndrome. Also, she was diagnosed to have Dichorionic diamniotic twin (DCDA) pregnancy.

After preliminary investigations,Hydrochlorothiazide was omitted and Nifedipine and $NaHCO_3$ continued throughout the pregnancy with Aspirin 75 mg, Folic acid, Iron and Calcium supplements. The first trimester was complicated with hyperemesis gravidarum. During the second trimester, her blood pressure began to rise (160/100 mmHg) and Labetalol 100 mg 8 hourly was added.Serial growth scans for the fetuses since the 24th week of gestation revealed a single fetal growth restriction at 28 weeks of gestation with an abnormal umbilical artery doppler (UAD) pattern in the same fetus.

At 32 + 4weeks of gestation, she developed Preterm Pre-Labor rupture of membrane and Pre-eclampsia with the presence of Urine Albumin 2+ in the urine dipstick test. After completion of Dexamethasone and Intravenous (IV)$MgSO_4$ 4g stat dose prior to the delivery, in the presence of the neonatal team she underwent elective lower segment cesarean section under spinal anaesthesia. She delivered a baby girl (Weight – 608 g) and a baby boy (Weight – 823 g). Initial metabolic screening of babies revealed normal potassium levels in their blood.

Initial postpartum period was complicated with severe headache, generalized body swelling, exaggerated knee jerk reflexes, clonus, high blood pressure (180/100 mmHg), hyperkalemia (5.6 mmol/l) and urine albumin 3+ which led to worsening of her condition. Multidisciplinary care was arranged within the ICU setup. Her blood pressure controlled with IV Hydralazine, and IV Labetalol and impending eclampsia was managed with IV $MgSO_4$ 4g stat dose followed by 1 g/hour infusion for 24 hours while monitoring serum magnesium level to detect toxicity. Her hyperkalemic gradually settled after adding Hydrochlorothiazide 25 mg bd to her treatment regimen. Currently, she is clinically stable. Her babies still remain in the special care baby unit but remains stable.

Discussion

During the pregnancy of a woman with PHAII, electrolytes and blood pressure should be monitored regularly, and blood pressure medication adjusted as needed. Some antihypertensive medications (including thiazide diuretics) have been associated with adverse fetal outcomes, especially when taken during the first trimester of pregnancy. The best time to discuss the risk to the fetus associated with maternal medication is prior to conception. Women with PHAII who become pregnant should be referred to an obstetrics group with expertise in high-risk pregnancies.

OP/O – 11

POSTERIOR REVERSIBE ENCEPHALOPATHY SYNDROME IN PREGNANCY: A CASE REPORT

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Introduction
Posterior Reversible Encephalopathy Syndrome (PRES) is rare clinical- radiological condition; characterized with headache, seizures, visual disturbances, confusion, and changes in mental status and focal neurological signs. PRES is associated with predisposing risk factors, renal insufficiency, immunosuppression, hypertension, especially, preeclampsia and eclampsia during pregnancy.

Case Presentation
29-year-old primi, DCDA twin mother, at POA of 32 weeks, diagnosed with type 2 diabetes mellitus on insulin, hypothyroidism on thyroxin 75 µg, admitted with a history of headache and being loss of consciousness for 30 minutes. On admission she was found to have blood pressure of 150/100mmHg, Tongue bites suggestive of seizures, facial puffiness and pitting oedema. Her GCS is 15/15, tendon reflexes were + and urine albumin was +. Thus, loading dose of Intravenous $MgSO_4$ and corticosteroids for lung maturation given. While on Intravenous MgSO41 ghour⁄ infusion, her blood pressure rises to 190/ 100mmHg which was managed with Intravenous hydralazine and prepared her for the Emergency Cesarean Delivery.

During immediate postpartum period her blood pressure was shooting up and it was managed with Intravenous hydralazine and as per neurological opinion, she underwent CT scan brain, which showed subtle focal white matter ischemic changes in B/L frontal and R/S occipital region, No intra cranial hemorrhage. Her MRI brain revealed, features suggestive of Posterior Reversible Encephalopathy Syndrome (PRES)

Discussion
PRES occurs in patients with eclampsia and vice versa. Though pathophysiology remains unclear, this is a potentially reversible neurotoxic state occurring in association with vasogenic cerebral oedema. Development of cerebral vasospasm and ischemia, with increased hydrostatic pressure resulting fluid extravasation causes disturbance of cerebrovascular auto regulation in affected vascular areas of the brain, mostly basal ganglia and bilateral parietal-occipital areas.

Diagnosis is by imaging as it is essential since the assessment of radiographs is the gold standard for the diagnosis of PRES. MRI is the choice of imaging modality. The typical finding is vasogenic edema in the bilateral parietal-occipital region, characterized by hyper intensity in T2-weighted and FLAIR imaging in MRI. Lesions usually disappear with proper treatment. Managing the underlying etiology, in addition to careful treatment of hypertension, is crucial for resolving of PRES. Prognosis of PRES is typically favorable.

Conclusion
PRES is underdiagnosed due to its lack of awareness thus predication, early identification and meticulous management may enhance the maternal recovery

OP/O – 12
AUDIT CYCLE ON IMPLEMENTATION OF WHO EPISIOTOMY POLICY IN TEACHING HOSPITAL, KEGALLE.

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Introduction
Adherence to World Health Organization positive childbirth guideline and selective episiotomy policy (February 2018) is vital to improve the quality of care provided for women, to have a comfortable labour.

It states, "Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth and based on the evidence, selective episiotomy may reduce incidence of severe perineal trauma".

Objectives
Audit project was focused to evaluate the adherence to WHO episiotomy policy among labour care providers at Teaching Hospital, Kegalle.

Methods
48 participants including 18 nurses, 15 midwives and 15 doctors specialized in providing labour care were audited. Audit was carried out collecting clinical data and calculating the episiotomy rate according to retrospective case note reviews of 289 mothers who underwent vaginal deliveries from 01.10.2021 to 30.11.2021. A questionnaire and observer check list was used to collect data about practices.

Baseline audit data were analyzed using simple statistical data analysis. An action plan was developed following identifying the potential barriers to adhere guidelines with interactive teaching and skills sessions being implemented over a period of 1 month with suppression of the audit leads. A prospective re-audit was carried out among the same study subjects and assessed 390 women who delivered over a period of 90 days in a similar manner.

Results
Baseline audit revealed 91.7% episiotomy rate without meeting 80% adherence to the standards, in areas of selective episiotomy policy and obtaining informed consent. Awareness about updated guidelines among nurses and midwives were 48% and 20% respectively and an average of 25% were not willing to change outdated practices. Following the action plan and re-audit, episiotomy rate was reduced to 76% with no grade ≥2 perineal tears. Though grade 1 tears were increased by 4%, infected wound rate decreased by 2.3% due to reduction of unnecessary episiotomy. Staff satisfaction was 100% following knowledge sharing. Fear of tears and getting accused, misbelieves such as episiotomy is essential for primiparous mothers and for less traumatic delivery of a pre-term baby were noted as main barriers, which were addressed successfully during action plan, thus we were able to achieve good adherence with 70% improvement in will to change practices.

Conclusion
Adherence to updated guidelines is essential to provide a quality care for women in labour. Audit cycle addressed the barriers and helped ensuring confidence, establishing proper skills and techniques among labour care providers thus leading to a remarkable outcome.

OP/O – 13
A CASE OF ATYPICAL ECLAMPSIA OF A SARS-COV-2 INFECTED WOMAN

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Introduction
Eclampsia is defined as the development of convulsions and/or unexplained coma during pregnancy or immediate postpartum in the presence of pre-eclampsia (PE). The definition of PE has been broadened as pregnancy-induced hypertension associated with significant proteinuria or other maternal organ dysfunction or uteroplacental dysfunction. In some instances, convulsions or unexplained coma are observed without significant proteinuria and/or elevated blood pressure. These cases are categorized as atypical eclampsia. Although there is no strict clinical definition according to limited evidence, atypical eclampsia constitutes about 8% of eclampsia cases. This can present before 20 weeks of gestation and after 48 hours postpartum and usually is complicated by HELLP syndrome. Because of the unpredictability of onset, it's difficult to

make a timely diagnosis, and resistance to $MgSO_4$ makes it harder to manage. More than 35% of patients with COVID-19 develop neurological sequelae including both PE and atypical eclampsia. Mechanisms suggested include virus activating glutamate receptors via cytokines in the brain and alteration of the renin-angiotensin hormonal system in the placenta.

Case Presentation
A 20-year-old primigravida at 25 weeks of gestation with an uncomplicated antenatal period without history of epilepsy, presented to the emergency department with three episodes of myoclonic seizures lasting 45 seconds in the absence of proteinuria or elevated BP. She was confirmed to be infected with the SARS-Cov-2 virus by a rapid antigen test. Her platelet count, liver function test, renal function test, EEG, and NCCT brain were normal. Ultrasound scan fetal growth parameters were compatible with gestation and the Doppler study was normal. She was treated in ICU with oral levetiracetam 500 mg, IV Acyclovir 500 mg, and IV ceftriaxone 2 g for 5 days. $MgSO_4$ was not given. Fortunately, she didn't develop seizures during her hospital stay and recovered dramatically. She was discharged with levetiracetam 500 mg until 6 weeks postpartum. The rest of the antenatal period was uncomplicated. She had to undergo category 2 cesarean delivery due to failure to progress with pathological CTG. Her postpartum period was uncomplicated.

Conclusion
In clinical practice, atypical eclampsia should be suspected as a differential diagnosis in SARS-Cov-2 infected pregnant women with new-onset seizures in the absence of pre-eclampsia. There is a gap in knowledge regarding the diagnosis and management due to a lack of good quality evidence.

OP/O – 14
CLINICAL AUDIT TO PREVENT UNDETECTED POSTPARTUM VOIDING DYSFUNCTION

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Introduction
A few numbers of women (0.4% to 4%) experience long term bladder dysfunction following childbirth. The bladder could be an unfortunate victim of childbirth. A single episode of bladder over distension can leads to irreversible damage to detrusor muscles. If there is large volume retention (>700 ml) a woman is more likely to need ongoing catheterization. Urinary retention is most likely to occur in the first 8 to 12 hours following delivery because of its onset may be slow and asymptomatic. The primary objective of this audit is to observe the current practice of postpartum bladder care in our unit and compare it with SLCOG guidelines. [June 2021]. In addition to that standardize practice for management of bladder cares postnatally and diagnose poor bladder emptying postnatally in a timely manner to avoid large volume urinary retention and prolonged voiding dysfunction. In the month of March 2022, we have come across two incident which we are unable to detect postpartum bladder distension early among 141 vaginal deliveries.

Objectives
The primary objective of this audit is to prevent postpartum bladder distension, if so early detection, intervention and observe the current practice of postpartum bladder care in our unit and compare it with SLCOG guidelines. [June 2021]. Guideline suggest documenting the time and volume of first void following delivery for the purpose of early detection of voiding disfunction. In addition to standardized practice for management of bladder care postnatally and diagnose voiding difficulties postnatally in a timely manner to avoid large volume urinary retention and prolonged voiding dysfunction.

Methods
This is a retrospective study which is conducted on mothers who delivered by vaginal delivery. In this study we checked all the bed head tickets (BHT) to see whether volume and time of first void are documented.

Results
Time and volume of first void were not documented in bed head ticket. After giving instruction during reaudit only 55.9% of bed head tickets found to have documented time and volume of first void.

Conclusion
Unit practice regarding postpartum bladder care is not up to the standard according to SLCOG guidelines. Finding of the reaudit recommend further improvement of documentation.

OP/O – 15

A CASE REPORT ON LATE PRESENTATION OF ACUTE FATTY LIVER DISEASE OF PREGNANCY WITH MULTI ORGAN FAILURE AND FRESH INTRAUTERINE DEATH

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Introduction
Acute fatty liver of pregnancy (AFLP) is a rare disorder of pregnancy. AFLP is a medical and obstetric emergency, which can lead to liver failure due to micro-vesicular fatty infiltration of hepatocytes. It usually occurs in the third trimester. Incidence of AFLP is reported to be 1/7,000 to 1/16,000 pregnancies. The Swansea criteria have been prospectively validated for the diagnosis of acute fatty liver of pregnancy when identifying six or more features in the absence of another explanation. Apart from liver failure, AFLP causes kidney failure, severe infection and other organ failures. These can be life-threatening for both mother and baby.

Case Presentation
A 26-year-old, Gravida 2, para 1, POA (32+0) weeks, with high risk factors of Type 2 DM, PIH, Class 1 Obesity BMI 34 kg/m^{-2}, was admitted with vomiting for 5 days, generalized body weakness and lower abdominal pain. She also complained mild suprapubic pain. On admission, Fetal movements were satisfactory. FHS was 158/min. On Examination, she looked ill, hemodynamically stable and urine albumin was nil.

Clinical picture was suggestive of acute fatty liver disease of pregnancy. Investigations supported Swansea criteria to be fulfilled with highly elevated liver enzymes, serum creatinine, APTT/PT. USS for fetal assessment revealed EFW of 2365 g with UAD with Good diastolic flow. Acute fatty liver disease in pregnancy was diagnosed and the patient was taken to ICU. Plan was to stabilize the mother, correct coagulopathy and delivery and further management. In the ICU, the patient was given 15 units of cryoprecipitate. During this time, the patient developed labour pain. Pain increased with time. USS was done to assess fetal wellbeing. In USS, No FHB was seen. Then, decision was made to allow the labour to progress. Fresh IUD male babywas delivered at 7.42 a.m. Retro placental clot of 150 ml was noted.The patient developed PPH following delivery despite the active management of third stage, which was managed with medical treatment initially followed by Bakri Catheter insertion. Bakri was removed on postpartum Day 01. Following delivery patient was developed to have the following complications such as Acute liver failure, Hepatic Encephalopathy (Stage ii), Coagulopathy (INR-3.2), AKI (K+-7.7 mEq/l), Sepsis (Blood Culture-Staphylococcus isolated), Hyperglycemia, Metabolic Acidosis, Electrolyte imbalance.She received multidisciplinary team management in the ICU for 10 days to correct each and every complication. After 10 days of ICU management, she was transferred to ward for further management where she stayed for further one week and discharged with milk suppression and long-term plan for management of diabetes and hypertension.

Discussion

Even though nausea and vomiting in pregnancy are common disorders, if any woman complains of vomiting in the latter half of pregnancy, clinicians should have high index of suspicion to exclude AFLP. Failure to detect AFLP may lead to severe complications and ultimately death of mother.

OP/O – 16

LOCAL INJECTION OF VASOPRESSIN REDUCES BLOOD LOSS DURING SURGERY FOR THE MORBIDLY ADHERED PLACENTA: CASE REPORT

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Introduction

The placenta accreta spectrum disorder refers to an abnormal invasion of part or all of the placenta into the myometrium or beyond. It has serious consequences such as antenatal, intrapartum and postnatal haemorrhages, requiring blood transfusion and emergency hysterectomies. Different methods are used to minimise blood loss during surgery, such as uterine massage, packing, compression sutures, devascularisation and Uterotonics. However, their effectiveness is questionable for placenta previa and accreta. Many gynaecologists use the local injection of vasopressin to uterine myometrium to decrease blood loss during myomectomies. Vasopressin is a known peripheral vasoconstrictor, which also contributes to myometrial contractions through V1α receptors. Injection of vasopressin to arrest haemorrhage from the placental bed can be used in surgeries for placenta accreta spectrum disorders.

Case Presentation

A 32-year-old woman with a previous emergency cesarean section was found to have placenta previa with placenta accreta. Placenta accreta was confirmed by 2D ultrasound scans, and an elective cesarean section was performed at 36 weeks of gestation. At the time of cesarean section, expectant management was done. The cord was ligated and cut near the placental insertion site, and the whole placenta was left in situ. The patient was kept under observation for possible internal bleeding and infections. Initially she was on Intravenous third generation cephalosporins for five days and then oral cephalosporins throughout. On postoperative day 07, She complained of generalised abdominal pain and vomiting. On examination, abdominal tenderness was noted, and the uterine size was 24 weeks. She was hemodynamically stable with normal vital parameters. Her haemoglobin count was 11 g/dl, and her CRP was high as 246 mg/dl. Intravenous antibiotics were started (Meropenem), and the patient was prepared for emergency laparotomy. Laparotomy was performed under general anaesthesia. During the surgery, high vascularity was noted in the vesicouterine pouch. Before dissection of the bladder, 1 ml (5 IU) of vasopressin diluted in 19 ml of normal saline was injected into the subserosal layer. It was noted that the bleeding was significantly reduced after the injection of vasopressin. A hysterectomy was performed, and she had an uncomplicated recovery.

Discussion

In a patient with placenta previa and placenta accreta, Profuse haemorrhage can occur after the separation of the placenta. Vasopressin can be injected into the placental bed and tissue planes to minimise blood loss during surgeries for placenta previa and accreta.

OP/O – 17

PERIPARTUM CARDIOMYOPATHY PRESENTING AS BRADYCARDIA IN TEENAGE TWIN PREGNANCY

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Introduction
Peripartum Cardiomyopathy in teenage twin mother who is presenting with asymptomatic bradycardia is rare. Timely diagnosis is necessary for good outcome.

Case Report
A 16-year-old primi mother underwent vaginal delivery for monochorionic diamniotic (MCDA) twin at the period of gestation of 36 weeks. Immediate postpartum period she was found to have low pulse rate of 46 beats per minute which was detected in Modified Early Obstetric Warning Score (MEOWS) chart. Her blood pressure was 140/80 mmHg. But she was free of symptoms. Her antenatal period was uncomplicated even though it was high risk pregnancy due to teenage monochorionic diamniotic twin pregnancy. Labour was spontaneous onset and it was progressed well. 1st twin was delivered via cephalic presentation and 2nd was breech delivery. Active management of third stage was performed. There was no postpartum haemorrhage. There was no past history of heart disease or hypertensive disorders. No family history of heart diseases. She was underweight. Haemoglobin was 12 g/dl. ECG showed sinus bradycardia. Her echocardiogram showed mild global left ventricular dysfunction with biatrial dilatation and ejection fraction was 45%. She was diagnosed as Peripartum Cardiomyopathy and managed with beta blocker, Angiotensin converting enzyme inhibitor, diuretics. Bradycardia was recovered gradually. Progesterone containing sub dermal long-acting reversible contraceptives method was offered. Cardiology follow up has been arranged.

Discussion
Peripartum cardiomyopathy (PPCM) is defined as idiopathic cardiomyopathy presenting with heart failure secondary to left ventricular systolic dysfunction towards the end of pregnancy or up to 6 months following delivery, where no other cause of heart failure is found. Afro-Caribbean lineage, Multiparity, multiple pregnancy, obesity, advanced maternal age and chronic hypertension are the risk factors for PPCM. Even though this patient had only multiple pregnancy as a risk factor, underweight and teenage are opposite to obesity and advanced maternal age respectively. Postpartum monitoring with MEOWS chart will be helpful to early detection of complications such as PPCM. Tachycardia is one of the red flag signs of heart failure in PPCM, but bradycardia can be present rarely like in this case.

Conclusion
PPCM can be presented with unusual signs as well like bradycardia. Postpartum monitoring with MEOS chart will be helpful for early detection of complications.

OP/O – 18
A CASE REPORT OF LIFE SAVING THERAPEUTIC PLASMA EXCHANGE IN HELLP SYNDROME

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Introduction
HELLP syndrome, can affect multiple organ systems & cause maternal and fetal mortality, is a serious complication of pregnancy characterized by microangiopathic hemolytic anemia, elevation of liver enzymes, and thrombocytopenia. The main treatment in HELLP syndrome is to stabilize the patient clinically prior to delivery & deliver the baby as much as earlier in severe cases. Platelet count returns

to normal within 24 hours in a majority of patients; however, a low platelet count may persist beyond delivery in some cases. LDH is another marker of hemolysis. These two parameters are used for follow-up of HELLP syndrome. we are reporting a case of successful outcome in therapeutic plasmapheresis in HELLP syndrome.

Case Presentation

A 30-year-old mother in her second pregnancy transferred from DGH Nawalapitiya at 23 weeks of gestation. First pregnancy has been ended up as a miscarriage in the first trimester. Her main complaint was one episode of tonic-clonic seizure associated with blood pressure of 160/110mmHg& severe generalized headache, 5 episodes of vomiting, poor oral intake, and reduced urine output. Her PR – 72 bpm, GCS – 15/15, T – 36.3 ^{0}C, SpO2–98% and reflexes were exaggerated. WBC – 11.61 x 103/µl and Hb – 11.4 g/dL, PLT– 39 x 103/µl, INR – 1.3, ALT – 338.7 IU/l, AST – 623 IU/l, Urine albumin – 4+ and Serum Creatinine – 122 mmol/l. Blood pressure (BP) was controlled with Hydralazine. $MgSO_4$ was administered. Intravenous (IV) Dexamethasone administered & USS revealed anhydramnios with a fetus of 332 g in weight. At Teaching Hospital Peradeniya, her BP was controlled with oral Labetalol and Nifedipine. A fresh stillbirth has been delivered by an emergency hysterotomy as cervix was unfavourable.

She was transfused multiple units of platelet and other blood products prior to and following the procedure. The MAHA characteristics were visible in the blood picture, and the LDH level was 930 IU/l. she was administered Methyl Prednisolone. She didn't show the expected rise in increased platelet count and a decreased in LDH level, despite six units of platelets & FFP transfusion and delivery of the baby. After a multidisciplinary meeting a decision was made for therapeutic plasma exchange. Following three therapeutic plasma exchange cycles PLT count began to rise & LDH level dropped to normal range. She was discharged with oral antihypertensive on day 10 of the surgery after all hematological and biochemical indicators returned to normal. APLS screening was arranged after 6 weeks of delivery.

Discussion

Intravascular hemolysis and thrombocytopenia almost always resolve spontaneously within a few days after delivery. Theories regarding the rapid resolution of these patient's persistent disease after plasmapheresis include removal of an endothelial toxin, interruption of an ongoing cascade of auto endothelial injury, or replacement of a necessary substance that inhibits endothelial damage.

Conclusion

Severe eclampsia is associated with low platelets & high LDH despite adequate transfusions. So therapeutic plasma exchange is a lifesaving treatment modality which is recently introduced.

OP/O – 19

PRE-OPERATIVE ANDPOST-OPERATIVE CHALLENGES OF PLACENTA ACCRETA SPECTRUM (PAS): A CASE REPORT

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Introduction

Placenta accreta spectrum (PAS) is a severe complication in pregnancy which is a common indication for emergency peripartum hysterectomy due to massive postpartum haemorrhage. This condition is associated with high degree of morbidity and mortality secondary to severe haemorrhage, disseminated intra vascular coagulation (DIC) and multiorgan failure. The mortality rate is very high unless prompt and timely interventions are taken during the management process. The number of cases of PAS are rising due to the increasing rate of caesarean deliveries. Proper antenatal diagnosis, preoperative preparation and planning of delivery with multidisciplinary approach are pivotal for management of such cases as they

carry high rate of morbidity and mortality. The main aim of this case discussion is to share the experience of some per-operative and post-operative complications and challenges which can develop in cases of placenta accrete spectrum.

Case Presentation

38-years-old mother of two children with past two caesarean deliveries, was diagnosed to have anterior major degree placenta previa during her routine ultrasound scan at 22 weeks of gestation. Repeated ultrasound scans done by the consultant radiologist at POA of 28, 32 and 36 weeks, suggested the possibility of placenta increta or percreta. She was provided with multidisciplinary care and at 37 weeks of gestation she underwent planned caesarean section (classical), B/L internal iliac artery ligation and subtotal hysterectomy respectively as the diagnosis was confirmed at the time of surgery. Two hours from initial surgery patient developed significant vaginal and abdominal bleeding which was thought to be from the cervical stump where placental vessels infiltrated. Following resuscitation abdomen was opened up and remaining part of the cervix was removed with difficulty. As an additional haemostatic measure abdominal packs were inserted and kept for 48 hours under ICU care.

There was no significant bleeding after removal of packs but patient suddenly became desaturated and collapsed at the theater.Poor ventilation to left lung was noted and vigorous resuscitation was done with maintenance of ventilation and blood transfusion. Patient recovered from the collapsed state but air entry to left lung was poor. Subsequent chest X-ray showed large plural effusion in left lung which the reason was unexplained. Plural tap was done which revealed a blood-stained effusion. Subsequently patient made a remarkable recovery.

Discussion

The most important step of management of PAS is antenatal diagnosis, or the antenatal risk assessment of PAS and take necessary precautions to optimize the management. All the cases of placenta previa or lower lying placentas especially with previous caesarean sections should be reviewed and reassessed in 3rd trimester with the opinion of a consultant radiologist to assess the risk of PAS. According to FIGO, the standard treatment for placenta accreta is subtotal hysterectomy with placenta left in situ after delivery of the fetus by a vertical incision avoiding the placental attachment site.

A better option to counteract the blood loss during the surgery is ligation or embolization of bilateral internal iliac arteries prior to hysterectomy. On the other hand, placenta increta and percreta may require total hysterectomy to achieve good hemostasis as there could be placental vessel infiltration of the cervix. However total hysterectomy is a challenging task which can cause intense bleeding and leads to complications such as ureteric and bladder damage. Therefore, Subtotal hysterectomy is recommended for most cases of PAS but before closure of abdomen significant vaginal bleeding should be excluded. In case of vaginal bleeding total hysterectomy is advisable without further observation to prevent catastrophic bleeding. Additionally, Injection of vasopressin to the vascular area of the lower segment in placenta percretamay reduce the blood loss.

Conclusion

Antenatal diagnosis, planning of delivery with multidisciplinary team approach, prompt and timely interventions and intensive post-operative care is the key to success in cases of PAS otherwise can lead to high morbidity and mortality

OP/O – 20

RARE CASE OF LIVE BIRTH OF CLASSICAL ISCHIOPHAGUS CONJOINED TWINS COMPLICATING PREGNANCY

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Introduction
Conjoined twins are a unique complication in monochorionic twin pregnancies, which occurs due to partial separation of amnios leading to physically connected embryos. Usually, it occurs due to separation of zygote after 12days of fertilization. Most often they are connected by chest, abdomen, pelvis, spine, trunkand head, with sharing internal organs. Ischiophagus twins are joined at pelvis, either face to face or back-to-back. Incidence of conjoined twins are 1.5 per 100,000 births and about 50% are live births. It can be screened and diagnosed by obstetric ultrasonography while magnetic resonance imaging aids the diagnosis.

Case Presentation
A 35-year-old second gravida mother with unplanned pregnancy presented at16 weeks of gestation for booking visit. On clinical examination she was found to have a fundus more than her period of gestation and obstetric ultrasound scanning suspected fused monochorionic mono-amniotic twins. Therefore, the mother was referredfor departmental ultrasound anomaly scan to ruled out conjoined twins. It showed conjoined twins fused with lower spine and pelvis, with a single bladder. Foetal MRI revealed fused spines below the lower lumbar vertebral level, sharing a single bladder and an anus. Neonatology and paediatric surgical opinion were taken at 26 weeks of gestation. With the multidisciplinary team involvement, the delivery was planned to be done at 34 weeks of gestation via an elective caesarean section. From 26 weeks of gestation, the patient had been reviewed 2 weekly at antenatal clinic until delivery.

At 34 weeks, she was admitted to prenatal ward and delivery was done by an elective caesarean section. Both babies were well and cried at birth and handed over to neonatology team. Babies stayed in preliminary baby care unit until their feeding get established and the weight gain get improved. Same time Paediatric surgical management started. They have undergone MRI scan during PBU stay and found to have a fused lower spine and an anus, with malformed bladder in one twin. Their surgical separation was planned to be done after 2 years of age with neobladder formation and anal reconstruction for one twin.

Conclusion
Conjoined twins are rare and unique complication of monochorionic twins. Multidisciplinary team approach was important to improve the pregnancy and infant outcome.

OP/O – 21
AUDIT ON PRESENTING PERIOD OF AMENORRHOEA FOR DATING SCAN AT DISTRICT GENERAL HOSPITAL MATALE

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Introduction
Dating ultrasound scan is done to confirm the estimated date of delivery. It should be ideally performed between 10 to 13+6 weeks of gestation using Crown-Rump Length (CRL) of the fetus(45 - 84 mm). In Sri Lankan setting it is done in Base Hospitals or above where consultant obstetricians are available. Even though Ultrasound dating can be done at second trimester, accuracy remains high during first trimester between 10 to 13+6 weeks of gestation using CRL.

Objectives
To audit the proportion of pregnant mothers attending the dating scan at 10 to 13+6 period of amenorrhoea to the antenatal clinic, District General Hospital Matale for dating scan.

Method
Data collection was done on mothers at antenatal clinic, District General Hospital Matale, attending for the dating scan from June to August 2022 over 10weeks period. Mothers with live pregnancies coming for dating scan, who are giving consent, were recruited for the study.

Their presenting POA to the dating scan was documented and compared with standard. (10 to 13+6 weeks POA).

Results
94 antenatal mothers were recruited for the study. 46 (48.9%) of them presented to the dating scan at correct period of amenorrhea (10 to 13+6weeks of POA).19 mothers (20.2%) presented after 14 weeks, and their dates were confirmed using head circumference (HC). 29 mothers (30.8%) presented to dating scan before 10 weeks of POA and considerable number of those mothers were between 7-8 weeks and sent back home giving second date for the dating scan.

Conclusion
Even though recommended POA for the dating scan is 10 to 13+6 weeks, many antenatal mothers (51.1%) are not presenting at recommended POA, due to delayed diagnosis of pregnancy, delayed presentation to field clinics, social & economic issues, irregular menstrual cycles, contraceptive failures and lack of awareness of importance of dating scan. Therefore, preconceptional counselling of eligible mothers regarding the importance of dating scan at recommended POA, advice on correct use of contraception and diagnosis of pregnancy and reporting to the field mid-wife at an early gestation are vital in the estimation of ultrasound calculated expected date of delivery.

OP/O – 22

ASSESSING RECOMMENDED USE OF PRE-CONCEPTIONAL FOLIC ACID AMONG MOTHERS ATTENDING ANTENATAL CLINIC AT DISTRICT GENERAL HOSPITAL MATALE (AUDIT REPORT)

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Introduction
Preconceptional use of folic acid reduces the occurrence of neural tube defects as well as it is a vital element requiring for nucleic acid synthesis, cell division, fetal growth, hemopoiesis and wide spectrum of functions. Even though during pregnancy women are advised to take 400 µg of folic acid at least 1 month before the conception, high risk mothers such as previous pregnancy complicated with neural tube defects, obesity, epilepsy on anticonvulsants, chronic diabetes and using antifolate medications are advised to take folic acid 5 mg daily at least 1 month prior to pregnancy and until 12 weeks of gestation.

Objectives
To audit the proportion of women taking correct dose and duration of folic acid during pregnancy and preconceptional period, attending the antenatal clinic at District General Hospital Matale.

Method
Data collection was done at antenatal clinic at District General Hospital Matale, among pregnant mothers attending for the booking visit, referred by field clinics from June to August 2022 over 10 weeks. Underlying risk factors, dose and duration of folic acid supplements were taken into consideration. Data analysis was done using SPSS software.

Results
Over 10 weeks of period 101 of pregnant women were recruited for the study. Out of that 63 (62.3%) of women taken folic acid in recommended dose at least 1 month prior to pregnancy. 25 (24.7%) women

started taking folic acid after the diagnosis of pregnancy at first trimester and 13 (12.8%) women took folic acid after first trimester, mainly due to uncertain dates and unplanned pregnancies.

Conclusion
Even though folic acid is recommended to be taken at least 1 month before the conception, considerable proportion of women attending to antenatal clinic at DGH – Matale have not taken folic acid due to unplanned pregnancies, poor educational and socio-economic back-ground and contraceptive failure. Therefore, counselling of eligible couples regarding the importance of preconceptional folic acid should be emphasized and strengthened further.

OP/O – 23

SUCCESSFUL PREGNANCY OUTCOME FOLLOWING PREGNANCY COMPLICATED WITH SEVERE COVID PNEUMONIA REQUIRING ICU CARE IN A BACKGROUND OF CLASS III LUPUS NEPHRITIS

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Introduction
Covid pneumonia is the most common cause of maternal deaths in 2021 in Sri Lanka. Covid 19 infection can be more severe in obstetric patients due to pregnancy associated hemodynamic changes, immunomodulation, respiratory and renal changes. Even though covid 19 infection can leads to minor consequences, covid pneumonia can leads to devastating feto-maternal morbidity. Covid 19 immunization by vaccination seems to be minimized the risk of feto-maternal morbidity and mortality associated with covid 19 infection.

Case Presentation
A 34-year-old diagnosed patient with systemic lupus erythematosus complicated with class III lupus nephritis and hypertension, had been on regular nephrology and medical follow-up, presented to the covid maternal ward at 33 weeks of pregnancy with fever, upper respiratory tract symptoms and positive rapid antigen for covid 19 infection, at day 3 of illness. She had taken 1st dose of covid 19 vaccine prior to the pregnancy. On admission the patient was hemodynamically stable and fetal well-being was satisfactory. At the day 5 of illness patient was started to deteriorate. Her arterial oxygen saturation was 90-92% on air and was started on face mask oxygen and routine covid pneumonia treatment regime with ceftriaxone, Tamiflu, enoxaparin anddexamethasone. Chest X-ray showed mild to moderate changes. At the day 7 of illness, while on face mask oxygen the patient was further deteriorated, and her repeat chest X-ray showed severe covid pneumonia changes. As patient was tachypnoeic and desaturating she was started on high flow nasal oxygen and baby was delivered by emergency caesarean section and admitted to the ICU for immediate postpartum monitoring. At postpartumday 2 (the day 9 of illness), while on high flow nasal oxygen the patient was desaturated, and the repeat chest X-ray showed further deterioration with bilateral pleural effusions. Therefore, the patient was intubated and invasively ventilated. The patient started to improve by the day 12 of illness and transferred to ward by the day 15 of illness. She was discharged after the day 21 of illness. During the acute state her renal and coagulatory functions, inflammatory markers were monitored closely and corrected accordingly with renal replacement therapy, blood and blood products, inotropes, immunoglobulins and other relevant measures.

Conclusion
Covid pneumonia in pregnancy is a challenging condition and if the patient is having serious medical comorbidities, it can be even more challenging. It is associated with significant risk of fetomaternal

morbidity and mortality, and can be minimized by multidisciplinary approach, close monitoring and timely interventions.

OP/O – 24

RETROSPECTIVE ANALYSIS OF ASSESSING THE CAUSATIVE FACTORS OF DEVELOPING CEREBRAL PALSY AMONG CHILDREN ATTENDING TO PULMONOLOGY CLINIC AT SIRIMAWO BANDARANAYAKE SPECIALIZED CHILDRENS HOSPITAL, IN AN OBSTETRICS POINT OF VIEW

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Introduction

Cerebral palsy is a neurological disorder due to non-progressive brain injury or a malformation that primarily affects motor control, cognitive behaviour and speech. World prevalence of cerebral palsy ranges from 1 to 4 per 1000 live births. Even though this is a childhood disorder, majority of children acquire the primary insult during their antenatal period. Hence studying on possible causative factors which are related to antenatal management will be extremely important to prevent this lifelong disability.

Objectives

Aim of this study is to assess the proportion of children who developed cerebral palsy secondary to obstetric complications and to analyze them according to the time of delivery, mode of delivery, birth weight, maternal complications and postnatal complications including PBU admissions, neonatal jaundice and sepsis.

Method

This is a retrospective observational study conducted among the children with cerebral palsy, who are attending to Pulmonology clinic at Sirimavo Bandaranayake Specialized Children's Hospital, Peradeniya. Patients' information from data base of Pulmonology Unit, from June 2020 to June 2022 had been utilized for this study. All the children with cerebral palsy registered in pulmonology clinic were included in the study excluding the children with no previous clinical records. The data was analyzed using SPSS software.

Results

During this 24-month period, 96 children with cerebral palsy were registered in the pulmonology clinic. Among them 6 children were excluded from the study due to loss of previous medical records. Out of 96 children, 90 children were recruited for the study, of which 56 (62.2%) cases were related to antenatal and intrapartum events, and 28 (31.1%) cases were associated with postnatal, neonatal, infantile and other pediatric causes. No obvious cause was identified in 6 (6.67%) cases. 51 (56.7%) children were delivered at term and 39 (43.3%) children were preterm. When analyzing the mode of delivery, 43 (47.8%) children were delivered vaginally and out of those 26 (28.9%) deliveries were assisted with forceps or vacuums. 47 (52.2%) children were delivered via cesarean section and out of that 33 (36.7%) were emergency sections. 32 (35.6%) pregnancies were complicated with maternal diseases such as antenatal infections, hyperglycemia and hypertension. 47 (52.2%) cases had low birth weight which is less than 2500 g, 32 (35.5%) had birth weight of less than 1500 g and 17 (18.9%) cases had birth weight of less than 1000 g. 64 (71.1%) cases had stormy neonatal period with PBU admissions due to neonatal sepsis, jaundice, prematurity and other reasons. 42(46.7%) cases were associated with labour complications such as forceps or vacuum deliveries and emergency sections due to lack of progress, prolonged labour or cord accidents. Out of 56 cases, 30 (53.6%) were related to obstetric causes which were possibly preventable.

Conclusion
Nearly two third of cerebral palsy cases are associated with obstetric events including antenatal and intrapartum complications. Significant proportion of cerebral palsy cases related to obstetric events which could be prevented with timely intrapartum interventions and frequent monitoring.

OP/O – 25
AUDIT OF EXTERNAL CEPHALIC VERSION

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Introduction
In term deliveries, 3-4% is complicated by breech presentation and more than 85% of pregnant women with a persistent breech presentation are delivered by cesarean. The safest mode of delivery for breech presentation is still debatable. The Term Breech Trial1 found Caesarean section was associated with reduced risk of perinatal morbidity and mortality. Since the publication of this trial there has been increased in incidence of Caesarean Section (CS) for breech presentation. Over time, caesarean section rates in Sri Lanka have been increasing. National data reveals that CS rates had risen from 34.5% in 2015 to 43% in 2021. One study concludes that according to the current trend, 50% of all births will occur through CS in Sri Lanka, by the year 2025. Further rising CS rate imposes an unnecessary economic cost on the country with limited resources for in an already financially stretched health care system. In Sri Lanka one single center study indicates CS for primi breech is 77%, and for multi breech is 36%. There are strategies developed to reduce CS, especially primary CS. External cephalic version (ECV) is a manoeuvre where appropriate pressure is applied around the mother's abdominal wall aiding the breech fetus into a cephalic position.

A review of strategies to reduce caesarean section rates identified ECV as the only clinical intervention with demonstrated Level 1 evidence for reducing primary caesarean section rates overall (Walker 2002). Now it's clear ECV at term reduces non-cephalic presentation at delivery hence CS rates.The rate of attempted external cephalic version was at a lower rate of 46%. External cephalic version for fetal breech presentation is likely underutilized, especially when considering that most patients with a successful external cephalic version will give birth vaginally. The purpose of this study is to audit antenatal detection of breech presentation, proportion of women with a breech presentation offered ECV, success rates of ECV, complications of/after ECV, mode of delivery after successful ECV.

Method
This is a prospective study that included all ECV performed during January 2022 to July 2022 in a tertiary healthcare centre's single obstetric unit. After 36 completed weeks of gestation, a total of 12 pregnant women were identified with breech presentation were included into the study. Three were primi and 9 were multipara. USS was done along with fetal biometry; liquor volume was assessed and the type of breech was identified. Following the exclusion of contraindications for ECV, informed verbal consent was taken for the procedure. It was carried out by a single operator under the direct supervision of the obstetrician. Prior to the procedure, CTG was done to establish a baseline for fetal activity. USS guided ECV was done followed by post procedure CTG. The patients were kept in the ward for 24 hours under observation and discharged. Further details were collected from labor room registry after delivery and analysed using excel sheet.

Results
1. Antenatal detection was 100%
2. 100% of women with breech was offered with ECV.
3. Success rate of ECV was 66% and 88% in primi and multi respectively.

4. No complications during or after procedure
5. Most women delivered vaginally (93%) after successful ECV. Recommendations
1) Every woman with breech should be offered ECV if there are no contraindications
2) Do a survey of maternal perception on ECV
3) Design a multilingual consent form specific to the procedure
4) ECV paves the way for a third delivery option by avoiding vaginal breech delivery or caesarean section and therefore acquiring the skills for this procedure is highly valued in post graduate training of obstetricians.

OP/O – 26
RECURRENT, SEVERE POLYHYDRAMNIOS? BARTTER SYNDROME

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Introduction
Polyhydramnios affects 1-2% of singleton pregnancies. Maternal diabetes and congenital anomalies are responsible for 8.5% and 20% of the cases respectively. Most of the mild cases are idiopathic. 80% of pregnancies with severe polyhydramnios are associated with structural fetal anomalies. Recurrent polyhydramnios is reported 1 in 1700 pregnancies. Early diagnosis, assessment of severity and underlying pathology are important to take necessary measures to prevent complications. We report a rare case of recurrent severe polyhydramnios due to Bartter syndrome (BS) of the fetus.

Case Presentation
A 29-year-old woman in her 5th pregnancy was diagnosed with severe polyhydramnios in an anomaly scan at 20 weeks of gestation. AFI was 36 cm. Fetal or placental anomalies were not detected. Maternal hyperglycaemia was excluded. The blood group was AB positive. She was immunized for Rubella. VDRL was non-reactive. No evidence of other congenital infections is noted. Family history of neuromuscular disorders were excluded. Her 4th pregnancy was complicated with severe polyhydramnios and PPROM. BS was suspected postnatally. Severe, early onset polyhydramnios in current pregnancy in the absence of obvious pathology increased the suspicion of BS. She was managed with the collaboration of a fetal medicine specialist and a neonatologist. Therapeutic amnioreduction is done due to severe maternal distress. Indomethacin started 50 mg twice daily. Baby is delivered vaginally with a birth weight of 1.5 kg following PPROM at 32 weeks.

The baby was found to have severe hyponatremia (Na+- 106.3 mmol/L) hypokalemia (K+ - 2.28 mmol/L) hypochloremia (Cl^- - 89.3 mmol/L) and metabolic alkalosis. Urine analysis confirmed salt wasting which is compatible with the clinical diagnosis of BS. Baby was managed with electrolyte replacement and Indomethacin.

Discussion
BS is a very rare autosomal recessively inherited disorder affecting salt reabsorption at the nephron. The incidence is 1 in 100000. Genetic studies for the mutation are 100% diagnostic. No conclusive evidence is found on prenatal diagnosis and little information available on is the disease progression.

Conclusion
Evaluation for polyhydramnios depends on the gestational age, severity, and the presence of fetal anomalies. Recurrent early onset severe polyhydramnios in the absence of other causes increases the suspicion of an underlying genetic disease. Amnioreduction should be considered only for severe maternal discomfort. Although indomethacin has some effect on reducing fetal urine production, its use is not recommended with the sole purpose of reducing AFV.

OP/O – 27

A CASE REPORT OF ACUTE FATTY LIVER OF PREGNANCY WITH ENCEPHALOPATHY, ACUTE KIDNEY INJURY, DISSEMINATEDINTRAVASCULAR COAGULOPATHY AND ACUTE RESPIRATORY DISTRESS SYNDROME

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Introduction

Acute fatty liver of pregnancy (AFLP) is a rare, life-threatening emergency, due to excessive accumulation of fat in the liver cells, usually affecting in third trimester or postpartum period. AFLP is common in first pregnancy, multiple pregnancies and pregnancies carrying a male fetus. Exact pathophysiology is remaining unclear. In some cases associated with defective mitochondrial fatty acid beta-oxidation in the fetus.AFLP is associated with complications, such as: disseminated intravascular coagulopathy (DIC), hepatic encephalopathy, and acute kidney injury (AKI).

Case Presentation

A 31-year-old primi gravida with dichorionic diamniotic twins, who was transferred from base hospital due to elevated liver function test and coagulopathy at 35+5 weeks of gestation. She admitted with a history of abdominal pain, jaundice and loss of appetite at 34 weeks. She was diagnosed with pregnancy induced hypertension at 25 weeks, was on nifedipine. On examination she was drowsy and icteric. Her investigation revealed, Haemoglobin - 12.3 g/dl, Platelet count - 136,000/mm3, Elevated liver enzymes (SGOT-238 IU/l, SGPT-211 IU/l), Serum creatine - 158 µmol/land evidence of coagulopathy (INR-1.8).Her capillary blood sugar was 52 mg/dl and urine albumin was negative. Ultrasound abdomen showed grade 1 fatty liver without any hepatomegaly or biliary obstruction. Hepatitis screening was negative. Emergency caesarean section was performed after correction of coagulopathy with FFP and cryoprecipitate. During post operative period, she was in AKI with low urine output, she was dialysed, and six cycles of plasma exchange had to be carried out to correct it. She was intubated on day two of ICU admission due to acute liver failure complicated with hepatic encephalopathy leading to low GCS level. After four days, extubation was failed and kept on controlled mechanical ventilation for another nine days due to acute respiratory distress syndrome. Her blood culture was positive for acinetobacter which required prolonged intravenous antibiotic therapy. Meanwhile other supportive therapy was implemented including physiotherapy, nutritional support and psychological support. Her liver and kidney function returned to normal, and she was discharged on day 32.

Discussion

AFLP has high maternal and perinatal mortality. Delayed diagnosis is associated with more complications and high mortality.Diagnosis of AFLP is difficult due to vague symptoms and misdiagnosis with other diseases such as preeclampsia and HELLP. Diagnosis is based on the Swansea criteria. Multi-disciplinary team (MDT) should be involved for management.The definitive management is delivery of the fetus and supportive therapy.

Conclusion

Early diagnosis, prompt termination of pregnancy and MDT involvement is necessary for better maternal and fetal outcomes.

OP/O – 28

TRANSABDOMINAL CERVICAL CERCLAGE AND PREGNANCY OUTCOME- TWO CASE REPORT

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Introduction
Cervical incompetence is defined as the inability of the uterine cervix to retain a pregnancy in the absence of uterine activity or ruptured membranes in the second trimester. The incidence is 0.5% to 1% of pregnancies and 30% risk of recurrence. Recommended treatment is therapeutic or prophylactic cervical cerclage. However, in some women, vaginal cervical cerclage cannot be performed due to anatomical cervical distortions due to congenital or acquired causes. For those women, transabdominal cerclage can be considered.

Case Presentation 1
A 31-year-old gravida 5 para 0, who has a history of four second trimester miscarriages between 15 to 19 weeks' gestation, and last two pregnancies were managed by vaginal cervical cerclage. Preconceptional transabdominal cervical cerclage has been placed and she spontaneously conceived after one month. Since 23 weeks, she had recurrent hospital admissions due to per-vaginal bleeding. Live baby (weight 1.8 kg) was delivered by emergency cesarean section at 32 weeks due to preterm labour.Postpartum period was uncomplicated.

Case Presentation 2
A 35-year-old gravida 6 para 5, with history of three second trimester fetal loss between 20 to 23 week of gestation and two preterm labours at 25 and 27 weeks with two neonatal deaths, underwent transabdominal cerclage at 12 weeks of gestation due to very short cervix and previous failed vaginal cerclage.She admitted to ward due to per-vaginal bleeding at 24 weeks. Emergency hysterotomy was done at 27 weeks due to suspected chorioamnionitis. Abdominal cerclage was also removed due to infection. Baby died at two days of age.

Discussion
If the woman has short cervix due to congenital or iatrogenic causes and history of failed vaginal cerclage, transabdominal cerclage is more beneficial, as higher placement of cerclage at cervicoisthmic portion provides better support. Other advantages are low risk of suture migration, and ability to leave it in situ for next pregnancy.It can be placed preconceptionally or post conceptionally by either laparoscopy or laparotomy which depends on the time that the patient presents. There is limited evidence regarding management of second trimester complications, such as intrauterine infection, fetal loss and prelabour rupture of membrane. Usually, the delivery is done by caesarean section after 37 weeks or immediate delivery when goes to labour or complications.

Conclusion
Transabdominal cerclage is more preferred in special situations, such as difficulty in insertion of vaginal cerclage or in failed vaginal cerclage. Outcome is dependent on patient selection, proper counselling, timing of insertion and technique used.

OP/O – 29
AUDIT ON DIAGNOSIS AND MANAGEMENT OF SPONTANEOUS PRETERM BIRTHS AT A TERITARY CARE HOSPITAL.

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Objectives
To audit the diagnosis and management of women who underwent spontaneous preterm delivery at University Hospital Kotelawala Defense University (UH KDU).

Method
Data on all spontaneous preterm births delivered between 28 to 36+6 weeks at UH KDU were collected retrospectively during the period of 1st of June 2021 to 30th June 2022. Demographic details, antenatal risk factors, data on clinical diagnosis, management and neonatal outcomes were collected. Findings were compared with National Institute of Clinical Excellence (NICE) guidelines on preterm birth.

Results
From 1883 deliveries during the study period 38 (2.01%) were spontaneous preterm deliveries. The mean age was 30.6 (± 5.9) years. Majority were primigravidae (42.1%). Of the deliveries 28 (73.6%) were late preterm (34 to 36+6weeks), 7 (18.4%) were moderate preterm (32 to 33+6weeks) and 3 (7.8%) were early preterm (28 to 31+6weeks) births. There were 2 (5.3%) uterine anomalies, 2 (5.3%) urinary tract infections, 2 (5.3%) covid in pregnancy, 5 (13.1%) hyperglycemia in pregnancy, 1 (2.7%) previous preterm delivery, 1 (2.7%) low BMI and 1 (2.7%) multiple pregnancy. 28 (73.6%) had preterm pre labour rupture of membranes. Cervical surveillance, prophylactic vaginal progesterone or prophylactic cervical cerclage were not used in the single patient with a history of previous preterm delivery. Cervical length measurement was used in only 1 (11%) of the 9 indicated to facilitate diagnosis. Regarding management of preterm labour from those indicated for treatment according to NICE guidelines only 1 (10%) had tocolysis, 22 (100%) received corticosteroids, 2 (16%) received $MgSO_4$ and only 27 (71%) received antibiotics. 11 (28.9%) received corticosteroids despite being late preterm. There were no in uterine transfers. 5 (13.1%) were treated for maternal sepsis. 14 (36.8%) underwent emergency caesarean section. Cord gases at delivery were abnormal in 7 (17.9%). Mean birth weight was 2.29 (±0.48) kg and 13 (34.2%) required neonatal intensive unit care. There were 2 (5.3%) neonatal deaths both early preterm.

Conclusion
Use of cervical length to assess spontaneous preterm birth was suboptimal. Administration of $MgSO_4$, antibiotics and tocolytics were suboptimal. Use corticosteroids was satisfactory. Overuse of corticosteroids and tocolytics were noted. After educating team members, a reaudit will be performed in 6 months.

OP/O – 30

AN AUDIT – THE MODIFIED OBSTETRIC EARLY WARNING SCORE AND ITS USE IN POST PARTUM MOTHERS IN COLOMBO NORTH TEACHING HOSPITAL, RAGAMA, SRI LANKA

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Introduction
The Modified Obstetrics Early Warning Score (MOEWS) used in Colombo North Teaching Hospital, Ragama - is a system implemented in order to decrease maternal morbidity and mortality in postpartum mothers. It monitors vital physiological parameters "tracks and triggers" allowing early recognition and thus management of patients who are clinically deteriorating.

Objective
The objective of the audit is to assess the proper maintenance of MOEWS in postpartum mothers.

Method
A retrospective analysis conducted between January and May 2022, of 99 postpartum mothers in ward 17 of CNTH Ragama, using their MEOWS charts. The recordings of the parameters at time intervals 1st and 2nd hour postpartum (immediate postpartum) were assessed.

Results

Themean age of the study population was 28.5 years with mean age of gestation being 38.6weeks. The demographic details and other identification details of patients were present in all charts. Documentation immediately after delivery was satisfactory with the recording of heart rate (HR), Systolic blood pressure (SBP), Diastolic blood pressure (DBP) being 95% and Respiratory Rate (RR) being 92 (92.9%). Only 90(90.9%) had temperature and 89 (89.9%) had oxygen saturation documented. Recording of Neurological status was substandard with only 64 (64.7%) documentations in addition to the pain score and urine output, which was only recorded in 72 (72.7%) and 70(70.7%) charts respectively. Total number of yellow and orange scores were documented only in 68(68.8%).

Conclusion

Even though the main vital parameters were properly monitored and documented, overall the maintenance of MEOWS chart was not satisfactory. A lecture is scheduled for the healthcare staff of the ward in order to highlight the importance of proper maintenance of MEOWS chart as a cost-effective bedside screening tool. Assessment of the knowledge and attitudes of nursing and midwifery staff prior to the lecture and afterwards as well as a re-audit later is planned to assess the improvements following the programme.

OP/O – 31

GROWING BURDEN OF CAESAREAN DELIVERY- EVIDENCE FROM LARGE SCALE SAMPLE SURVEY IN INDIA

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Background

Caesarean section (CS) delivery rate has increased significantly both globally and within India posing a burden on overstretched health systems.

Methodology

Analysis of secondary data (National Family Health Survey) of a nationally representative sample of 230,870 women (year 2019-21) was undertaken to explore the trends, distribution, and determinants of CS deliveries in India and within states. Multivariable analyses were performed to determine the proximate variables associated with CS and elective CS. The relative interaction effect of confounding factors such as number of ANC visit, place of residence and wealth status on cesarean delivery were assessed. A composite index was generated using trust, support and intimate partner violence variables named as partner human capital index (PHI) to study its influence on CS deliveries. State wise spatial distribution of most significantly associated factors namely wealth quintile and ANC checkups were also analyzed.

Results

Overall prevalence of CS is 21.4% which had risen from 6.6% in 1998-99. The adjusted odds of CS deliveries were significantly higher among women who were highly educated (OR:7.30; 7.02 - 7.60), with four-or-more ANC visit (OR: 2.28; 2.15 - 2.42), belonging to high wealth quintile (OR:7.87; 7.57-8.18), and from urban region. Increasing educational attainment of the head of the household (OR: 3.05; 2.94 - 3.16) was also found to be a significant determinant of CS deliveries. The odds of selection in cesarean delivery based on elective and emergency were also significantly higher among richer (OR: 1.66; 1.25-2.21), and women belonging to Christian religion (OR: 1.67; 1.14-2.43). Adjusting the cesarean delivery by PHI, the odds of outcome were significantly higher among the women with moderate and high PHI compared to their counterpart women with low PHI (OR:1.46; 1.36 - 1.56& OR:1.61; 1.49 - 1.74

respectively, p<0.001). The interaction effect of confounding factors confirms that the women with more than 4 ANC checkups, high PHI and belonging to richer wealth quintile were more likely to undergo cesarean delivery (OR: 22.22, p<0.001) compared to those with no ANC visit, low PHI, and poorest women.

Conclusion

Increasing trend of CS deliveries across India is raising concerns. Better education, wealth and good partner's support have been incriminated as the contributory factors. There is a need to institute proper monitoring mechanisms to assess the need of CS, especially when performed electively. Also, underutilization of CS among poorer, less educated women with lower PHI raises serious concerns about access to a life-saving procedure.

OP/O – 32

COARCTATION OF THE ABDOMINAL AORTA IN PREGNANCY, IS A RARE CAUSE OF SEVERE RESISTANT HYPERTENSION DURING PREGNANCY

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Introduction

1 : 2000-3000 women are affected by Coarctation of the aorta (COA).It is a rare cause of severe resistant hypertension among pregnant women.Clinical manifestations of this condition are highly variable and depend on the location and extent of obstruction and the presence of associated cardiac anomalies. On most occasions, early diagnosis and operative treatment result in decreasing numbers of women reaching their reproductive years with untreated coarctation. Morbidity and mortality are very high in the population in which COA undiagnosed or has not been surgically corrected for both mother and fetus. Maternal complications which include hypertensive crisis, congestive heart failure, cerebral infarction, aortic dissection, aortic rupture, and infective endocarditis as well as pre-eclampsia and eclampsia. Fetal complications include fetal growth restriction and premature birth with increased risk for placental ischemia or abruption with uncontrol hypertension.We present a case of coarctation of the aorta which was first diagnosed during pregnancy and managed successfully throughout the pregnancy.

Case Presentation

A 22-year-old primigravida with a period of gestation (21+3) weeks pregnant with young hypertension + Left ventricular dysfunction during pregnancy, was found to have a blood pressure of 200/90 mm Hg in a peripheral hospital and transferred for further management. Hypertension was initially managed with Nifedipine Labetalol and Methyldopa. She was referred to cardiologist and Echocardiography showed a non-dilated, concentric left ventricular hypertrophy with ejection fraction >60% good systolic function, and a trivial AR, normal aortic and narrowing of descending thoracic aorta and abdominal aorta small with a diameter of 0.6 mm. She was managed inward throughout the antenatal period and several Multidisciplinary team meetings were held and decided to extend the pregnancy beyond 32 weeks while closely monitoring for signs of pre-eclampsia.When reaching the early 3rd-trimester needed the maximum doses of antihypertensives. Therefore, decided to terminate the pregnancy at 31 weeks of gestation. CT aortogram was performed post-partum period, showed long segment narrowing of the lower thoracic and abdominal aorta up to aortic bifurcation.With the CT aortogram, referred to vascular surgical opinion and planned for surgical corrections after the post-partum period.

Discussion
The optimal management of COA in pregnancy is unclear because the evidence in the current literature is limited. Therefore, close monitoring and individualized blood pressure control and arranging multidisciplinary care in a tertiary obstetric center to guide management and monitoring are essential.MRI aortogram can diagnose abdominal coarctation because it is not invasive and does not use ionizing radiation and is the procedure of choice in pregnancy since it provides better visualization intra-abdominally and retroperitoneally.It is essential to have a serial echocardiogram for surveillance of aortic root dilationand myocardial contractility and functions.Surgical management of COA includes balloon angioplasty alone, transcatheter stent implantation, and surgical coarctectomy.

Conclusion
Management of coarctation aorta during pregnancy is clinically challenging and maintain adequate placental perfusion and prevent complications. A multidisciplinary approach and close monitoring are essential for planning the management of pregnancy and delivery.

OP/O – 33
A SUCCESSFUL PREGNANCY OUTCOME IN A WOMEN ON PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE FEEDING

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Introduction
Paragangliomas originate from parasympathetic nerves. Forty percent of them are familial. Presence of a neck lump is the commonest presentation and majority are managed surgically (97%). Following surgery around 9% of patients developed dysphagia which settled spontaneously. However, cranial nerve damage during surgery may cause long term dysphagia. In such patients, use of a naso-gastric tube, a PEG tube and total parenteral nutrition are available options. Use of a PEG tube has demonstrated good outcomes in pregnancy.

Case Presentation
A 36-year-old woman was found to have a neck lump and diagnosed to have a left sided carotid body tumour. Ultrasound and CT scans showed naso-pharyngeal involvement. During surgery, Xth, XIth and XIIthcranial nerves were involved in the tumour and required excision including a mandibulectomy. Immediately after surgery feeding was commenced via a nasogastric tube. Subsequently she conceived within her next menstrual cycle. She underwent a PEG tube insertion at 15 weeks and continued enteral feeding throughout pregnancy. She was managed with the close liaison of a Consultant Obstetrician, Neurosurgeon, Gastroenterologist, Anaesthetist, ENT surgeon, medical nutrition therapist and a speech and language therapist. She didn't develop PEG tube associated complications. Her antenatal period was complicated with mild anaemia and late onset FGR. At 37 weeks she underwent an elective Caesarean section due to FGR under spinal anaesthesia and delivered a baby girl with a low birth weight of 2.06 kg. In the immediate postpartum period, she was assessed by a speech and language therapist followed by FEES test by ENT team and decided to continue PEG tube feeding.

Discussion
PEG tube feeding has achieved better nutritional outcome over nasogastric feeding with less tube related complications and problem free survival. Parenteral nutrition has shown to be associated with mechanical, metabolic and gastro-intestinal complications specially related to pregnancy. Although use of PEG tube in pregnancy has raised concerns with regard to possible uterine damage, fetal injury, pre-term labour and infections its use has demonstrated to be safe. Even during the 3rd trimester, it can be inserted safely by transillumination. PEG tube insertion and its long- term use is associated with wound infections,

pneumoperitoneum, gastric outlet obstruction, peritonitis, aspiration pneumonia, buried bumper syndrome, bowel perforation and necrotizing fasciitiswhich did not affect this patient.

Conclusion
The use of PEG tube is a viable option at any gestation in pregnancy in whom oral feeding is not feasible and will help to achieve favourable feto-maternal outcomes.

OP/O – 34
AUDIT ON USE OF ANTENATAL CORTICOSTERIOD IN PRETERM LABOUR

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Introduction
Preterm birth is defined as delivery at any gestation before 37 weeks completed. In Sri Lanka 10% of babies are born preterm. It is the leading cause for perinatal morbidity and mortality and long-term disabilities. Maternal administration of antenatal corticosteroids before anticipated preterm delivery is one of the most important interventions to improve neonatal outcomes. They are effective in reducing neonatal respiratory morbidity and other complications of prematurity such as intraventricular haemorrhage and reduce developmental delay in childhood.

Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No.74 on Antenatal corticosteroids to reduce neonatal morbidity and mortality recommends offering antenatal corticosteroids to women between 24+0 and 34+6 weeks' gestation in whom imminent preterm birth is anticipated. It should be given within the seven days prior to preterm birth to reduce perinatal and neonatal death and respiratory distress syndrome.

Objective
The aim of this audit is to assess the current practice of use of antenatal corticosteroids in preterm birth in ward 17, Colombo South Teaching Hospital, Kalubowila.

Methods
All the preterm deliveries in ward 17 Colombo South Teaching Hospital from 1st of January 2022 to 31st of May 2022 were audited for the use of antenatal corticosteroid usage. The RCOG Green-top Guideline No.74 was used as the gold standard. Data on use of antenatal corticosteroids from the bed head tickets of preterm delivery patients were obtained and current usage practice assessed.

Results
42 preterm births were recorded. Among them 30 were Lower segment caesarean sections and 12 were vaginal deliveries. 52% of deliveries were between 24+0 and 34+6 weeks' gestation and 48% were between 35 and 36+6 weeks of gestation. Those who delivered between 24+0 and 34+6 weeks' gestation, 81% of mothers received a course of antenatal corticosteroids prior to delivery and rest of 19% mothers received half course of antenatal corticosteroids. 10% of preterm mothers, who received antenatal corticosteroids, gave birth eight or more days after administration of antenatal corticosteroids.

Conclusion
Current practice on usage of antenatal corticosteroids on preterm birth was not up to the gold standard. Suspecting and diagnosing the preterm labour is crucial to start the antenatal corticosteroids. A lecture was conducted on updates of management of preterm labour in order to provide continuing medical education for the medical staff of the unit. A re-audit is recommended to evaluate the sustainability of practice.

OP/O – 35

TRANSPLACENTAL PASSAGE OF COVID-19 RESULTING IN A FETO-MATERNAL HAEMORRHAGE: A CASE REPORT

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Background

Coronavirus disease 2019 (COVID-19) is a global pandemic that has ravaged the world. There is evidence to suggest transplacental passage. We report a case of vertical transmission of COVID-19andfeto-maternal haemorrhage in a neonate.

Case Presentation

A 27-year-oldprimiparous mother was admitted at 37 weeks with reduced fetal movements. This was a planned pregnancy, and the booking visit was done at 12 weeks. All her booking investigation results were normal. Her blood group was O Rhesus positive. At 16 weeks she was diagnosed with hypertension and was started on Nifedipine 20 mg bd and Aspirin 75 mg nocte. The anomaly scan at 20 weeks was normal.

On admission, she was haemodynamically stable with a respiratory rate of 24/min, oxygen saturation of 99% on room air, pulse rate of 90/min, blood pressure of 150/100 mmHg and fetal heart rate of 150/ min. There were no pre-eclamptic features or proteinuria. Although she had no COVID-19 symptoms, the routine nasopharyngeal swab on admission was positive for coronavirus 2 (SARS-CoV-2) infection. Subsequently, an emergency caesarean section was performed due to a suspicious CTG and unfavourable cervix. She delivered a single live baby boy weighing 2700 g. The baby cried soon after birth but looked pale. The baby was admitted to the neonatology intensive care unit (NICU) as the haemoglobin was 3 g/ dlwhich required packed red cell transfusions to correct the haemoglobin to 17 g/dl. The direct and indirect Coombs test was negative with normal serum bilirubin level. Kleihauer test was positive confirming the feto-maternal haemorrhage (FMH).The nasopharyngeal swab of the baby was also positive for COVID-19.

Conclusion

In conclusion, whilst this case highlights the impact of COVID-19 in the perinatal period, it also shows the importance of sticking to basics when encountering new clinical scenarios in the face of mounting challenges in low-resource settings. Although there is no direct association between COVID-19 and FMH, placental microthrombi and infarcts due to COVID-19 may have been the cause for the FMH.

OP/O – 36

AUDIT ON ANAEMIA IN PREGNANCY- SCREENING

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Introduction

Anaemia is the most common medical disorder in pregnancy. The global prevalence of anaemia in pregnancy is estimated to be approximately 41.8%. At least half of this anaemia burden is assumed to be due to iron deficiency. Pregnancy causes 2-3-fold increase in requirement of iron. Iron deficiency

(ID) is the commonest nutritional deficiency among pregnant women worldwide. The WHO estimates Iron deficiency anaemia (IDA) to affect approximately 42% of pregnant women. IDA in Sri Lanka was estimated to be around 29%.

Anaemia is defined by Haemoglobin (Hb) less than 11 g/dl in the first trimester, less than 10.5 g/dl in the second and third trimesters and less than 10 g/dl in the postpartum. Royal College of Obstetricians and Gynaecologist (RCOG) Green-top Guideline No.47 and British Committee for Standards in Haematology (BCSH) guidance recommended to perform FBC to assess anaemia at booking and at 28th week gestation. The cut-off value of Hb for the delivery in an obstetrician led unit is 9.5 g/dl.

Objective
The aim of this audit to assess the current practice of screening and diagnosis of anaemia at ward 6 of Castle Street Hospital for Women, Colombo.

Method
All the women, who were admitted to ward 6 Castle Street Hospital for Women during the month of July, were recruited for the audits. Their clinical records were used to obtain data. Royal College of Obstetricians and Gynaecologist (RCOG) Green-top Guideline No.47 and British Committee for Standards in Haematology (BCSH) guidance used as gold standard.

Result
76 mothers were admitted for the confinement. All the mothers were assessed for anaemia during the booking visit and 74% of mothers were assessed for anaemia during 28th week of gestation. 20% of mothers were diagnosed as anaemia during booking and 28th week of gestation. Hb level of 6% of mothers were less than recommended cut-off value for delivery.

Conclusion
Screening percentage during booking visit was up to the standard but screening at 28th week was suboptimal. Satisfactory percentage of mothers didn't achieve the cut-off level of Hb during the time of delivery. It was planned to educate the mothers regarding dietary information to maximize iron intake and absorption. Medical officers will be updated on latest guidelines on management of anaemia in pregnancy. A re-audit is recommended to evaluate the efficacy and sustainability of interventions.

OP/O -37

AN AUDIT ON LEVEL OF IMPLEMENTATION OF POST-PARTUM SIX WEEK BLOOD GLUCOSE REASSESSMENT WITH ORAL GLUCOSE TOLERANCE TEST (OGTT) AMONG GESTATIONAL DIABETES MELLITUS (GDM) WOMEN

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Introduction
GDM is a common medical problem encountered during pregnancy. Asian and other minor ethnicities have higher risk of GDM than Caucasians. Women with GDM have higher risk of developing Diabetes in later life compared to non GDM women. Therefore, it is important to reassess GDM women at 6 to 12 weeks postpartum and followed by annual screening for Diabetes. It will enhance the early detection of Diabetes in reproductive age women. Early detection will lead to optimum care for Diabetes in general and preconceptional period. It is recommended to do postpartum OGTT in Sri Lankan guideline for GDM.NICE guidelines recommend FBS instead of routine OGTT.

Objectives

1. To identify the percentage of GDM women who underwent postpartum six weeks OGTT as recommended in Sri Lankan guideline.
2. To identify the barriers for successful implementation of the recommendation.
3. To address the barriers with effective solutions for successful implementation of the concept.

Methods

A retrospective audit had been carried out using details acquired through interviewer administered questioner from 100 Gestational Diabetes Mellitus (GDM) women who delivered at Ward 25 North Colombo Teaching Hospital and completed post-partum twelve weeks. SLCOG guideline recommendation of 100% postpartum OGTT testing consider as Gold Standard.

Results

Out of 100 GDM postpartum women 64 had done the OGTT.4 Women out of 64 confirmed as type 2 Diabetes and currently on treatment. 35 out of remaining 60 women planned to do annual screening for Diabetes whilst 25 women not aware about it. 13 women out of 36 who didn't do OGTT were not informed about it during hospital stay and postpartum period. 23 women who were informed but didn't do OGTT expressed many reasons like busy life schedule (06 out of 23), completely forgotten (06/23), Unhappy to drink 75 g glucose solution (05/23), was a difficult task with Covid pandemic (03/23) and difficult to afford (03/23)

Conclusion

All GDM women should receive information about post-partum blood glucose reassessment and its importance. It was 77% during the audit. Only 42% aware about annual blood glucose screening test which should raise up to 100%. We have planned for ward staff education program, preparing patient information leaflet, preparing a seal to paste on postpartum care prat of national maternal record to remind OGTT testing to woman and field care midwife. Reaudit will be carried out after implementation of these concepts.

OP/O – 38

DETECTION OF LATE ONSET HYPERGLYCEMIA IN PREGNANCY AND SELECTED MATERNAL AND FETAL OUTCOMES AMONG PREGNANT WOMEN ATTENDING DE SOYSA HOSPITAL FOR WOMEN: A DESCRIPTIVE STUDY

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Introduction

Hyperglycemia in pregnancy (HIP) is one of the commonest endocrine disorders encountered in pregnancy. Although all the pregnant mothers are screened at booking and towards the end of 2nd trimester, they are not routinely checked in the third trimester, unless a well-known complication of diabetes in pregnancy such as polyhydramnios is encountered. A recent community-based study carried out in a sub-urban district of Sri Lanka, reported the prevalence of DIP as 13.9%, out of which 7.2% were late onset(in 3rd trimester).

Objectives

General objective was to calculate the proportion of 3rd trimester onset GDM. Calculating the proportions of selected maternal and fetal outcomes of 3rd trimester onset GDM mothers, were the specific objectives.

Methods
This descriptive study was carried out at antenatal clinic and in the ward 16, at DMH – Colombo from December 2019 to August 2020. All singleton pregnant mothers who were screened negatives for HIP until 28 weeks of POA, who were consented, were included in the study. Pregnant mothers with pre-existing diabetes mellitus and those who had previous caesarean deliveries were excluded. Study participants were screened for DIP by an OGTT at 32-34 weeks of POA. Screened positives were managed as DIP according to the guidelines. Sample size was 290 and an interviewer administered questionnaire was used to collect data. Ethical approval was granted from the ERC, NHSL – Colombo.

Results
19 mothers were found to have late onset HIP. Out of them, 2 mothers had polyhydramnios and 4 mothers were carrying macrosomic babies (Weight more than 3.5 kg) where 2 mothers with macrosomic babies underwent elective caesarean sections. Out of 2 mothers who had vaginal deliveries, one had a PPH with a blood loss of around 1000 ml. 2 had polyhydramnios and no one had perineal tears or IUDs. Out of those who had normal OGTT values, 6 mothers delivered macrosomic babies, 2 mothers had PPH, 1 had a perineal tear and none of them had IUDs.

Conclusion
Prevalence of late onset hyperglycemia in pregnancy was 6.5%. Polyhydramnios, macrosomia, PPH were the adverse outcomes of them, but they were not significant, compared to the normal population. Further cohort studies are needed for the recommendation of OGTT in third trimester.

OP/O – 39
WARFARIN WINDOW IN PREGNANCY: A CASE REPORT OF IN-UTEROSUBDURAL HEMORRHAGE AND PERINATAL OUTCOME

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Background
Pregnancy and Prosthetic heart valve, both are risk factors for thrombosis. Anticoagulation is essential to minimize risk of valve thrombosis and systemic thrombo- embolism which can result deadly complications in pregnant woman with prosthetic heart valve. Fetal intracranial haemorrhage is a rare event with incidence of 0.6–1/1,000. It can be intraventricular, intracerebral, cerebellar, subarachnoid and subdural, depending on the anatomical location. We report a rare case of Warfarin induce fetal Subdural Hemorrhage with successful perinatal outcome with intrauterine diagnosis and timely interventions

Case Presentation
34-year-old woman presented to us with unplanned third pregnancy which was confirmed at fifteen weeks of gestation. She was on Warfarin 5.5 mg daily dose during her first and early second trimester. She had undergone Mitral valve repair and synthetic ring annuloplasty for Bi-leaflet Mitral valve in 2009 followed by lifelong Warfarin therapy. There were no features of Fetal Warfarin syndrome in mid trimester anatomical survey. Tentative ultrasonical diagnosis of left Fetal subdural hemorrhage (SDH) with contralateral Ventriculomegaly was made at 34 weeks of Gestation which was confirmed in post-natal period by ultrasound and CT scan. Throughout the pregnancy her PT/INR value was less than 3 and there was no history of fever with rash. There were no episodes of abdominal trauma or thrombocytopenia. Fetus was delivered by Cesarean delivery as a safer option to minimize fetal bleeding manifestations. Then neonate was treated with surgical evacuation of hematoma at premier specialized Children Hospital in the country. Post operative CT scan confirmed complete evacuation of hematoma. Currently baby is recovering well without neurological impairment

Discussion

Fetal haemorrhage risk is higher than maternal since there is more free form of warfarin in the fetus compared to mother. Therefore, maternal INR value will not represent fetal anticoagulation effect. The fetal impact of warfarin appears to be dose dependent. Fetal SDH has overall poor perinatal outcome, including stillbirth, neonatal death, and abnormal neurological outcome. About 80% of neonates will be affected with poor neurological outcomes. Fetal SDH can be due to effects of anticoagulation, fetal infections like toxoplasmosis, Parvo and Cytomegalovirus infections, maternal abdominal trauma, maternal vitamin K deficiency, fetal vascular anomaly, autoimmune thrombocytopenia and alloimmune thrombocytopenia.

Conclusion

Use of lowest effective Warfarin dose and avoidance during first six to twelve weeks of gestation and close monitoring for possible complications is recommended. Early detection of complications and appropriate timely interventions will improve both maternal and fetal outcome

OP/O – 40

AN AUDIT WRITING PROPER OPERATIVE NOTE AFTER PERFORMING INSTRUMENTAL DELIVERY

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Introduction

10 - 15% of women undergo instrumental vaginal delivery in developed countries to prevent second stage cesarian section. Incidence of serious maternal complications is 21% in all instrumental delivery. 91.7% of them occur after forceps delivery. Main maternal complications are 3rd-degree perineal tears and cervical tears. Out of all neonates delivered by operative vaginal deliveries, 24.5% developed complications. To improve the quality of instrumental delivery, the Operator should adhere to the correct technique and proper documentation of operative notes.

Objectives

1. To identify the percentage of proper documentation in instrumental deliveries.
2. To identify what are the common mistakes during writing operative notes.
3. Identify solutions for preventing such errors.

Method

A retrospective audit was carried out using details obtained from medical records of patients who had undergone instrumental vaginal deliveries at ward 25 Colombo North Teaching Hospital Ragama. SLCOG guidelines for assisted vaginal delivery operative notes annexure 1 was used as a guide for this audit.

Results

Out of 30 instrumental vaginal deliveries, all had some operative notes. 80% of operative notes contained basic introduction such as patient's demographics, time, date and the operator's name. All cases held maternal assessment and fetal assessment before performing the procedure. Out of 30 cases, 20 cases mentioned the indication for instrumental delivery. 66.6%had documentation regarding anesthesia that was used. Only 40% of occasions, application methods and traction were said. 86.6% of the time number of pulls and placental examinations after placenta delivery were documented. In all cases, the perineal assessment was mentioned. In only 80% of cases mentioned the neonatal condition after the delivery. 2 out of 30 cases had the operator's signature at the end of the notes.

Conclusion
60% of operative notes did not fulfil the criteria mentioned in the SLCOG guideline's checklist at the first audit cycle. We have planned for a ward staff education program and preparing an operative note structure to improve the quality and reliability of operative notes in assisted vaginal deliveries.

OP/O – 41
AUDIT ON PROPOTION OF TUBAL ECTOPIC PREGNANCIES IDENTIFIED ON INITIAL SCAN IN GYNECOLOGY AND OBSTETRICS UNIT B TEACHING HOSPITAL, ANURADHAPURA.

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Introduction
Ectopic pregnancy (EP) is defined as a pregnancy occurred outside of the uterine endometrium. The large majority (95%) of ectopic pregnancies occur in the fallopian tube. EP occurs in about 2% - 3% in all pregnancies and combined intra-uterine and extra-uterine pregnancy or heterotopic pregnancy is rarely encountered. EP is the number one cause of maternal deaths in the early first trimester of pregnancy and early diagnosis is essential to reduce this risk. Initial transvaginal ultrasound diagnosis of EP is not only potentially decreasing mortality and surgical intervention rates, but also promotes modern management modalities including expectant or medical management. Current diagnosis of EP based on combination of the clinical presentation and examination, pelvic or transvaginal ultrasound scan findings and Serum β-hCG levels.

Objectives
The aim of this Audit is to evaluate the proportion of tubal EP identified on initial scan in Gynecology and Obstetrics unit B Teaching Hospital, Anuradhapura. Ultrasound findings of EP can vary widely between different individuals, and depend on a variety of factors, including the gestation of the pregnancy, route of scanning (trans abdominal or trans vaginal), experience of the sonographer as well as features of the scan equipment.

Methods
A retrospective audit of the management of women with a diagnosis of ectopic pregnancy was carried out over one year from May 2020 to February 2022, at Gynecology and Obstetrics unit B, Teaching hospital Anuradhapura.

Results
During this period, 32 women who presented with abdominal pain and per-vaginal bleeding were diagnosed having tubal ectopic pregnancy. 56.3% cases were diagnosed by the senior most medical officers and 31.3% were diagnosed by the Consultant.

From the initial scan, ectopic pregnancies were diagnosed among 26 patients (81.2%). Most of the diagnosis (93.5%) were made using trans-vaginal scan, whereas no cases were diagnosed in-ward with a trans-abdominal scan alone. Radiologists' contribution in diagnosing ectopic pregnancy was minimal (3.1%).

Conclusions
According to RCOG guidelines the proportion of tubal pregnancy identified from the initial scan should be 90%. RCOG standards can be achieve if provision of adequate facilities as well as organizing proper training programs for the medical officers in Gynecology units.

OP/O – 42

POSTPARTUM INTRAUTERINE CONTRACEPTIVE UPTAKE: A COST-EFFECTIVE FAMILY PLANNING INTERVENTION, EXPERIENCE IN PAKISTAN

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Introduction & Objectives

The study was part of an intervention "institutionalization of Immediate Postpartum Family planning (PPFP) services, particularly insertion of Postpartum Intra Uterine Contraceptive Device (PPIUCD)" in selected health facilities across Pakistan. Skilled Birth Attendants (SBAs) conducting deliveries at the selected health facilities were trained to provide PPIUCD services to at least 30% of women delivered.

Method

National Committee for Maternal & Neonatal Health (NCMNH) piloted the PPIUCD intervention in two hospitals of Karachi and scaled up to52 health facilities in Karachi, Hyderabad, Lahore, Islamabad and Rawalpindi. All cadres of SBAs at the intervention sites were trained, followed by supportive supervision. PPFP counseling was done at ante-natal clinics, labour rooms (women in early labour) and postnatal wards by dedicated counselors. Contraceptives were available 24/7 in labour rooms and operation theatres. PPIUCD was inserted within 10 minutes of delivery of the placenta after a normal or caesarean delivery, or within 48 hours of normal childbirth. Women were followed up at 6 weeks and 6 months' post insertion.

Results (April 2012- April 2022)

During the intervention 2,713 SBAs were trained, included doctors and midwives. A total of 648,126 women delivered at the intervention sites and 179,508 (28%) had PPIUCD inserted. 47% of the women were followed up at six weeks, the continuation rate was 95%, IUCD was expelled in 3% and was removed in 2% of women. The reason for removal was mainly socio-cultural.

Conclusion

PPIUCD insertion is safe and effective. When counseled appropriately, is acceptable to women and the health care providers. A burgeoning population of 207.7 million and more and more women coming to health facilities for childbirths, (currently 69% childbirths at health facilities), makesPPFP a one stop solution for improving Maternal & Neonatal Health and decelerating the Population Growth. Institutionalization of immediate PPFP, particularly PPIUCD is a step in the right direction!

OP/O – 43

FACTORS AFFECTING FOR ADHERENT TO THE TREATMENT MODALITY AND AWARENESS OF COMPLICATIONS IN DIABETES COMPLICATING PREGNANCY

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Introduction

Adherence to the treatment is key to the successful management of any disease.

Objective

Lack of local statistics regarding the above topics was the main reason for the study.

Methods

Data was collected using interviewer-based questionnaires from antenatal clinics in CSHW. Patients who were on current treatment modality for more than one month duration without other medical comorbidities

were selected. The data was collected through the eight-item Morisky Medication Adherence Scale (MMAS). The total MMAS score ranges from 0 to 8 and the patients were classified into two groups: non-adherent (MMAS score < 6) and adherent patients (MMAS score ≥ 6). Awareness of complications of diabetes in pregnancy was collected by open ended questions. SPSS 24th version used for the analysis.

Results

Total number of 57 pregnant mothers with diabetes selected from that 15 (26.3%) were chronic diabetes while rest were detected with hyperglycemia in pregnancy (n=42, 73.7%). Mode of sample Period of amenorrhea (POA) was 32 weeks (10-38 weeks). Mean age of the sample was 30.28 years (18-40). Among them 36.8% (n=21) were primi. 20 of them were (35.1%) managing only with medical nutrition therapy (MNT), 16 (28.1%) and 21 (36.8%) managing with Metformin therapy alone, Insulin +/- Metformin respectively. Majority were educated up to or below O/L (n=32, 56.1%). 47 (82.5%) pregnant mothers were adherent to the treatment while 10 (17.5%) were not. Statistically significant better adherent noted in Metformin alone or Insulin+/- Metformin group (n=35, 94.6%) compared to MNT only group (n=8, 40%) (p=0.001).

Majority were aware about fetal macrosomia (n=42, 73.7%) as complication. Other most aware complications were; congenital anomalies (n=34, 59.6%) fetal demies (n=15, 26.3%), polyhydramnios (n=14, 24.6%), delivery problems (n=9, 15.8%) respectively. Mothers who had awareness of 2 or more complications (n=34, 89.5%) had better compliance compared to others (n=13, 68.4%) (p=0.049). Level of education, type of diabetes (chronic vs. hyperglycemia in pregnancy) and parity were not statistically significantly associated with the adherent to the treatment according to this study. (p>0.05)

Conclusion

Pregnant mothers have higher concerns regarding her pregnancy outcome compared to the general population with diabetes despite their level of education and parity. This must be the reason for the above findings and the higher adherence (n=47, 82.5%) compared to the general population with diabetes (n=95, 38.4%). A large sample size study covering different areas of Sri Lanka needs to be carried out for better statistical details.

OP/O – 44

FACILITATORS AND BARRIERS IN UPTAKE OF COVID 19 VACCINATION IN PREGNANT AND POSTPARTUM WOMEN

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Introduction

There has been remarkable progress invaccine research and development in recent years. Yetthere is still considerable hesitancy in its uptake in the pregnant population.

Objectives

The purpose of this study is to understand the factors which facilitate and those which act as barriers to Covid vaccination in pregnant patients.

Method

All pregnant and postpartum patients were asked to participate in this cross-sectional study. Data were recorded on a pre-designed research questionnaire. Statistical analysis was performed using SPSS version 20.

Results
A total of 171 participants were enrolled. Ninety (52.63%) participants responded that Covid vaccine is either not safe or they are not sure regarding its safety during pregnancy. Ninety-one (53.21%) participants responded that Covid vaccination is either not safe or they are unsure regarding its safety during breast feeding. One hundred thirty-one (76.6%) subjects responded that Covid vaccine protects against severe Covid disease while 49 (28.65%) responded that it protects against Covid infection. 25 (14.61%) participants mentioned that they face difficulty in getting Covid vaccine. One hundred twenty-nine (71.3%) were satisfied with the vaccination center services.

Conclusion
Despite mass awareness regarding Covid, about half of the patients were of the opinion that Covid vaccination is either not safe or were unaware about its safety during pregnancy and lactation. Further efforts are needed to increase awareness regarding Covid vaccination safety especially during pregnancy and lactation.

OP/O – 45
AN AUDIT OF CAESAREAN DELIVERY RATES USING ROBSON'S TEN CLASSIFICATION IN A TERTIARY CARE UNIT

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Introduction
Rising caesarean delivery rates is a major public health concern worldwide. Robson's Ten classification system serve as an initial structure with which caesarean delivery rate can be analysed and allow us to change our practice.

Objective
To determine the rates of lower segment caesarean delivery and their indications using Robson's criteria

Method
Retrospective audit was conducted in De Soysa Maternity Hospital, ward 16 and comprised review of record over a period of 6 months from 1st of January 2022 to 30th of June 2022, related to all caesarean deliveries. The data was classified according to Robson's ten classification system

Results
Of the 723 deliveries, 272 (37.6%) were caesarean deliveries. According to the criterion used, the major contributor to overall caesarean delivery rate was group 5 (37.8%) which entails previous caesarean deliveries single cephalic >37 weeks, followed by group 1 (14.3%) which entails nulliparous >37 weeks spontaneous onset of labour. Nulliparous contribute to 31.5% of the overall caesarean delivery (group 1,2A,2B).

Conclusion
Robson's Ten classification system helped us in auditing the caesarean delivery rate, Group 5 and group 1 contributing the maximum for caesarean deliveries. Encouraging and adequate counselling for Vaginal Birth After Caesarean Section (VBAC) in women with previous scar and allow Trial of Labour After Caesarean Section (TOLAC) when appropriate would reduce the caesarean section rates.

OP/O – 46
A CLINICAL AUDIT ON "EFFECTIVE USAGE OF PARTOGRAM" IN OBSTETRIC UNIT BASE HOSPITAL - WATHUPITIWALA

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Introduction
World Health Organization recommends partogram for universal use during labour as a necessary tool and it can be used for continuous monitoring during labour. The tool helps to identify early warning signs and gives an account on deviations and intervene timely. The maternal mortality is reported to be persistently low despite that Sri Lanka is a developing country. Since partogram is used to detect obstructive labour early, it helps to reduce maternal mortality by preventing uterine rupture, postpartum haemorrhage and puerperal infections. Peri-natal mortality and morbidity rate is reduced when traumatic deliveries are less. It appreciates the use of the tool as it is inexpensive, simple and freely availability.

Objectives
The aim of this audit is to assess the effective use of partogram in the local ward setting. There are about 350 - 400 total cesarean and normal deliveries are done in maternity ward, Base Hospital -Wathupitiwala per month where partogram is routinely used for assessing and managing mothers at labour room. The document is maintained by the Senior House Officer, Intern House Officer, Nursing Officer and Midwife together.

Method
For this audit, Bed head tickets (BHTs) were observed for a period of one month from 01st January 2022 to 31st January 2022 (A descriptive retrospective study). Total number (185) of mothers who are admitted to labour room during this period are included to sample. The aim of this clinical audit is to assess the effective use of partogram in the ward setting.

Results
Contraction free interval (0%), duration of contraction (0%) and abdominally descent (1.18%, n=1) were not marked in the majority and the technical errors noted during marking. Though alert line (57.99%, n=107) and action line (58.58%, n=108) were drawn frequently but cervical dilatation was not marked in the majority.Maternal monitoring during labour wasn't recorded in the majority.Action taken was not documented in the partogram.Fetal monitoring of the 2nd stage hasn't documented in almost all the time. Closing of the partogram has done hardly.Date and time of the delivery and Postpartum and Modified Early Warning System was maintained in majority.

Conclusions
Value of partogram in monitoring and maintaining real time during the labour must be discussed. Training and education programme on maintaining of National Partogram should be arranged and encouraged. Practical issues in monitoring and documenting and Importance of maternal monitoring during labour should be highlighted.

OP/O – 47
DO WE HAVE THE POTENTIAL AND CAN WE SAFELY REDUCE OUR CAESARIAN SECTION RATE DURING THIS ECONOMIC CRISIS?

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Introduction
The Caesarean Section (CS) rates reported in Sri Lanka have increased from approximately 8.4% in 1988

to 13.3% in 1998 and 30.6% in 2007. Even higher rates are reported in private sector. In 1985, the World Health Organization (WHO) recommended an optimum CS rate of 10 to 15% and stated that there was no justification for any region in the world to have higher rates than this. However, even up to date there is no consensus regarding an acceptable caesarean delivery rate or what rate achieves optimal maternal and infant outcomes and how we should get there.

In a large cross-sectional study performed in United States revealed that the rate of Vaginal Birth After Caesarean Section (VBAC) in 2009 was 20.7% and VBAC success rate was 41.4%. Indications for ERCS include absolute and relative contra indications for vaginal birth and declined trial of scar by the mother. The latter being the most frequent indication and represents the group of mothers whom we can think of as a deciding factor of CS rate in the unit.
In addition to well-known potential maternal and neonatal risks of Caesarean section, Sri Lanka is experiencing an Economic crisis at the moment which has dramatically affected the medical resources both directly and indirectly causing serious limitations in CS surgeries even in tertiary care hospitals.

Method
The study setting was the Professorial Unit (ward 3 and 15) of the De Soysa Hospital for Women. A detailed analysis of the master database file of the RobsonApplication was used to retrieve the data. Data collected from 2019 to 2021 were used. A MySQL database was used to store the input data from the RobsonApplication. It was this file which was queried using the SQL language and the data outputs are given in the results.

Results
Total number of deliveries during this period was 1974. Of these, 602 (30.4%) were conducted by CS (This rate also included CS done after failed VBAC). A total of 209 had a previous history of one CS, 55 had 2 or more CS. VBAC trial was given to 98 (37.1%). Remainder of 166 (62.8%) had ERCS. The success rate of VBAC was 52.0% and there has been no incidents of uterine rupture, maternal death or stillbirth following VBAC trial.Most common reason for failed VBAC was failure to progress in labour (21.4%).

Maternal request was the most frequent indication for ERCS in our unit (52.4%), followed by previous 2 or more CS (27.7%), breech presentation(7.2%), medical diseases complicating pregnancy (4.2%), multiple pregnancy(3.6%), miscellaneous indications (3%) and past failed VBAC(1.8%).12.6% of all CS performed in our unit during this period were due to maternal request.

Discussion and Implementation
Caesarean section rate performed in our unit during this period (30.4%) is significantly higher than the WHO accepted level (10-15%). Even though ERCS rate (62.8%) was in accepted level, this comprised of unacceptable higher percentage of women (52.4%) who underwent ERCS solely with their request without any absolute or relative contraindications to VBAC. On the other hand, the success rate of VBAC in our unit (52.0%) was also higher than the reported international rates. These findings indicate that we have the potential to reduce our CS rate by diverting more mothers to VBAC who prefer ERCS.

To achieve the outcome mentioned by this article efficiently and safely, two aspects need to be addressed. These are implementation to increase the acceptance of VBAC among mothers and to increase VBAC success rate. Further studies are needed to achieve two targets mentioned above. This may include studies specifically targeting the population of VBAC candidates to assess their knowledge, attitudes regarding VBAC and change of protocols to select patients with evidence based favourable factors for successful VBAC. Latter increases the confidence of both the mother and the doctor in selecting VBAC as the delivery option and also a more promising way of achieving the desired outcome. This study included statistics before economic crisis in Sri Lanka. Therefore, the results and rates of this study can also be used to compare statistics of similar futures studies done during economic crisis.

OP/O – 48
AUDIT ON USE OF ANTENATAL MAGNISIUM SULFATE IN PRETERMBIRTHS

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Introduction
Preterm birth is a delivery of a live fetus before the completion of 37 weeks of gestation. 1 out of 10 live births is a preterm birth. Preterm neonates are vulnerable to more morbidity and mortality than term neonates. Among them neuro disability is a major concern in preterm neonates. Neurological disabilities include cerebral palsy, motor dysfunction, epilepsy, visual impairment, hearing defect and cognitive and behavioral defect. 35%of cerebral palsies are due to preterm birth. Survival of preterm births increased and the incidence of neuro disability therefore increasing. Maternal administration of Magnesium sulfate in suspected or planned preterm deliveries has a neuroprotective effect in fetus/neonates and therefore reduce neurodisability.

NICE guideline 25 regard to preterm labour and birth recommend intravenous administration of Magnesium Sulfate as 4 g bolus over 15 minutes and then 1 g/hr infusion until delivery in 24 + 0 to 29 + 6 weeks of gestation with suspected or planned preterm birth. Also, to consider in 30 + 0 to 33 + 6 weeks of gestation. Should be given within 24 hours of delivery.

Objective
The aim of this audit is to assess the current Magnesium sulfate use in preterm labour and births in ward 17 of Colombo South Teaching Hospital,Kalubowila.

Method
All the preterm birth from 1st of January 2022 to 31st of May 2022 in ward 17 of Colombo South Teaching hospital Kalubowila were taken as samples. NICE guideline 25 was used as gold standard. Data obtained from the relevant bed head tickets and assessed.

Results
There were 16 preterm births between 24 + 0 to 33 + 6 weeks of gestation. 75% were delivered by caesarean section and 25% by vaginal delivery. All the 16 preterm term births received loading dose of Magnesium sulfate and only two had received loading and infusion of Magnesium sulfate. Therefore only 12.5% had received recommended regimen of Magnesium Sulfate.100% received it within 24 hours prior to delivery.

Conclusion
Magnesium sulfate administration for preterm neuroprotection is not up to the standard. To achieve the standard early identification of preterm labour and proper knowledge about Magnesium sulfate regimen is important. Several lectures arranged to increase the awareness among health staff. Plan to reaudit in six months.

OP/O – 49
AUDIT ON CAESAREAN SECTION ANTIBIOTIC PROPHYLAXIS IN TEACHING HOSPITAL JAFFNA.

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Introduction
Prophylactic antibiotics should be used for all caesarean sections. It reduces the incidents of surgical site infection by 61%, endometritis by 62% and serious maternal infectious complications by 69%. Cefuroxime is a commonly used antibiotics in Teaching Hospital Jaffna. A single dose of antibiotic should be administered intravenously on starting anaesthesia. Therefore, auditing the proper use of prophylactic antibiotics based on evidence will help to evaluate our institution to compare the current practice and suggest appropriate future practice.

Objectives
To evaluate the current practice on Caesarean Section antibiotic prophylaxis and compare with the standard practice.

Methods
A prospective audit was conducted in professorial unit TH, Jaffna using observational data collected on prophylactic antibiotic usage on mothers for Caesarean Section for 6 months, between February and July 2022.We collected the time of spinal anaesthesia, Intravenous antibiotic injection and the time of abdominal incisions made.

Results
Among 222 total number of Caesarean sections including emergency and electives, we followed 183 mothers. all the mothers received IV antibiotic prophylaxis. 120 mothers (65%) received single IV antibiotic before the incision made. 21 mothers (12%) received the prophylactic antibiotics after the abdominal incision made. 46 mothers (23%) received Intravenous (IV) infusion at the time of anaesthesia.

Conclusions
This preliminary audit shows satisfactory usage of Caesarean Section antibiotic prophylaxis. 88% of mothers have received at the proper time before incision made or at the time of anaesthesia. 12% of mothers received IV antibiotics after the incision made. This can be reduced by a discussion with anaesthesia team and carry out a reaudit in the future. This will improve the proper timing of caesarean section antibiotic prophylaxis.

OP/O – 50
AUDIT ON ANTENATAL CORTICOSTEROID USE IN PRETERM DELIVERIES FROM 24 WEEKS TO 34 WEEKS OF GESTATION IN WARD 1 AT CASTLE STREET HOSPITAL FOR WOMEN.

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Introduction
Antenatal corticosteroid administration is an intervention carried out to reduce the perinatal and neonatal morbidity and mortality. Antenatal corticosteroid administration in preterm deliveries reduces the perinatal mortality, neonatal death, neonatal respiratory distress syndrome, intraventricular hemorrhage and developmental delay in childhood.

Objectives
This audit aims to identify the proportion of women who received the antenatal corticosteroid among

the women who got admitted with suspected preterm labour. The set standard is administration of dexamethasone 12 mg, 2 doses 24 hours apart or 6 mg, 4 doses 12 hours apart as the antenatal corticosteroid therapy for pregnant women at the gestational age between 24 weeks and 34 weeks.

Methods
Sample size: All the pregnant women in preterm labour who got admitted to the ward one at castle street hospital for women in the gestational age in between 24 weeks to 34 weeks. Retrospective data collection was made from bed head tickets and labour room birth registry from 1st July 2021 to 31st December 2021. There were 88 admissions fulfilled the inclusion criteria. Data entry was done directly in excel sheet.

Results
Eighty-eight samples were collected. Of which 13.6% (12) were not given with intramuscular dexamethasone due to lack of time to administer corticosteroid as they delivered soon after the admission and 86.4% were given intramuscular dexamethasone. Practiced dexamethasone dose regime in the particular unit was either 12 mg, 2 doses12 hours apart or 6 mg, 4 doses 6 hours apart. From the sample size 72% were given 12 mg, 2 doses 12 hours apart regime. One patient was given 6 mg regime. 9% of the sample size have been only given a single dose as they delivered their baby before the second dose.

Conclusion
Majority of preterm deliveries were covered with antenatal corticosteroid therapy however the dose regime was not same as in the standard recommendation. Though the unit practices antenatal corticosteroidwith dexamethasone, the dose regime is not up to the standard of RCOG recommendation. Therefore, the recommendations were instructed and implemented in the unit, and it needs to be reassessed in due course.

OP/O – 51
AUDIT ON CAESAREAN SECTION RATE USING ROBSON'S CLASSIFICATION IN WARD 1 AT CASTLE STREET HOSPITAL FOR WOMEN.

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Background
Caesarean section (C-Section) is a major obstetric intervention for saving lives of women and their newborn from pregnancy and childbirth related complications. C-Section rate is considered an important indicator for measuring obstetric services in any country, region, or institution. In many countries, based on population, all-cause C-Section rates have increased steadily during the past half century. The high and rising C-Section rate is certainly a cause for concern, and evidence-based information is needed as to how or why the C-Section rate has increased and what needs to be done. Robson classification is a WHO proposed global standard for assessing, monitoring and comparing caesarean section rates both within healthcare facilities and between them. The system classifies all women into one of 10 categories that are mutually exclusive and, as a set, totally comprehensive. The categories are based on 5 basic obstetric characteristics that are routinely collected in all maternities such as parity, number of foetuses, previous caesarean section, onset of labour, gestational age, and foetal presentation. In this study, we analysed the distribution of caesarean sections in ward 1 at castle street hospital for women in the month of December 2021 according to the Robson's classification.

Objective
To analyse and compare the caesarean section rate in ward 1 at castle street hospital for women.

Methods
This study was conducted as a facility based cross sectional study. Here we reviewed patient hospital records and birth registry for the December 2021.

Results
In December 2021 there were 272 deliveries happened in the unit. Here 41.9 % of deliveries were by caesarean section. Robson's group 2 and 5 were in the top of the order with equal contribution (26.32%). Group 1 (13.16%) was next in the list. These 3 groups contributed more than 60% for the Caesarean section. There were no one belongs to Robson's group 9. All the mothers in Robson's group 6,7 and 8 had delivered their babies by caesarean section.

Conclusion
The caesarean section rate in this unit is higher than the national set standard. Detailed analysis from the Robson's class reveals the induction category contributes more for the higher rate. Reducing the number of induction and waiting for spontaneous onset of labour would reduce the rate of caesarean section. Trial of scar in mothers with previous one caesarean section should be encouraged in suitable candidates.

OP/O – 52
AUDIT ON INDICATIONS FOR CAESARIAN SECTIONS BASED ON MODIFIED ROBSON CRITERIA

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Introduction
Caesarian section with appropriate indication is an essential life saving obstetric surgery. Even though it is unavoidable in obstetrics practice, it carries significant morbidity on mother in addition to economic burden on health system. Therefore, auditing the indication for caesarian section based on ten group classification system will help us to self-evaluate our value with other institution and compare past and presence of our self for a well appropriate future practice.

Objectives
To evaluate the indication for caesarian sections and compare it with national and international practice.

Methods
A retrospective audit was conducted in professorial unit, Teaching Hospital Jaffna using an observational checklist which include basic information about the patient and classification of indication for caesarian section according to the Robson criteria from 20th February 2022 to 20th August 2022.

Results
Total number of childbirths occurred in that period was 552 out of them 231 were caesarian sections with the rate of 41.8%. The leading category for caesarian section was nullipara single on cephalic >37 weeks section done before labor (Robson group 2B), which represents 24.67% and the main indications were medical disorder complicating pregnancy, fetal growth restriction and pregnancy following assisted reproduction. The second leading category was singleton nullipara cephalic more than 37 weeks induced (Robson group 2A) which represents 19.48% and 64% of which was contributed by unsuccessful induction especially early induction for diabetes mellitus complicating pregnancies. The leading indication for preterm caesarian section was pre-eclampsia. Past section contributed 24.55% of the caesarian sections. Women who underwent caesarian section belonging to age group between 30 - 40 represents the majority (55%) indicating advanced maternal age is significantly contributing to maternal morbidity.

Conclusion
This preliminary audit shown more caesarian section were done in category 2A and 2B. Since, professorial unit, Jaffna is involving with medically complicating pregnancy management and assisted reproductive technology treatment in northern province, caesarian section rate is higher than the standards including category 2A and 2B. Changes were implemented and planned to carry out re-auditing in the future. This will improve caesarian section rate in future.

OP/O – 53
OGILVIE'S SYNDROME FOLLOWING A CAESAREAN SECTION: STAFF AWARENESS IS VITAL

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Background
Ogilvie's syndrome (acute colonic pseudo-obstruction) is known as an acute colonic dilatation, typically affects caecum and right hemi colon, without any mechanical obstruction. Ogilvie's syndrome has a fatality rate of up to 45%. Its pathogenesis is not entirely understood, but if left untreated, the distension can lead to bowel rupture, ischemic perforation, fecal peritonitis and maternal mortality. The etiology appears to be multifactorial and hypothesized to be secondary to imbalance in the autonomic nerve supply to the colon. Most frequently, Ogilvie's syndrome appears following a caesarean section. However, it can happen to women after a vaginal birth or during their pregnancy.

Case Presentation
Delivery was scheduled for a 35-year-old diabetic mother with a bad obstetric history and a prior cesarean section at 37 weeks of gestation. Prior to delivery, antenatal corticosteroids were administered. She had an emergency cesarean delivery due to fetal distress. The patient was initially stable, tolerated a normal diet and oral hydration. Uterus contracted, audible bowel sounds, and the abdomen was soft. She had not emptied her bowels or passed any flatus. Approximately 24 hours postoperatively, a significantly distended abdomen was noted with sluggish bowel sounds.

However, there was no signs of peritonism. Including potassium, the test results were unremarkable. Following surgical referral, the patient underwent conservative management with a nasogastric decompression, limiting oral intake, intravenous hydration, active mobilization, cessation of opioids, fluid balance monitoring, close clinical monitoring, and administration of pro-kinetic agents. The volume of nasogastric aspirates was minimal. Without a definite source of infection, there was mild pyrexia and a rise in CRP. The plain X-ray abdomen confirmed the diagnosis of Ogilvie's syndrome, showing grossly dilated large bowel loops with an 8cm maximum ceacal diameter which allowed the conservative treatment remained in place. On day 10, she was discharged after a remarkable recovery.

Conclusion
In this patient C-section, corticosteroids, opioids, oxytocin, immobility, spinal anaesthesia could have contributed. When postoperative bowel obstruction is suspected, Ogilvie's syndrome should always be taken into consideration. Patients may rapidly deteriorate if its signs and symptoms are not promptly identified. Although it is rare, it is crucial for obstetricians to identify and treat it as soon as possible to prevent any catastrophic issues later on. Ogilvie's syndrome will be seen more frequently with the increasing numbers of C-sections. Accurate clinical assessment, close observation with initial conservative management is needed in suspected cases. The patient's reevaluation is important because the failure of the conservative treatment should have warranted for a medical or surgical intervention

OP/O – 54

AN AUDIT ON MAINTENANCE OF PARTOGRAM – "ARE WE DOING IT CORRECT?" IN COLOMBO NORTH TEACHING HOSPITAL, RAGAMA, SRI LANKA

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Introduction

The partogram is a graphical representation of the events in labour. It monitors not only the progression but also the well-being of mother and the fetus during labour process.

Objectives

The objective of this audit was to assess the standard use of National Partogram in ward 17, Colombo North Teaching Hospital, Ragama, Sri Lanka.

Methods

Conveniently selected partograms of 75 mothers who delivered between January and June 2022 were analyzed retrospectively. The gold standard is 100% maintenance of the partogram.

Results

Mean age of the study population was 29years and the mean gestational age was 38.9weeks. Out of all the components none had met the gold standard. Proper documentation of the identification details was 90%. Fetal heart rate was documented in 91% in 1st stage but only 80% during the 2nd stage. Initial cervical dilatation was documented in 93%, yet further cervical assessments were documented only in 79%. Details with regard to uterine contractions (duration and contraction free interval), station of the presenting part, oxytocin administration, descent of fetal head abdominally and vaginally, description on liquor and not only that but also details on extent of caput and moulding were poorly documented. Documentations of maternal wellbeing was also substandard.

Conclusion

Partogram maintenance in labour was not met up-to the gold standard. A lecture on importance of proper monitoring and documentation of details in the partogram is scheduled for health staff, practical problems encountered by staff are to be addressed there. A re-audit is to be performed a few months following the lecture to re-assess advances in care.

OP/O – 55

SUCCESSFUL OUTCOME FOLLOWING ANTENATAL DIAGNOSIS OF SUCCENTURIATE PLACENTA WITH VELAMENTOUS INSERTION OF THE UMBILICAL CORD AND VASA PRAEVIA: A CASE REPORT

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Introduction

Morphological abnormalities of the placenta are rare but can result in increased maternal and fetal mortality and morbidity.Succenturiate placenta is the presence of one or more small accessory lobes that develop in the membranes at a distance from the periphery of the main placenta, to which they usually have vascular connections of fetal origin. Maternal age >35 years and pregnancies resulting from in vitro fertilization increase the risk of a succenturiate placenta. Velamentous cord insertion (VCI) is an abnormal cord insertion in which the umbilical vessels diverge as they traverse between the amnion and chorion

before reaching the placenta. VCI is strongly associated with vasa praevia (VP), where umbilical vessels lie in close proximity to the internal cervical os. VP leaves the vessels vulnerable to rupture, which can lead to fatal fetal exsanguination. Only 1.6% of succenturiate placentas are associated with VCI and VP and carry fetal mortality ranging from 33% to 100%. This case report is a successful antenatal ultrasound detection of a succenturiate placenta with VCI and VP and timely planned delivery minimizing potential complications leading to a successful pregnancy outcome.

Case Presentation

A 36-year-old lady in her third pregnancy with two previous first trimester miscarriages presented at 31 weeks' gestation with antepartum haemorrhage. She had previously undergone a laparoscopic myomectomy and hysteroscopic resection of a uterine septum. She is a non-smoker, and her pregnancy was a natural conception. During her routine anomaly scan, a placenta praevia completely covering the internal OS was diagnosed. However, on admission at 31 weeks, a combined transabdominal and transvaginal ultrasound scan revealed an anterior low-lying main lobe and a succenturiate low-lying posterior lobe with velamentous insertion of the umbilical cord and vasa praevia. She received tailored in-patient care considering her symptoms of persistent spotting, the long distance to the hospital and the non-availability of transport. She was counselled about the risks of preterm delivery and obstetric haemorrhage. Although the initial growth scan was normal, a repeat growth scan at 33 weeks showed reduced growth velocity with a small for gestational age fetus and umbilical artery doppler PI above the 95th centile. A category four lower segment caesarean section at 34 weeks' gestation was performed with activation of the placenta praevia care bundle, including multidisciplinary team involvement. A postpartum placental examination confirmed the diagnosis. Both mother and newborn were discharged on day 12 postpartum with no complications.

Discussion

Confirming a diagnosis of this placental abnormality often occurs at birth, after visual inspection of the placenta, with only a few cases successfully diagnosed antenatally on ultrasound. In our case, the diagnosis was made at 31weeks at the time of presentation with antepartum haemorrhage. Detailed ultrasound imaging of the placenta and umbilical cord enables clinicians to identify most placental complications and allow strategic planning of antenatal, intrapartum and postpartum care, improving maternal and fetal outcomes. Previously published reports have shown that the presence of a succenturiate lobe is a risk factor for vasa praevia, which causes sudden unanticipated fetal death.Shukunami et al.

reported two cases with failure of antenatal detection of a succenturiate lobe complicated by placenta praevia leading to adverse outcomes.VCI, when associated with VP and succenturiate placenta, increases the risks of prematurity and impaired fetal growth. The rupture of blood vessels traversing over the internal os through the membrane connecting lobes of the placenta during delivery has catastrophic effects on the fetus. Therefore, careful planning of the delivery time is vital, considering many factors to minimise complications. Further data, however, is needed, particularly regarding the optimal gestational age for delivery of pregnancies complicated by VCI.

Conclusion

Early diagnosis of placental abnormalities using a detailed ultrasound scan and optimal management, including planning the delivery time, is vital in minimizing fetal and maternal morbidity and mortality.

OP/O – 56

USE OF ROBSONS CLASSIFICATION IN UNDERSTANDING AND IMPROVING CS RATES IN A TERTIARY UNIT IN COLOMBO, SRI LANKA.

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Introduction
Worldwide, Cesarean Section (CS) rates are increasing with a characteristic upward trend. Although a timely CS is lifesaving, there are concerns as unwarranted CS could give rise to significant maternal and neonatal morbidity and mortality. Therefore, it is important to audit and analyze CS rates to improve outcomes. Since obstetric populations are diverse, it is difficult to analyze and compare CS rates in different institutions/ settings.

World Health Organization (WHO) proposed the Robson (ten groups) classification as a globally accredited system for analyzing, monitoring and comparing cesarean section rates within as well as among health care facilities.

Objectives
We aimed to identify the current trend of CS in a tertiary care center in Sri Lanka for provision of targeted strategies to achieve a justifiable CS rate.

Methods and Results
This is a retrospective analysis conducted in a tertiary care center in Sri Lanka. A total of 2066 deliveries were reviewed using the Robson classification. The overall cesarean section rate, size of each Robson group and absolute and relative contribution of each group to the cesarean section rate were calculated. There was a total of 646 cesarean sections at a rate of 31.2%(646 out of 2066). Group 5a (N=; 20.59%) and Group 1(N=; 16.41%) were the main contributors. Majority were multiparous women (61.9%) with a scarred uterus.

Conclusion
Evidence based interventions to improve care during delivery include, offer and support for trial of labour following previous CS (TOLAC), offer of TOLAC in >1 previous CS, implementation of a labour companion and review of CTG use in uncomplicated labour. Labour induction policies and process need review. It is important to prevent primary CS in low-risk groups.

OP/O – 57
THE MICROBIAL SPECTRUM OF HIGH VAGINAL SWABS AMONG PREGNANT WOMEN ADMITTED FOR DELIVERY AND ITS ASSOCIATION WITH NEONATAL SEPSIS: A RETROSPECTIVE CROSS-SECTIONAL STUDY.

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Introduction
Neonatal sepsis (NS) is the most common cause of neonatal deaths in developing countries.The microbial flora in the vagina changes during pregnancy due to alterations in the hormonal, metabolic, and immunological status, which may cause ascending infections to the fetoplacental unit and maternal bloodstream leading to preterm deliveries, preterm prelabour rupture of membranes, and early neonatal sepsis.Therefore, it is vital to study the vaginal bacterial spectrum and investigate its association with adverse pregnancy and neonatal outcomes. This study aimed to identify the microbiological spectrum of maternal vaginal flora among pregnant mothers admitted for delivery and its association with neonatal sepsis in a Sri Lankan setting.

Objectives
To identify the prevalence of positive high vaginal swab cultures (HVS) and its association with neonatal sepsis among pregnant women admitted for delivery.

Methods
This is a retrospective cross-sectional study conducted at ward 9, Sri Jayewardenepura General Hospital (SJGH), from June 2020 to December 2020. All consecutive pregnant women who delivered after 24 weeks of gestation during the study period were included. It was a routine local practice to perform a high vaginal swab at admission on all antenatal mothers admitted to ward 9, SJGH. Maternal and neonatal data were collected retrospectively from the bed head tickets and the hospital's electronic database. Data analysis was performed using SPSS version 20.

Results
A total of 258 women were included. The mean maternal age was 31.5years, and the mean gestational age at admission was 38 weeks + 1 days. 33.3% (86/258) of women admitted for delivery had positive high vaginal swabs. The vaginal microbial spectrum among them included Candida in 48.8%, Group B Streptococci (GBS) in 22.1%, Gram-positive bacilli in 15.1%, Acinetobacter in 8.1% and Gram-negative enteric organisms in 5.8%. The prevalence of NS was 3.9%, and the pathogens identified included GBS among 50%, Gram +ve Bacilli in 20%, and 10% each for Candida, Acinetobacter, and Gram -ve enterococci.

NS was significantly associated with a positive high vaginal swab culture compared with those with a negative high vaginal swab culture among women who had a vaginal birth or attempted vaginal birth (two-tailed p-value is 0.031, < 0.05). No significant association was found when comparing NS among women with a positive HVS culture having a vaginal birth or emergency CS in labour to those having a planned caesarean section (two-tailed p-value is 0.083, >0.05). 73.9% of women who delivered preterm had positive HVS cultures.

Conclusions
In our setting, one-third of all women admitted for delivery have positive HVS cultures, while almost two-thirds delivering preterm have positive HVS cultures. Among women having a vaginal birth or attempted vaginal birth, a positive vaginal culture is strongly associated with NS. These findings will help develop prevention and treatment strategies in hospitals to reduce maternal transmission of neonatal infection, thereby reducing perinatal morbidity and perinatal mortality.

OP/O – 58
PERINATAL OUTCOMES IN ANTENATALLY DIAGNOSED CASES OF CPAM – A CASE SERIES

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Introduction
Prenatal diagnosis of echogenic lung lesions can be achieved using high-resolution ultrasound during the second trimester. The most common causative lesions are congenital pulmonary airway malformation (CPAM) and pulmonary sequestration (BPS). Few studies have described the prognosis and prenatal and postnatal management of these lesions. We hereby report the first of the two cases of CPAM managed successfully in Pakistan with favourable outcomes.

Case Presentation
The first case of Primigravida presented at 20 weeks with echogenic lung lesions of microcystic and macrocytic type. Since it was unilateral with no signs of hydrops or polyhydramnios, she was encouraged to continue the pregnancy. Later she had a planned delivery and delivered a healthy baby boy of 3 kg that remained asymptomatic through the antenatal period. The second case is of a Multigravida patient who presented for second opinion at 22 weeks with a scan showing large macro-cystic echogenic lesions

occupying 50% of the right lung. She had been advised termination by multiple physicians but after the scan was reassured of the favourable outcome. She underwent a Caesarean section at term due to breach presentation and delivered a healthy and asymptomatic boy.

Conclusion
Antenatal presence of CPAM is usually associated with favourable outcomes and hence after detailed scans are performed to rule out any other associated anomalies parents should be reassured about the good prognosis and avoidance of termination of pregnancy.

OP/O – 59
FETAL GROWTH RESTRICTION: AN EVIDENCE BASED APPROACH

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Introduction
Fetal Growth restriction (FGR) is one of the leading causes of perinatal mortality and morbidity and is seen in around 5 - 10% of all pregnancies. This multifactorial disorder is mostly caused by placental dysfunction. Other causes are less common. Prematurity and Stillbirth are the two risk factors associated with this condition.More than 40% of the unexplained stillbirths are related to FGR and this risk is low when the growth is above the 9th centile. Also, nearly half of these are likely to be missed on routine antenatal checkups.

Objective
The main aim of this is to present the evidence-based approach towards the diagnosis and management of this condition which will ensure optimal outcome.

Methods
After accurate dating of pregnancy, the diagnosis of fetal growth restriction is made by performing fetal biometry. It is recommended to use population-based growth fetal growth reference charts for growth assessment, while Hadlock Formula to be used for the estimation of fetal weight calculation. If the growth is below the 10th centile and those with Oligohydramnios, Doppler surveillance is recommended. Dopplers mainly comprise of umbilical, middle cerebral artery and Cerebroplacental ratio and Ductus Venosus. Both early and late FGR are characterized by different doppler changes. Umbilical artery Doppler changes are more relevant in early FGR while Middle Cerebral artery doppler and CPR are used in monitoring of late FGR. The management of FGR therefore should be individualized based on whether it is uteroplacental origin or less commonly genetic or infectious nature of the disorder, gestational age and parental counselling.

Conclusion
Management of Fetal Growth Restriction remains to be individualized. Dopplers play a vital role in surveillance and hence deciding for the optimum time of delivery.

OP/O – 60
A RE-AUDIT ON ARTIFICIAL SEPARATION OF MEMBRANE (ASM) AT 40 + 0 WEEKS AND 40 + 3WEEKS IN LOW-RISK PREGNANCY

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Introduction
Induction of labour (IOL) is defined as the process by which labour is started before its spontaneous onset by artificial stimulation of uterine contraction and/or progressive cervical dilation and effacement. Pregnancy continuing beyond 41 + 0 weeks may increase complications over time and these include increased likelihood of caesarean birth, increased likelihood of the baby needing admission to a neonatal intensive care unit and increased likelihood of stillbirth and neonatal death.Mechanical methods such as Foley catheter ASM and ARM and pharmacological methods such as Prostaglandin and Syntocinon are used for the induction of labour in clinical practice.

Pharmacological IOL are not without side effects such as failed IOL, uterine hyper-stimulation, cord prolapse and emergency caesarean birth In south Asian population, it is believed that placental maturity and post maturity complications occur earlier than Caucasians. Therefore, we practice inducing the labour at 40+5 weeks in our ward. This audit was conducted as re-audit for the previous audit in low-risk pregnant women who were admitted at 40 weeks to wad 1and 2, castle street hospital for women were recruited to that study. During the study period, 89 antenatal mothers were participated in this study. 41 (46%) of them went into spontaneous onset of labour while others needed IOL.

Objective
The purpose of this study is to acknowledge the proportion of low-risk pregnant women who develop spontaneous onset of labour at / before 40 + 5 weeks after artificial separation of membrane at 40 + 0 weeks and 40 + 3 weeks.

Method
Low risk pregnant women who were admitted at 40 weeks to ward 1 and 2, castle street hospital for women, were recruited to this study. This study was conducted from the period of April 2022 to June 2022. All mothers underwent ASM at 40 weeks and mothers who did not develop labour again underwent ASM at 40 +3 weeks. Mothers who didn't develop labour were offered prostaglandin induction. Data were analyzed using SPSS.

Results
During the study period, 114 antenatal mothers were participated in this study. 29(25%) developed labour after 1stASM and 56(49%) developed labour after 2nd ASM. Overall, 74% went into labour. Rest was offered IOL with prostaglandin.

Conclusion
Artificial separation of membrane at 40 + 0 weeks and 40 + 3weeks significantly reduces formal induction and help to prevent post maturity and related complications.

OP/O – 61
AUDIT ON INDUCTION OF LABOUR (IOL) AT 40 + 5 IN LOW-RISK PREGNANCY

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Introduction
IOL is defined as the process by which labour is started before to its spontaneous onset by artificial stimulation of uterine contraction and/or progressive cervical dilation and effacement. Pregnancy continuing beyond 41 + 0 weeks may increase complications over time and these include increased likelihood of caesarean birth, increased likelihood of the baby needing admission to a neonatal intensive care unit and increased likelihood of stillbirth and neonatal death.

Mechanical methods such as Foley catheter Artificial separation of membrane and artificial rupture of membrane and pharmacological such as Prostaglandin and Syntocinon after artificial rupture of membrane are used for induction of labour in clinical practice.

In south Asian population, it is believed that placental maturity and post maturity complications occur earlier than Caucasians. Therefore, we practice inducing the labour at 40 + 5 weeks in our ward.

Objective
The purpose of this study is to acknowledge the proportion of low-risk pregnant women who develop spontaneous onset of labour at / before 40 + 5 weeks without any antepartum interventions.

Method
Low risk pregnant women who were admitted at 40 weeks to ward 1and 2, Castle Street Hospital for Women, were recruited to this study. This study was conducted from the period of January 2022 to March 2022. Data were analyzed using SPSS.

Result
During the study period, 89 antenatal mothers were participated in this study. 41(46%) of them went into spontaneous onset of labour while others needed IOL.

Conclusion
Artificial separation of membrane at 40 + 0 weeks and 40 + 3 weeks would reduce number of formal inductions to prevent post maturity related complications.

OP/O – 62
AUDIT ON PARTOGRAPH MAINTENANCE

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Background
The partograph is defined as a graphical representation of the progression of labour, assessment of fetal well-being and maternal well-being during labour. The use of WHO partograph during labour has demonstrated its value in improving both maternal and fetal, neonatal outcome. Out of two WHO recommended partographs the modified one has been shown to be more user friendly compared to the composite one which includes the monitoring during latent phase of labour as well.Despite these facts it has found out that the use of partograph had been sub-optimal in local hospitals as wells as internationally.

Objective
The assessment of adherence to the partograph maintenance in a tertiary care hospital in Sri Lanka.

Method
The data from 56 women who delivered vaginally in a maternity ward at National Hospital Kandy over a period of 3 months was obtained by going through the partograph in each woman retrospectively. All the fetuses were in cephalic presentation and were singleton pregnancies at term. The assessment was done paying attention to the completeness of the documentation with regard to the patient's details, the fetal and maternal monitoring and the progression of labour. The data were analysed using Microsoft Excel programme and the results were presented as frequency analysis.

Results
Out of 56 partographs of women which were included in the analysis a one woman has spent around 260 minutes of mean time in the labour room from the time of admission to the delivery.

The analysis of documentation with regard to the filling of basic information of the woman in labour, other important problems and the instructions to manage them were not complete. Most importantly the special instructions have not been mentioned (94%) in majority of partographs where it was applicable. The fetal monitoring had been also documented in a suboptimal manner which was stressed well with non-documentation of fetal heart rate monitoring in 2ndstage of labour in 100% of the cases.

The maternal monitoring was also incomplete according to the documentation and in 18 women out of 56 though it has commenced not been continued throughout the labour process. The assessment of the progression of labour also had been documented in a substandard manner as it is depicted in the table below. As it can be appreciated the commencement of intervention like starting intravenous oxytocin which will need more intensified fetal and maternal monitoring had not been documented properly. The result of this audit is comparable with what it has been found out during previous similar audit which was conducted at Colombo North Teaching Hospitalwhere the substandard documentation of contractions (31.2% versus 30%) and fetal heart rate monitoring (77% versus 98% in first stage and 0% in second stage) was noted.

Conclusion

The documentation of labour related events will be beneficial for the health staff to identify problems associated with the labour and to have favourable outcome for both the woman in labour and the neonate ultimately. Having said so its use has been found to be substandard repeatedly with assessments. It would be beneficial to plan a study to evaluate the reason for its substandard use and take necessary actions to amend those.

OP/O – 63

MATERNAL BODY MASS INDEX AS A DETERMINANT OF NEONATAL BIRTH WEIGHT: A CLINICAL AUDIT

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Introduction

Maternal nutritional status is one of the key factors that influence fetal wellbeing. Body mass index (BMI) is an internationally accepted tool to assess maternal nutritional status before conception. 18.2% of adult women in Sri Lanka are underweight, 37.8% have normal BMI, 28.7% are overweight and 15.2% are obese. Pre-pregnancy BMI is known to influence fetal wellbeing and thus one neonate's birth weight.

Objectives

This audit was conducted to assess the influence of pre-pregnancy BMI on neonatal birth weight.

Methods

A previously collected data set from the Colombo North Teaching Hospital, between 2020−2021 was used for this clinical audit. Multiple pregnancies and antenatal records with missing information on maternal BMI and neonatal birth weight were excluded. Out of 3176 deliveries recorded, 2569 live singleton births were considered in this audit (80.9%). Maternal BMI categories based on 2004 WHO definitions for the Asian population as underweight <18.5, normal 18.5 to 22.9, overweight 23.0 to 27.4, and obese ≥27.5, were used. Normal neonatal birthweight is defined as between 2.5 – 4 kg. Data were analyzed using IBM SPSS version 28.

Results

The BMI range of the sample is between 12.25 – 39.99 kgm^{-2}. 308 (11.84%) of the sample were underweight, 821 (31.46%) had normal BMI, 921 (34.94%) were overweight and 568 (21.76%) were obese. Neonatal birth weight ranged from 535 g to 4465 g. 35.2% of the variability observed in the

birth weight is explained by the regression model. As this is >30%, the predictors (clinical maturity, maternal BMI) affect neonatal birth weight. In collinearity diagnostics, unstandardized beta values for both maternal BMI and maternal BMI and clinical maturity carry positive values indicating between the dependent variable (neonatal birth weight) and predictors. (BMI – 16.643, Clinical maturity – 597.901) As the P values are less than 0.05, there's a statistically significant correlation between both neonatal birth weight and maternal BMI (correlation value – 0.144, P value <0.001) and neonatal birth weight and clinical maturity of the fetus. (Correlation value – 0.589, P value <0.001)

Conclusions
There is a significant variation in neonatal birth weight with maternal pre-pregnancy BMI. This warrants more studies on the topic to define the exact degree of the relationship.

OP/O – 64
AN AUDIT ON THE EFFECTIVENESS AND ADVERSE EFFECTS OF THE USE OF VAGINAL MISOPROSTOL IN THE MANAGEMENT OF FIRST TRIMESTER MISCARRIAGE

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Introduction & Objectives
Misoprostol has been used for many years in Sri Lanka as an effective and safe method for the management of miscarriages. Misoprostol is a synthetic prostaglandin E1 analogue, which binds to the smooth muscles of the myometrium and induces uterine contractions and relaxation of the cervix.Misoprostol is available as oral, sublingual, buccal, and vaginal preparations in strength range of 200 µg to 800 µg. The most common side effects of misoprostol use include abdominal pain, nausea, vomiting, fever, chills, headache and diarrhoea. In this study we have evaluated the effectiveness of two cycles of vaginal misoprostol use and the rate of adverse effects in 57 women who attended to the Gynaecology ward for the management of missed miscarriage.

Methods
A cross-sectional study was conducted in the ward 6, Colombo North Teaching Hospital, Ragama, between November 2021 to May 2022. Data were collected using bed head tickets for the demographic characteristics, drug frequency, outcomes, and adverse effects. All of the selected patients received800 µg of vaginal misoprostol at once and if unsuccessful the second dose was inserted 24 hours apart (as per the unit protocol) and the responses were evaluated. An endometrial thickness of 15 mm or less was considered as the cut off value for a complete miscarriage.

Results
Of the 57 women recruited to the study, mean age was 33 years and mean gestational age was 8 weeks. Among 57 women, 21 (37%) were nulliparous and 36 (63%) were multiparous. The success of the treatment of misoprostol at 24 hours after the first dose was 36% and at 48hours was 39%. Among them highest success was seen at nulliparous women (35%) and women who had per vaginal bleeding prior to misoprostol insertion regardless of the parity.

Among all, fourteen (25%) patients underwent surgical management for the miscarriage. Adverse events due to misoprostol were reported in 17 (30%) patients and the most common side-effect was Nausea/ vomiting (14%).

Conclusions
Misoprostol is a well-tolerated drug in medical management of miscarriages with the success rate of 75%. Vaginally administered misoprostol may be an effective alternative to surgery.The odds of successful treatment appear to be greatest for nulliparous women, and those who have lower abdominal pain or vaginal bleeding within 24 hours before receiving the misoprostol.

OP/O – 65

A CASE REPORT OF RARE OCCURRENCE OF ABDOMINAL WALL ECTOPIC PREGNANCY AND PERSISTENCE TROPHOBLASTIC DISEASE TREATED WITH METHOTREXATE

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Introduction

An ectopic pregnancy occurs when a fertilized egg implants and grows outside the main cavity of the uterus. In more than 90% of cases, the embryo implants in a fallopian tube. Whatever the type of ectopic pregnancy, it remains potentially life-threatening condition. Maternal mortality of 0.2/1000was estimated.

Case Presentation

A 40-year-old, G3P3C2, POA – 8 + 6 weeks, presented with lower abdominal pain. Initial USS was suggestive of pregnancy of unknown location. Initially, patient was managed conservatively with serum β-hCG monitoring. As pain increased with time without any evidence of intrauterine pregnancy and cause for pain couldn't be explained except for ectopic pregnancy, diagnostic laparoscopy was planned. During laparoscopy both ovaries and tubes looked normal. There was an anterior abdominal wall mass seen towards right site which was highly suggestive of abdominal wall pregnancy. That mass lesion was removed carefully and sent for histology. histology confirmed ectopic pregnancy. Post operative period was uneventful.serum β-hCG measurement weekly until a negative result is obtained since the day of surgery was planned. Initially, β-hCG was 525 mIU/ml which was lower than preoperative value. But consecutive values were increasing. Serum β-hCG increased to 2394 over three weeks.

Patient was asymptomatic despite elevation in the β-hCG and USS abdomen was normal. Then, persistence trophoblastic disease was diagnosed. After counselling with patient, she agreed to go for medical management. 80 mg of IM methotrexate was given. Thereafter, β-hCG was checked at day 4 and 7 and values were 1934 mIU/ml and 1230 mIU/ml respectively. Patient was discharged with the follow up plan with weekly β-hCG measurements. After 4 weeks of discharge, her beta became negative.

Discussion

After the management of ectopic pregnancy conservatively, medically, with salpingotomy or surgical removal of ectopic from a site other than fallopian tube, clinicians should have a suspicion of developing persistence trophoblastic disease. Failure to detect persistence trophoblastic disease may lead severe maternal complications.

OP/O – 66

A CASE REPORT OF POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME ASSOCIATED WITH ECLAMPSIA

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Introduction

Posterior Reversible encephalopathy Syndrome (PRES) is a clinico-radiological syndrome. Common symptoms are altered consciousness, visual disturbance, seizure, nausea and headache. Signs are dysphasia, hemianopia, focal neurological deficits and paresis. Radiological findings are white matter lesions in the posterior parietal lobes, occipital lobes and posterior temporal lobes. Pathophysiology of PRES is unclear, but endothelial dysfunction and failure of cerebral auto regulation is the main hypothesis. PRES is commonly associated with acute hypertension, preeclampsia, eclampsia, autoimmune disease and sepsis.

Case Presentation

A 26-year-old primi gravida presented in unconscious stage following two episodes of convulsion at 34 weeks of gestation. Her antenatal period was uncomplicated and no past history of hypertension or epilepsy. On examination, she had bilateral ankle oedema and exaggerated reflex. Her blood pressure was 170/110 mmHg with +2 urine albumin. Investigations revealed haemoglobin level-12.3 g/dl, platelet count-120,000/m3, SGPT-66 U/l, SGOT-120 U/l and, clotting profile and renal function tests were normal. At the ward, she has developed further two episodes of generalized tonic clonic convulsions (GTC) with prolong postictal drowsiness. Her blood pressure was controlled with labetalol and hydralazine. $MgSO_4$ was started and live fetus was delivered via emergency caesarian section after stabilizing the mother. Post-operative intensive care was given due to prolong postoperative drowsiness. She has developed a further episode of GTC convulsion at intensive care unit (ICU). Her non-contrast computerized tomography of brain revealed as posterior reversible encephalopathy syndrome. Levetiracetam was started and blood pressure (BP) was controlled with antihypertensives. ICU care was given for four days and discharged with oral antihypertensive drugs after one week of ward care.

Discussion and Conclusion

Delayed diagnosis and treatment cause irreversible brain damage and high mortality. Diagnosis depends on clinical and radiological findings. Effective therapy is mostly supportive treatment, such as control BP, anticonvulsant therapy. If eclampsia presents with multiple convulsions, prolong altered consciousness during non-convulsive phase and focal neurological defect, the presence of PRES should be excluded early. If recognized and treated early, patient recovers within a week without any residual brain damage.

OP/O – 67

AN AUDIT CYCLE ON THE MATERNAL AWARENESS OF INCREASED RISK OF CHROMOSOMAL ANEUPLOIDY WITH INCREASING MATERNAL AGE, SCREENING TEST FOR CHROMOSOMAL ANEUPLOIDY AND DIAGNOSTIC TESTS IN MOTHERS AGED 35 YEARS OR MORE

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Introduction

Although most babies are normal, some others have a risk of having a baby with chromosomal anomaly including down syndrome, this risk increases with increasing age. Measurement of the nuchal translucency together with maternal age and measurement of maternal hormones will allow estimation of the mother's individual risk. Mothers with a high predicted risk (usually 1:300 or greater) may then decide to have diagnostic tests (amniocentesis or chorion villous sampling) if they wish.

Method

This audit cycle was conducted in mothers of 35 years or more, who attended to ward 01& 02 antenatal clinic of castle street hospital for women, to assess the maternal awareness of increased risk of chromosomal aneuploidy with increasing maternal age, screening test for chromosomal aneuploidy and diagnostic tests. The audit was conducted from January 2022 to February 2022. Following this audit, leaflets containing information regarding increased maternal age increasing risk of having chromosomal aneuploidy, aneuploidy screening (combined test) and diagnostic tests were distributed to 120 mothers aged 35 years or more attending to booking visit. An reaudit was conducted from March 2022 to May 2022.

Results

107 mothers participated in this audit. Only around 22% were aware about increased risk of chromosomal aneuploidy with increasing maternal age. Out of those mothers, only around 8% knew that there is a screening test for chromosomal aneuploidy and around 3% knew that there are diagnostic tests.

98 mothers were interviewed in reaudit, among them 88% were aware about increased risk of chromosomal aneuploidy with increasing maternal age. All those mothers had positive attitudes to undergo combined test. Two antenatal mothers had full aneuploidy screening in private sector.

Conclusion and Recommendation
Distributing leaflet and conducting awareness programme in booking visit to mother aged 35 or more would increase knowledge regarding chromosomal aneuploidy, aneuploidy screening tests and diagnostic tests.

OP/O – 68
AN AUDIT ON LEVONORGESTREL IMPLANTS (JADELLE) AS REVERSIBLE CONTRACEPTIVE METHODS AMONG PREGNANT MOTHERS

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Introduction
Inter-pregnancy interval (IPI) of at least 24 months is recommended, and it is associated with reduced incidence of neonatal and perinatal mortality, low birth weight, small for gestational age baby and preterm delivery. In addition, allows child mother to experience the benefits of optimal breastfeeding for two years. It is also evident that IPI of more than six months reduces incidence of maternal mortality, preeclampsia, prelabour rupture of membranes, anemia and the incidence of unsafe abortions. Jadelle as one of LARC provides effective and convenient long-term contraception.

Objective
The purpose of this study is to evaluate knowledge and attitude on Jadelle as post-partum contraceptive method after first pregnancy.

Method
Pregnant mothers who were attending to antenatal clinic at 36 weeks of gestation at castle street hospital for women from March 2022 to May 2022 were included. Data collected by medical officers using interviewed administered questionnaire.

Results
75 mothers were included in the audit. More than 60% of them selected Jadelle as preferred contraceptive method. among them 68% and 72% of believed insertion and removal of Jadelle are very painful respectively. Surprisingly, 1 in 2 did not know that it is inserted and removed after local anesthesia.1 in 5 thought insertion of Jadelle suppress milk production.64% thought it is associated with weight gain.92% of them didn't know that Jadelle in situ for years would cause reduction in bone mineral density. 1 in 2 knew it can cause amenorrhea can be inserted immediately after delivery.84% knew it can be retained for 5 years.

Discussion and Intervention
According to this analysis, knowledge and attitude about Jadelle as postpartum contraceptive methods are not satisfactory. Most mothers as well as their partners need proper counseling to provide suitable post-partum contraception. Separate lecture session was arranged regarding contraceptive method in antenatal classes.

Recommendation
Women as well as male partners need proper counseling throughout the pregnancy. Providing printed information leaflets will be helpful to register the knowledge in busy clinic set up.

OP/O – 69

AN AUDIT ON MATERNAL AWARENESS ABOUT CAESAREAN SECTION AS MODE OF DELIVERY AND RELATED COMPLICATIONS

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Introduction

Caesarean delivery is the most common surgery performed in the world, and its incidence is increasing. Caesarean section accounts for over 40% and over 25% of all deliveries annually in Sri Lanka and the UK, respectively. In general, maternal morbidity and mortality among these women remains substantially higher than among those who deliver vaginally; and these risks increase with each subsequent caesarean delivery. There are a number of immediate and delayed complications that may be encountered, and the obstetrician must be familiar with and able to rectify these. Maternal request to have cesarean section is one of the causes for increasing c-section rate even though this is not an absolute indication. Maternal fear of having a vaginal birth (Tokophobia) or vaginal examinations are among the common causes for maternal request. But having awareness of caesarean section may increase positive thought towards vaginal delivery.

Objective

The purpose of this study is to assess the knowledge of pregnant women at 28 weeks in Antenatal clinic about Maternal awareness about Caesarean section as mode of delivery and related complications.

Method

Pregnant women who attended to antenatal clinic of castle street hospital for women were recruited to this study. This study was conducted from the period of April 2022 to June 2022. All mothers were given preset questionnaire. Data were analyzed using SPSS.

Results

During the study period, 120 antenatal mothers participated in this study. Everybody knew cesarean section is major surgery to deliver the baby where benefit of caesarean section outweighs the vaginal delivery. Among them 70% knew caesarean sections are done for some elective reasons and 80% knew that caesarean sections are done for some emergency reasons. During analysis about the intra operative complications of c section less than 30% knew about maternal complications (bladder, bowel, ureteric injury, etc.) and less than 10% knew about foetal complications (lacerations to babies). During analysis about the immediate postoperative complications of c section 80% knew about post operative pain, while 20% knew about bleeding and infection risk. During analysis about the long term complications of c section 80% knew about the risk of repeated C section in subsequent pregnancies, while only a few knew about other complications in subsequent pregnancies (uterine rupture 30%, placenta praevia/accreta 25%, antepartum stillbirth 5%).

Conclusion

Most of the mothers know that caesarean section is a major surgery to deliver the baby. However, awareness about the complications related to caesarean section is not satisfactory. Increasing the awareness among mothers would reduce the preventable cesarian section rate and related complications.

Recommendation

Distributing leaflet and conducting awareness programme at or beyond 36 weeks would increase knowledge regarding maternal awareness about c section as mode of delivery and related complications.

OP/O – 70

AN AUDIT ON KNOWLEDGE ABOUT POSTPARTUM CONTRACEPTION WITH IUCD AMONG HEALTHCARE WORKERS

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Introduction

An IUCD is a copper-containing tiny device that acts as a long-term, reversible birth control method. Inter-pregnancy interval (IPI) of at least 24 months is recommended, and it improves maternal physical and mental health by preventing unexpected pregnancy. In addition, it allows the child to experience the benefits of optimal breastfeeding for two years. It also prevents neonatal and perinatal mortality, low birth weight, small for gestational age baby and preterm delivery in the next pregnancy.

Objective

The purpose of this study is to evaluate the knowledge and attitude of health care workers (nurses and midwives) on IUCD as LARC.

Method

Health care workers in the castle street hospital for women were recruited for this audit. Data were collected by medical officers using an interviewer-administered questionnaire from May 2022 to June 2022were included.

Results

66 health care workers were included in the study. 80.5% of them knew IPI of < 12 months increased the risk of complications. Only 35% of them selected IUCD as the preferred contraceptive method. 34.4% of them knew that IUCD can be inserted immediate partum up to 48hrs. Among them, 59% and 45% of them believed insertion and removal of IUCD are very painful respectively. 1 in 5 believed that it is associated with reduced milk production. 45% of them knew it can cause minor menstrual problems after some time of insertion. 57.9% of them knew that IUCD can be retained for 10 years.

Discussion and Intervention

According to this analysis, knowledge and attitude about IUCD as postpartum contraceptive methods among health care workers is satisfactory to some extent. But the knowledge regarding post-partum contraception, not only IUCD but also all other methods, needs to be upgraded as they encounter most of the antenatal mothers.

Recommendation

Conducting frequent audits, arranging workshops and lectures and developing local information sheets and leaflet would improve and updates the knowledge and attitude of health care works on IUCD as LARC.

OP/O – 71

EFFECT OF IMPLEMENTING GUIDELINES AND CHANGING PRACTICES ON CAESAREAN SECTION RATES IN THE OBSTETRICS UNIT OF AL NAFEES MEDICAL COLLEGE HOSPITAL

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Objective
To evaluate the effect of implementation of guidelines and changing practices on caesarean sections rates at Al Nafees Medical College Hospital without compromising maternal or perinatal morbidity and mortality.

Hypothesis
Caesarean section rate can safely be reduced by interventions that involves the personnel working in the obstetrics department.

Study Design
Quasi experimental study.

Intervention
During the study period we instituted a program of increased awareness, regular audits, more aggressive laboring techniques, confidential feedbacks and clinical guidelines.

Methodology
For the purpose of study, the data was subdivided into 12 monthly periods for analysis and comparison. Sampling technique used is convenient sampling. New labor management guidelines were implemented along with regular audit and feedback in January 2014. We analyzed the delivery statistics of our institution before and after these guidelines to describe a successful program of caesarean section delivery reduction and to help us understand the efforts and the factors which led to this reduction. Descriptive statistics were utilized and all results were presented as frequencies, means and percentages.

Results
The overall caesarean rate fell from 36.6% in 2013 to 24.5% in 2016, similar reductions were noted in primary (28.4% to 15.5%) and repeat caesarean section rates (35% to 20%). The decrease in repeat caesarean section rate is explained by a significant increase in trial and successful vaginal birth (29.2% in 2012 to 68% in 2016) after caesarean section. No increase in maternal, fetal, or neonatal morbidity or mortality was observed.

Conclusion
We have demonstrated that caesarean delivery rate can be safely lowered in a teaching hospital when you change the clinical practices of the doctors, paramedical staff. All they need is constant supervision, audits, feedbacks and clear clinical guidelines.

OP/O – 72
ENHANCING PERSON-CENTRED CARE AND ADHERENCE TO EVIDENCED-BASED STANDARDS FOR INDUCTION OF LABOUR IN A TERTIARY CARE CENTRE IN SRI LANKA: A QUALITY IMPROVEMENT PROJECT CONDUCTED AT DSHW, COLOMBO.

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Introduction

Induction of labour (IOL) should be performed only when there is a clear medical indication, and the expected benefits outweigh its potential harms. Sri Lanka has the highest IOL rate in Asia (35.5% of total deliveries). Previous evidence showed that IOL when compared to spontaneous labour in low-risk women is associated with maternal and fatal complications. Hence, women should be fully informed and involved in the decision-making process of whether to perform IOL. This study reports on a quality improvement project conducted at DSHW, Colombo, aiming at improving person-centred care and adherence to the evidence-based IOL practices.

Methods

This project was conducted in four phases during May 2020 to April 2022. Phase 1 was a retrospective audit of 100 patient's records. Records of women who undergo IOL from July 2019 onwards were selected for review. Key practices of case management were assessed, according pre-defined international and national standards. In Phase 2, audit findings were discussed within a group of 22 health professionals with a participatory approach, and four priority low-cost quality improvement interventions were identified: a) a patient information leaflet; b) a patient safety checklist; c) a ward protocol; d) a staff awareness workshop. Phase 3 was the implementation of the agreed intervention, carried out over a period of six months. In Phase 4 a second audit was performed, with the same methodology as Phase 1, to assess changes in case management.

Results

Key gaps in quality of care identified in the first audit and finding after the interventions:

1. indication for IOL was made explicit in 59% of the cases which was improved to 95%.
2. informed consent prior to IOL was obtained only in 2% and this was improved to 90%.
3. the sequence of interventions prescribed and administered were recorded only in about one third of case (30%) and this improved to 95%.
4. before induction, only in 24% cases fetus was evaluated by cardiotocography (CTG); and this improved to 90%.
5. where applicable, practices regarding PGE2 administration, oxytocin regimen and dose titration were up to the standard in 70% the cases and this improved to 95%.

Conclusions

The project was successful in improving several indicators of key practices related to IOL. Findings of the first audit suggest that person-centred care and evidenced-based standards should be regularly assessed in the Sri Lankan setting. Further studies should aim at assessing IOL rates and related practices over time and at further improving them.

ORAL PRESENTATIONS - GYNAECOLOGY

OP/G – 01

SUBCUTANEOUS EMPHYSEMA AND HYPERCARBIA AFTER TOTAL LAPAROSCOPIC HYSTERECTOMY

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Introduction

Laparoscopic hysterectomy is the most popular gynaecological procedure for almost all benign gynaecological conditions. It has many advantages over the abdominal and vaginal route, but severe serious life-threatening complications result from carbon dioxide (CO2) insufflation

Case Presentation

A 50 -year-old para 2 , followed up at a gynaecology clinic for 3 years for perimenopausal bleeding. On examination, the abdomen was soft without palpable pelvic masses. Bimanual examination revealed an 8 -week sized anteverted mobile non-tender uterus with normal adnexa. A sonogram showed the anteverted adenomyotic uterus 6.2 x 5 cm in size, regular endometrium with 0.8 cm thickness & normal adnexal structures. She was initially managed medically with mefenamic and tranexamic acid, cyclical norethisterone and levonorgestrel-releasing intrauterine system (LNG-IUS) after endometrial sampling.

The patient was not satisfied with medical management, so a laparoscopic hysterectomy was planned. Her preoperative assessment & basic investigations were normal with good glycemic and blood pressure control. At the operation, the patient was placed in Lloyd Davies position, pneumoperitoneum achieved with the use of Veress needle and 3 l of CO_2 insufflated at a pressure of 20 mmHg . Four trocars were placed and surgery extended over two hours. CO_2 retention with pCO_2 71 mmHg and extensive subcutaneous emphysema was noted in the immediate postoperative period. So mechanical ventilation continued, extubation was done with spontaneous breathing and ICU care was given for the post-op day one. Both hypercarbia and subcutaneous emphysema resolved spontaneously. The patient was discharged on post-op day four and followed up in the clinic.

Discussion

The proportion of laparoscopic hysterectomies has gradually increased over the last few decades as minimally invasive surgery. Compared to the abdominal and vaginal approach it has a short hospital stay, less blood loss, less pain, and fast recovery as advantages but it takes longer operation time and needs experts and expensive instruments. In laparoscopy, CO_2 is used to insufflate the peritoneum to make a stable operative field. CO_2 insufflation can result in subcutaneous emphysema, hypercarbia, pneumomediastinum, and CO_2 embolisms leading to cardiorespiratory depression, especially with the elderly and patients with suboptimal respiratory function. The operating time >200 min , older age, use of >5 ports, and high intra-abdominal pressure precipitate to those complications. But most of the time they are managed expectantly.

Conclusion

Laparoscopic surgeons must be aware of the complications of CO_2 insufflation in the immediate postoperative period and adhere to possible preventive measures as much as possible during surgery.

OP/G – 02

RE-ADOPTION OF AUTOLOGOUS FASCIA SLING FOR STRESS URINARY INCONTINENCE – A CASE SERIES IN TEACHING HOSPITAL PERADENIYA

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Introduction

Stress urinary incontinence (SUI) is a common problem affecting one third of women, which cause severe psychosocial distress. Different surgical techniques have evolved over the last few decades to treat SUI. Although the synthetic slings have gained widespread popularity with its introduction, due to recent concerns over increasing number of complications and litigations, it is imperative to look for alternative surgical options to treat SUI and autologous sling procedure is slowly gaining back its recognition as a viable alternative.

Method

Patients who attended gynaecology clinic of Teaching Hospital Peradeniya from July 2020 to June 2021 with SUI and stress predominant mixed urinary incontinence, not responding to conservative management were offered autologous rectus fascia pubovaginal sling insertion. Patients with significant uterovaginal prolapse and obstructive urinary symptoms were excluded. Seven patients who consented were offered surgery under spinal anaesthesia. A 10 x 2 cm strip of rectus fascia was obtained via a small suprapubic transverse skin incision. Both ends of the sling were suspended with 1 prolene. The sling was inserted via anterior vaginal wall incision using curved reusable metal inserter, taken out via the abdominal incision and tied across the rectus sheath without tension. Following surgery, catheter was kept in-situ for 48 hours. Patients were assessed for obstructive urinary symptoms and post void residual volume by ultrasound scan before discharge. All were reviewed in one month in clinic and followed up over the phone after 1 year and 2 years of surgery to assess urinary symptoms and complications.

Results

The mean age of the patients at the time of surgery was 56 ± 11 years. Two patients (28.5%) were offered gentle urethral dilatation on post-surgery day 11 for urinary retention due to excessive tension on urethra. Among them one had recurrence of SUI and underwent repeat autologous sling insertion after four months. At two years, five (71.4%) patients were contactable. Regarding the efficacy of treatment, four (80%") had complete cure of SUI and one (20%) had recurrence of SUI. Comparing the adverse effects, one (20%) developed de novo urgency and urge incontinence and another (20%) had mild persistent perineal pain.

Conclusion

Autologous rectal fascia sling insertion is an effective surgical treatment for SUI and stress predominant mixed incontinence. It has many advantages compared to other surgical alternatives. It is productive to learn the technique of autologous rectus fascia sling insertion and utilize it to treat patients with SUI.

OP/G – 03

QUALITY OF THE DOCUMENTATION OF GYNAECOLOGICAL SURGERIES

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Introduction
Operative note is an important document, which is often produced in a court of law as documentary evidence, either by the plaintiff or the defendant. The errors of documentation are known to occur in all medical specialties with possible range of clinical and medico-legal consequences. There are various formats for writing operative notes and the given by Royal College of Surgeons of England (RCS England) is a well-accepted one.

Objectives
This study is to compare operation note documentation against guidelines published in Good Surgical Practice by the RCS England, 2014, and to improve adherence to these guidelines, through educating surgeons.

Methods
The retrospective audit was carried out at a gynaecology ward of the De Soysa Maternity Hospital. 50 operation notes of the patient who underwent laparotomy during June 2019 to September 2019 were analyzed and compared the results with the guidelines published in Good Surgical Practice by the RCS England, 2014 as the gold standard. Our findings were presented to the doctors of the unit and common format was made available in the theater. Re-audit was carried out and 30 operative notes were analyzed in the period of November 2019 to January 2020.

Results
All the operative notes were handwritten. All had variables like name, age, sex, date of surgery, pre-operative diagnosis, surgical procedure, per-operative findings and surgeon's name written in a legible manner. There were frequent uses of the abbreviations in all the operative notes. Date and time, Elective / Emergency were documented in 22 (44%) and 18 (36%) respectively. Most of the notes had the name of the operating surgeon and assistant 46 (92%), operative procedure carried out in 47 (94%), incision 43 (86%) and details of closure technique in 38 (76%). Operative findings and anticipated blood loss were documented in 29 (58%) and 6 (12%) respectively. Antibiotic prophylaxis, DVT prophylaxis were marked in 5 (10%), and 4 (8%) operative notes. Detailed postoperative care was marked in only 23 (46%) operative notes. None of operative notes had signature. On re-audit an improvement was seen in all the above fields.

Conclusion
Education of surgeons about standard record keeping and providing guidelines to the theatres clearly improved documentation of operation notes in compliance with the Royal College of Surgeon's guidelines. Quality of the operative notes can be improved by adding aide-memoire attached to operative note sheets or by introduction of computerised operative notes.

OP/G – 04
MIGRATION OF AN INTRAUTERINE CONTRACEPTIVE DEVICE TO URETHRA : A CASE REPORT

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Introduction
Perforation is a rare complication of IUCD insertion. If occurs, it is usually identified incidentally either with 'missing threads' or with an unplanned pregnancy. We report a 35 -year-old woman with migration of the IUCD into the urethra.

Case Presentation
Index case was a 35 year-old woman, para 2, has had two normal vaginal deliveries. Following the first delivery she had a Copper IUCD inserted at postpartum 6 weeks. While having the IUCD she got conceived for the second time however there were no records of IUCD localization in the antenatal or postnatal period. She has had recurrent episodes of dysuria and treated several times by general practitioners for suspected urinary tract infections. She presented with severe pain in urethra aggravated with micturition and inability to pass urine due to pain. Examination revealed a hard structure protruding through the urethral orifice with two tips of the IUCD threads. A pelvic ultrasound scan and a X-ray was performed which had found that the IUCD was in close relation to the bladder neck and urethra.

She underwent IUCD removal under spinal anaesthesia. An artery forceps was used to grab the tips of the threads and gentle persistent traction was applied to remove the IUCD without breaking the threads. No significant bleeding was noted from the urethra, however an indwelling catheter had been kept in situ. IUCD thread and the body had calcium deposits making a structure more like calculi. Following day, the patient was discharged without any complications and catheter was removed after two weeks. Patient was followed up in the clinic on two occasions and did not develop any urinary tract complications.

Discussion
The risk of uterine perforation at IUCD insertion is known to increase during the puerperium and during breast feeding which predisposes to IUCD migration. A migrated IUCD may remain undetected for a long time before it is noticed missing. The prevalence of IUCD migrating to the bladder can be as high as 14% out of all ectopic sites. It tends to present with inability to feel the thread, urinary frequency, urgency, dysuria, haematuria, urinary tract infections, calculi and uterovesical fistulas. The index patient has persistent Dysuria and was mistaken by many practitioners as UTI. Since patient was in severe pain with retention, we arranged immediate IUCD removal under anaesthesia. But most of these cases were managed with endourological techniques.

Conclusion
Obstetricians need to be vigilant to locate the missing IUCD if a patient comes with a pregnancy. Migration of IUCD to bladder can remain unnoticed for several years and rarely it can further descend to urethra.

OP/G – 05
PRIMARY PERITONEAL SEROUS CARCINOMA (PPSC): A CASE REPORT

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Background
Primary peritoneal serous carcinoma (PPSC) is a rare malignant tumour that has similar characteristics to serous ovarian cancer. Due to minimal identifiable symptoms, most of the cases were recognized during the advanced stages.

Case Presentation
A 71 year-old woman with a history of hypertension, dyslipidaemia and bronchial asthma presented with chronic lower abdominal pain, dysuria, and a lump at the vulva of one month. The lower abdominal pain and discomfort were progressively increasing in severity compromising her day-to-day activities. The general examination was unremarkable. The abdomen was soft with mild lower abdominal tenderness. The vaginal examination showed a first-degree uterovaginal prolapse. A transvaginal ultrasound scan showed an atrophic uterus and ovaries. Her basic investigations were unremarkable. CA-125 was 329.2 U/ml and her MRI showed multiple uncomplicated gall stones. At the review, it was noticed that the uterovaginal prolapse was not evident as in the previous examination, therefore decided to go ahead with laparotomy.

At surgery, it was noticed that she had multiple seedling deposits on the peritoneum, intestine, diaphragm and paracolic gutters as well as an omental deposit. A staging laparotomy with transabdominal hysterectomy and bilateral salpingo-oophorectomy was done. Histopathology revealed unremarkable ovaries, fallopian tubes and uterus with malignant cells in the ascitic fluid. The peritoneal and omental deposits consisted of malignant serous cells. Therefore, a diagnosis of primary peritoneal serous carcinoma was made.

The patient had an uneventful postoperative recovery. A Contrast Enhanced CT scan of the chest, abdomen and pelvis was performed three weeks after surgery was compatible with the clinical and histopathological findings which showed mild ascites with multiple, small, focal contrast enhancing peritoneal nodules of 3-9 mm . Following a multidisciplinary team meeting, systemic chemotherapy was started. Currently, she is awaiting maximum debulking surgery with hyperthermic intraperitoneal chemotherapy (HIPEC).

Conclusion
Primary peritoneal serous carcinoma is a rare malignant entity that should be suspected in patients with peritoneal carcinomatosis and normal-sized ovaries without a primary serous ovarian tumour. This case demonstrates the importance of meticulous assessment, timely diagnosis, and expeditious therapeutics through a multidisciplinary approach for a favourable outcome.

OP/G – 06
TYPICAL CASE REPORT OF COMPLETE ANDROGEN INSENSITIVITY SYNDROME.

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Introduction
Androgen Insensitivity Syndrome (AIS) is a very rare X linked disorder of sexual development, caused by a mutation in androgen receptor. It is a disorder seen in genetically males with a prevalence of 2 to 5 per 100,000 . It can lead to spectrum of presentations extending from male to female phenotypes depending on the degree of androgen receptor involvement. Complete AIS is the most severe form which presents typically as primary amenorrhoea in an adolescent female and less commonly in infancy with bilateral inguinal/labial swellings.

Case Presentation
A 16 -year-old girl presented to gynaecology clinic at DGH Matale with primary amenorrhoea without a history of cyclical abdominal pain. She had undergone bilateral inguinal hernial repair at the age of 6 years. Physical examination revealed female secondary sexual characteristics with breast development compatible with Tanner's stage 4 , axillary and pubic hair in line with tanner stage 2 and two surgical scars in inguinal regions compatible with previous surgeries. Her department ultrasound scan showed absence of uterus, fallopian tubes and ovaries with bilateral ovoid echogenic structures deep to deep inguinal ring suggestive of testicular tissue. Thus, she underwent karyotyping which confirmed XY

chromosomal pattern. Patient and her mother were counselled regarding her condition and explained long term management including hormonal therapy, gonadectomy, fertility and psychological support.

Discussion

Complete androgen insensitivity syndrome is a very rare genetic disease characterized by varying degrees of feminization in individuals with a male karyotype. It usually presents with primary amenorrhea and well-developed secondary sexual characteristics. Thus, it was previously known as Testicular feminization syndrome. The management of AIS involves multi-disciplinary specialities with gynaecologists, clinical geneticists and psychological counsellors. It can lead to emotional turmoil due to change in gender roles, infertility, sexual activity, menstruation, external appearance and social stigma. Gonadectomy need to be considered after puberty to prevent development of malignancy. Bilateral inguinal hernias in female children need to be evaluated for undescended testes to diagnose AIS at an early stage.

Conclusion

Complete AIS is an androgen receptor defect associated with vaginal and uterine agenesis in women with a 46 XY karyotype. It warrants multidisciplinary team involvement for clinical diagnosis and management from infancy to adulthood. Hormone replacement, gonadectomy, vaginal reconstruction, sexual and psychological issues are the main concerns.

OP/G – 07

AN AUDIT ON SURGICAL NOTE DOCUMENTATION IN MAJOR GYNAECOLOGICAL CANCER SURGERIES

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Introduction

Operative notes are the most important segment in the clinical records of surgical patients. Not only for patient management, but it is also important on legal grounds. Poor documentation has been observed in all surgical specialties worldwide. Although there are no established guidelines for documenting gynaecological oncological procedures, many centers follow their own protocols or depend on the experience of the surgeon. Proper documentation in gynaecological oncology procedures is crucial as they almost always require long-term follow up which mainly relies on the operative notes. Royal College of Surgeons (RCS) England has published the guidelines for good practice points in surgical documentation. This audit is aimed to improve the quality of operative note documentation.

Methods

Eighteen criteria (date, time, elective/emergency procedure, names of the operating surgeon and assistant, anesthetist, operative procedure, incision, operative diagnosis, operative findings, complications, any extra procedure, details of tissue removed, added, or altered, use of any implants/prosthesis, closure technique, blood loss, antibiotic and DVT prophylaxis, postoperative care instructions, signature) from RCS as stated in 'Good Surgical Practice' and seven additional criteria (patient position, indication for operation, mode of anaesthesia, surgical stage, completeness of the surgical cytoreduction, state of hemostasis and the insertion of drains) that were relevant to operation notes were assessed retrospectively over the 3 months. Scores 0, 1, and 2 were given for zero, incomplete and complete documentation respectively.

Results

Sixty-four operative notes of laparotomies were randomly selected. Date, procedure, name of

the surgeon and assistant, incision, indication, extra procedures, and surgical complications were mentioned completely in more than 80% of cases. Operative findings were documented satisfactorily for cancer staging only in 38 notes (9.4%) and only 36 notes (56.3%) included the tissues sent for histological analysis. Patient position (n=2, 3.1%), operative stage (n=10,15.6%), state of cytoreduction (n=20,31.3%), estimated blood loss (n=20,31.3%), use of drains (n=6,9.4%) and signature (n=10,15.6%) were not mentioned satisfactorily. Time, elective/ emergency nature, and use of prosthesis were not mentioned in any operative note.

Conclusions

Although most components are documented in operative notes, there are significant lapses in some legally and oncologically important criteria including the state of cytoreduction/ surgical stage. Data were presented in the ward meeting and possible solutions were discussed with the surgical team. Printed proforma was introduced including all main criteria which were attached to all patient tickets as a guide for surgeons/ assistants. Re-audit is currently underway.

OP/G – 08

AN AUDIT OF EARLY POSTOPERATIVE COMPLICATIONS OF GYNECOLOGICAL ONCOLOGY LAPAROTOMIES USING CLAVIEN-DINDO CLASSIFICATION

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Introduction

Clavien–Dindo (CD) classification is used to standardize the reporting of post-operative complications. This comprises five main grades (I-V) and two sub-grades (IIIa/b,IV a/b) which cover the spectrum of complications ranging from Grade I (Any deviation from the normal postoperative course without the need for drugs or intervention) to Grade V (death). The aim of the audit was to assess the early postoperative complications of gynaecological oncology laparotomies using CD classification.

Method

A retrospective analysis of 56 patients who underwent laparotomies between 2022 May to 2022 July was included. Data collected included patients' demographics, types of surgery, recorded post-operative complications, and assigned CD classes. Categorical variables were summarized using frequency and percentages.

Results

The mean age of the patients was 48.5 years. Most of them (n=41,73.2%) had education up to GCE O/L and above. There were 9 (16.1%) diabetic patients and 17 (30.4%) were obese. Twenty-six (46.4%) had midline and 24 (42.9%) had Pfannenstiel incision. There were 6 (10.7%) hospital re-admissions. The overall complication rate was 57.1% however all were only Grade I (n=14,25%) and II (n=23,41%). The commonest complication was blood transfusion (n=19,33.9%) and infections requiring antibiotics (n=11,19.6%). Of them wound infections (12.5%) were the commonest and UTIs (10.7%) and respiratory tract infections (7.1%) were the next most common. Postoperative fever requiring antipyretics was seen in 8 (14.3%) patients. Overall mortality was 0%.

Conclusions

The overall rate of postoperative complications was relatively higher compared to available literature

however the mortality rate is significantly low. Most patients need adjuvant treatment within 3 weeks' time hence to improve wound healing, the current ward policy has a low threshold for a blood transfusion which could have exaggerated the number of grade II complications. Infections are relatively common. Over the period of the audit, all complications were only graded I and II despite the high number of surgeries performed and the nature of radicality. Planning of a continuous audit process is currently underway.

OP/G – 09

DO PATIENTS NEED MORE INFORMATION PRIOR TO DISCHARGE IN GYNAECOLOGICAL CANCERS? - AN AUDIT ON PATIENT POST-OPERATIVE INFORMATION.

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Introduction

Gynaecological cancer surgeries are often radical in nature involving the upper and lower abdomen with extensive tissue resection, anastomosis and re-implantations. Vigilant post-operative care is required following surgeries since they are more prone to develop complications. Hence receiving information about the surgery is essential for the early identification of life-threatening or morbid complications. In contrast, proper adherence to post-operative advice (e.g., analgesics, prophylactic antibiotics) could reduce the re-admissions which are not significant to provide inward care. In addition, health education is crucial for the proper oncological follow-up. Patients from various social backgrounds and different literacy levels are treated at the National Cancer Institute. Current practice is verbal advising patients regarding the surgery and the post-operative care, prior to hospital discharge. The aim of the audit was to assess the adequacy of knowledge of the treatment, awareness of early warning signs and follow-up.

Method

A retrospective analysis of 56 patients who underwent laparotomies between 2022 May to 2022 July was included. An interviewer-based questionnaire was given in a month's time prior to discussing the histology.

Results

The mean age of the patients was 48.5 years. Most of them (n=41,73.2%) had educated up to GCE O/L and above. All patients knew the uterus was removed and 17 (30.4%) knew all the anatomical structures were removed accurately. Fifty-four patients (96.4%) were aware and on regular analgesics for mild pains. Forty-eight (85.7%) patients remembered the early warning symptoms for immediate admission. Most patients (n=47,83.9%) wanted to seek medical care in case of wound infection. For delayed symptoms (after 1 week) patients concerned seeking care if they have persistent back pain (n=45, 80.4%), persistent abdominal pain (n=42,73.2%), fever (n=28,50%), vomiting (n=27,48.2%). All patients knew the need of reviewing the histology and only six patients (10.7%) were informed of the possible need for chemotherapy/ radiotherapy for the follow-up.

Conclusion

Although all patients knew the main surgery, it is important to improve their knowledge of surgery in the majority. Awareness of early warning signs is satisfactory however, lapses in delayed onset symptoms especially indicative of bowel obstruction could cause more morbidity. The need for adjuvant treatment can be definitively decided with histology yet informing possible needs could be helpful to arrange

psychological and social support. A patient information leaflet and additional sessions of post-operative counselling were arranged. Re-audit is planned to carry out in 3 months.

OP/G – 10

KNOWLEDGE AND PRACTICES TOWARDS HORMONE REPLACEMENT THERAPY AMONG HYSTERECTOMIZED PATIENTS ATTENDING TO GYNAE-ONCOLOGY UNIT, MAHARAGAMA

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Introduction

Iatrogenic menopause by means of surgery or chemoradiation is common among patients attending Gynae-oncology units. The risk of cancer-related death has often overweighed the complications due to loss of estrogens and progesterone. The safety of hormone replacement therapy (HRT) in gynaecological malignancies is not fully understood due to the limited evidence, however, HRT is proven safe in certain instances. A significant proportion of young or middle-aged patients who reach iatrogenic menopause are observed to be not on HRT. This preliminary study was carried out to assess the knowledge and practices towards HRT among hysterectomized patients attending to gynae-oncology unit, Maharagama.

Method

A self-administered questionnaire covering the knowledge and practices of HRT usage and menopausal symptoms was provided to randomly selected 81 patients who underwent hysterectomy at the gynaeoncosurgical unit.

Results

Participants were ranging from 17 years to 71 years while the commonest responders (n=29, 35.2%) were categorized between 51 to 55 years. The majority (53.1%) were menopaused at the time of hysterectomy. Sixty-three (77.7%) had a school education at least up to the ordinary level. Only 12 (14.8%) had a family history of gynaecological malignancies. Histology has confirmed malignancy in 58 patients. Most of the patients (n=75, 92%) had undergone oophorectomy. Only one patient was a current user of HRT. Beneficial effects of HRT were not known to 91.3% of patients. Sixteen patients were aware that lifestyle changes alleviate menopausal symptoms. Only ten patients (12.3%) were willing to use HRT.

Conclusion

The usage and knowledge regarding HRT are significantly low in hysterectomized patients. Significantly low knowledge is likely to result in the minimum usage of HRT. Even the knowledge regarding non-hormonal/pharmacological methods to alleviate menopausal symptoms seems poor. Measures to improve their knowledge of menopause and HRT will be important to increase the usage of HRT in this high-risk group which in turn will improve the health and quality of life. Health education programs and information leaflets are planned to improve the knowledge of the clinic patients.

OP/G – 11

INVESTIGATION OF FEMALE INFERTILITY IN EASY AND TRADITIONAL METHOD BY GYNECOLOGIST

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Introduction
Infertility is an important health problem in Bangladesh as it causes social instability, marital disharmony and many disgraceful conditions. Female factor is responsible in 40% case, male factor in 40% , both in 10% and unexplained infertility in 10% case. But females are mostly suffered as the other members of the family and the society at first blame the woman for infertility before consulting the physician. Overall, the economic condition is also affected during treatment. Most woman consult late due to thinking of high economic burden.

Objective
The aim of the study is to find out the cause and management of female infertility in easy and traditional method.

Method
This observational, cross sectional prospective study was carried in a private chamber of General Hospital during the period 17-12-2014 to 13-05-2019 . Only female infertility 102 cases are included. Data analysis is done under SPSS method.

Results
Most of the female are between the age of 20 - 34 years (72.54%). 63.72% female has history prolong duration of 5 - 8 years infertility. 51.96% suffering from primary infertility. Regarding the causes of female infertility is Polycystic Ovary causing anovulation 41.18% , Non-Polycystic Ovary ovulation disorder 35.33% , Tubal factor 14.70%, Endometriosis 5.88% , uterine fibroid 2.94%, developmental anomaly of hymen 1.96% . Regarding Investigations - TVS, Serum TSH, Blood Sugar 2 hours after 75 g Glucose in 100% , Serum AMH, FSH, Prolactin to see ovulation disorder in 64.70% and Hysterosalpingography (HSG) is done to see tubal factors in 29.41%. Management of female infertility is done by OID like letrozole in 35.29%, OID + FSH + metformin + myoinositol in 41.16% , Endometriosis removal in 5.88% , myomectomy 3.29% , hymenectomy in 1.96%, Therapeutic hydrotubation in incomplete tubal block 4.90%. Referred to be infertility centre for ART in 13.72% .

Conclusion
Majority of female infertility can be diagnosed effectively by careful history taking, Pervaginal examination and judicious investigations. Methodically approach treatment in easy and traditional way by the Gynecologist bring a success in female infertility and reduce female sufferings.

OP/G – 12
GYNECOLOGICAL CANCER SURGERIES IN TERTIARY CARE HOSPITAL OF PAKISTAN IN THE ERA OF COVID-19 PANDEMIC

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Objective
In this study we have evaluated results and complications of gynecological cancer surgeries in a tertiary care hospital during Covid pandemic.

Method
We analyzed the medical charts of patients who underwent surgeries from March - December 2020 .

Results
The study included 116 patients, 48 endometrial, 50 ovarian, 14 cervical and 4 vulval & vaginal cancers. Majority were in early stage (64%). The median age was 58 years. Surgical approach was laparotomy in 77.6% including 48% complex surgeries. Based on the BGCS framework for prioritization most of our surgeries belong to priority level two (89%) and three (11%). COVID verbal screening was done in 90% of patients. COVID testing by PCR for all pre-operative patients was commenced later and hence 89 (77%) of patients underwent this testing. Only two patients were found COVID positive, and the surgery was deferred. Complications based on Clavien-Dindo grade 1, grade 4a and grade 5 were observed in four patients. Out of 12 patients with clinical suspicion of COVID within 30 days of surgery three were found to be Covid positive, one requiring ICU admission.

Conclusion
The results show that with adequate preventive measures cancer surgeries can be performed with low risk of severe complications and post-surgical COVID positivity.

OP/G – 13
THE CLINIC-PATHOLOGICAL FEATURES AND ONCOLOGIC OUTCOMES OF CARCINOSARCOMA OF UTERUS IN TERTIARY CARE HOSPITAL OF PAKISTAN.

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Objectives
The aim of this study was to ascertain clinic-pathological features, survival and recurrence data analysis.

Methods
Retrospective, single center study. The study design was descriptive with survival data analysis. Medical record of patients was reviewed 2007 - 2018 . Associations between categorical covariates and the recurrence of cancer was assessed by using chi square tests, while the t-test was used for continuous variables. The p-value ≤ 0.05 considered statistically significant. Survival analysis was done using the Kaplan–Meier method and compared between treatment groups by Log-rank test.

Results
The study included 29 patients. Mean age of study patient was 63 years (62.62 ± 8.85) and mean BMI 34 kg/m^2 (34.57 ± 3.75). Postmenopausal bleeding was the most common presenting complaint in 19 (65.5%) patients. Hypertension was noted in 20 (69%) and diabetes in 14 (48%) patients. Primary staging laparotomy was performed in majority of patients 24 (82.8%) while interval surgery after neoadjuvant chemotherapy was commenced in 05 (17.2%). The surgical approach was hysterectomy with removal of ovaries, tubes and pelvic lymph nodes in 24 (82.7%) patients. Adjuvant chemotherapy was received by 18 (62.1%). Extended beam radiation therapy was given to 10 (34.5%), 05 (17.2%) patients had vaginal brachytherapy only. Overall recurrence was seen in 13 (44.8%) patients with distant metastasis in 09 (31.0%). Median overall survival was 24 months (95% CI: 8.02 - 40.85). Nine of the patients died within a year after surgery.

Conclusion
Carcinosarcoma of uterus has high distant recurrence rate. Standard surgery followed by radiation have more impact on overall survival than chemotherapy.

OP/G – 14
AN UNCOMMON PRESENTATION OF A SEROUS ADENOCARCINOMA OF THE ENDOMETRIUM

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Introduction
Serous carcinoma of the endometrium accounts for 18% of all endometrial cancers, but responsible for 40% of endometrial cancer related deaths. Typically, they originate in elderly females in their 70s and commonly present at an advanced stage.

Case Presentation
A 69-year-old mother of one child presented with abdominal distension for three weeks associated with loss of appetite, loss of weight and early satiety. She attained menopause nineteen years ago. She did not complain of post-menopausal bleeding which is a cardinal feature of endometrial cancer. She had no family history of gynecological malignancies.

On examination her abdomen was distended with a large palpable mass and ascites. On bimanual vaginal examination, cervix was atrophic, uterine size could not be delineated and a mass was palpable in the pouch of Douglas which was attached to the uterus.

With her CA 125 value at 1399 U/ml, her RMI score was 20,985 . An ultrasound scan followed by a CT scan of the abdomen and pelvis revealed an ill-defined heterogeneously enhancing solid and cystic lesion in the pelvic cavity with multiple peritoneal and omental deposits. All features were in favor of a primary ovarian malignancy.

She underwent a staging laparotomy with maximum debulking of the tumor. There was a heterogenous mass in the right adnexiae. Her surgical stage of tumour was stage 3C . Histology revealed a high-grade serous carcinoma involving an endometrial polyp.

Discussion
This patient presented at the age of 69 years resembling the median age of presentation for serous endometrial carcinoma compared to the much commoner low-grade endometrioid type endometrial cancer which usually presents earlier. However, in contrary to post-menopausal bleeding, which is the commonest presentation in endometrial cancer, this patient presented with features suggestive of a high grade serous epithelial ovarian cancer. Common risk factors for the development of serous endometrial cancer were not evident in this woman. A CT scan of the abdomen and pelvis was done since the working diagnosis was ovarian cancer. The surgical findings were compatible with a high grade serous epithelial ovarian cancer. Even though it is recommended to assess pelvic and para-aortic lymph nodes in Type 2 endometrial cancers, it was not carried out since the clinical diagnosis was an ovarian cancer.

Conclusion
A Type 2 endometrial cancer may present with subtle symptoms similar to a high grade serous epithelial ovarian cancer. It is important to obtain a biopsy for histology prior to planning curative treatment if the diagnosis is uncertain.

OP/G – 15
A RARE CASE REPORT OF STRUMA OVARII

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Introduction
Struma ovarii is a rare ovarian tumor comprising 0.5-1% of all ovarian tumors. They are either composed predominantly (50%) in the background of a mature teratoma, exclusively of benign thyroid tissue or with any amount of malignant thyroid tissue.

Case Presentation
Thirty-three-year-old, mother of 2 children presented with intermittent lower abdominal pain for 2 years. She had no medical co-morbidities and currently was on DMPA for contraception. She had been amenorrheic for 6 months. She had no dysmenorrhea or deep dyspareunia. At the age of 27 years, she had an ovarian cystectomy which revealed to have a mature cystic teratoma, however the details of laterality were not available. Her pain was of moderate intensity and not associated with bowel habits or menstruation. Ultrasound scan showed left ovarian mass measuring 11.5 x 14 x 8 cm with cystic and solid areas, but no free fluid. CA-125 was 9.9 IU/ml . She underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, and omental biopsy. Macroscopy revealed a large cystic irregular shaped left tubo-ovarian mass, the cut surface of which showed a multiloculated cyst containing watery material of amber and red color. There were no solid or papillary areas. Microscopy of the left ovarian mass revealed benign thyroid follicles of varying sizes filled with colloid. There were no teratomatous elements, features of malignant transformation or capsular breaches noted. Bilateral fallopian tubes, right ovary, uterus, and omentum were histologically unremarkable. It was concluded as a Struma ovarii of left ovary. Her TSH (2 mIU/l) and free T4 (1.13 ng/dl) were normal. USS neck did not reveal any abnormality in the thyroid gland. She was started on hormone replacement therapy.

Conclusion
Only 8% of patients with benign Struma ovarii present with hyperthyroidism and it may mimic an ovarian malignancy ultrasonically. Histological assessment is crucial for diagnosis and exclusion of malignant transformation, which is rare. Clinical and radiological assessment of the thyroid gland is recommended to exclude a thyroid abnormality followed by histological assessment to exclude a primary thyroid carcinoma metastasizing to the ovary.

OP/G – 16
MANAGEMNET OF UTERINE PROPLAPSE: VAGINAL HYSTERECTOMY THE ONLY CHOICE?

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Introduction & Objectives
Pelvic organs prolapse is a disease in which one or more of the female pelvic organs like bladder, uterus, rectum, intestines or vaginal vault descend through the vagina. Uterus preserving procedures (abdominal cervicopexy, modified Purandare's procedure and Manchester repair) and vaginal hysterectomy were compared for success of repair, duration of surgery and stay, blood loss, and post operative complications especially in older women.

Method
This study was conducted in Gynaecology and Obstetrics unit C of Ayub Teaching Hospital, Abbottabad

for the period of two years and 3 months from October 2018, till December 2021. Sample size was calculated and all the subjects who fulfilled the inclusion criteria underwent a complete workup including history and examination. Data collected on predesigned proforma including demographic variables, obstetrical history, history of any illness, type of prolapse, type of procedure, duration of surgery and stay in hospital, amount of blood loss, type of anaesthesia and postoperative complications. All participants were assigned to either vaginal hysterectomy or uterus preserving procedures. Data was analysed by SPSS version 10 .

Results

Out of 73 patients, 41 had vaginal hysterectomy and AP repair and 32 patients had uterus preserving procedures. Mean duration of surgery for vaginal hysterectomy was 68 minutes and for uterus preserving procedures was 40 minutes. Mean blood loss for vaginal hysterectomy was 291 ml and for uterus preserving procedures was 155 ml . Mean duration of hospital stay for vaginal hysterectomy was 5days and for uterus preserving procedures was 3.5 days. Six patients had complications with vaginal hysterectomy and 5 patients had complications in uterus preserving procedures.

Conclusion

The advantage of uterus preserving procedures over vaginal hysterectomy is that it maintains pelvic anatomy integrity and duration of surgery, blood loss and hospital stay are significantly reduced and can be safely used in older women too.

OP/G – 17

AN AUDIT ON INTRODUCTION AND IMPLEMENTATION OF CONSENT FORM FOR PATIENTS UNDERGOING LAPAROSCOPIC SURGERY

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Introduction

In modern medicine with the wide array of surgeries available, these surgeries have their own inherent complications. Laparoscopy gynecological surgeries also have several complications. Thus, for the safety and knowledge of the patient along with medico legal safety of the health personnel the consent form is in place. But, more often than not most hospitals in Sri Lanka function by using a makeshift consent that is written just before the surgery by the doctor and signed by the patient. We constantly underestimate the value of a good consent form.

Method

The audit was carried out as a prospective analysis where 24 patients were offered a consent form. The consent form had 10 components considered important. Two intern medical officers were requested to fill the 10 components separately. They were requested to explain each component to the patient and tick the particular part for conformation. The following audit was carried out at Teaching Hospital Anuradhapura, unit B. The time frame of conduct was from 27/04/2022 to 28/06/2022.

Results

None of the consent forms were fully completed (0%). 92% of the forms were partially filled. 8% were fully incomplete. Amongst the two doctors who were serving during the time frame of the audit both constantly neglected each component of the consent form to a certain degree with individuality.

Conclusion

There needs to be a mechanism to educate each incoming interns of importance of consent form in constant and standard manner. There should be mechanism to monitor the fully completion of the form. Patients need to be armed with their own knowledge to make sure the doctors give full attention to the consent. The patient should be allowed are feedback to further improve the consent form.

OP/G – 18

PRACTISING ENHANCED RECOVERY PROGRAMME ON DISCHARGE FOR THE PATIENS UNDERWENT MAJOR GYNAECOLOGICAL SURGERIES

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Introduction

Enhanced recovery program is an evidenced based concept that has been introduced in order to improve the post-operative recovery by reducing the length of hospital stay, reducing the need for opioid analgesia, reducing post-operative complications and reducing the cost. This includes pre-operative, intra operative and post-operative components.

Methods

An audit was carried out at the Professorial Gynaecology Unit, National Hospital of Sri Lanka on using enhanced recovery program on discharge. 34 patients who underwent open abdominal hysterectomy over a period of two months included in the study. Data extraction sheet was used to collect the data and they were interviewed at the histology clinic.

Results

A total of 34 patients were included in the study. The advice given on discharge were documented. All the patients were given the information on adequate rest, establishing daily routine gradually and continuing routine medication for the preexisting illnesses. Among them 61% (n=21) advice on balanced diet. None of them was given information on bowel issues like trapped wind and constipation where 44% (n=15) had the issue. On postoperative infections all the patients were informed regarding fever and 79% (n= 27) of them were advised on surgical site infections and 4 of them developed surgical site infections. No one was given details in urinary tract infections, peritonitis, and deep vein thrombosis and no one developed these issues. In view of restarting daily routine all of them were informed when to return to work and 58% were given information on sexual activity. Information on exercise, travelling and driving was not given.

Conclusion

Implementation of enhanced recovery protocol is proven to reduce the morbidity and increase patient satisfaction by improving the quality of life. This can be effectively implemented in low resource setting. Involvement of all categories of the health care staff can make it a success. Auditing for the compliance is essential for the sustainability.

OP/G – 19

SIDE EFFECTS CAUSING EARLY REMOVAL OF JADELLE IMPLANTS AMONG CLIENTS WITH SIDE EFFECTS, ATTENDING SELECTED GYNAECOLOGY AND FAMILY PLANNING CLINICS IN GALLE DISTRICT

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Introduction

Levonorgestrel-releasing implants are a method of long-acting female hormonal contraception. Jadelle implants are subdermal implants consisting of two small silicone rods, each containing 75mg of Levonorgestrel in a polymer matrix, approved for 5 years of continuous use.

Objective

To determine the common side effects leading to removal of Jadelle implants before completion of 5 years, among the clients attending selected gynaecology and family planning clinics in Galle district.

Method
Descriptive cross-sectional study over 3 months period, conducted among clients with side effects due to Jadelle implants attending Gynaecology units of the three Base Hospitals and three randomly selected family planning field clinics in Galle district.

Results
Of 400 women who presented with side effects following Jadelle implants, 86.0% (n=344) complained of menstrual irregularities including irregular bleeding (46.5%), prolonged bleeding (21.0%), and heavy bleeding (18.5%). Other side effects were excessive weight gain (9.0%,n=36), local side effects (4.0%,n=16), and headache (2.0%,n=8). Commonest age group of presentation was 25 - 30 years (40.5%), with 25.5% presenting after 1 - 2 years following Jadelle insertion. Out of the 400 women, 38 (9.5%) wanted early removal of Jadelle implants. Commonest cause for early removal was menstrual irregularities (89.4%,n=34) including prolonged (42.1%), heavy (26.3%), and irregular bleeding (21.0%). 2 women (5.2%) wanted early removal due to excessive weight gain, and another 2 (5.2%) due to local infections.

Conclusion
Menstrual irregularities are the commonest side effect after Jadelle insertion and the commonest cause of early removal of Jadelle implants.

OP/G – 20
SURGICAL OUTCOMES AND PATIENT SATISFACTION FOLLOWING TOTAL LAPAROSCOPIC HYSTERECTOMY: SINGLE-CENTER EXPERIENCE

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Introduction
Hysterectomy is the most frequently conducted major gynecological surgical procedure worldwide. Several approaches to hysterectomy are available to surgeons and of the less invasive approaches total laparoscopic hysterectomy (TLH) is gaining popularity over recent past years in Sri Lanka compared to traditionally performed total abdominal hysterectomy.

Objectives
The aim of the study was to assess the surgical outcomes and patient satisfaction in patients who undergo TLH in a Sri Lankan setting.

Methods
Patients who underwent TLH between 2017 - 2020 were interviewed 3 weeks post-operatively. The surgical team, theatre setup, and post-operative care protocols were similar.

Results
There were 73 patients with a mean age of 49.3 years (range 39 - 68). The majority (89%) had a minimum education up to GCE O/L and there were 16 graduates (21.9%). Forty (54.8%) patients were menstruating at the time of hysterectomy. Ten patients had diabetes and 7 had hypertension. Thirteen (17.8%) patients had previous open surgeries. Endometrial type abnormal uterine bleeding (AUB-E) (42.5%) was the commonest indication and fibroids (31.5%) and premalignant lesions (19.2%) were the next commons. The majority (n=49,67.1%) had their ovaries preserved and one patient had an oophorectomy and pelvic node dissection for endometrial carcinoma. Most of the patients (n=48,65.8%) were discharged within 24 hours and only 4 patients (5.5%) had the longest stay of 2 days of inward care. The mean post-op pain score was 3.58/10 (range 1-5) and the mean of 3.36 days were taken to completely omit analgesics.

An average of 1.2 days were taken to go to the toilet without assistance. They were able to attend normal housework in an average of 4.97 days and returned to full preoperative functional capability in an average of 9.23 days. Post-op complications were mild (n=5), and all could manage in an outpatient setting. Lower abdominal pain (n=3,4.1%) was the commonest concern and there were one case of urinary tract infection and a fever. All patients were highly satisfied with the surgery, and everyone would want to suggest it to others.

Conclusions
Surgical complications are minimal and patient satisfaction is extremely high following TLH. Developing infrastructures for TLH in gynaecological units are challenging during the financial crisis yet, in the long-term TLH provides better surgical outcome and quality care.

OP/G – 21
STUDY ON THE KNOWLEDGE ON CERVICAL CANCER SCREENING AND HPV VACCINATION IN "30 - 40" YEAR AGED GROUP WOMEN

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Introduction
Cervical cancer presents a significant global health burden and the leading gynecological malignancy in Sri Lanka as well. HPV is a double-stranded DNA virus, that infects squamous epithelia, is well known as causative organism for cervical carcinoma. In the United Kingdom (UK), cancer incidence has reduced by 75% since the introduction of the successful national screening programme in the 1970 s. The World Health Organization (WHO) recommends screening for cervical cancer to be started at the age of 30 years and to continue until the age of 65 years. Currently in Sri Lanka, considering the rising incidence of cervical cancers, women who had been sexually active can be offered cervical smear screening 3 to 5 years since their first sexual intercourse. HPV vaccination of young children before they start sexual activity has been successfully implemented in Sri Lanka. HPV vaccination has shown to be highly effective against acquiring HR HPV in sexually active populations.

Objective
The purpose of this study is to evaluate knowledge and attitude about cervical cancer screening and HPV vaccination in 30 - 40 -year aged group women who attended to gynecology clinic for another gynecological condition.

Method
Pregnant mothers who attended to gynecology clinic at castle street hospital for women from April 2022 to June 2022 were included. Data collected by medical officers using interviewed administered questionnaire.

Result
66 patients participated in this audit. Surprisingly, only 10% knew that Cervical cancer is the most common cancers among all cancers which arise from ovary, uterus and cervix in Sri Lanka. 60% knew that there is test (Pap smear) to screen cervical cancer. But less than 5% knew about HPV triage. However, less than 30% knew that regular screening can be done since the start of sexual activity ideally 3 yearly until the age of 50 years and 5 yearly afterward up to the age of 64 years. Around 1 in 5 knew that HPV vaccination for young girls for the prevention of cervical cancer.

Comment
According to this analysis, knowledge and attitude about cervical cancer screening and HPV vaccination in 30 - 40 - year aged group women are not satisfactory.

Recommendation
Women as well as male partners need proper counseling throughout the pregnancy. Providing information leaflets and contacting lecture sessions in MOH areas will be helpful to improve awareness cervical cancer screening and HPV vaccination among young population.

OP/G 22
CLINICAL SKILL TRAINING IN OBSTETRICS AND GYNAECOLOGY AMONG FINAL YEAR MEDICAL STUDENTS IN FACULTY OF MEDICINE, UNIVERSITY OF KELANIYA: A CLINICAL AUDIT

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Introduction
Clinical skill training is a major aspect of the medical curriculum. In Sri Lanka, medical students receive clinical training for 3 years at a teaching hospital. During the final year, they receive training for 8 weeks each in five specialties.

Objectives
Our objective was to assess the level of completion of the given clinical tasks for the professorial Obstetrics and Gynaecology appointment.

Method
The audit was undertaken at the Faculty of Medicine, University of Kelaniya among 32 final-year students who completed the professorial Obstetrics and Gynaecology appointment during June/July 2022. Data were collected from the logbooks submitted at the end of the appointment and analyzed using MS Excel 2010 .

Results
The 32 students were assigned numbers randomly. 39 tasks were expected to be completed during the appointment. Tasks and their average performance frequencies were as follows. Presentation of an obstetric history - 1.75, gynaecological history - 1.50, Performance and presentation of obstetric examination - 1.03, gynaecological examination - 2.16, Assessment of Bishop score - 2.47, Setting up an oxytocin infusion - 2.41, Maintain a partogram - 3.63, Management of labour - 3.31, Episiotomy repair - 3.43, Catheterization - 0.53, LSCS preparation - 2.31, Assisting at LSCS - 3.28, Advice on postnatal exercises - 0.19, Contraception advice - 0.25, Writing operation notes for LSCS - 2.97, Suture removal - 0.06, Venipuncture - 0.84, Set up intravenous drips - 1.75 , Administer blood transfusions - 1.19, Urine albumin and sugar ward tests - 0.84 , Filling investigation forms - 4.69, Prepare patients for gynaecological surgeries - 2.34 , Assisting major surgeries - 2.41, Write notes for minor surgeries - 0.59, major surgeries - 1.94, Write diagnosis cards - 4.72. Tasks to be observed: Performing a dating scan - 3.44 , mid-trimester scan - 1.63, fetal wellbeing scan - 3.09, Pap smear test - 1.50, High vaginal swab - 1.53, Insertion of vaginal pessary - 0.59, Forceps delivery - 0.38, Vacuum delivery - 0.88, Twin delivery - 0.53 , Breech delivery - 0.44 , Manual removal of placenta - 1.38 , Repair of vaginal tears - 1.34, Resuscitation - 0.31 . The least performed task is removing sutures and the most performed task is writing diagnosis cards. The average of a student performing a clinical task is 1.78, which is lesser than the expected 5. Out of 32 students, only 1 student had performed more than 50% of the expected frequency (2.5 times).

Conclusion
Performance of the clinical tasks is below the expected level. Factors contributing to this could be, not collecting proof of completion and having tasks that are not routinely done currently, e.g., urine ward tests.

OP/G – 23
A RARE CASE OF MIXED GERM CELL TUMOR OF OVARY

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Introduction
Malignant Germ cell tumours account for 2.6% of all ovarian malignancies. These tumours are derived from primitive germ cells and dysgerminoma is the commonest type.

Case Presentation
A 25-year-old unmarried woman presented with abdominal distension, lower abdominal pain and dyspeptic symptoms for 3 months. A large abdomino-pelvic mass was detected along with intraperitoneal free fluid. Ultrasound scan revealed an adnexal mass with free fluid. Her serum β-hCG was 5451.4 mIU/ml , LDH 689 IU/l and CA-125 was 252 U/ml . Radiological staging could not be performed urgently due to limited recourses. During staging laparotomy, a right-sided ovarian mass was found with deposits over the uterine surface. Other abdomino-pelvic organs were free of tumor deposits. Right side salpingo-oophorectomy and infracolic omentectomy was performed. Histology showed a mixed germ cell tumour with 60% dysgerminoma, 30% yolk sac and 10% embryonal carcinoma. Cytological analysis of peritoneal fluid was negative for atypical cells. Biopsies from uterine surface demonstrated metastatic deposits and omental histology revealed extensive reactive mesothelial cell proliferation. Surgico-pathological staging was IIA . Patient was referred for adjuvant chemotherapy.

Discussion
Malignant germ cell tumours are the commonest type of ovarian malignancy during second and third decades of life. Presence of a pelvic mass associated with abdominal discomfort is the commonest presentation. Germ cell tumours of the ovary are classified into four types including dysgerminoma, embryonal carcinoma, teratoma and extra-embryonal differentiation (Choriocarcinoma, yolk sac tumour). This patient's histology revealed three out of four main histological types. Germ cell tumours are highly sensitive to chemotherapy. Conservative surgery is the standard of care even in the advanced disease. Preserving the uterus and contralateral ovary is recommended. In stage III or IV disease treatment outcomes of neoadjuvant therapy followed by surgery were comparable to what it has been achieved with surgery followed by adjuvant chemotherapy. Chemotherapy regimens commonly include bleomycin, etoposide and cisplatin. Fertility sparing surgery has a high rate of survival (up to 97%) with at least a one pregnancy in 66% of women who had planned to conceive.

Conclusion
Malignant germ cell tumors are rare type of ovarian tumour, commonly identified in young women at their 2nd or 3rd decade of life. They can be successfully treated with the fertility sparing surgery followed by chemotherapy with good overall prognosis.

OP/G – 24
AN AUDIT ON POLYCYSTIC OVARIAN SYNDROME AMONG WOMEN AGED BETWEEN 20-35 YEARS

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Introduction
PCOS is one of the most common endocrine disorders and is frequently diagnosed by gynecologists in women of reproductive age. prevalence is as high as 26%. PCOS is often complicated by chronic

anovulatory infertility and hyperandrogenism with the clinical manifestations of oligomenorrhoea, hirsutism and acne. Many women with this condition are obese and exhibit an adverse cardiovascular risk profile, characteristic of the cardiometabolic syndrome as suggested by a higher reported incidence of hypertension, dyslipidemia, visceral obesity, insulin resistance and hyperinsulinaemia.it is therefore important that there is a good understanding of the short-term and long-term implications of the PCOS to offer a holistic approach to the disorder.

Objective

The purpose of this study is to evaluate knowledge and attitude about polycystic ovarian syndrome among women aged between 20-35 years.

Method

Data were collected by medical officers using interviewed administered questionnaire in gynecology Clinic from patients who were diagnosed clinically with PCOS according to Rotterdam criteria in castle street hospital for women from January 2022 to March 2022. Data were analyzed using SPSS.

Result

25.5% of women know above fact that Polycystic ovary syndrome is the most common endocrine disorder to affect women during their reproductive years. They don't have satisfactory knowledge on facts such as menstrual cycle disturbance 12%, features of hyperandrogenism (hirsutism, acne, alopecia) 9%, fertility problems 12%,obesity 17% and psychological issues 9% in relation with PCOS.11% of them think overeating and under-exercising is associated with PCOS. When assessing the knowledge about long term problems of PCOS, very few knew that type 2 diabetes (5%), the metabolic syndrome (2%) and endometrial cancer (0%) are the long-term sequels of PCOS. Regarding management of PCOS,10%thinks weight loss through exercise and dietary modification would improve the endocrine profile and short-term and long-term complications. But no one knew that bariatric surgery is an option for patient with a BMI of more than 40 kg/m^2. Only 5% think Menstrual irregularity can be treated with low dose COCP. No one knows about Endometrial production with COCP, or progestogen induced a withdrawal bleed for at least once in 03 months. No one knew about Insulin-sensitising agents(metformin) both inhibits the production of hepatic glucose and also enhances insulin sensitivity.

Discussion & Conclusion

According to this analysis, knowledge and attitude about polycystic ovarian syndrome among women aged between 20-35 years are not satisfactory. young reproductive age group women need awareness about PCOS as this condition is most common endocrine disorders with short-term and long-term implications.

Recommendation

Health care education in school syllabus and conducting awareness programs and distribution of leaflets at MOH clinics would improve the knowledge and attitude about polycystic ovarian syndrome. Increasing awareness may lead to seeking early medical advice and lifestyle modification among women.

E - POSTERS - OBSTETRICS

EP/O – 01
DELAYED-INTERVAL-DELIVERY OF MONOCHORIONIC DIAMNIOTIC TWIN PREGNANCY: A CASE REPORT

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Introduction
Delayed-Interval Delivery (DID) of twin pregnancy is not yet considered as a plan of delivery in twin pregnancies but it is sometimes considered in selective twin pregnancies depending on patient's individual circumstances. There are no larger studies for these types of twin deliveries except for case reports and case series.

Case Presentation
31-year-old female in her second pregnancy at POG of 26 weeks and 5 days presented to our unit with brownish color vaginal discharge and intermittent lower abdominal pain and back pain. On examination she was otherwise well, found to have altered blood on speculum examination with partially opened cervix. On abdominal ultrasound, she had first twin of breech with no fetal heartbeat and second twin of cephalic with fetal heartbeat. Thus, Intrauterine Death of first twin and live second twin was diagnosed.

As she was complaining of increasing intermittent abdominal pain and on vaginal examination cervix being dilated, she was sent to labour room where macerated fetus was delivered by breech. After delivery of first twin, cervical os was closed and second twin was found to be well in utero. Therefore, we cut the cord of first twin high in vagina and administered corticosteroids for lung maturation with a coverage of tocolytics with oral nifedipine and intravenous magnesium sulfate for neuroprotection of second twin. We also administered oral erythromycin as prophylactic antibiotics as membrane was ruptured. Cervical cerclage was not performed as the cord of first twin was present through cervical os. Mother was closely monitored for development of chorioamnionitis clinically and biochemically and she delivered her second twin at POG of 27 weeks and 2 days, with birth weight of 915 g, APGAR of 6, 7, 10 in 1, 5, 10 minutes respectively. The baby was admitted to premature baby unit for further care.

Discussion
The incidence of multiple pregnancy is rising with increased maternal age and use of assisted reproductive techniques. Multiple pregnancies are associated with high risk of perinatal mortality and morbidity that comes with risk of preterm birth, premature pre labour rupture of membranes, intrauterine fetal demise etc.The presentation of preterm deliveries (15 - 20%) in multiple pregnancies are identified in three subtypes, spontaneous preterm labour, preterm prelabour rupture of membranes, preterm labour due to maternal and fetal complications.

Prevention and management of these complications need to be individualized. DID has been practiced for dichorionic diamniotic twins, but in monochorionic twins it has been considered as contraindicated due to presence of vascular anastomosis in placenta between twin fetuses that may add additional risks of perinatal morbidity and mortality, and increased risk of chorioamnionitis. However, DID for monochorionic diamniotic (MCDA) twins will be possible but challenging with closely monitoring and aggressive treatment. This will allow us to continue the pregnancy until the remaining fetus become viable or complete treatment of lung maturation.

Success in terms of neonatal outcome in these cases are highly variable, and there are no larger studies regarding DID of twin pregnancies especially for the MCDA twins as of above risks. However, there are several case reports of successful DID deliveries, with most recent one reported in 2019. Therefore, we report successful DID MCDA twin delivery where first twin was non-viable and second twin was delivered after four days of closely monitoring to improve neonatal outcome.

EP/O – 02
SPONTANEOUS RECTUS SHEATH HEMATOMA DURING PREGNANCY: A CASE REPORT

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Introduction
Rectus sheath hematoma (RSH) in pregnancy is a rare clinical condition that presents with upper abdominal pain. Majority of RSH is due to damage of inferior epigastric vessels resulting in extra peritoneal hematoma with a possibility of massive blood loss. Diagnosis of RSH may be challenging due to its rarity and clinical resemblance to conditions such as placental abruption, placenta percreta, degenerating leiomyoma and torsion or bleeding into adnexal masses.

Case Presentation
We report a 34 -year-old patient presented with sudden onset left sided abdominal pain that had a large rectus sheath hematoma at 25 weeks of gestation. She has had 3 days of cough followed by gradually worsening continuous left sided abdominal pain which exacerbated with movements. She was admitted to the hospital 12 hours after the onset of the abdominal pain.

Patient was mildly pale, haemodynamically stable on examination and with a Hb of 7.3 mg/dl, platelet count 287 x 103/ml, PT/INR 0.996 and no evidence of coagulopathy in the ROTEM. Abdominal ultrasound revealed a large mixed echogenic mass closely related to uterine wall with live intrauterine pregnancy. CTG trace showed baseline heart rate of 140/min with >5 baseline variability with symmetrical decelerations with no evidence of uterine contractions.

Exploratory laparotomy was planned suspecting Intra-abdominal hematoma and revealed a left sided large rectus sheath hematoma extending between perinatal peritoneum and rectus sheath. Compete evacuation was done. Source of bleeding was unable to identify, and no active bleeding was noted intra-operatively. A blood loss of two liters was estimated and two units of red cell concentrate were transfused during the procedure. Peritoneal cavity was devoid of blood, pelvic and abdominal organs appeared normal. Her pregnancy continued without significant issues following hematoma evacuation.

Discussion
Rectus sheath hematoma should be considered as an important differential diagnosis which can result in significant morbidity and even mortality in mother or the fetus. Maintaining a high index of suspicion is important particularly in situations such as abdominal trauma, coagulopathy and in conditions with increased intra-abdominal pressure as in severe vomiting or cough. If readily accessible and the patient is haemodynamically stable, MRI imaging provides a better diagnostic accuracy compared to Ultrasound imaging.

EP/O – 03
RARE CASE OF MID TRIMESTER MISCARRIAGE OF MONOCHORIONIC MONOAMNIOTIC QUADRUPLETS

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Introduction
Monochorionic monoamniotic quadruplets means development of 4 foetuses sharing a single placental mass in a single amniotic cavity. It is a very rare presentation of multiple gestation with an incidence of less than 1 in 15 million pregnancies. They very rarely persist until the age of viability and failed at early ages of gestation due to various pathologies, mainly due to placental insufficiency and luteal failure.

Case Presentation
A 28 -year-old second para with a past history of 2 uncomplicated normal vaginal deliveries presented to the antenatal clinic at 11 weeks of period of gestation, found to have monochorionic monoamniotic triplets without any other significant comorbidities. She denied any treatment of ovulation induction. She was started on routine vitamin supplements and progesterone support. Ultrasound scan was repeated at 15 weeks of gestation to confirm her dates, monochorionicity and monoamniocity where it showed 3 foetuses with almost similar gestational ages. As the pregnancy was uneventful, routine management with supplements and luteal support was continued. She admitted to the gynaecology ward at 19 weeks of gestation complaining of abdominal pain and PV bleeding with passage of clots. Examination revealed fundus larger than the gestation with open cervical os. Ultrasound scan showed 3 viable foetuses. But few hours after the admission she ended up with a miscarriage and passed 4 foetuses in a single placental mass. It was managed with supportive care along with psychological support to the mother.

Discussion
Incidence of quadruplet gestation is around 1 in 700,000 pregnancies. Out of that occurrence of monochorionic monoamniotic quadruplets is less than 1 in 15 million pregnancies. These types of advanced multiple gestations are ended up in early pregnancy miscarriages, mainly due to placental insufficiency and luteal failure. Approximately 90 percent of quadruplet pregnancies are associated with assisted reproductive technology, but monochorionic monoamniotic quadruplets are occurred due to spontaneous division rather than assisted conception.

Conclusion
Advanced multiple gestations including triplets, quadruplets and higher gestations associated with poor pregnancy outcome and increased pregnancy associated complications. Amnioreduction may help to improve the pregnancy outcome.

EP/O – 04
OVARIAN VEIN THROMBOSIS FOLLOWING ASYMPTOMATIC COVID-19 IN PUERPERIUM: MIMICKING MALIGNANCY

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Introduction
Ovarian vein thrombosis (OVT) in pregnancy and puerperium is a serious complication with an incidence of 0.05%. Unusual thrombotic events in pregnant women contracted with Coronavirus Disease 2019 (COVID-19) were reported. Reporting rare and abnormal clinical presentations would trigger further studies and updating the management plans of pregnant women with COVID-19.

Case Presentation
A 31-year-old otherwise healthy mother of 3 children, admitted at the 4th week of her postpartum period following an uncomplicated vaginal birth. She complained of right iliac fossa (RIF) region colicky

pain for one week, dysuria and frequency without fever. She had undergone appendicectomy during her childhood. Her BMI was 23 kg/m^2, found to have RIF tenderness and shifting dullness in the flanks. She did not have typical COVID-19 symptoms, but her SARS COV-2 RNA PCR was positive, which was negative during Labour. Her White cell count was 7700/µl ; CRP was 52 mg/l, while her urine culture yielded Coliform growth. CA 125 value was 23 IU/ml .

Ultrasound scan (USS) detected moderate amount of free fluid within the peritoneal cavity without any definite adnexal mass. CECT detected Right OVT, prominent pelvic veins around the Right adnexa and omental thickening. Peritoneal fluid cytology was suggestive of an inflammatory process. UTI was treated with antibiotics. Therapeutic dose of Low molecular weight heparin (LMWH) was started, while planning for a diagnostic laparoscopy.

Discussion
Patient defaulted follow up and presented at the 9th week of post-partum free of any symptoms. Repeat USS found normal bilateral ovaries without any ascites.CA 125 dropped to 76.2 IU/ml. Warfarin therapy was started considering OVT and the possibility of ovarian malignancy was less likely. Review planned in 3 months with repeated CA 125 and USS. Neither ovarian malignancy nor the OVT is frequently encountered among the pregnant and postpartum women. Hematological impact of asymptomatic COVID-19 on pregnant women needs further evaluation. Clinical features suggestive of a malignancy in a pregnant woman should be carefully evaluated to prevent unnecessary interventions. Early thromboprophylaxis may reduce the morbidity caused by OVT.

Conclusion
OVT may mimic and cause a diagnostic dilemma with ovarian malignancy. Increased risk of thrombotic events in pregnancy and puerperium is aggravated by COVID-19 . Administration of thromboprophylaxis for asymptomatic low risk pregnant women with COVID-19 needs further systematic evaluation.

EP/O – 05
SINGLETON LIVE FETUS WITH A PARTIAL MOLAR PLACENTA: A CASE REPORT

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Introduction
Gestational trophoblastic diseases occur due to abnormal fertilization, out of which, partial molar pregnancy with a live fetus is an extremely rare incidence accounting for 0.005 – 0.01% of all pregnancies.

Case Presentation
We report a case of partial molar pregnancy with a healthy live fetus of diploid karyotype, delivered at term via an elective caesarean section indicated due to past section. Pregnancy of the 27 -year-old lady was uncomplicated except for vomiting in pregnancy which settled at early second trimester. There was no history of vaginal bleeding during the course and had normal serial fetal growth assessments. At surgery, baby weighing 2.9 kg was delivered and the placenta appeared to have an abnormal cystic appearance on the maternal surface. Histological studies revealed a normally weighing complete singleton placenta with a normal fetal surface but having many cystically enlarged villi at the distal maternal surface with irregular trophoblastic proliferation along with normal villi suggestive of a partial molar placenta. Mother didn't have evidence of recurrence during follow-up with serial chorionic gonadotrophin (β-hCG) levels.

Discussion
Known types of molar pregnancies are twin pregnancies having a complete or a partial mole with a co-existing live fetus. However, cases of a singleton live fetus with a partial molar placenta, similar to our

case patient, have been reported in literature very rarely. Though our patient experienced only an episode of hyperemesis, presence of vaginal bleeding, pre-eclampsia and hyperthyroidism like symptoms are signs suggestive of a molar pregnancy. Normally progressing pregnancy with a normal live fetus is challenging to diagnose antenatally, but have an increased risk of miscarriage, fetal growth restriction, pre-term labour and mal presentations. Risk of Persistent trophoblastic disease cannot be excluded and should be followed up with serial β-hCG measurements. Karyotyping of the baby and the placental tissues can confirm the diagnosis after delivery though the tissue sample karyotyping facility is still unavailable in Sri Lanka. Characteristic pathological examination features of the placenta can give an accurate diagnosis in the hands of an experienced pathologist in such situations.

Conclusion

Following all deliveries, careful examination of placenta is mandatory to diagnose asymptomatic, antenatally undiagnosed cases of molar pregnancies, as such patients essentially needs counselling and proper follow-up after delivery for the risk of persistent trophoblastic disease.

EP/O – 06

A VERY RARE CASE OF BILATERAL RENAL LYMPHANGIECTASIA DURING PREGNANCY – DIAGNOSIS AND MANAGEMENT

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Background

Renal Lymphangiectasia (RL) is a very rare benign lymphatic malformation in the kidneys. It can be complicated with other cystic renal masses, most commonly polycystic kidneys. Here, we report a very rare case of bilateral RL which was detected as an incidental finding on ultrasound during pregnancy at the booking visit.

Case Presentation

Mrs. H.M is 27-year-old mother of a living child who presented in her third pregnancy with past 1 vaginal delivery and second-trimester miscarriage in her second pregnancy. She presented at POA of 10 weeks after detecting urine albumin 3+ at the village clinic without ongoing urinary tract infection or elevated blood pressure (Booking visit BP- 110/70 mmHg). She underwent ultrasound scan of the abdomen which revealed intrauterine pregnancy with a single live fetus (CRL – 10 weeks + 4 days) and enlarged cystic kidneys with preserved cortico-medullary demarcation and largest perinephric cyst in the right kidney measuring 8.2 cm x 5.7 cm. Investigations were performed, [Serum Creatinine – 51.39 mmol/l, Blood urea – 2.9 mmol/l, Serum Sodium – 137 mmol/l, Serum Potassium – 3.8 mmol/l, 24 h urine creatinine excretion – 6.5 mmol/24h, 24 h urine protein excretion – 1.2g (< 0.15 g/24h)] which revealed normally functioning kidneys. MRI scan of the abdomen showed Renal lymphangiectasia involving perinephric space forming multiple cysts with 7.2 cm x 7 cm x 7.3 cm large cyst in the upper pole of the right kidney causing compression of the upper pole, diffuse peritoneal and retro-peritoneal lymphatic malformations, gravid uterus with a single fetus. Due to the compression effect of a large cyst in the right upper pole she underwent ultrasound-guided therapeutic and diagnostic fluid aspiration which removed 400 ml of chylous fluid which contains 100% of lymph suggestive of lymphatic involvement. Throughout her pregnancy her blood pressure, blood Urea, and serum creatinine values were normal. A serial ultrasound scan of the fetus and abdomen was done after 24 weeks of gestation to assess the growth of the baby and the size of the cyst within her kidneys which revealed fetal growth restriction without affecting the

size of her kidneys. At 37 weeks of gestation, she delivered a baby girl (Birth weight – 2.3 kg) vaginally without any intrapartum or postpartum complication. She underwent an ultrasound scan of the abdomen on second day of postpartum period which didn't show significant changes in her kidneys. Renal function parameters also remained static and the Nephrology team planned to review her in one month.

Discussion

Renal lymphangiectasia is also known as renal lymphangiomatosis or renal lymphangioma is a rare benign disorder that accounts for approximately 1% of all lymphangiomas. It has been reported in adults as well as in children of both sexes. It may be unilateral or bilateral and focal as well as diffuse. The main causative factor is non-communication of peri-renal and peri-pelvic lymphatic channels with the main lymphatics.

Most commonly the condition is asymptomatic and is diagnosed incidentally. It may have nonspecific presentations like flank pain, abdominal distension, haematuria, fever, hypertension, or altered renal functions. The symptoms can be aggravated by pregnancy. During abdominal examination presence of ascites and unilateral or bilateral ballotable kidneys may lead to further investigation.

The main differential diagnoses are polycystic kidney disease, hydronephrosis, multilocular cystic nephroma, lymphoma, and urinoma. Radiological imaging modalities like Ultrasound, CT, or MRI may help differentiate those cases. The ultrasound will show multiple non-communicating septated anechoic cysts with thin walls at inconstant locations in the renal parenchyma or pararenal or parapelvic areas. Magnetic resonance imaging (MRI) will show the lymphatic cysts as hypodense or hyperdense on T1 and T2, respectively. Again, there is no enhancement or opacification of lymphatic cysts during the magnetic resonance excretory phase of T1. MRI is especially useful during pregnancy as it doesn't contain radiation. In polycystic kidneys, the renal cortex shows the presence of cysts whereas, in RL, the renal cortex appears normal. Similarly in RL, the pelvicalyceal system appears normal in contrast to hydronephrosis. Ultrasound-guided aspiration of cyst fluid can be performed to relieve pain and for diagnostic purposes. Cyst fluid is a sterile, chylous fluid containing the majority of lymphocytes (more than 80-90%), and a small amount of fat.

Haematuria, ascites, hypertension, renal vein thrombosis, and altered renal function can occur as complications of RL. Hypertension and pain can be managed with medical treatment. However, most patients are asymptomatic and can manage conservatively but symptomatic large collections are treated by marsupialization or nephrostomy. Refractory hypertension and renal vein thrombosis are complications where nephrectomy is done as last resort.

Conclusion

Renal Lymphangiectasia is a very rarely seen benign usually asymptomatic condition where imaging studies can play a very important role in differentiation from other conditions. In this case first trimester ultrasound scan helped to detect this condition incidentally which shows the importance of booking visit examination and ultrasound scan.

EP/O – 07
HETEROTOPIC PREGNANCY: CASE REPORT

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Introduction

Heterotopic pregnancy is the simultaneous occurrence of intrauterine and ectopic pregnancy. This is a very rare condition among pregnant mothers (1:30,000 pregnancies), while recently, with the development of

assisted reproductive techniques, the incidence has increased to 1:100 – 1:500 pregnancies. The aim of this case report is to present the situation of coexistence of intrauterine pregnancy and leaking tubal pregnancy.

Case Presentation
A 32-year-old development officer on her third ongoing pregnancy with previous two first trimester miscarriages. She was married for five years, and this is an ovulation induction pregnancy. She detected her pregnancy by urine pregnancy test at four weeks of pregnancy and ultrasound scan was done, intrauterine pregnancy detected. Informed her to repeat the scan in two weeks' time although she developed brownish vaginal discharge after a week and repeated the scan. At 7 weeks and 3 days of period of amenorrhea again she admitted with abdominal pain and per vaginal bleeding. Ultrasound scan shows intrauterine viable pregnancy, moderate amount of free fluid in Cul-de-sac with right side adnexal mass. Diagnosis was made as Heterotopic pregnancy and patient was prepared for emergency laparotomy.

On admission to the hospital her Blood pressure was 100/70 mm Hg, heart rate 105 beats min-1, temperature 37^0C. In the physical examination, the abdomen was hard with peritoneal symptoms, pallor of the skin. The patient complains of severe pain in the right lower abdomen, On the gynecological examination vulva vagina looks normal, bleeding from the cervical canal with cervical excitation Uterus was about ten weeks size with bilateral tender appendages difficult to assess. Basic investigation looks normal. She was discharged after a day following laparotomy with the plan of reviewed in four weeks. Later in eleven weeks of gestation viable intrauterine pregnancy was noted with correcting dates. Following surgery specimen was sent for histology and it confirms the diagnosis.

Conclusion
The described case indicates that the existence of intrauterine pregnancy does not exclude the existence of ectopic pregnancy and emphasizes the great importance of correctly and accurately carried out ultrasound examination in the first trimester of pregnancy. Early diagnosis of heterotopic pregnancy reduces the risk of complications.

EP/O – 08
A RARE CASE OF MIDDLE CEREBRAL TERRITORY INFARTION IN IVF PREGNANCY

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Introduction
The pregnancy is a hypercoagulable state and risk of developing thrombosis is increased with co existent of the other comorbidities like chronic hypertension, Type 2 diabetic mellitus, chronic kidney disease, dyslipidemia etc. However, it is superimposed by ovarian hyper stimulation in ART. Thromboembolic disease associated with ovarian stimulation is an uncommon, yet potentially fatal complication of ART. Thromboembolism is associated with ovulation induction. We report a case of middle cerebral artery infarction in IVF pregnancy with multiple comorbidities however who safely delivered a healthy baby by LSCS in Teaching Hospital Peradeniya.

Case Presentation
A 50-year-old primi mother admitted to the ward at a POA of 24 weeks with the history of slurring of voice, L/S paresthesia and R/S headache and sudden onset dizziness. She is a known patient with chronic hypertension, Type 2 diabetic mellitus, chronic kidney disease stage 3, dyslipidemia. This is an IVF pregnancy following 4 years of subfertility. On neurologic examination, mild disorientation, motor

aphasia, and right-side hypoesthesia were noted. Other physical examination findings were unremarkable, Transabdominal ultrasound scan showed an estimated fetal weight of 432 g, and good Doppler flow. Hb - 8.8 g/dl, Serum K+- 6.0 mmol/l, Serum creatinine - 124.53 µmol/l, AST, ALT were normal. Input/Output chart, low K+ diet, Calcium resonium 15 g tds, Nifedipine 20 mg bd, if SBP > 140/90 mmHg. NCCT brain revealed acute right MCA territory infarct with mass effect.no hemorrhagic transformation. Trop I was high (715 IU/l) no significant ECG changes unless T Flattening. Her hyperkalemia state was managed with insulin dextrose and calcium gluconate. 2D echo done it was normal systolic & diastolic function, no hyperkinetic changes. Repeat Trop I array because CKD causing High Trop I. She received nephrological support and was managed with mannitol. She was treated inward for three weeks & closely followed up until delivery with time-to-time MDT involvement.

At POG 31+1, she noticed reduced fetal movements, Doppler scan found to have Intermittent absent diastolic flow in UAD with normal MCA Doppler. She delivered a baby boy by Emergency cesarean section after completion of IM Dexamethasone under insulin coverage. Birth weight was 1.480 kg. Baby received NICU care. Following LSCS, she got generalized tonic clonic seizures. NCCT brain and CXR were done once patient stabilized which turned out to be normal. Levetiracetam was initiated after neurology assessment for seizures. She was discharged from the ward with a healthy baby on long term follow up plan for her medical conditions management. Before discharging she was informed to relevant MOH & PHM regarding the patient due high risk.

Conclusion

In our case appreciate higher risk of complications during the pregnancy due to multiple comorbidities with her advancing age. It was superimposed by IVF. However, this complicated pregnancy was successfully managed with multidisciplinary involvement.

EP/O – 09

A CASE REPORT OF DICHORIONIC TWIN PREGNANCY DISCORDANT FOR FETAL ANENCEPHALY WITH FETAL DEATH

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Introduction

In twin pregnancies discordant for anencephaly, Development of polyhydramnios, severe preterm delivery and death of the anencephalic fetus are the complications of discordant for anencephaly fetus in twin pregnancy. There are three management options in dichorionic twins discordant for anencephaly. Selective fetocide, serial ultrasound examination for polyhydramnios or expectant management. we present our experience with a case of twin pregnancy discordant for anencephaly which was managed conservatively.

Case Presentation

29 years old primi mother was admitted to our ward with the labor symptoms at POG 37 weeks. She was primary sub fertile and conceived with ovulation induction treatment and intrauterine insemination after 4 ½ months of subfertility. She had no comorbidities and her blood was group B positive. Ultrasound scan was done at 12 weeks and it revealed DCDA twin pregnancy. However, there was a doubt regarding Absent of fetal skull in 2nd twin it was confirmed at 16 weeks of gestation as anencephaly fetus. T2 development was concordant with gestational age and no abnormalities were seen ultrasonically. Serial growth scan was done every four weekly as DCDA twin management. Anomaly scan revealed no fetal heart sound in anencephaly fetus and other fetus was normal growth but increased liquor volume for gestation. Mother underwent spontaneous onset of labour at POA of 37 weeks. Delivered live non asphyxiated baby weighing 2350 g and a dead fetus with anencephaly weighing 600 g. mother and baby were discharged in postpartum day 3 without any complication.

Discussion

Anencephaly, with spina bifida, is the most common and multifactorial neural tube defect, incidence in about 1 in 1000 births. Prenatal detection of anencephaly by ultrasound is possible in almost 100% of cases. In twin pregnancies complicated with one anencephalic fetus, there is an increased risk of either neonatal death due to severe preterm delivery secondary to development of polyhydramnios or intrauterine death. Another major risk is development of discordant fetal growth. The prevalence of discordance for anencephaly is higher in monochorionic than in dichorionic twins. After diagnosis of an anomaly in one fetus with a normal co-twin, the general management options are the following: abortion of both fetuses, continuation of pregnancy without intervention or selective fetocide of the abnormal twin

Conclusion

As a result, dichorionic twin pregnancy discordant for fetal anencephaly is a rare case but may have serious consequences. Although both expectant management and selective fetocide have good outcomes, close follow-up of these patients is very important in management.

EP/O – 10
A CASE REPORT OF OVARIAN DYSGERMINOMA IN PREGNANCY

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Introduction

Dysgerminoma is an uncommon malignant tumor arising from the germ cell of the ovarian. It is common in the first two decades of life. Dysgerminoma in pregnancy is extremely rare, incidence is 0.2 – 1 per 100,000 pregnancies. If dysgerminoma develop during pregnancy, which cause various medical and ethical dilemmas and unusual to complete the pregnancy without fetal or maternal compromise

Case Presentation

A 23-year-old primigravida at 28 weeks of pregnancy was found to have intraabdominal mass during routine follow up ultrasound scan. On physical examination, she had normal vital signs. Pelvic ultrasound revealed a large cystic and solid mass measuring 20 × 20 cm, which covering the whole posterior surface of the gravid uterus and difficulty to differentiate whether it was a degenerative fibroid or ovarian mass. MRI revealed a large intraperitoneal mass. The multidisciplinary team meeting considered all the factors, explored patient's wishes, and a decision was made to follow up the patients, allowing the pregnancy to continue.

She presented with shortness of breath at 34+5 weeks of POG. On examination she had left side pleural effusion additional to above finding. After stabilizing her condition she underwent a midline laparotomy and 2300 g weight live baby was delivered. Large right side ovarian cysts with solid and cystic area and moderate ascites were found at operative time. Right side salpingo-oophorectomy was performed, and specimen was sent for histology and immune-histochemistry which reviewed as a dysgerminoma. She was referred to oncology unit for further follow up and adjuvant chemotherapy.

Discussion

Usually, patients with ovarian tumors remain asymptomatic until they have symptoms due to their large size or related complications. In this case, the volume of which may rapidly increase within a very short period while the tumor remains asymptomatic and first diagnosed during routine follow-up scan. Most of the time dysgerminoma is misdiagnosed as uterine fibroid with cystic degeneration by ultrasound examination. MRI has a 98% of specificity to detect the origin of tumor. Optimal management starts with proper counseling. Dysgerminoma can be curable, and reproductive potential also can be retained after fertility- preserving surgery and chemotherapy. During the operation, if lesion is highly suspicious

for malignancy, oophorectomy should be performed. After confirming malignancy by histopathology, further management depends on various factors: the stage of cancer, patient wishes and preferences and reproductive history.

Conclusion

Pregnancy associated with ovarian malignancy presents with multiple challenges. There is limited evidence regarding appropriate management due to rarity of ovarian cancer in pregnancy. The principles of management remain the same and proper counseling and individualizing treatment on a case-to-case basis is important.

EP/O – 11

MATERNAL DEATH SECONDARY TO HISTOLOGICALLY CONFIRMED AMNIOTIC FLUID EMBOLISM

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Introduction

Amniotic fluid embolism (AFE) is one of the catastrophic complications in pregnancy where amniotic fluid, and other debris enter into the maternal circulation results in cardiovascular collapse. Incidence is 1 in 40000 deliveries with a mortality rate of 20 to 60%. It may occur in healthy women during labour and up to 48 hours of post-partum.

Case Presentation

A 21-year-old primi at 38 weeks, presented with pain and had an uneventful antenatal history. On admission she was hemodynamically stable. She was 2-3 cm dilated with reactive CTG. Ultrasound done on admission was unremarkable. Patient was sent to the labour room at os 6 cm and liquor was clear. She was augmented with oxytocin due to inadequate contractions. She delivered a baby weighing 3.4 kg and admitted to PBU due to poor cry at birth. Placenta was completely delivered after 7 minutes, and she developed PV bleeding after 20 minutes. On examination she had a poorly contracted uterus and given Intravenous (IV) Syntocinon. She had significant PV bleeding necessitating IV tranexamic acid, and blood was sent for urgent FBC and DT. After 30 minutes from the delivery patient showed evidence of hypovolemia, but blood transfusion was delayed due to 2 hemolysed samples. IM ergometrine was given as patient continued to have bleeding. Patient was sent to the theater for further management and on the way to the theater with oxygen, peripheral cyanosis, shortness of breathing and low saturation were noted. Examination under anaesthesia was done and a partially contracted uterus without active PV bleeding was noted. No retained products or any tears except a small episiotomy was noted. Fundal massage continued for another 30 minutes, and a Bakri catheter was inserted, and blood was sent for ROTEM while patient is being resuscitated with blood and blood products. Patient developed signs of increasing coagulopathy with bleeding from puncture sites. In defiance of above management, the patient had persistent peripheral cyanosis, absent peripheral pulse and low blood pressure. Following consultation with a second expert, further surgical intervention was not considered due to clinical DIC which was confirmed by ROTEM results. Thus the patient was managed at ICU and started on tranexamic acid infusion, FFP, cryoprecipitate and blood transfusion. Opinion was taken to give factor VII or PCC (prothrombin complex concentrate). Regardless of all above therapeutic interventions except PCC, patient died. Judicial postmortem and subsequent histological examination revealed a classical amniotic fluid embolism.

Discussion

Possible effects of AFE are anaphylaxis, vascular occlusion and spasms secondary to particulate matter,

prostaglandins and vasoactive substances leading to development of DIC. Induction of labor, multiparity, increased gestational age, advanced maternal age, multiple pregnancies, operative vaginal deliveries and polyhydramnios are presumed risk factors. It must be suspected in any patient who collapses or bleeds excessively during labour or the immediate post-partum period. The diagnosis is clinical and arrived by exclusion, based on the rapid development of clinical features of sudden cardiovascular collapse, acute left ventricular failure with pulmonary edema, DIC, and neurologic impairment. AFE is ideally managed with multidisciplinary team. Supportive care involving correction of coagulation, volume status, adequate tissue oxygenation and blood pressure support play a vital role in management. However, it carries a poor clinical outcome.

Conclusion

AFE is a sudden and unexplained life-threatening birth complication that can affect both mother and baby. It is a rare obstetric emergency with a very poor prognosis.

EP/O – 12

A CASE OF ACUTE APPENDICITIS IN PREGNANCY- CONSERVATIVELY MANAGED PATIENT

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Introduction

Acute appendicitis is a surgical emergency which needs early detection and prompt treatments. It is uncommon in pregnancy with a prevalence around 1/800 - 1/1500 with highest incidence in the second trimester.

Case Presentation

Previously well 22-year-old primipara at 29 weeks of gestation presented with right sided abdominal pain with associated fever for 1 day. She had nausea but no vomiting. She had a temperature of 99.8^{0}F. Examination revealed a 28-week size gravid uterus and right iliac fossa tenderness. Investigations revealed a white cell count of 23 × 109/l with a C-Reactive Protein of 138 mg/l. Acute appendicitis was suspected. Upon consultation surgical team opted for conservative management. Intravenous antibiotics for 10 days and analgesics were given. Patient recovered in a few days. Her white cell count reduced to 8 × 109/l and C-Reactive Protein to 9 mg/l. She was discharged on day twelve with oral antibiotics for 4 days.

Discussion

Classically, Acute appendicitis presents as central abdominal pain followed by localization to right iliac fossa. But, due to the gravid uterus, in the pregnancy, the site of localized pain can move to anywhere in the abdomen. This makes the diagnosis difficult in pregnancy. In this case the right iliac fossa pain prompted clinical suspicion.

Leukocytosis with neutrophilia and increased CRP levels indicate inflammation. In our case patient had a white cell count of 23 × 109/l with a C-Reactive Protein of 138 mg/l which was indicated acute inflammation and confirmed the diagnosis.

Ultrasound scanning, usually helpful, is usually not helpful and is unreliable in pregnancy. In this patient also, the ultrasound scan of the abdomen did not show any remarkable features. Both maternal and fetal mortality increase with the severity of disease. Early diagnosis and prompt treatment yield a better outcome. Though surgical treatment is the mainstay of management in acute appendicitis, here we managed the patient conservatively. We monitored the response with clinical findings and inflammatory markers with inputs from multidisciplinary team. The patient responded and was discharged on day 12 with no maternal or fetal complications.

Conclusion
Acute appendicitis is a diagnostic challenge in pregnancy due to its unusual presentation and atypical clinical findings. Maternal and fetal complications are linked to the severity of the disease. Although surgery is the mainstay of management, mild forms of the disease can be successfully treated conservatively with antibiotics and good clinical monitoring.

EP/O – 13
A CASE OF ACUTE PANCREATITIS IN PREGNANCY - A RARE CASE REPORT
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Introduction
Acute pancreatitis is a surgical emergency that presents with clinically diverse spectrum of severity. It is a rare disorder in pregnancy that causes disastrous effects to both mother and the baby. Common causes of acute pancreatitis in pregnancy are gall stone related (70%), alcohol abuse and hypertriglyceridemia. It is challenging to diagnose acute pancreatitis in pregnancy due to maternal changes of pregnancy and atypical presentations.

Case Presentation
We report a case of 21-year-old primipara mother with period of amenorrhea of 32+5 weeks with epigastric pain. Diagnosis was confirmed with high serum amylase levels and ultrasound scan findings. We managed the patient with fluid therapy and adequate pain relief. We started early enteral feeding and treated with broad spectrum antibiotics. The patient recovered without maternal or fetal complications. After delivery both mother and the baby were healthy and discharged on post-operative day 3.

Discussion
Diagnosis of Acute pancreatitis is mainly based on clinical and biochemical alterations. Pregnancy itself causes various biochemical alterations. So, some of the biochemical parameters are less efficient to diagnose Acute pancreatitis. The disease is usually present in multiparous women in their third trimester with upper abdominal pain radiating to back with associated fever, nausea and vomiting. Biochemically serum amylase or lipase levels are elevated. Ultrasound scan is used as the mainstay imaging modality during pregnancy. But magnetic resonance imaging (MRI) is used in evaluating complications.

In pregnancy, increase in serum amylase and serum lipase can be used as a good marker to diagnose Acute pancreatitis. We used ultrasound scan for early diagnosis of acute pancreatitis and it was enough for the initial management. In managing Acute pancreatitis, keeping the patient nil by mouth, providing adequate analgesics and nutritional support are very important, especially in this case, as the patient was diagnosed with gestational diabetes mellitus and was on medical nutrition therapy. Early enteral feeding has been associated with better outcome in pregnant mothers. So, we started early enteral feeding in a sequence manner.

Conclusion
Acute pancreatitis in pregnancy is a rare but severe disease that cause both maternal and fetal complications. It is essential to suspect the diagnosis when a pregnant mother presents with epigastric pain. After confirming the diagnosis, symptomatic management with early use of broad-spectrum antibiotics may be beneficial.

EP/O – 14
AN ACUTE ABDOMEN IN PREGNANCY? IS IT AN ABRUPTION

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Case Presentation
29-year-old mother at the period of amenorrhea (34+2) weeks admitted with nausea and vomiting for 2 hours duration. This is her first pregnancy and she had endometriosis and has undergone In Vitro Fertilization to become pregnant. she also complained severe abdominal pain especially in the upper epigastrium and had no per vaginal bleeding or discharge. she was not febrile, pale or icteric but very ill looking with tachycardia and blood pressure of 110/70 mmHg. Her urine albumin was nil. Abdomen was distended and tender to touch. Fetal basal heart rate was 120/min with reduce variability. Ultrasound revealed no evidence of placental abruption. Initial full blood count (FBC) showed leucocyte count of 4690/µl with other normal investigations.

With a provisional diagnosis of placental abruption decided on emergency caesarean section. Uterus was hard and contracting. Liquor was meconium stained and baby was delivered. Placenta and membranes showed no evidence of placental abruption. Infected peritoneal fluid noted with a bad smell and infective cause was suspected immediately surgical team arrived and inspected the peritoneal cavity. Inflamed appendix was found adhered to right side tubo ovarian complex leading to a tubo-ovarian abscess and peritonitis. Inflamed tissues ware excised & peritoneal cavity was thoroughly washed. Intravenous piperacillin and tazobactam were started which were continued for 14 days as Culture report was positive for E. coli. C-Reactive Protein (CRP) shows 222 mg/l, which came down with subsequent resolving of the infection. Histology confirmed the inflamed appendix and tubo-ovarian abscess.

Discussion
Diagnosis of the acute abdomen in pregnancy remains as one of the most challenging tasks. Acute appendicitis is one of the commonest acute surgical causes of abdominal pain in pregnancy and it tends to occur most commonly in the second trimester. Because of gravid uterus appendix may be mobilized from right iliac fossa and the diagnosis could be challenging. Appendiceal perforation owing to stretched peritoneum is more common in third trimester. Biochemical tests may reveal evidence of elevated acute inflammatory markers especially CRP. Ultrasound may show an enlarged and inflamed appendix with surrounding inflammatory exudates.

Conclusion
Abdominal Pain is a common symptom in pregnancy, but the diagnosis can be challenging as many obstetric and non-obstetric causes may lead to it. In this lady the peritonitis from inflamed appendix had caused preterm labor as well as fetal distress which led to early delivery and surgical treatment. As evident CRP remained as reliable acute inflammatory marker during pregnancy.

EP/O – 15
LEAKING PRIMARY ABDOMINAL ECTOPIC PREGNANCY

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Introduction
Abdominal pregnancy is a rare form of ectopic pregnancy with very high maternal and fetal morbidity and mortality. A high index of suspicion and expertise in ultrasound scan is crucial for prompt diagnosis

and management especially in low-resource base hospital level.

Case Presentation

A 36-year-old woman with period of amenorrhoea 6 weeks and 3 days, (gravida 4, para 3) with past 3 normal vaginal deliveries, presented with lower abdominal pain, dysuria, vomiting and faintishness to the gynaecology ward base hospital Mawanella. On admission, urine β-hCG test was positive. A trans abdominal ultrasound was performed revealing a fetus with a head circumference of 13weeks and 6 days with an empty uterine cavity and intact fallopian tubes along with free fluid in the abdomen. The diagnosis of primary abdominal pregnancy was confirmed. A diagnostic laparoscopy was carried out. Intraoperatively, the fetus was seen in an intact amniotic sac in her abdomen. The placenta was attached to the right side fimbrial end of the fallopian tube, pelvic peritoneum, posterior wall of the uterus and to part of the caecum. The amniotic sac with fetus was removed. The placenta was dissected away completely and safely. No postoperative complications were observed.

Conclusion

The life-threatening complication in abdominal ectopic pregnancy is bleeding from the detached placental site. Ultrasound is the investigation of choice to diagnose an abdominal ectopic pregnancy. In addition, laparoscopy is useful for localization of the placenta intraoperatively.

EP/O – 16
A CASE OF OVARIAN CYST IN PREGNANCY - A DERMOID CYST

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Introduction

Ovarian cysts are uncommon in pregnancy and represents around 0.3% of pregnancies. Out of them dermoid cysts are common. Dermoid cysts contain mature tissues derived from all three germ cell layers. They are detected either through first trimester ultrasound scan or due to cyst complications. The patients present with common symptoms like abdominal pain or palpable abdominal mass. Pain could be due to rupture of the cyst, torsion of cyst, hemorrhage into the cyst. The management depends on the size, symptoms, characteristics of the ovarian mass. Here we present a case of dermoid cyst in pregnancy where the patient presented with lower abdominal pain.

Case Presentation

Previously well primipara presented with left side lower abdominal pain for 2 weeks duration at period of gestation 12 weeks. She had no fever, urinary of bowel symptoms. She had a tender palpable mass on left side of the abdomen. Ultrasound scan revealed a 14.1 x 6.4 cm cystic mass with cystic and solid areas. She was hemodynamically stable. Tumor markers were not done due to unavailability of reagents. She underwent an infraumbilical midline laparotomy. Left sided 14 x 6 cm size ovarian cyst was found and there was some free fluid in the abdomen. A 12-week size gravid uterus was noted with normal right-side ovary, right side fallopian tube and left side fallopian tube. Liver, spleen, bowel, omentum and bladder were normal. Left side cystectomy and ovarian reconstruction was done. Histology confirmed a mature cystic teratoma without malignant transformation.

Discussion

Abdominal pain in pregnancy often causes diagnostic dilemma. Presence of an ovarian cyst in pregnancy can complicate the pregnancy by causing cyst accidents. And diagnosing cyst complications and differentiating them from intrauterine pathology may be difficult. Ultrasound scan is used safely in pregnancy to diagnose the ovarian cyst. But if the diagnosis is in doubt MRI scan is useful and can be used safely. Conservative management may not be suitable if the ovarian cyst is more than 5 cm as probability of further cyst complications is higher.in this case the ovarian cyst was 14 cm in size and laparotomy was

performed and ovarian cystectomy done with ovarian reconstruction.

Conclusion
Ovarian cysts are rare in pregnancy that need early diagnosis and prompt treatment to reduce the morbidity to both mother and fetus. Timely interventions reduce the chance of cyst accidents and effects to the pregnancy.

EP/O – 17
A RARE CASE OF SPLENIC HAEMANGIOMA DURING PREGNANCY OF AN E-BETA THALASSAEMIC MOTHER, SUCCESSFULLY DELIVERING A NEAR TERM BABY!

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Introduction
Thalassaemia is a common occurrence at Anuradhapura district. However, E beta thalassaemia is one of the rarities within its spectrum. New onset haemangioma at the spleen in a patient with E-beta thalassaemia is a clear indication for a splenectomy. Concomitant pregnancy however challenges all these management strategies putting the obstetrician, mother and the fetus all in a very perplexed situation. We report a case of a 21-year-old E-beta thalassaemic primi mother successfully delivering a near term baby following conservative management for a new onset splenic haemangioma during pregnancy.

Case Presentation
A 21-year-old primi mother at a POA of 10 weeks presented for her booking visit with a newly diagnosed splenic haemangioma. She is a known patient with E-beta thalassaemia since the age of 6 years. Her baseline haemoglobin level was always maintained around 5-6 g/dl without symptoms with only 3 blood transfusions until this pregnancy. An MDT meeting was held with the participation of Haematologist, Transfusion specialist, Gastroenterology Surgeon, Anaesthetist, Radiologist, Microbiologist, and Consultant Obstetrician at 12 weeks of gestation regarding further management of the patient. A decision of continuing the pregnancy with close follow up of splenic haemangioma size every 2 weekly by the same radiologist was made. If any rapid increment in size of the haemangioma was noted, an emergency splenectomy was planned. Delivery was planned at 37 weeks of POA by an elective caesarean section. However, our patient presented at 35 weeks of POA with and delivered a healthy baby via an emergency caesarean section. Following delivery patient had ICU care for 3 days with the development of lower respiratory tract infection. However, she recovered fully and was discharged at postpartum day 10.

Discussion
E-beta thalassaemia is a spectrum of disease where many sufferers are transfusion dependent. Development of a splenic haemangioma in a setting of E-beta thalassaemia is challenging and surgical resection is advised. However, in the background of pregnancy all these management strategies and decisions are often difficult to make since there is no such evidence to favour any option. Changes of a splenic haemangioma during pregnancy is not well understood. Sudden increase in size with pregnancy induced changes and the risk of splenic haemangioma rupture leading to life threatening internal haemorrhage was always anticipated with this patient. A mammoth team effort from all the team members made it possible for this mother to carry a healthy baby home against all odds.

Conclusion
Data is lacking on the behaviour of haemangiomas during pregnancy. Conservative management is an ideal approach with a high alert team and an educated cooperative patient to achieve a successful outcome during pregnancy!

EP/O – 18

CHRONIC LIVER DISEASE IN PREGNANCY- A CASE REPORT AND REVIEW OF LITERATURE

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Introduction

Chronic liver disease complicating pregnancy is uncommon. We describe and review the evidence on the evaluation and management of a case of chronic liver dysfunction diagnosed in pregnancy.

Case Presentation

44-year-old mother of 3 children with a background of poorly controlled type 2 diabetes was transferred at a POG of 27 weeks for further evaluation of decompensated chronic liver disease incidentally detected and newly diagnosed in the current pregnancy. Detailed assessment revealed a probable aetiology of non-alcoholic steatohepatitis with portal hypertension and hypersplenism. She delivered by cesarean and opted for sterilization. Both the mother and the baby had an uneventful postpartum period.

Discussion

Over the last decade, there is a shift in the underlying causative factors from hepatitis/alcohol to non-alcoholic fatty liver disease resulting in more young women with cirrhosis. If possible, preconceptional planning is important for risk stratification and optimization of disease status for the best possible outcome. Model for end stage liver disease (MELD) score facilitates prediction of specific outcomes in pregnancy. Management is primarily focused on regulation of portal hypertension and prevention of related complications. Mode of delivery is decided with the intent of avoiding Valsalva maneuver or cesarean delivery or vaginal delivery with assisted second stage.

Conclusion

A multidisciplinary approach in the management of chronic liver dysfunction is essential. Anticipation and early detection of portal hypertension related complications can lead to better maternal as well as neonatal outcome.

EP/O – 19

SIGMOID VOLVULUS COMPLICATING PREGNANCY – CARE REPORT

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Introduction

Intestinal obstruction is an extremely rare cause for abdominal pain in pregnancy. It carries significant maternal and fetal morbidity and mortality. Timely diagnosis and early intervention are necessary for the good outcome.

Case Presentation

A 34-year-old mother in her first pregnancy at Period of Amenorrhea of 31 weeks presented with abdominal pain for 3 days duration. She developed sudden onset on and off abdominal pain which was progressively increased with abdominal distension, constipation and vomiting. This was an uncomplicated pregnancy

until this presentation. She didn't have any medical complication or any past surgeries. She had a regular clinic visits and fetal wellbeing was satisfactory. Initially she was managed as suspected Preterm Labour and later diagnosed as intestinal obstruction. Initially conservative management was offered. It was progressed. Emergency flexible sigmoidoscopy was performed, and it revealed ischemic looking large intestine proximal to recto-sigmoid junction up to the transverse colon suggestive of ischemic sigmoid colon. On examination she was ill looking, and abdomen was distended with tenderness, uterus was deviated to right side with dilated bowel loops in left side with absent bowel sounds. She was tachycardic and blood investigation revealed features of early sepsis. Fetal growth was normal with normal fetal heart sound. Emergency laparotomy was performed under general anaesthesia and found to have large intestinal obstruction due to sigmoid volvulus. Dilated gangrenous toxic megacolon was resected. It was decided to perform lower segment caesarean section and it was a stillbirth. Colostomy was performed. Post operatively intensive care was given. Later she underwent colorectal anastomosis 3 months after first operation and recovered uneventfully.

Discussion

Intestinal obstruction is an extremely rare in pregnancy and sigmoid volvulus (SV) is one of the causes of intestinal obstruction apart from adhesions and intussusception. In pregnancy enlarging uterus can cause abnormally long sigmoid colon to displace out of pelvis and twist around to form sigmoid volvulus. The diagnosis of SV in pregnancy is often delayed because the symptoms mimic typical pregnancy associated complaints such as abdominal pain. Plain abdominal radiography is helpful for the diagnosis of obstruction. SV in pregnancy is an acute surgical emergency. Initially can manage with colonoscopic detorsion and tube decompression. Sigmoidectomy is the definitive treatment. In third trimester delivery of fetus is recommended in order to get access to retro uterine space for sigmoidectomy and colostomy.

Conclusion

SV is uncommon and it should be recognized as a surgical emergency. Diagnosis requires high index of suspicion. Prompt intervention is necessary to minimize complications.

EP/O – 20

UNEXPLAINED ASCITES TWO WEEKS AFTER CAESAREAN DELIVERY: A CASE REPORT OF DELAYED PRESENTATION OF URINARY ASCITES.

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Background

New onset ascites in post-partum period has many underlying aetiologies and correct diagnosis can be challenging task. Post Caesarean section ascites can be due to iatrogenic pelvic organ injury or non-surgical aetiology like infective cause, pregnancy related or non-related medical complication.

Case Presentation

25-year-old woman who had given birth to her second child in local hospital by elective repeat Caesarean delivery and discharged on postpartum day two. Then readmitted to the hospital on post operative day fifteen with gradually worsening abdominal distension for four days and associated fever and generalised malaise. Then she was transferred to tertiary care maternity hospital for further evaluation of unexplained multilocular ascites which was detected ultrasonically.

There was no ascites, ovarian cysts or other abnormality in pelvic anatomy at the time of surgery. Neither significant past medical disorders like liver disease, renal disease, rheumatological or haematological disease. Her abdomen was grossly distended with mild tenderness and shortness of breath on examination. Blood pressure was 140/90 mmHg with 130 beats per minute tachycardia. she had oliguria and steady

rise in serum creatinine level with 100^0F fever. There was no thrombocytopenia, anaemia or leukopenia in her full blood count. Her CRP level was 321 mg/dl. Ascitic fluid creatinine level (957 µmol/l) revealed a suspicion of urinary ascites since it was three times higher than serum creatinine level (380 µmol/l). Contrast enhanced CT (CECT) cystogram confirmed the diagnosis of bladder injury. Patient was managed conservatively with indwelling foley catheter as suggested by Genito urinary team. She improved markedly in next two days with normalisation of serum creatinine and resolving of ascites. Urinary catheter was removed after 21 days. Delayed Cystoscopy confirmed complete healing of injury

Discussion

Post operative ascites is a very rare complication of caesarean section. There are different aetiologies and evaluating clinician should keep in mind possibility of infective aetiology like Dengue fever, Tuberculosis and Pregnancy related liver, Pancreatic, Renal or Cardiac disease and preeclampsia related ascites. Even Peritoneal inflammatory process, allergy and lymphatic fluid leakage can be the culprit. Possibility of iatrogenic Genitourinary and Gastrointestinal injuries also should be kept in mind in post-surgical patient evaluation. Most of the undetected bladder damages were presented with symptoms in early post operative period. Infection, thermal injury, devascularization, prolonged arrest with strong clamp, or hematoma can lead to partial wall thickness injuries which can lead to leakage or fistulas later. Delayed presentation of ascites made the diagnostic dilemma.

EP/O – 21
UTERINE ARTERIOVENUS MALFORMATION FOLLOWING A FIRST TRIMESTER MISCARRIAGE

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Introduction

Uterine arteriovenous malformation (AVM) is a rare condition which causes 1-2% of life-threatening vaginal bleeding. These AV malformations could be idiopathic or acquired. Idiopathic condition occurs due to developmental anomalies and acquired conditions are due to delivery, surgical procedures within the uterine cavity, and malignancies. The exact pathophysiology for development of acquired AV malformations are not clearly identified. We report a rare case of acquired uterine AV malformation following a medically managed first trimester miscarriage.

Case Presentation

A 27-year-old woman in her third pregnancy with past two uncomplicated pregnancies were diagnosed to have a missed miscarriage during her dating scan done at 10 weeks of gestation. She underwent medical management of missed miscarriage. Medical management was done with misoprostol according to FIGO guideline. On discharge the uterine cavity was empty. Three weeks after discharge she presented with profuse vaginal bleeding with hemodynamic compromise. She had spotting for few days after discharge and until the heavy bleeding episode she was asymptomatic. On admission she was pale, and tachycardic (heart rate 108 bpm) with low volume pulse. Blood pressure was 90/60 mmHg.

Ultrasound showed an endometrial thickness of 9 mm and rest of the USS findings were within normal parameters. She was managed with Intravenous tranexamic acid and blood transfusion. A CT angiogram of the pelvis was done due to continuous vaginal bleeding, which showed an AV malformation of the uterus. She underwent bilateral uterine artery embolization by PVA particles. Post embolization angiogram showed significant reduction of uterine artery blood flow. Her vaginal bleeding significantly reduced after the embolization.

Discussion

Uterine AV malformations due to a secondary cause is a rare event. In association to pregnancy and post-

partum period it usually occurs after instrumentation or surgical procedures Eg; Dilatation and Curettage, Evacuation of retained products of conception. Patients usually present with heavy vaginal bleeding. Ultrasonography features of the uterine AVM can be nonspecific. It can show a mass lesion of the uterus. Color doppler can show high velocity low resistant flow. CT angiogram or MR angiogram can show the abnormal vessels of AVM including abnormal blood flow. Uterine artery embolization remains the best method of managing patients with uterine AVM. It is minimally invasive and fertility preserving. Hysterectomy and uterine artery ligation can also be done but rarely performed now due to the availability of uterine artery embolization.

EP/O – 22

INTRAUTERINE FETAL DEMISE IN THE BACKGROUND OF PPROM, PLACENTA PREVIA AND PAST CAESARIAN DELIVERY

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Introduction

Intra uterine fetal death in the background of placenta previa is a rare event. The management of such scenario is challenging as it carries high risk of maternal morbidity and mortality and negative effects in next pregnancy. The risks are more when there is history of past caesarian delivery as it carries increased risk of placenta accreta spectrum disorder.

Case Presentation

A 32-year-old in her second pregnancy, POA of 30 weeks presented with reduced fetal movements and watery vaginal discharge for one day. There was no bleeding or abdominal pain. Pregnancy was complicated with a fetal anomaly, isolated ascites, oligohydramnios, abdominal circumference less than 3rd centile with a suspicion of a metabolic syndrome. The first pregnancy ended up as an elective caesarian delivery at term and had 3.1 kg healthy child two years back.

Examination revealed absent fetal heart sound and pre-term pre labor rupture of membranes without evidence of infection. Ultrasound scan confirmed intra uterine fetal demise with a 1.4 kg fetus and anterior placenta previa. (Placenta reaching the internal os). There were no obvious evidence of placenta accreta. Conservative management failed and medical management with misoprostol was done according to FIGO guideline. She delivered a macerated fetus and the placenta was completely delivered without postpartum complications

Discussion

Management of mid trimester intra uterine fetal death itself carries maternal risks. In the background of placenta previa and past section it carries additional risks as it has higher risk of placenta accreta spectrum disorder. The ultrasonography has around 89% sensitivity and 98% negative predictive value in diagnosing placenta accreta. However, in the presence of IUD, where the placental blood flow is absent the diagnosis is challenging. Induction of labour in such situation can cause massive obstetric hemorrhage due to morbidly adherent placenta. Induction carries higher risk of uterine rupture in the presence of a scarred uterus. Expectant management reduces the utero placental blood flow and cause placental atrophy. Majority will deliver the fetus within four weeks and development of coagulopathy is rare during first four weeks. Therefore, induction following failed expectant management gives less risks than immediate induction. Caesarian delivery to deliver the dead fetus carries additional risk to the next pregnancy hence should be avoided if possible.

The risk of intrauterine infection is higher with rupture of membranes. Chorioamnionitis is a serious condition with high risk of maternal mortality and morbidity and if present delivery of the IUD should

not delay.

EP/O – 23

SMALL BOWEL OBSTRUCTION DUE TO ADHESION BANDS DURING SECOND TRIMESTER

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Introduction

Small bowel obstruction is a rare condition which occurs during pregnancy about in 1 in 5000 pregnancies. It has high risk of maternal (6%) and fetal (26%) mortality, commonly due to delay in diagnosis. The diagnosis is challenging as the pregnancy symptoms and gravid uterus can complicates clinical symptoms and examination findings, and the reluctance to use the tests includes radiation considering the risk tm the fetus.

Case Presentation

A 26-year-old primi in her POA of 22 weeks presented with abdominal pain and distention, vomiting and constipation over a week which was gradually worsening. She was medically uncomplicated and had an appendicectomy during her childhood. On examination she was ill looking with a fever of 100^0F. She was tachypneic with a respiratory rate of 24 per minute, dyspneic, pulse rate was 144 bpm regular and blood pressure of 136/80 mmHg. Abdomen was grossly distended and bowel sounds were absent. There was an empty rectum in digital rectal examination.

Ultrasound scan of the abdomen revealed dilated small bowel loops with a diameter of 6.6 cm with preserved vascularity. There was no free fluid. The fetus was alive and EFW 554 g. The ABG showed severe metabolic acidosis (pH 7.1, pCO_2 19 mmHg, HCO_3-1.7 mEq/l, lactate 0.6 mmol/l). Her WBC was 17 x 109/l, K+- 4.5 mEq/l, Na+-125 mEq/l and CRP - 108 mg/l. Urgent surgical referral was made. Nasogastric decompression was done and 800 cubic centimeter of bilious drainage was observed. She was started on IV fluids and IV antibiotics. She underwent a midline laparotomy and found a closed loop bowel obstruction. Terminal ilium twisted around an adhesion band on the RIF region possibly formed by open appendicectomy done during childhood. The terminal ilium was gangrenous, which was resected, and end ileostomy had been done. She was treated with noradrenaline due to septic shock. Post-operative day 2 fetal heartbeat was absent and medical management performed after the recovery from the surgery.

Discussion

Acute intestinal obstruction is a rare cause of abdominal pain during pregnancy. Although rare it is a non-obstetric surgical condition which needs surgical interventions. It is common during the third trimester and the most common cause is adhesions which account for more than 50% of the cases. Other possible causes are volvulus, intussusception, hernia, malignancies and idiopathic. The most common clinical features are abdominal pain, vomiting and constipation. Tender abdomen and absent peristalsis are common examinations findings. However, the clinical features are not specific and the gravid uterus limits the examination of the abdomen.

Plain X-ray of the abdomen will be positive in about 80% of the cases. Ultrasound scan will show dilated bowel loops filled with fluid, interloop fluid, peristalsis, and evidence of bowel gangrene. CT scan and MRI can be used for the diagnosis. The fetal exposure of ionizing radiation by plain abdominal X-ray is 100 mrad and CT abdomen is 3.5 rad, which is not associated with adverse fetal outcomes. The management includes conservative and surgical. Conservative approach includes NG decompression, IV fluid, antibiotics, electrolyte correction. Surgical interventions are used for the patients with failed conservative management, evidence of gangrenous bowel and fetal distress. Caesarian section can be performed at the same time and minimal handling of the uterus is necessary.

EP/O – 24

FETUS PAPYRACEOUS IN DICHORIONIC DIAMNIOTIC TWIN PREGNANCY: A CASE REPORT

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Introduction

The term "Fetus Papyraceous" (FP) or "Fetus Compressus" is used when intrauterine fetal demise of a twin occurs early in pregnancy, with retention of the fetus for a minimum of 10 weeks resulting in mechanical compression of the small fetus and loss of fluid represent as mummified, flattened, compressed such that it resembles parchment paper. In this rare condition, one of twin expires then compressed between the uterine wall and membrane of the other fetus. It becomes dry and papery like because fluid content of dead fetal tissues gets absorbed. It may occur in both varieties of twins, but more common in monozygotic twins. Incidence reports as 1:12,000 pregnancies and between 1:184 and 1:200 of twin pregnancies. It results from failure to completely reabsorb the dead fetus If this occurs in Monochorionic twins, surviving infant is at high risk of developing multiple complications secondary to the release of inflammatory factors and thrombi. We present a case of dichorionic diamniotic twin pregnancy with single live normal fetus and with papyraceous formation of the other twin presented to Obstetrics unit B Teaching Hospital, Anuradhapura.

Case Presentation

36-year-old female presented in her fifth pregnancy following failure of ligation and resection of tubes (LRT) and registered routine antenatal clinic at 7+6 weeks of period of gestation (POA) Her obstetric score was G5P3C3. First pregnancy was a complete miscarriage and second pregnancy was a uncomplicated vaginal delivery. Third and fourth pregnancies ended up with lower segment cesarean sections. Booking visit scan was diagnosed to have live dichorionic diamniotic (DC/DA) twin pregnancy compatible with POG. Repeat ultrasound scan done at 10 weeks of POG which live fetuses with compatible size and dates confirmed. At 18 weeks she was diagnosed to have co twin fetus expired and the other fetus was alive. Since then, serial ultrasound scans were performed. Anomalies were not found in live co twin. Growth was adequate and was delivered by repeat elective lower segment cesarean section followed fimbrectomy for permanent sterilization. Healthy baby girl was delivered (2.900 kg) and papyraceous fetus was delivered with separate placentae.

Conclusion

FP can be diagnosed early by ultrasound scan during ante natal care visits. Conservative management is preferred when detect intrauterine demise of one of the fetuses in DC/DA twin pregnancy. The time of fetal death can be calculated on the basis of the length of the Femur.

EP/O – 25

A CASE OF HYPERTENSIVE INTRACRANIAL HEMORRHAGE DURING POSTPARTUM PERIOD IN A NORMOTENSIVE PATIENT DURING PREGNANCY

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Introduction

Cerebrovascular accidents are rare but serious conditions which carry a significant morbidity and mortality in pregnancy and postpartum period. Hypertensive disease in pregnancy, vascular abnormalities and

coagulopathy are the leading causes of intracranial hemorrhages.

Case Presentation

The patient was in her third pregnancy with three uncomplicated term vaginal deliveries. She was normotensive during pregnancy and immediate postpartum period and she did not have any coagulopathy and was not on antithrombotic therapy. Patient got readmitted on postpartum ninth day with worsening headache, blurred vision and right side upper and lower limb numbness and weakness for three days duration. On admission her blood pressure was 170/100 mmHg with trace amount of urine albumin. Her neurological examination revealed numbness of right side of the body with mild reduction of power (4/5) in right upper and lower limbs. Deep tendon and plantar reflexes were normal in both upper and lower limbs. Her NCCT brain revealed intracranial hemorrhage involving left Parieto-Occipital region. CT angiogram and venogram did not revealed aneurisms and her coagulation profile was normal. Patient was managed conservatively with close blood pressure monitoring and her weakness and numbness improved.

Discussion

Hypertensive disease and serious complications can occur during postpartum period without a history of hypertension during pregnancy. It can be treated successfully and minimize complications if detected early. Mothers should be educated and encouraged to check blood pressure during postpartum period especially when presence of symptoms such as headache visual abnormalities and generally "not feeling well" at any time.

EP/O -26
CAROTID BODY TUMOR COMPLICATING PREGNANCY

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Introduction

Pregnancies complicated by carotid body tumours (pheochromocytoma or paraganglioma) are very rare, about 0.007% of all pregnancies can complicate this condition. This condition can affect both the well-being of the mother and fetus and management could be difficult. So far management options for pheochromocytoma or paraganglioma in pregnancy are not well established. As this is very rare in pregnancy, management is based on case reports, small case series, and expert opinions. In the 1960s, maternal and fetal mortality in pheochromocytoma and paraganglioma were reported as 48% and 55%, respectively. If the condition is diagnosed in the first 24 weeks of gestation, the tumour should be removed, preferably by a laparoscopic approach in the second trimester, if it is discovered in the third trimester, surgical excision should be delayed until the fetus is viable and able to be delivered, with the tumour being removed either immediately after delivery or at a later date.

Case Presentation

A 37-year-old housewife on her fifth ongoing pregnancy with four successful vaginal deliveries in 39 weeks of amenorrhea was admitted for delivery. She was under vascular surgical follow-up since the first trimester for a right-side neck lump for three years duration and which was diagnosed as a carotid body tumour by ultrasound scan. She noted this lump three years back and it was asymptomatic. First, she consults an oncology surgeon and refers to a vascular surgeon. There she underwent an ultrasound scan they plan to arrange a CT scan neck and she defaulted. She was hemodynamically stable throughout the pregnancy and asymptomatic. She was not evaluated regarding this condition further during pregnancy. On admission, her POA is 39 weeks, hemodynamically stable with normal pulse rate and blood pressure. An ultrasound scan shows a viable fetus with normal fetal biometry. We have arranged an urgent physician and Anesthetist referral and decided to deliver the baby by caesarian section and manage the immediate postpartum period in the intensive care unit with close monitoring. She delivered a 2.1 kg baby by emergency caesarian section on 08.08.2022. The Postpartum period was uneventful. We have arranged

vascular surgical referral following discharge.

Conclusion

The overall maternal mortality rate was 9.8% in pheochromocytomas and 3.6% in paragangliomas Fetal mortality was calculated after excluding those pregnancies, which resulted in elective termination Fetal mortality in women with pheochromocytomas was 16% compared with 12% for those with paragangliomas. The diagnosis was made antenatally in 84% of patients with paragangliomas and 80.3% of those with pheochromocytomas. Hypertension was the most common presenting feature in pregnancy, reported in 87% of pheochromocytomas and 86% of PGLs. The degree of elevation in the urinary/ plasma catecholamines or metanephrines was documented in 54.8% But there is no correlation between the degree of elevation in the catecholamines and fetal or maternal mortality There was also no clear correlation between the size of the lesions and the probability of fetal or maternal mortality, but again only incomplete data were available for tumour size.

EP/O – 27

RARE CASE OF AMAN TYPE GUILLAIN BARRE SYNDROME IN PREGNANCY.

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Introduction

Guillain-Barre syndrome (GBS) is a rare heterogeneous group of autoimmune disorder in which immune system attacks on the nerves. GBS is rare in pregnancy with estimated incidence between 1.2 - 1.9 cases per 100000 people annually. GBS can occur in any trimester of pregnancy and postpartum period but specially in third trimester GBS generally manifests as systemic motor paralysis with or without sensory and autonomic disturbances. As initial nonspecific symptoms of GBS may mimic changes in pregnancy which can delay the diagnosis.

Case Presentation

We report a case of 30-year-old mother at her third pregnancy with two previous vaginal deliveries which are uncomplicated transferred from a district general hospital at POA of (35 + 2) weeks for further management of ascending bilateral lower limb weakness on transfer she has 3 weeks history of bilateral lower limb numbness which was gradually progressed to both upper limbs and later develops both lower limb and upper limbs numbness in her fingers and toes. she didn't have any symptoms suggestive of autonomic dysfunction. Respiratory rate and room air oxygen saturation were within normal range. On examination features of flaccid paralysis. noted in her upper and lower limbs specifically reduced power in her proximal muscles. No cranial nerves involvement. GCS 15/15, B/L pupils were equally reactive to light. Sensory level is at L1. Fetal assessment was done with CTG and USS, both are reassuring. Her investigations revealed CPK level 134 (normal), serum potassium was 3.4 mEq/l, serum sodium was 146 mEq/l, ESR was 52 mm/h, serum creatinine was 48 mg/dl, AST was 24 U/l and ALT was 15 U/l, WBC - 34 x 10^9/l, Hb was 11 g/dl. Nerve conduction study and EMG came as normal in upper and lower limbs except for abnormal f waves. EMG shows proximal conduction blocks most likely diagnosis is early GBS. After urgent Neurology opinion IV Immunoglobulins are initiated in dose of 20 g daily and continued for 5 days, with supportive physiotherapy. After 5 days of therapy patient was well improved with minimum residual sensory and motor weakness without autonomic dysfunction and respiratory failure. Throughout the period fetal surveillance was done with intermittent auscultation of fetal heart sound and daily GTG and supported by USS fetal biometry. As she recovered rapidly, she was retransferred to same hospital at POA of (36 + 5) weeks for delivery. Neurologist allowed for any mode of delivery but stressed that she may need assisted vaginal delivery during second stage due to lack of maternal pushing due to muscle weakness.

Conclusion
Even though GBS is a rare condition with high morbidity and mortality in pregnancy, early diagnosis and appropriate treatment result in better outcome. It's important to keep in mind ascending paralysis with bilateral involvement is important to exclude GBS with NCS and EMG.

EP/O – 28
ABDOMINAL WALL MASS IN PREGNANCY: DESMOID TUMOR - A CASE REPORT

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Introduction
Abdominal wall masses in pregnancy can be missed easily or misdiagnosed. Desmoid tumors or desmoid fibromatosis is a benign tumour of mesenchymal origin that can become destructive due to local invasion especially in pregnancy due to the proximity of the gravid uterus. It is a very rare condition with an incidence of 2 - 4 per 1 million people. We present a case of an abdominal wall desmoid tumour that was identified in a pregnant woman. A combined a surgery was performed to deliver the baby and resect the tumour by a multidisciplinary team of specialists.

Case Presentation
A 27-year-old woman, early in her second pregnancy, was referred to Teaching Hospital Kalutara following the incidental finding of an abdominal wall mass. A comprehensive history was taken revealing the mass had been present before pregnancy but began to grow recently. An ultrasound scan revealed the presence of a solid, well-defined mass within the right anterior abdominal wall of 12 x 8 cm in size with increased vascularity, raising suspicion of a rhabdomyosarcoma. Further imaging was deferred due to the pregnancy and an ultrasound guided biopsy was arranged. This revealed a low to intermediate grade spindle cell neoplasm. The multidisciplinary team decided to deliver the baby and resect the tumour at 39 weeks. Until then, tumour surveillance was arranged at our clinic. A 15 x 13 x 8 cm tumour was resected with clear margins, a healthy baby girl was delivered, and the patient had an uneventful recovery. The histopathology report confirmed desmoid fibromatosis.

Discussion
An abdominal wall mass detected in pregnancy can be easily misdiagnosed as a uterine fibroid. There is no alternative to a meticulous examination by palpation to differentiate such masses. Ultrasound scanning can be used to further clarify one's findings. Close follow-up is warranted as the growing mass may impact the pregnancy adversely and complicate antenatal care and delivery. Multidisciplinary care is necessary to plan resection of the tumour and a safe delivery.

Conclusion
Management of a pregnancy with an abdominal mass poses a considerable challenge to the aspiring clinician especially in a low-resource country like ours. There is very limited understanding on how these rare tumours behave during pregnancy and further studies are needed.

EP/O – 29
PREGNANCY WITH CHRONIC MYELOID LEUKEMIA: CASE REPORT

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Introduction

Chronic myelogenous leukemia (CML) is a myeloproliferative neoplasm with clonal proliferation of progenitor blast cells which is associated with neutrophilic leukocytosis and anemia. Chronic myeloid leukemia (CML) in pregnancy is a very rare condition, with less than one per 100,000 pregnancies. It is not associated with adverse pregnancy outcomes; but treatment which cannot be delayed during pregnancy is challenging due to ethical and therapeutic concerns associated with adverse effects of chemotherapy. Tyrosine Kinase inhibitors (TKI) are considered the most effective therapeutic agent against CML; but are teratogenic. It raises the need for an alternate therapeutic agent during pregnancy.

Case Presentation

A 33-year-old lady in her second pregnancy, with previous uncomplicated antenatal period and vaginal delivery, detected to have abnormal full blood count with white cell count of 197.79 x 10^9/l at her booking visit at 9 weeks of period of gestation. Initial investigations confirmed the diagnosis of CML in chronic phase. Management was liaised with multidisciplinary team which agreed to start interferon since the tyrosine kinase inhibitors are teratogenic. Baseline 2D Echocardiogram, Renal functions, Liver functions, serum electrolytes, serum amylase were normal.

Leukapheres is was performed two times in the first trimester. Anomaly scan was normal. As a side effect of interferon, she developed pancytopenia in third trimester. Interferon was discontinued in third trimester and started on prednisolone. Intravenous immunoglobin was commenced to correct thrombocytopenia. As response was suboptimal G-CSF was started in addition. She was admitted at 36 weeks of gestation; Six packs of platelets were transfused at the admission. Nine packs of platelets were transfused just before the delivery. She had an uncomplicated vaginal delivery at 37 weeks of gestation following prostaglandin induction with 3400 g of Birth weight. Postpartum, she was transfused blood and blood products in four occasions due to drug induced hypoplastic bone marrow.

Discussion

Patients are screened for anaemia at booking visit, 28 weeks and 36 weeks of gestation. Some are practicing performing FBC and others only with haemoglobin levels. This patient was detected to have very high white cell count at routine booking investigations by field midwife, which would have missed if only Haemoglobin level was checked. Cytotoxic treatment for CML during pregnancy poses a very difficult therapeutic dilemma, with variable immediate and late effects on the fetus. The risks are concentrated in the first trimester and depend on the chemotherapeutic agents used. Interferon-alpha (IFN-α) was the non-transplant treatment of choice for most patients with CML before the advent of TKI. IFN-α acts by selective toxicity against the leukemic clone, enhancement of 'immune' regulation and modulation of bone marrow micro-environmental regulation of hematopoiesis. IFN-α does not cross the placental barrier to a great extent due to large molecular weight. Due to the lack of concrete evidence of any teratogenic effect of interferon, it is considered a safe medication to be administered throughout pregnancy.

Conclusion

For all antenatal mothers FBC should be recommended during routine antenatal clinic visits instead of isolated haemoglobin testing. Interferon and Leukapheresis are relatively safe procedure in pregnancy. Patients should be screened for complications of interferon throughout pregnancy - pancytopenia- and should be treated accordingly. Meticulous treatment, screening and treatment of complications of interferon, ultimately results in a successful pregnancy outcome with CML.

EP/O – 30

A CASE OF BLADDER DAMAGE MIMICKING ACUTE KIDNEY INJURY FOLLOWING CAESAREAN SECTION

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Introduction
Bladder injury is a well-known complication of cesarean section. Its incidence lies in the order of 1/1000 and this rate even goes up with each successive caesarean section. However, most of the bladder injuries are diagnosed intraoperatively and repaired at the same time. As such, it is extremely rare to have a delayed presentation of bladder injury during the postpartum period.

Case Presentation
A 34-year-old woman having one previous caesarean section underwent her second caesarean section electively at 38 weeks and delivered a healthy baby weighing 3.8 kg. Caesarean section was relatively uncomplicated except for mild adhesions of the bladder onto the anterior uterine wall. Her first 24 hours of recovery following the surgery was uneventful. Her hemodynamic parameters and the urine output were normal throughout the period.

Her urinary catheter was removed 24 hours later and she failed to pass urine for 10 hours after the removal of the catheter. By then, she was complaining of increased abdominal pain. Abdominal palpation revealed a moderate tenderness over the suprapubic region with no guarding or rigidity. Hemodynamic parameters were still within the normal range. A Trans-abdominal scan revealed an empty bladder with moderate ascites. A presumptive diagnosis of leakage of urine into the peritoneal cavity was made. However, her serum Creatinine had risen to 2.4 mg/dl. She was catheterized again and a Cystourethrogram was planned. Within 8 hours of re-catheterization, she passed 2 liters of urine and the ascites had resolved when the transabdominal scan was repeated 12 hours later. Cystourethrogram revealed extravasation of urine into the peritoneal cavity with a possible injury at the dome of the bladder. She underwent reopening laparotomy. Injury at the dome of the bladder was noted and repaired in two layers. She recovered uneventfully and her Creatinine dropped to normal range within two days. Later she was discharged from the hospital and her catheter was kept for two weeks. Once it was removed, she had no further complaints.

Discussion
Bladder injury commonly occurs while opening into the peritoneum and extending the uterine incision. 60% of the time, it is the dome that is affected. However, as the patient was asymptomatic in the initial 24 hours following surgery, it is more likely that the bladder was ruptured during the postpartum period. One postulated mechanism of delayed bladder rupture is through a partial mural tear in the bladder wall sustained during the caesarean section due to diathermy or dissection of the lower segment of the uterus from the bladder and this later becomes a full thickness tear as the bladder pressure rises after the removal of the catheter. This may present later with abdominal pain and urinary ascites with biochemical parameters mimicking acute kidney injury as the urinary creatinine gets reabsorbed into the blood through the peritoneum. As anuria, elevated serum creatinine and ascites are features of acute kidney injury, it is very important to be aware of various presentations of bladder injury for a prompt diagnosis.

EP/O – 31
A RARE CASE OF POSTPARTUM DIAGNOSIS OF RUPTURE OF UNSCARRED UTERUS

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Introduction
Uterine rupture is a well-known obstetric emergency having dreaded consequences to the mother and the fetus. It is commonly anticipated in laboring mothers with scarred uteruses due to previous cesarean section accounting for a prevalence of 0.2 % to 9%. However, it is very rare among the mothers with

unscarred uterus and the prevalence is less than 0.01%.

Case History

A 33-year-old mother in her second pregnancy with one previous vaginal delivery of 3.3 kg baby 2 years back was admitted to the labour room (LR) with spontaneous onset of labor at a period of gestation of 40 weeks.

Her cervix was dilated up to 4 cm on admission to the LR and she progressed well through the labor without the use of Syntocinon and delivered a live non asphyxiated baby weighing 3.8 kg within 5 hours. Fetal heart sounds were monitored as routine along with periodic CTGs which were all normal. After one hour of delivery, mother developed features of haemorrhagic shock with no significant vaginal bleeding. On examination, uterus was well contracted; however, a soft abdominal mass lateral to the uterus was palpated on bimanual palpation along with fullness in the ipsilateral adnexa. A presumptive diagnosis of broad ligament haematoma was made, and exploratory laparotomy was done. On opening into the peritoneal cavity, gross hemoperitoneum with lateral rupture of the lower segment of the uterus along with ipsilateral broad ligament haematoma was noted. Total abdominal hysterectomy was carried out achieving haemostasis. She recovered well and was discharged 3 days later.

Discussion

Uterine rupture is commonly diagnosed during labor before the delivery and presents with abnormal CTGs, severe abdominal pain, acute onset of scar tenderness, abnormal vaginal bleeding, haematuria, cessation of previously efficient uterine activity, loss of station of the presenting part, maternal hypotension and tachycardia and change in abdominal contour. Any delay in early diagnosis and prompt intervention result in both maternal and neonatal mortality and morbidity.

The documented risk factors for uterine rupture are previous cesarean deliveries, previous myomectomy, advanced maternal age, overdue pregnancy, macrosomia, shorter intervals of deliveries and induction of labor with prostaglandin or oxytocin. Postpartum diagnosis of uterine rupture is classified as delayed diagnosis. In our case however, she did not have any intrapartum features suggestive of uterine rupture nor did she have any risk factors except for the marginally high birthweight of the baby.

The management principles of uterine rupture include expediting the delivery, resuscitation of the mother and the neonate and achieving haemostasis. As our patient had a rupture beyond repair which is the case in most of the ruptures in unscarred uteruses, a total abdominal hysterectomy was performed. As uterine rupture is a rare, but a life-threatening emergency, awareness and education of healthcare workers directly involved in labor room activities cannot be overemphasized.

EP/O – 32

A CASE REPORT OF BRAIN MENINGOTHELIAL MENINGIOMA DURING PREGNANCY.

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Background

During pregnancy pituitary gland undergoes global hyperplasia due to progressive increase in serum estrogen levels. Meningiomas are found in more than one third of all intracranial tumors with 3:2 female to male ratio and a disease of elderly. Meningothelial meningioma is histologically classified as WHO grade 1 with 7 - 25% recurrence rate and far less invasive.

Meningiomas during pregnancy are rare and estimate 5, 6 cases for 100,000 Central nervous system tumors. Rapid growth during pregnancy can produce life threatening complications. Most present in

second and third trimesters of pregnancy and explained by two dominant hypotheses. FSH and LH are low due to negative feedback and in vitro studies has showed they inhibit tumor cell proliferation. hPL and prolactin has shown to stimulate tumor progression. Hypervascularity and extracellular edema are likely to be responsible for rapid tumor growth. Most frequent symptoms are headache, dizziness, focal symptoms and fits. It is important to differentiate from hyperemesis gravidarum, eclampsia, postpartum psychosis. MRI is the preferred choice. If possible first choice is to close observation until labour. Preventing epileptic seizures is a major goal of therapy to avoid fetal hypoxia during a fit. Surgical resection is still the mainstay of treatment.

Case Presentation

A 38-year-old primi mother with history of hemithyroidectomy and myomectomy presented with headache and ptosis at 36 weeks of gestation. This pregnancy was otherwise uncomplicated with good fetal growth. MRI brain orbit, MRA revealed Sella mass measuring 1.38 cm by 1 cm compressing optic chiasma concluding possible pituitary macroadenoma, Lymphocytic hypophysitis. Left sided partial third nerve and sixth nerve palsy identified. Hormone profile found to be normal. An elective caesarian section planned at 37 weeks of gestation following neurosurgical opinion. Cesarean section was performed under epidural anesthesia and healthy single baby was delivered. Trans sphenoidal hypophysectomy was performed 3 months following the birth. Histology revealed meningothelial meningioma of WHO grade 1. Patient was discharged following endocrinology inputs.

Conclusion

'Gestational meningioma' is a rare but frequently life-threatening disease that is characterized by unusual behaviour compared to meningiomas of non-pregnant women. Diagnosis in most cases is possible based on clinical symptoms, physical examination and modern imaging techniques. Due to severe and sometimes lethal consequences, often only timely therapy can save the lives of mother and fetus.

EP/O – 33

APLASTIC ANEMIA COMPLICATING PREGNANCY: A CASE REPORT

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Introduction

Aplastic anemia is a rare syndrome of bone marrow failure defined by pancytopenia and bone marrow hypo-cellularity. During pregnancy it could be life-threatening to both mother and fetus. The only causal therapy for aplastic anemia is bone marrow transplantation, which is contraindicated during pregnancy because of potential embryo toxicity. Treatment options are erythrocyte, platelet transfusions and immunosuppressive therapy. There is, however, no agreement about the optimal treatment regime for this disorder during pregnancy

Case Presentation

A 36-year-old mother of three presented at 12 weeks of gestation with fatigue, breathlessness on exertion & frequent febrile episodes for a month duration. She was a diagnosed patient with aplastic anemia for 2 years having defaulted medical follow up pre conceptionally. This was an unplanned pregnancy. Routine laboratory tests showed bicytopenia (leukocytes – 4 x 10^9/l, Hb - 6 g/dl and platelets - 23 x 10^3/l). Blood picture - presence of bicytopenia likely due to aplastic anemia with no red cell fragmentation. Retic count was 2.4%. She was restarted on cyclosporine as advised by the haematologist and recommended to maintain hemoglobin at a target of > 8 g/dl and platelet counts of > 20 x 10^9/l. The hematologist warned that even though it is possible for a patient with aplastic anemia to undergo a pregnancy while being on transfusion support and immunosuppressive therapy it carries high risk of antepartum, postpartum hemorrhage and sepsis for the mother and Preterm labour leading to prematurity, fetal growth restriction

and death in utero for the baby.
With maternal mortality rates as high as 20% - 60% depending on the severity of disease and standard of care available & fetal complication rates up to 60% it was decided in a multi-disciplinary team meeting involving the obstetrician, anesthetist, haematologist and the couple to terminate the pregnancy taking into consideration the potential harm to the mother's life. Medical termination was carried out with close monitoring for vaginal bleeding followed by evacuation of the retained products of conception with laparoscopic salpingectomy being carried out simultaneously for family planning purposes.

Conclusion
While continuing the pregnancy seemed a reasonable alternative with transfusion support and immunosuppression the possibility of a maternal death due to aplastic anemia even in the best standards of care were as high as 20% and making an individualized close assessment on this patient termination of pregnancy was carried out in the first trimester following a multidisciplinary approach.

EP/O – 34
A CASE REPORT OF PERIMORTEM CESSARIAN SECTION AFTER CARDIAC ARREST DUE TO PERIPARTUM CARDIOMYOPATHY

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Background
Peripartum cardiomyopathy (PCM) is a rare potentially life-threatening condition commonly present in postpartum period, but small subset may present in second and third trimester. It is marked by left ventricular dysfunction and rapid onset heart failure. Often woman may recover cardiac functions but has long lasting morbidity and mortality on some occasions. Even though peripartum cardiomyopathy is consided as idiopathic different hypothesis are suggested for pathophysiology. Risk factors are family history, black ethnicity, multiparity, preeclampsia etc. It's a diagnosis of exclusion. If you suspect PCM After good history taking, all women should be thoroughly assessed Urgent cardiac investigations with electrocardiogram and natriuretic peptide measurement (if available) should be performed. Echocardiography follows as the next step in investigation. Management is same as cardiac failure in an adult.

In the other hand perimortem caesarian (PMC) section surgical delivery of the fetus, performed during maternal cardiopulmonary arrest after 20 weeks of pregnancy. If maternal resuscitation is continued beyond 4 min, then PMCS should be undertaken to assist maternal resuscitation. Usually this should be achieved within 5 minutes of the collapse. PMCS should not be delayed for move the woman to operation theater. It should be performed where maternal collapse has occurred and resuscitation is taking place. The operator should use the incision, which will facilitate the most rapid access.

Case Presentation
This patient is 23 years old with previous normal vaginal delivery, at time of presentation period of gestation was 39 weeks. She had uncomplicated antenatal period before this admission. she presented to emergency unit with severe shortness of breath and high blood pressure of 150/100 mmHg. Saturation was 87% and pulse was 120/min with RR of 25 breaths/min. respiratory examination reveals B/L fine crepitation in lower zones. Albumin was 1+. Ultrasound examination performed to assess fatal wellbeing revealed absent diastolic flow even though growth is age appropriate. Initially managed with high flow oxygen and Intravenous furosemide after medical and cardiology opinion. Despite of initial management patient saturation gradually dropped to less than 60% and went into sudden cardiac arrest. Immediate cardiopulmonary resuscitation started and as the patient needs more effective resuscitation decided to go

with perimortem caesarian section in ETU. Incision was Pfannenstiel with blind tissue dissection. Baby was delivered within 5 min of resuscitation. Even though baby did not cry at birth baby heart sounds were heard and baby was intubated by neonatology team. After delivering the whole placenta and membranes uterus was sutured in two layers and routine closure done for rectus and skin. During the surgery maternal saturation improved because of effective resuscitation. mother was intubated and transferred to ICU.

During ICU stay echocardiogram was performed and found to have ejection fraction (EF) is 30% and retrospectively diagnosis was done as peripartum cardiomyopathy, and manged accordingly Patient was in ICU for 5 more days after gradual extubation. when transferred to ward EF improved up to 40%. Baby was intubated after 6 days. Patient stayed in ward for 13 days while in the Ward EF improved up to 45%, At day 13 patient discharged from the ward after arranging cardiology follow up.

Conclusion
Cardiomyopathy is a rare potentially life-threatening condition which need early diagnosis and prompt intervention. With correct management and follow up morbidity and mortality will reduce.

EP/O – 35
DELAYED INTERVAL DELIVERY IN A TRIPLET PREGNANCY: A CASE REPORT

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Introduction
Miscarriage and preterm pre-labour rupture of membranes are risks associated with multiple pregnancies. Delayed interval delivery is the practice of conservative management after the delivery of one fetus, and delivery of the other fetus(es) after some time has elapsed. Here we present the case of delayed delivery of two fetuses in a triplet pregnancy, where the initial delivery occurred at less than 20 weeks, and the pregnancy was prolonged by 126 days.

Case Presentation
A 29-year-old primigravida was diagnosed to have a trichorionic triamniotic twin pregnancy following ovulation induction, after primary subfertility for 3 years. She presented at 17+6 weeks gestation with ruptured membranes. Fetal heartbeat was absent in T1, and the fetus was in the cervical canal. Both other fetuses were live, with estimated weights of 183 g and 172 g. She was managed conservatively with oral antibiotics. T1 spontaneously delivered on the following day. She was put on tocolytics and oral progesterone. She subsequently developed fever with yellowish vaginal discharge. The cord was cut close to the cervix. She was started on Intravenous (IV) Meropenem and Metronidazole. Inflammatory markers dropped and fever settled within 3 days. The high vaginal swab isolated Group B Streptococcus, sensitive to Penicillin.

She underwent cervical cerclage on day 12 after admission and was discharged following IV antibiotics for 18 days. She was then followed up with fortnightly ultrasound scans. She developed pregnancy induced hypertension which was managed with Methyldopa. Growth restriction of both fetuses were noted, and referral to fetal medicine specialist with more frequent monitoring of growth and dopplers done.

As the presenting fetus was found to be in breech presentation, it was decided to deliver the fetuses by elective caesarean section after steroids, at 36 - 37 weeks. However, she admitted at 35 + 6 weeks with abdominal pain and fever, and emergency caesarean section was performed for suspected chorioamnionitis. 2 baby boys were delivered with birth weights of 1.74 kg and 1.72 kg. They were discharged following in-ward observation for 3 days. The neonatal period was uneventful with a single admission at 21 days for poor weight gain. Both infants are doing well now, at 5 months of age.

Conclusion
Delayed interval delivery is an acceptable management option with possibility of good maternal and fetal outcomes, even with triplet pregnancy and initial fetal demise at less than 20 weeks' gestation. Antibiotics, cervical cerclage, tocolytics and progesterone can be considered in the management.

EP/O – 36
A CASE REPORT OF A TUBAL ECTOPIC PREGNANCY IN A HEMI-UTERUS WITH A RUDIMENTARY HORN

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Introduction
A hemi-uterus with a rudimentary horn is a rare Müllerian anomaly, based on ESRE/ESGE classification, which occurs from incomplete atresia of one of the Mullerian ducts during development and rudimentary horn is connected through a streak of tissue to the hemi-uterus. The prevalence of this anomaly in fertile women is approximately 1 in 100,000. In 75% of the cases, there is no communication between the two endometrial cavities. Patients with rudimentary horns with a non-functional and non-communicating endometrial cavity are primarily asymptomatic. However, a non-communicating horn with a functional endometrial cavity is the crucial factor for symptoms and complications such as dysmenorrhoea, haematometra, haematosalpinx, or endometriosis following retrograde menstruation. A pregnancy in the rudimentary horn may lead to ectopic pregnancy, uterine rupture and haemoperitoneum with a high risk of maternal mortality. This case report is of a ruptured tubal ectopic pregnancy in the tube connected to the hemi-uterus with a rudimentary horn in a subfertile patient.

Case Presentation
A 36-year-old lady in her second pregnancy at ten weeks of amenorrhoea was admitted with vaginal bleeding for one week and lower abdominal pain for one day and a positive urine β-hCG. She attained menarche at 12 years; since then, she has had regular cycles with normal flow; however, she complained of progressive dysmenorrhoea since menarche. She had been investigated several times in the past for dysmenorrhoea and right-sided lower abdominal pain. A first-trimester miscarriage complicated her first pregnancy, after which she has had secondary subfertility for five years. On admission, a transvaginal scan showed no evidence of intrauterine pregnancy, a left side adnexal mass and moderate free fluid in the Pouch of Douglas. She underwent an emergency laparoscopy for a suspected left-side ruptured ectopic pregnancy. The laparoscopy findings included a hemi-uterus with a right rudimentary horn. The left tube and ovary were connected to the hemi-uterus, with a ruptured left tubal ectopic and 150 ml of hemoperitoneum. The right tube and ovary were attached to the rudimentary horn, which was connected to the hemi-uterus with a streak of tissue. Left side salpingectomy was done. Communication between the cavity of the hemi-uterus and the rudimentary horn was not assessed at the time of the emergency laparoscopy but was scheduled for later.

Discussion
Diagnosing asymptomatic hemi-uterus with rudimentary horn is challenging and often delayed due to its low prevalence, lack of clinical suspicion and limitations of conventional ultrasonography. Diagnostic modalities include hysterosalpingography (HSG), 2D-ultrasound scan (USS), 3D-USS, MRI, and combined laparoscopy with hysteroscopy. 3D-USS has a higher accuracy rate than 2D-USS, while MRI offers a sensitive, non-invasive approach to assessing internal and external uterine contours. Many have suggested that hysteroscopy combined with laparoscopy is the gold standard as this offers the advantage of concurrent treatment, such as resection of the rudimentary horn. Our case is one where the diagnosis was made only during emergency laparoscopy for a ruptured left tubal ectopic pregnancy. Further, evaluation

has been planned with MRI to assess communication between the hemi-uterus and rudimentary horn, the presence of functional endometrium and associated renal anomalies and hysteroscopy in case of further diagnostic doubt. Once diagnosed, surgical excision of the non-communicating functional rudimentary horn is recommended to avoid further potential complications.

Conclusion

The above case highlights the importance of having a high index of suspicion in cases of progressive dysmenorrhoea and abdominal pain among women after menarche. Different diagnosing modalities are essential for early diagnosing of this condition, which is essential to prevent gynaecological or obstetric complications.

EP/O – 37

A CASE REPORT OF AN ABNORMAL TREND IN SERUM BETA HCG LEVELS WITH A VIABLE INTRA- UTERINE PREGNANCY IN A MOTHER WITH 22 WEEKS SIZE MULTIPLE FIBROID UTERUS AND SUBFERTILITY FOR 5 YEARS

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Introduction

Human chorionic gonadotropin (hCG), a hormone produced by trophoblast cells surrounding a growing embryo, is used as biomarker of early pregnancy. Tracking the changes in serum β-hCG levels over time can give an insight to the viability of the pregnancy. According to Royal College of Obstetricians &Gynaecologists (RCOG), the minimal rate of increase of β-hCG for an intrauterine pregnancy is 66% in 48 hours. It also recommends that intrauterine pregnancy should be visible on ultrasound with sensitivity approaching 100% in β-hCG values ranges from 1000 - 2400 IU/l. At levels below this minimum threshold, the pregnancy may be considered non-viable: either failing or extrauterine.

Case Presentation

She is a 38-year-old mother with multiple fibroid uterus and primary subfertility for 5 years presented to us on 02/06/2022 with the period of amenorrhea (POA) of 6 weeks. Her urine β-hCG was positive on 21/05/2022. She was very much concerned about this pregnancy. There was no ultrasonic evidence of an intra-uterine pregnancy. Serial serum β-hCG monitoring were done in every 48 hours and the results are as follow:

4445 mIU/ml (01/06/2022)
↓
34%
5987 mIU/ml (03/06/2022)
↓
42%
8536 mIU/ml (05/06/2022)
↓
36%
11696 mIU/ml (07/06/2022)

Since there was continuous sub optimal rise in serum β-hCG values, it was decided to manage as a pregnancy of unknown location, and she was offered with medical management with methotrexate. But the mother insisted on expectant management, and it was offered as patient was haemodynamically stable. Ultrasound scan showed a viable intrauterine pregnancy in a week time. A repeat ultrasound scan was done at 9 weeks of gestation on 27/06/2022 showed a single live well-formed fetus found within the uterine cavity with the Crown Rump Length (CRL) corresponding to POA. Now she is a happy mother in her second trimester.

Discussion
This case report demonstrates that the standard β-hCG curve does not always rise in a "normal" fashion. Further, diagnosing an intrauterine pregnancy by ultrasound scan is very challenging even at β-hCG values more than 8000 mIU/ml specially in a patient with anatomically distorted uterus. Management plans were well discussed with the patient and her concerns were well respected. So, this case was appropriately managed from both providers' and the patient's perspective.

Conclusion
The above case report highlights that the health care providers should not deem a pregnancy abnormal until all factors have been considered and should not expeditiously recommend diagnostic or treatment modalities in these situations if it is a desired pregnancy. Always seek the help of the specialist radiologist in a complex case where there is anatomical distortion of the uterus (large /multiple fibroid) to diagnose/ exclude an intra-uterine pregnancy.

EP/O – 38
RARE CASE OF MID TRIMESTER MISCARRIAGE OF MONOCHORIONIC MONOAMNIOTIC QUADRUPLETS

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Introduction
Monochorionic monoamniotic quadruplets means development of 4 foetuses sharing a single placental mass in a single amniotic cavity. It is a very rare presentation of multiple gestation with an incidence of less than 1 in 15 million pregnancies. They very rarely persist until the age of viability and failed at early ages of gestation due to various pathologies, mainly due to placental insufficiency and luteal failure.

Case Presentation
A 28-year-old second para with a past history of 2 uncomplicated normal vaginal deliveries presented to the antenatal clinic at 11 weeks of period of gestation, found to have monochorionic monoamniotic triplets without any other significant comorbidities. She denied any treatment of ovulation induction. She was started on routine vitamin supplements and progesterone support. Ultrasound scan was repeated at 15 weeks of gestation to confirm her dates, monochorionicity and monoamniocity where it showed 3 foetuses with almost similar gestational ages. As the pregnancy was uneventful, routine management with supplements and luteal support were continued. She was admitted to the gynaecology ward at 19 weeks of gestation complaining of abdominal pain and PV bleeding with passage of clots. Examination revealed fundus larger than the gestation with open cervical os. Ultrasound scan showed 3 viable foetuses. But few hours after the admission she ended up with a miscarriage and passed 4 foetuses in a single placental mass. It was managed with supportive care along with psychological support to the mother.

Discussion
Incidence of quadruplet gestation is around 1 in 700,000 pregnancies. Out of that occurrence of monochorionic monoamniotic quadruplets are less than 1 in 15 million pregnancies. These types of advanced multiple gestations are ended up in early pregnancy miscarriages, mainly due to placental insufficiency and luteal failure. Approximately 90 percent of quadruplet pregnancies are associated with assisted reproductive technology, but monochorionic monoamniotic quadruplets are occurred due to spontaneous division rather than assisted conception.

Conclusion
Advanced multiple gestations including triplets, quadruplets and higher gestations are associated with poor pregnancy outcome and increased pregnancy associated complications. Amnioreduction may help

to improve the pregnancy outcome.

EP/O – 39

A CASE REPORT OF RARE OCCURRENCE OF HETEROTROPHIC PREGNANCY WITH TWIN PREGNANCY

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Introduction

Heterotopic pregnancy is defined as the presence of multiple gestations, with one being present in the uterine cavity and the other outside the uterus, commonly in the fallopian tube and uncommonly in the cervix or ovary. It was first reported in 1708 as an autopsy finding. In natural conception cycles, heterotopic pregnancy is a rare event, occurring in <1/30,000 pregnancies. It occurs in about 0.08% of all pregnancies. Whatever the type of ectopic pregnancy, it remains potentially life-threatening condition. maternal mortality of 0.2/1000 is estimated.

Case Presentation

20-year-old primi mother presented to booking visit at her 8 weeks of POA. this was a spontaneous pregnancy and there was no any family history of multiple pregnancy. she complained of right iliac fossa pain. Transvaginal ultrasound was performed, which showed a twin pregnancy and a right adnexal mass separately seen from another right-side 3 × 4 cm ovarian mass with small amounts of free fluid. Ultrasound scan finding tallied with departmental ultrasound scan. As monitoring with serum β-hCG is not reliable, diagnostic laparoscopy was planned and performed. Diagnostic ultrasound revealed right side tubal mass without any evidence of rupture and right-side ovarian mass (luteal cyst of pregnancy). Right side salpingectomy was done. histology confirmed tubal ectopic pregnancy. Her post operative period was uneventful. She was discharged with progesterone support until 12 weeks and with routine antenatal management plan.12 weeks scan confirmed monochorionic diamniotic twin pregnancy.

Discussion

Even though when there is an intrauterine pregnancy, if any woman complains of lower abdominal pain in first trimester of pregnancy, clinicians should have a suspicion of heterotrophic pregnancy to exclude the rare possibility of another pregnancy outside the uterine cavity. Failure to detect heterotrophic pregnancy may lead severe complications and ultimately death of mother.

EP/O – 40

TUBAL HETEROTOPIC PREGNANCY: A RARE CASE REPORT

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Background

Heterotopic pregnancy describes the simultaneous presence of intrauterine and extrauterine gestations occurring in a single pregnancy event. It's a very rare condition occurring in 1:30,000 of spontaneous pregnancies and more common with the use of assisted reproductive techniques. It can be a great challenge to diagnose due to its complex clinical, radiological and laboratory findings. In this study, we present a patient with heterotopic pregnancy in her first trimester that was diagnosed by ultrasound and managed successfully.

Case Presentation

A 33-year-old mother of two lady with spontaneous pregnancy presented with faintishness and sudden

onset of lower abdominal pain for 1 day duration with fresh bleeding per vagina. Trans-abdominal and transvaginal ultrasound was performed and revealed a viable intrauterine pregnancy of 7 weeks, associated with moderate amount of free fluids and right adnexal ectopic pregnancy. Emergency laparotomy was performed and revealed a ruptured right fallopian tube ectopic pregnancy. Right salpingectomy done and the specimen sent for histopathology. The patient tolerated the procedure well and continues her pregnancy to date without any complications. The histopathological report confirmed the diagnosis of tubal ectopic pregnancy.

Conclusion
Even though it's a rare condition, Heterotopic pregnancy should be suspected in any pregnant woman presenting with early pregnancy bleeding with abdominal pain despite having an intrauterine pregnancy. In any suspicion the patient should be extensively evaluated using ultrasound and MRI if needed. Clinicians must be alert to the fact that confirming an intrauterine pregnancy clinically or by ultrasound does not exclude the coexistence of an ectopic pregnancy. Early detection and meticulous management are crucial for the survival of intrauterine pregnancy.

EP/O – 41
A RARE CASE OF SPONTANEOUS HEMOPERITONEUM BY UTERINE VESSEL RUPTURE IN PREGNANCY

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Background
Spontaneous rupture of uterine blood vessels in pregnancy, is a rare occurrence yet associate with increased feto-maternal morbidity and mortality. The clinical symptoms and signs are vague and non-specific rendering diagnostic difficulties. The most common locations include broad ligament, posterior surface of the uterus and its anterior surface. The prevalence rate of spontaneous rupture of uterine blood vessels is estimated to be around 1 in 10,000 births and is the most common form of hemoperitoneum during pregnancy, particularly during the third trimester. We report a case of a 32-year-old woman at 18 weeks' gestation presenting with abdominal pain who was found to have a spontaneous uterine artery rupture.

Case Presentation
A 32-year-old para 3 with past two vaginal deliveries presented to our ward at a period of gestation of 18 weeks complaining diffuse abdominal pain and faintishness for one day duration. Upon admission despite stable vital signs her physical examination revealed pale conjunctiva and abdominal guarding with rebound tenderness. Transabdominal ultrasound scan demonstrated intrauterine live fetus with moderate amount of free fluid in the peritoneal cavity. Her haemoglobin level dropped by 2 g/dl on repeated assessments and as she became clinically unstable, emergency laparotomy was performed. During surgery hemoperitoneum of 1.5 l was evacuated and pelvis was explored in view of finding the source of bleeding. Bleeding from a ruptured surface uterine vessel was evident at the posterior surface of the uterus. The initial attempt to ligate the lesion was unsuccessful and, it was decided to proceed with hysterectomy.

Conclusion
Spontaneous rupture of uterine blood vessels is very rare and lethal, hence rapid diagnosis is crucial for the survival of both lives. The uterine artery rupture must be suspected and treated promptly. In the event of a sudden abdominal pain with hemodynamic collapse, this diagnosis should be excluded. Currently, the treatment consists in aggressive resuscitation and haemostatic control. Most cases of hemoperitoneum will end up in termination, usually by caesarean section along with midline laparotomy but maintaining pregnancy with surgical haemostasis should be considered in selected cases. The risk of recurrence of spontaneous uterine artery rupture is unknown and there is no evidence in the literature regarding

subsequent pregnancies after spontaneous hemoperitoneum.

EP/O – 42

A CASE REPORT- THORACO-OMPHALOPAGUS CONJOINED TWINS

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Introduction

Conjoined twins are very rare phenomenon, and it occurs in roughly 1 in 50,000 to 1 in 100,000 pregnancies. Its etiology is unknown and most acceptable theory is the fertilized egg splits partially. Conjoined twins are classified by the most prominent site of conjunction; thorax (thoracopagus), abdomen (omphalopagus), Sacrum (pygopagus), pelvic (ischiopagus), skull (cephalopagus) and back (rachipagus). Thoracopagus is the most common type. Conjoined twins are associated with high mortality rate.

Case Presentation

A 27-year-old mother of one child, presented to the tertiary care center for the first time in the 20th weeks of gestation in her second pregnancy was found to have conjoint twins. The ultrasound scans revealed a common hepatic artery and a common heart, suggesting the difficulty of separation and poor prognosis. She was investigated with MRI, which revealed ventrally conjoint thoracopagus conjoined twins with a single heart and a common liver. A fetal echocardiogram was carried out with the intention of surgical separation of the twins after delivery. Unfortunately, the fetal echocardiogram also revealed a single heart reducing the possibility of successful surgical separation of the fetuses. It was finally decided, through a multi-disciplinary team (MDT) meeting, to terminate the pregnancy. After termination of pregnancy with mifepristone and misoprostol, a vaginal delivery of the conjoined twins was achieved without complication.

Discussion

Early diagnosis of conjoined twins is important. Once conjoined twins are diagnosed, detail assessment should be done to identify the type and severity of the abnormality with three-dimensional ultrasound, computed tomography, or magnetic resonance imaging. Surgical separation depends on the point of attachment and the internal organs and structures that are shared. Most cases of separation are extremely risky and life-threatening. Mortality and morbidity ratios for the conjoined twins are still high despite the developments in the radiological imaging methods and surgical treatment techniques. Once the diagnosis of conjoined twins is established, the family should be counseled with detailed information on prognosis and results. Decisions should be taken following MDT meeting. Therefore, making an early diagnosis and detail assessment with radiological imaging of conjoined twins, gives the chance to elect termination of pregnancy earlier without much complication.

EP/O – 43

DIFFERENT PRESENTATIONS OF COLORECTAL CANCERS IN PREGNANCY – TWO CASE REPORTS

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Introduction

Incidence of colorectal cancer (CRC) in pregnancy is 1:13,000, with a rise in increased childbearing age. In pregnancy, most CRCs were diagnosed late since symptoms such as constipation, dyspepsia, abdominal pain, nausea, vomiting are mistaken for pregnancy symptoms. Another reason for delayed diagnosis is aggressive behavior of CRCs when occurring among young and in immunological alterations like pregnancy. Here we discuss two presentations of CRCs.

Case Presentation

Case No 01

A 38-year-old was transferred with subacute intestinal obstruction, confirmed via ultrasonography. She was in her third pregnancy with two past caesarean sections at period of gestation (POG) of 28 weeks. Persistent abdominal pain was masking preterm labour. Emergency laparotomy was performed with midline incision for delivery and to identify obstruction. A ruptured uterus and dead fetus were noted, and a hysterectomy performed for lifesaving. A tumour was noted at transverse colon with lymph-node enlargement. Extended right hemi-colectomy was performed with ilio-colic anastomosis. Clinical staging was cT3-4N2MX. Histology confirmed moderately differentiated adenocarcinoma staged pT3N2aMX. Contrast enhanced computerized tomography (CECT) excluded distant metastasis.

Case No 02

A 34-year-old primi at POG of 37 weeks planned for caesarean section at 39 weeks, presented with generalized abdominal pain & loss of appetite over three days. Examination showed generalized abdominal tenderness. Fetal assessment was normal expect for persistent tachycardia. The section was expedited, and yellowish exudate was discovered in the pelvis upon entry. Pelvic organs were normal, but a mass was found at the transverse colon with enlarged lymph nodes. A midline laparotomy was decided following consent. As there was no macroscopic distant spread, she underwent an extended right hemicolectomy and perilesional lymphadenectomy.

Discussion

86% CRCs in pregnancy occur in the rectum. A per-rectal examination may reveal a growth. Carcinoembryonic antigen is not an effective screening tool as a higher value in pregnancy is normal. Colonoscopy is the gold standard of diagnosis despite risks like fetal exposure to medication, maternal hypoxia, and placental abruption. Since majority of CRCs are confined to lower colon and rectum, flexible recto-sigmoidoscopy is preferred for diagnosis. Upon unconfirmed diagnosis, colonoscopy is considered. MRI is safe for staging. CECT should be avoided. It's better to deliver the fetus before commencing chemotherapy unless fetus is extremely premature. Termination of pregnancy is possible if diagnosed during first or early second trimester.

Conclusion

In a pregnant patient with nausea, vomiting, constipation, haemorrhoidal bleeding or non-specified abdominal pains, CRC should be considered. A multidisciplinary team should decide on comprehensive care as there're no fixed guidelines for management.

EP/O – 44
UROTHELIAL CARCINOMA OF BLADDER IN PREGNANCY: A RARE CASE REPORT

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Introduction

Bladder cancer in pregnancy is a rare occurrence with less than 50 cases described. Transitional cell carcinoma accounts for majority of bladder cancers in pregnancy. Key to diagnosis is to be alert of

painless macroscopic or microscopic hematuria in urinalyses.

Case Presentation

A 32-year-old lady in her second pregnancy presented at 21 weeks period of gestation (POG) with two episodes of red color urine without any other symptoms. She is a non-smoker, who wasn't exposed to known carcinogens, with no family history of malignancies. General examination, speculum examination and ultrasound fetal assessment were unremarkable. Urinalysis showed only gross hematuria. Urine culture was negative. Transabdominal sonography revealed an intravesical papillary growth 4.0 cm × 3.5 cm with intralesional vascularity with normal kidneys. Cystoscopy was performed under general anaesthesia (GA) and a fungating tumor was found close to left uretero-vesical opening. Transurethral resection of bladder tumor (TURBT) was performed, and patient was discharged post-operative day one. Histology revealed an invasive low grade urothelial carcinoma with lamina propria invasion staged as pT1. She had antenatal and urological follow-up during antenatal period and was admitted for elective cesarean section at 37 weeks POG. Caesarean section and postnatal period were uncomplicated. Her second-look cystoscopy at 32 weeks POG was normal.

Discussion

With male predominance and tendency to occur in old age, bladder carcinomas are rare among pregnant women. The majority of patients with bladder cancers in pregnancy were at their third decade of life. The commonest presentation in bladder cancer is hematuria. 22% of patients with hematuria associated with bladder cancer initially mistook it for vaginal bleeding. Gold standard for diagnosis is cystoscopy since it facilitates staging and if performed under GA, also enables resection. Despite this being a low-risk non-muscle invasive bladder cancer, risk factors like lamina propria invasion, satellite lesions, tumor being larger than 3 cm, warranted her to receive immediate post-TURBT adjuvant therapy. Due to Inadequacy of data in pregnancy, adjuvant therapies were avoided. In patients with muscle-invasive bladder carcinoma, platinum-based neo-adjuvant chemotherapy is indicated, followed by radical cystectomy. The timing of treatment is individualized on POG. In metastatic cancer, treatment is palliative chemotherapy.

Conclusion

Despite rare occurrence of bladder cancers during pregnancy, they should be considered in presence of urological symptoms. Urothelial variant is the commonest histological type with the best prognosis. Early diagnosis with multi-disciplinary care offers a better outcome. Trimester of pregnancy and stage at diagnosis are key in management.

EP/O – 45
CONJOINED TWINS: LATE DIAGNOSIS AND MANAGEMENT CHALLENGES

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Introduction

Physically fused twins at birth are known as conjoined twins (CT). These occur when monozygotic twins cleave 12 days from fertilization. The rarest form is parapagus, in which fusion side by side with shared pelvis. These complicated pregnancies require multi-specialty involvement for efficient management.

Case Presentation

24-year-old G5P2C1 with 3 first trimester miscarriages, had delayed diagnosis of parapagus CT by ultrasonography (USG) and MRI at 27 weeks of gestation. She delivered a female CT with birth weight of 3.4 kg, at 36 weeks by elective LSCS. They died 3 hours later. Autopsy was not done due to parental refusal.

Discussion

In 1% of monozygotic twins, CT are the most extreme form of monozygotic twinning. There are no association with genetic or environmental risk factors with occurrence of CT. Diagnosis of conjoined twins via USG requires expertise and meticulous techniques. With extreme fusion, it can be mistaken for a singleton pregnancy. Identification of the following classical signs could suggest the diagnosis: heads in the same plane, atypical backward flexion of the cervical spine, no alteration in the relative position after maternal movement or manual manipulations and inability to separately identify bodies. MRI plays a vital role to evaluate this unusual anomaly. Psychological trauma of delivering congenitally abnormal baby, cannot be overemphasized. Ethical consideration, and late diagnosis it was decided to continue her pregnancy. Few case reports mention vaginal delivery for CT eventually ending up in emergency CS. Separation of CT still poses a major challenge. In our country, there are no cases reported for separation of CT.

EP/O – 46
FETAL THANATOPHORIC DYSPLASIA

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Introduction

TD is most common lethal skeletal dysplasia in neonatal period. Sub type 1 and type 2 has percentage of 80 and 20 respectively. Genetic mapping of chromosomes aids for diagnosis. In type 1 FGFR3 extracellular domain there is substitution of cysteine for arginine at 248 positions (Arg248Cys) while in type 2 there is a substitution of glutamate for lysine at 650 (Lys650Glu).

Case Presentation

25-year-old mother in her 3rd pregnancy with an uncomplicated preconception and antenatal period found to have a fetus with TD in routine anomaly scan at POA 20 weeks. As termination is not permitted in Sri Lanka both parents are counselled and decided to continue pregnancy. At 38 weeks of gestation baby was delivered without complications. baby boy weighing 2.4 kg delivered and baby was expired on the day one despite ventilator support.

Discussion

TD is a congenital, sporadic, usually lethal skeletal dysplasia with two clinically defined subtypes, type I and Type II with some overlap. Thanatophoric dysplasia or dwarfism literally meaning death bearing dwarf was first described by Maroteaux et al. In prenatal diagnosis of TD by three-dimensional ultrasound examination in second trimester aids in visualizing facial features and other soft tissue findings such as cloverleaf skull, very short extremities and small thorax. Affected individuals never survive or remain dependent on ventilator for prolonged period. Therefore, disorder never passes to next generation. Recurrence risk is also not increased above that of the general population as it is a de novo mutation.

Conclusion

Thanatophoric Dysplasia is a congenital, sporadic and lethal dysplasia at birth, surviving newborns either ventilator dependent or suffer from severe neurological symptoms. Early diagnosis is important as mother can be counselled regarding the fetus before delivery.

EP/O – 47
A RARE CASE OF JEUNE SYNDROME, IN JUNE

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Background
Jeune syndrome which is also known as Asphyxiating Thoracic Dystrophy (ATD), is a rare autosomal recessive skeletal dysplasia with multi-organ involvement (1 in 100,000–130,000 live births). It was first described in 1955 by a French Paediatrician Jeune. Diagnosis is based on clinical and radiographic findings. International Working Group on Constitutional Diseases of Bone; classified short rib and polydactyly syndrome into 6 types: ATD and Ellis van Creveld Syndromes which have often but not always been lethal. Clinically, ATD is characterized by a small, narrow chest, variable limb shortness, postaxial polydactyly of both hands and / or feet. However, multi organ involvement is seen in lot of cases. Here we report a case of Jeune syndrome which was diagnosed based on the 2nd trimester anomaly scan findings.

Case Presentation
A 27-year-old lady in her 2nd Pregnancy with a previously healthy offspring delivered via caesarian section, was followed up at ANC, DGH – Mullaitivu. In her Mid-trimester anomaly scan apart from the low-lying placenta it was apparent that there was extremely short limbs and a constricted thoracic cavity. The fetus had a normal looking skull with brain matter and the abdominal circumference was on 95th centile. She was referred to Ragama Fetal Medicine Unit for further evaluation, where the abnormalities were reconfirmed with a probable diagnosis of Jeune syndrome, and the poor outcome was explained. She presented at 26 + 3 weeks of gestation to the emergency unit in labour with a transverse lie and an Antepartum Haemorrhage, on 19th June 2022. Ultrasound scan showed no heartbeat. Emergency Hysterotomy was carried out and a dead foetus was delivered. External appearance confirmed the antenatal scan findings. A postmortem was rejected due to religious reasons.

Conclusion
Jeune syndrome is an extremely rare congenital disorder with a spectrum of abnormalities of which thoracic hypoplasia is the most striking. It can be diagnosed on early antenatal USS by its characteristic skeletal and morphological features which can guide further management of pregnancy as well as preparing for the expected outcome.

EP/O – 48
A CASE OF PATHOLOGICAL UTERINE ROTATION: POOR OUTCOME

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Background
Uterine torsion is the rotation of the uterus along its longitudinal axis, clockwise (dextrorotation) or counterclockwise (levorotation). It may be physiological if the rotation is less than 45˚ and pathological if it is more than 45˚.

Case Presentation
A 36-year-old gravida 3, para 1 at 28 weeks of gestation with a singleton pregnancy complicated with

chronic hypertension and diabetes with good glycemic control. She presented with a history of severe abdominal pain and absent fetal movements, last felt 8 hours prior to admission. On examination she was pale, tachycardic and hypotensive. Ultrasound showed an intrauterine fetal demise in breech position and a large retroplacental clot. Her hemoglobin was 7.4 g/dl with a normal coagulation profile. A diagnosis of fetal demise, maternal shock followed by placental abruption was made. Despite blood transfusion her vitals did not improve, and expert opinion was sought for exploratory laparotomy with a consent for caesarean hysterectomy. Intraoperatively, the right round ligament, ovary and fallopian tube were seen anteriorly with a bluish uterus affirming levorotation of uterus. Manual correction was performed, and the baby was delivered by a standard uterine incision. Following delivery of the placenta a large retroplacental clot (1500 ml) was noted. After de-torsion, the uterus regained its pink colour and uterine closure was done after insertion of Bakri postpartum balloon catheter to prevent bleeding due to atonicity. Total blood loss was 3500 ml and she required transfusion of 6 pints of blood. Her recovery was uneventful and was discharged in good health on post-operative day 3.

Discussion

The first reported case of uterine torsion was by Virchow in 1863 and states that its symptoms mislead the diagnosis. Torsion of uterus is associated with a variety of consequences from fetal distress and asphyxia to abruption and maternal shock. The symptoms of uterine torsion such as acute abdominal pain with abruption and fetal demise usually misleads the primary diagnosis and affects its outcome. The etiology for torsion is not clear, but uterine anomalies, fetal malpresentation, large fibroids, adnexal masses, lax abdomen and ligaments were noted in reported cases. Most of the cases reported an intraoperative diagnosis during laparotomy or elective caesarean section. A clinical diagnosis is rare and is usually missed.

EP/O – 49

HYPERHAEMOLYSIS SYNDROME FOLLOWING DELAYED TYPE HAEMOLYSIS TRANSFUSION REACTION: A CASE REPORT

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Introduction

Delayed type Hemolysis Transfusion Reaction (DHTR) is an adverse reaction following blood transfusion, usually occurring in patients with haemoglobinopathies receiving multiple transfusions

Case Presentation

33-year-old mother of one child with thalassemia trait POA of 26 weeks, admitted with haemoglobin of 7.0 g/dl for management of anemia. Initial she was transfused with 3 units of blood and her post transfusion haemoglobin was 8.7 g/dl. Following transfusion of 2 more units, her post transfusion haemoglobin was 9.1 g/dl. Meanwhile she develops mild icterus so that her liver function tests were done which showed rising AST, ALT and her bilirubin. Her next day hemoglobin was 8.3 g/dl thus we investigated for hemolysis. Blood picture showed hemolysis, reticulocyte count was 1.4% (low normal) and LDH were rising. As per Hematology plan, antibody screening was done. Direct and indirect Coombs tests were negative. Unexpected antibodies and red cell antigens were negative. Following next few days her haemoglobin was dropping to 7.6 g/dl and reticulocyte count was 1.4% thus, Hyperhaemolysis Syndrome following delayed type hemolysis transfusion reaction was suspected.

As bone marrow suppression was suspected with low haemoglobin and low reticulocyte counts, Intravenous Immunoglobulin was prescribed. But as it was not available at that moment, Intravenous Methylprednisolone was administrated after excluding infection. Folic acid 5 mg per day and vitamin B12 therapy was started as supportive treatment for bone marrow stimulation and followed up with

blood picture which showed further haemolysis, but reticulocyte count was rising. IV immunoglobulin two doses given, and oral prednisolone was started. Response to treatment showed in next blood pictures with no further haemolysis and raised reticulocyte count to 2.2%. Her latest haemoglobin at 29 weeks is 8.3 g/dl and she is continuing pregnancy with no complications so far.

Discussion
DHTR is a rare complication less commonly seen with thalassemia, usually due to red cell antibodies. Diagnosis is by clinically, laboratory results after excluding other differential diagnoses. Laboratory tests include failure to rise post-transfusion haemoglobin concentrations of 1 g/dl per unit, a raised indirect bilirubin, an increased reticulocyte count and fragmented red blood cells on blood film. Following transfusion if haemoglobin falls rapidly, below pre transfusion haemoglobin level, hyperhaemolysis is suspected. Treatment avoids transfusion and supportive treatment with immunoglobulin and steroids

Conclusion
Reported cases of these are fewer, thus, we report a case of successfully managed hyperhaemolysis syndrome and DHTR in pregnancy.

EP/O – 50
SUCCESSFUL PREGNANCY WITH A CONTINENT CUTANEOUS URINARY DIVERSION

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Introduction
Cystectomy and ileocaecal neobladder is a form of CCUD performed for urinary incontinence due to neurogenic bladder. Management of pregnancy and delivery with CCUD is challenging. As this is rated a high-risk pregnancy it requires multidisciplinary inputs. Main complications of pregnancy are urinary tract infections (UTI), pyelonephritis, dilatation of upper urinary tract, preeclampsia, early miscarriage and foetal growth restriction (FGR).

Case Presentation
30-year-old mother with history of lumbosacral meningomyelocele, congenital talipes equinovarus, cystectomy and ileocaecal neobladder with diversion in her 1st pregnancy was found to be complicated with recurrent UTI, pyelonephritis, gross hydronephrosis and FGR. At 37 weeks and 5 days of gestation live baby weighing 2.1 kg delivered by an elective cesarean section under general anesthesia due to unfavorable cervix.

Discussion
Women with CCUD are able to become pregnant but rated as high risk and require multidisciplinary inputs including urologist. Urinary diversions using bowel segments have an increased incidence of asymptomatic bacteriuria. 20 - 30% with bacteriuria develop acute pyelonephritis and responsible for preterm delivery and FGR. Frequent screening is needed antibiotic prophylaxis is needed for symptomatic recurrent UTI. Neobladders are situated ventrally to uterus and cause upper tract dilatation. Most prefer elective cesarean section to protect integrity of pelvic floor, but evidence is lack for this, and vaginal delivery is possible unless obstetrically contraindicated. Lower midline skin incision is preferred in view of altered anatomy and previous operations with consecutive adhesions.

Conclusion
Pregnancy with CCUD carries high risk antenatally and delivery is challenging with increased intraoperative risks. Frequent screening for bacteriuria and foetal complications are advised with multidisciplinary inputs to reduce perinatal morbidity.

EP/O – 51

RECURRENT ACUTE PANCREATITIS IN PREGNANCY IN A PATIENT WHO HAS UNDERGONE CHOLECYSTECTOMY: A TREATMENT PARADIGM BASED ON OUR HOSPITAL EXPERIENCE

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Introduction

Acute pancreatitis in pregnancy is a rare event affecting around 3:10,000 pregnancies. The common predisposing causes of pancreatitis in pregnancy are cholelithiasis and hypertriglyceridemia attributed to increased estrogen due to pregnancy and familial tendency. Recurrent acute pancreatitis in a pregnant woman who has previously undergone a cholecystectomy is very rare.

Case Presentation

A thirty-year-old woman in her second pregnancy at the period of amenorrhoea (POA) of 35 weeks and six days presented with acute onset epigastric and left hypochondriac pain of one-day duration. She had no fever, itching, or the passage of dark urine and pale stools. During her first pregnancy, she was diagnosed to have acute pancreatitis in the late third trimester and underwent an emergency caesarean section at a POA of 39 weeks. It resulted in a neonatal death at 14 days due to meconium aspiration. She underwent laparoscopic cholecystectomy one year later, where the histology showed chronic cholecystitis. She was overweight, with a BMI of 29 kg/m^2. On admission, she was afebrile, not icteric, and had normal vitals with mild tenderness over the epigastric region. Fetal well-being assessed by ultrasound and cardiotocography was normal. Her pancreatic enzyme amylase was elevated at 495 U/L. Serum lipase was not assessed. Complete blood count, coagulation profile, liver profile and renal profile were normal. An ultrasound scan showed features of acute pancreatitis with a hypoechoic oedematous pancreas texture and grade 2 fatty liver changes. Multidisciplinary team input was sought, which included the surgeon, radiologist, and physician. The patient was administered a low-fat diet, intravenous (IV) antibiotics (Cefuroxime & Metronidazole), IV ranitidine, and IV pantoprazole. As the patient experienced persistent pain, a category four caesarean section was performed four days after admission. Significant improvement in symptoms occurred immediately following delivery. The baby was discharged from NICU after seven days.

Discussion

There are no standard diagnostic and management protocols for acute pancreatitis in pregnancy. Diagnostic blood tests include serum amylase and lipase, with serum lipase being more sensitive. Additional blood tests include triglyceride levels, calcium levels, and a complete blood count. Imaging of the pancreas can be performed using abdominal ultrasound and CT scan, with ultrasound being the technique of choice for pregnant women. Other imaging modalities, such as Magnetic resonance cholangiopancreatography (MRCP), are superior in diagnosing biliary aetiology for acute pancreatitis. Conservative medical management is the mainstay of treatment with analgesics, intravenous fluid therapy, probiotics, a fat-free diet and antibiotics. Ideally, laparoscopic cholecystectomy and endoscopic retrograde cholangiopancreatography (ERCP) should be performed in the second trimester for those not responding to medical treatment when the risk to the fetus is the least. During the third trimester, delivery should be expedited for those not responding to conservative management, following which cholecystectomy should be considered. Additionally, in patients who have undergone cholecystectomy, as in our case, non-biliary causes like hyperthyroidism, hereditary causes, acute fatty liver in pregnancy, and preeclampsia should be excluded.

Conclusion

Acute pancreatitis in pregnancy could be due to biliary or non-biliary causes. It has a high recurrence rate in subsequent pregnancies. Early diagnosis and management are vital in preventing adverse maternal

and fetal outcomes. Conservative management is the mainstay in treatment. Advances in imaging and therapeutic endoscopy have contributed to improvements in pregnancy outcomes.

EP/O – 52

ANAUDIT ON EPIDURAL ANAESTHESIA WITH REGARD TO KNOWLEDGE,AWARENESS, FEARS AND CONCERNS PREGNANT WOMEN IN A TERTIARY CARE UNIT

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Background

Labour pain is ranked among the most painful experiences. Management of pain during the labour is a major component of the labour care which makes the labour a satisfying experience for women. Although different pharmacological methods and non-pharmacological methods are available for the pain relief, epidural analgesia remains a highly effective method. Even though in Sri Lankan setting epidural analgesia is not widely practiced it remains a popular mode of labour analgesia among women in western countries.

Objective

To find out perceptions regarding the epidural analgesia used for the management of labour pains including awareness, fears and concerns.

Method

A clinical audit was carried out among two hundred women who were attending antenatal care clinic using interviewer-administered questionnaire in which questions were designed to find out awareness, knowledge, benefits and risks, fears and concerns with regard to epidural anaesthesia.

Results

Out of the total study population(n-200) 166(83%) of women were not aware of the epidural analgesia and most of them believed that pain is essential to complete the delivery successfully. 34(17%) women were aware about the epidural analgesia but unfortunately majority of them were not aware that it is available in government sector (n -15), and most commonly perceived concerns among the latter population were long standing back pain(88%), possibility of longstanding limb weakness(90%) and foetal concerns(40%). And most of the women in the study group believed that they would benefit from an educational programme on labour analgesia (100%).

Conclusion

All women are rightful to experience a childbirth withminimal pain. Women should be empowered with a proper educational programme and materials to choose an effective mode of analgesia including epidural. Re-audit is planned in three months after an introduction of routine educational programme at antenatal clinics.

E - POSTERS - GYNAECOLOGY

EP/G – 01
AGGRESSIVE ANGIOMYXOMA OF VULVA: A CASE REPORT

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Introduction
Aggressive angiomyxoma (AA) is a rare infiltrative spindle cell neoplasm arising in the soft tissues of the vulvovaginal region, perineum and pelvis. The term aggressive describes the high local infiltration and local recurrence rate but distal metastasis is very rare. Due to its rarity, they are frequently misdiagnosed as Bartholin's cyst, Gartner cyst, hernia or lipoma. The neoplasm was first described by Steeper and Rosai in 1983. Up to now, only fewer than 350 cases have been reported in literature and we are reporting a case of vulval AA in a 31-year- old Sri Lankan lady.

Case Presentation
A 31-year-old apparently healthy lady presented with a progressive, slow growing, painless lump in the mons pubic area for 6 years duration. Her main concerns were the progressive nature of the lump and the aesthetic appearance of the lump. On examination the lump was 10 cm x 8 cm in size, non-tender, mobile, with smooth well-defined margins which extended from the hair line to 3 cm above the clitoris. The skin over the lump was not discoloured and not ulcerated but peau d'orange appearance was noted. Remainder of her abdominal, lower limb and bimanual examination were unremarkable. Initially she was offered an ultrasound scan of the abdomen which revealed 10 cm x 8 cm homogeneous mass with well-defined margins just underneath the skin of mons pubis with mild intralesional vascularity. A decision to perform an excision biopsy was decided after a multidisciplinary discussion. The biopsy was suggestive of AA of the vulva. An MRI of the abdomen and pelvis revealed a lesion within the subcutaneous fat of mons pubis with possible infiltration into the labial skin which was compatible with histological findings of AA.

The patient was counselled regarding the management options and high recurrence rate and was offered surgical management. Patient underwent surgical excision of the lump with adequate surrounding subcutaneous fat. Post operative period was uneventful and histology confirmed the diagnosis of AA. Immunohistochemical studies confirmed the presence of oestrogen receptors and progesterone receptors, and the patient was offered gonadotropin releasing hormone (GnRH) analogues. We are planning to follow-up the patient regularly to assess local recurrence.

Discussion
AA is a rare neoplasm and often the patients are asymptomatic and rarely present as pelvic fullness or perineal swelling. Macroscopically it has been described as a mass with rubbery consistency, poorly circumscribed with local tissue infiltration present in many cases. Microscopically AA typically describes a lesion with myxoid storm, prominent thick wall blood vessels and cells that are typically bland with coarse chromatin and little to no mitotic activity. AA often expresses oestrogen and progesterone receptors and immunohistochemical staining should be performed.

On ultrasound imaging AA often performs low or mixed echoes and inside blood flow colour signals can be detected. If it infiltrates into the surrounding soft tissues, 'fingers like' projections can be seen. On CT imaging it usually presents as attenuation less than or equal to the that of skeletal muscle. Due to the presence of collagen fibers within the myxoid lesion MRI demonstrates alternating hyper and hypo linear

areas. Also on MRI, AA shows the characteristic "swirl sign". Surgical resection is the usual first line option, but incomplete resection is often performed due to the local infiltration and non-encapsulated nature of the lesion. Interestingly even after complete resection 30% of tumours will recur.

Most of the cases of AA exhibit oestrogen and progesterone receptors. In literature many patients with positive hormonal receptors had been successfully treated with GnRH agonists. GnRH agonists have been given as adjuvant therapy, neoadjuvant therapy or treatment for the recurrence. Selective oestrogen receptor modulators like Raloxifene and Tamoxifen are also being used. Radiotherapy and chemotherapy have poorly responded mainly due to the low mitotic activity of the tumour.

Conclusion

AA is a rare mesenchymal neoplasm usually occurring in the vulvovaginal area, the perineal region and the pelvis. The term "aggressive" highlights the high local infiltration and local recurrence rate. Several imaging modalities can be used for the diagnosis of this condition. MRI would reveal the characteristic "swirl sign" but histology should be done for the definitive diagnosis. AA often expresses oestrogen and progesterone receptors, which can be confirmed using immunohistochemistry. Surgery is the primary and commonly offered treatment option. If immunohistochemistry results are positive antioestrogens can be administered as adjuvant, neoadjuvant therapy as well as treatment for recurrences.

EP/G – 02
MAYER-ROKITANSKY-KUSTER- HAUSER SYNDROME

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Introduction

The Mayer-Rokitansky-Kuster-Hauser syndrome (MRKH) is considered the second most common cause of primary amenorrhea among other causes. Gonadal dysgenesis is the commonest cause. MRKH consists of congenital absence of the vagina with variable uterine development, due to Mullerian duct agenesis or hypoplasia. The incidence is 1 in 5000 (range 1 per 4000 to 10,000 females).

Case Presentation

A 16 years and seven months old schoolgirl from Kalutara was admitted to the Gynecology ward, THM in June 2022 for further evaluation and management of primary amenorrhea with the presence of normal secondary sexual characteristics. She was complaining of monthly, cyclical abdominal pain for one year. She denies any clinical features suggestive of chronic diseases, excessive exercise, long-term medications, anorexia, clinical hypothyroidism, or hyperandrogenism. No family history of amenorrhea. Mother attends menarche at age 12 and she does not have any sisters. Physical examination: weight 51 kg, height is 1.67 m, female phenotype, symmetrical breasts (B4), in genital examination hairiness gynecoid (P4/P5), Her external genitalia appears normal. Pelvic ultrasonography is inconclusive with normal adnexa. She was informed to admit for diagnostic laparoscopy

Conclusion

Usually, they have a karyotype of 46XX and are phenotypically female. MRKH may associate with extragenital anomalies as well, most commonly in the urinary system. Clinically it can be divided into main three types. They are typical MRKH, Atypical MRKH, and MURCS syndrome.

a. Typical MRKH: Isolated uterovaginal aplasia or hypoplasia
b. Atypical MRKH: Uterovaginal aplasia or hypoplasia, renal malformation, and ovarian dysfunction
c. MURCS syndrome: Uterovaginal aplasia or hypoplasia, renal, skeletal, and heart malformation

Among them 64% of patients had the typical form, 24% atypical and 12% had MURCS syndrome. Treatment is usually delayed until the patient is ready to begin the sexual activity. They are often associated with somatic and psychosocial disorders such as depression. The restorative treatment may or may not be surgical, but the method chosen must be adapted to individual needs, it depends on the patient's interest and available options. There were various techniques used for the creation of a neovagina. The colon and rectum, peritoneum, skin autograft, and even muscle flaps have all been used to correct this anomaly.

Restorative treatment, whether surgical or nonsurgical could allow the patient to have normal sexual function. A small percentage (2 - 7%) do have a uterus with a functioning endometrium. They do have the potential to carry a pregnancy. In the past gestational surrogacy was the only option to have genetically related offspring. But successful uterus transplantation is now an option.

EP/G – 03

SUCCESSFUL UTERINE DEVASCULARIZATION PRIOR EVACUATION OF CHORIOCARCINOMA IN AN UNSTABLE PATIENT- A CASE REPORT.

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Introduction

Choriocarcinoma is a malignant gestational trophoblastic neoplasm with an incidence of 9.2 per 40000 pregnancies in Southeast Asia. Torrential bleeding during surgical or oncological management is an extreme challenge for clinicians, especially in a woman with fertility wishes. Uterine artery embolization has been attempted prior to molar pregnancy evacuation in case reports although it is not recommended routinely. However, interventional radiology is not readily available in most cases, and we successfully managed by internal iliac artery ligation instead.

Case Presentation

A nineteen-year-old unmarried female who was previously healthy presented with lower abdominal pain for 2 days. She had regular menstrual cycles with normal flow and no dysmenorrhea. Examination revealed intra-abdominal pelvic mass up to the umbilicus. An ultrasound scan showed a vesicular mass on the right adnexa and β-hCG was 12,000,000 mIU/ml. LDH, CA-125, and AFP were normal. Laparotomy revealed normal ovaries with a bulky uterus, but no biopsy was obtained. CECT chest/abdomen/pelvis revealed a large uterine mass suspicious of choriocarcinoma and pulmonary metastasis 2 mm. At National Cancer Institute, EMA/CO chemotherapy regime was started following the MDT discussion. Her blood pressure was elevated but there were no pre-eclamptic toxemic symptoms. After 3 doses of chemotherapy, she started heavy vaginal bleeding, and hemoglobin dropped to 4.5 g/dl and required dobutamine inotrope support to maintain blood pressure. Her platelets were 45 x 10^9/l. A suction evacuation was planned. She had B/L pleural effusion and evidence of heart failure. Saturation was 89%. She underwent laparotomy via the same previous incision and B/L internal iliac artery ligation was done. Suction evacuation was done under direct vision avoiding uterine perforation. Prophylactic oxytocin was given, and intrauterine catheter and vaginal packing were done. There was no significant post-operative bleeding and packs were removed on post-operative day 3. Post-evacuation she developed pre- eclampsia which was successfully managed medically.

Conclusion

Heavy life-threatening bleeding followed by pre-eclampsia is a fatal complication of choriocarcinoma at two extremes of blood pressure regulation. Element of heart failure could be due to shock or effects of the choriocarcinoma. Since the patient had a recent previous midline laparotomy, laparotomy was made in case it requires immediate hysterectomy. Internal iliac artery ligation reduced the uterine blood supply resulting in less operative bleeding and laparotomy facilitated the complete evacuation of molar tissues without perforating the fragile uterus. This method can be employed for selected cases of choriocarcinoma in resource-limited settings.

EP/G – 04
NEUROLOGICAL MANIFESTATION OF METASTASIZING ENDOMETRIAL CARCINOMA: A RARE CASE REPORT

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Introduction

Endometrial carcinoma (EC) is the third commonest gynaecological cancer in Sri Lanka. Post-menopausal bleeding and abnormal uterine bleeding are the commonest presentations and usually EC is diagnosed at the early stages. Primary presentation of stage IV-B EC without bleeding manifestations is uncommon. The lung was the main site of extra pelvic spread; however, the brain is rare.

Case Presentation

A 67-year-old, a previously healthy woman presented with sudden onset slurring of speech and body weakness. She was a mother of 2 children and there were no cardiovascular stroke risk factors. There were no episodes of post-menopausal bleeding. On admission, her GCS was 13, and neurological examination was suggestive of left hemiparesis. MRI brain revealed well- defined isointense two focal lesions in right superior frontal cortex lobe (1.8 cm x 1.7 cm and 1.4 cm x 1.3 cm). There was significant perifocal white matter edema extending to the right basal ganglia and genu of corpus callosum concerning malignant neoplastic lesions. Mass effect compressing right lateral ventricle with early subfalcine herniation. The brain stem, cerebellum, and rest of the brain were normal. MR angiogram was normal. She underwent craniotomy and space-occupying lesions were excised. Immunohistochemistry confirmed metastatic carcinoma favouring the primary genital tract (Endometrium/Breast). The patient received adjuvant radiotherapy and during evaluation CECT abdomen pelvis suggestive of endometrial carcinoma with local invasion. Laparotomy showed grossly enlarged pelvic lymph nodes with locally disseminated endometrial carcinoma. She underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy which revealed Endometrioid type Adenocarcinoma of the endometrium (FIGO-grade III). There was no lymphovascular invasion. She received adjuvant radiotherapy.

Conclusion

Although it is a known site, distant metastasis to the brain in EC (stage IV-B) can occur rarely. Hence neurological manifestation could be the primary presentation. Cervical stenosis in elderly patients preventing the appearance of bleeding had been reported in the literature. Treatment of stage IV disease needs to be individualized and often it is a combination of surgery, radiotherapy, and either hormonal therapy or chemotherapy. Evidence for the role of cytoreductive surgery is limited and the major objectives of treatment are to achieve local disease control in the pelvis including palliate bleeding, vaginal discharge, pain, and fistula formation. Lymphadenectomy was not carried out considering the risk of vascular injury and postoperative morbidity. Although primary radiotherapy is also an option, a simple hysterectomy with adjuvant radiotherapy was planned to minimize surgical morbidity and prevent future bleeding risk during treatment.

EP/G – 05

OVARIAN CANCER RECURRENCE OVER THE MONS PUBIS: A CASE REPORT OF AN UNCOMMON TUMOR SITE RECURRENCE

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Introduction

Ovarian cancer recurrence commonly occurs in the pelvis and the peritoneum/ abdominal cavity. Isolated extra-peritoneal recurrences occur occasionally, and the mons pubis is an uncommon site of ovarian cancer recurrence. Here, we present an ovarian cancer recurrence over the mons pubis in an 80-year-old woman.

Case Presentation

She was a mother of one child who reached menopause at age of 50 years. She was otherwise healthy and at the age of 69 years had lower abdominal pain. An ultrasound scan detected a cystic mass and CA-125 was 22 U/ml. Total abdominal hysterectomy and bilateral salpingo-oophorectomy with infra-colic omentectomy revealed high-grade serous cystadenocarcinoma of the left ovary (stage I-C) where she was treated with 6 cycles of carboplatin & paclitaxel. She was followed up with CA-125 and ultrasound scans. Over the next 7 years, she underwent 3 laparotomies for pelvic recurrences and an abdominal wall deposit excision last time. She received cisplatin, etoposide, and cyclophosphamide subsequently following each laparotomy in order. Five years following the last laparotomy she presented with a mass over the mons pubis however her CA-125 was 8.9 U/ml. CECT showed a suspicious cystic lesion on mons pubis and an enlarged common iliac node. Her repeat laparotomy excised the lesion over the mons pubis and the suspicious lymph nodes. There was a large cystic mass measuring 120 x 110 x 85 mm. Multilocular cyst filled with brownish hemorrhagic material. Histology showed an encapsulated metastatic deposit of known primary serous papillary cyst adenocarcinoma. No evidence of lymphovascular invasion or necrosis. Lymph nodes were free of tumors. She was arranged for adjuvant chemotherapy.

Conclusion

Mons pubis is an uncommon site of ovarian cancer recurrence. It is likely to disregard the option of surgery, in an advanced aged patient with a long uneventful follow-up since final surgery and chemotherapy with normal tumor markers. This rare case emphasizes the importance of seeking early medical attention in any abnormal growth and histological evaluation regardless of disease-free interval and tumor marker status.

EP/G – 06

RECURRENCE OF CERVICAL CARCINOMA WITH VESICOVAGINAL FISTULA MANAGED WITH TOTAL PELVIC EXENTERATION: A CASE REPORT

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Introduction
Pelvic exenteration (PE) is an extremely complex surgical procedure that requires special expertise for the right candidate selection, operative skills, postoperative care, and handling of complications. Recurrence of carcinoma cervix is one of the commonest indications while PE is used to treat vesicovaginal fistula in selected cases in some cancer centers.

Case Presentation
Fifty-two-year-old mother of 2 children presented with left loin pain for 1 month. She was a known diabetic and asthmatic patient with good control. There was a cervical growth extending to the left parametrium in the vaginal examination. Biopsy revealed moderately differentiated non-keratinizing squamous cell carcinoma. CECT abdomen/ pelvis confirmed the cervical growth extending to the left lateral pelvic wall with left hydroureter and hydronephrosis (stage III-B). serum creatinine was slightly elevated (126 µmol/l) and ureteric stenting was done. She received external beam radiotherapy and intra-cavitatory radiotherapy. Three years later she complained of per vaginal discharge and a biopsy proved the carcinoma recurrence. PET-CT showed the involvement of bladder base, vesicoureteric junction, distal left ureter, upper vagina and rectum, and rectosigmoid junction. No metabolically active regional or distant lymph node metastases.

The patient was planned for total pelvic exenteration. A midline incision was made and a recto- sigmoid segment was resected en-bloc with the uterus and the urinary bladder (Total pelvic exenteration). Coronally the dissection extended to the resection of the pelvic diaphragm, levator ani, whole vagina, and the vulva (Type III). Colostomy was created by the descending colon. Part of the ileum was resected and both ureters were implanted (Bricker uretero-enteric anastomosis) and a urostomy was made. Midline and perineal incisions were closed leaving two stomas on the anterior abdominal wall for urine and feces. Operative blood loss was 700 ml. Histology confirmed poorly differentiated squamous cell carcinoma involving the bladder, uterus, vagina, large bowel, and rectum. Her post-operative period was complicated with urinary tract infection and a wound infection which required surgical debridement and re- suturing of the wound. Her hospital stay was 40 days.

Conclusion
PE is an extremely radical surgical procedure and is not performed frequently. Patient selection is a key element for a successful outcome. Not only the physical morbidity, living with two stomas is psychologically challenging. Postoperative morbidity is frequent and needs vigilant post-operative monitoring for early detection and management of surgical complications.

EP/G – 07
A RARE CASE OF A SOLITARY VAGINAL METASTASIS IN AN ENDOMETRIAL CARCINOMA

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Introduction
Endometrial carcinoma (EC) is the commonest gynaecological malignancy in developed countries. Endometrioid type is the commonest type of EC. Local invasion, lymphatic spread, and hematogenous spread are the three common patterns of spread. EC extending to the cervix and subsequently to the vagina is not uncommon. However, primary cancer with the normal cervix and upper vagina with the skip lesion on the mid vagina and bladder base is rare. This vaginal metastasis can occur by submucosal lymphatic or

vascular metastases. Due to the rarity of this entity, these lesions could go untreated at the primary health care setting.

Case Presentation
Eighty-two-year-old mother of 2 children presented with post-menopausal bleeding for one month. She was a known patient for diabetes, hypertension, and on dual antiplatelets for ischemic heart disease. Examination revealed a bulky uterus, normal cervix and upper vagina however, there was a reddish color nodule (1 x 1 cm) in the anterior vaginal wall at the bladder base. Endometrial thickness was 32 mm on the ultrasound scan. CECT showed a heterogeneously enhancing lesion with a central non-enhancing area measuring 4.7 x 4.2 cm involving the fundus of the uterus & right adnexa. there was no lymph node involvement or distant metastasis. Biopsy of the solitary vaginal nodule confirmed the diagnosis of endometrioid type endometrial adenocarcinoma by histology and immunohistochemistry. The patient was referred for adjuvant radiotherapy.

Discussion
Post-menopausal bleeding with increased endometrial thickness at primary clinical encounter favours the diagnosis of EC. The reddish vaginal lesion could be suspicious of vaginal carcinomas which are rare. In contrast to EC, the commonest type of vaginal carcinoma is squamous cell carcinoma. Assuming as a benign lesion, prescribing local application of pharmacological treatment is possible due to the solitary nature of the lesion. Yet she needs hysterectomy with bilateral salpingo-oophorectomy with wide local resection of the anterior vagina or hysterocolpectomy. Hysterocolpectomy is a radical surgery with significant surgical morbidity. However, she was not offered surgery considering her age, physical performance status, medical co-morbidities, and anticipated surgical morbidity. She was planned for adjuvant radiotherapy. This emphasizes the importance of obtaining a biopsy in a solitary lesion despite having a labeled diagnosis of a malignancy which could change the management.

EP/G – 08
A CASE REPORT OF LEFT UNICORNUATE UTERUS WITH WIDELY SEPARATED RUDIMENTARY NON-COMMUNICATING RIGHT HORN WITH IPSILATERAL RENAL AGENESIS.

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Introduction
Unicornuate uterus with or without rudimentary horn is a developmental anomaly which occurs due to abnormal or failed development of one of the paired mullerian duct or fusion of the ducts. Women with unicornuate uterus have increased incidence of obstetric complication like spontaneous abortions, preterm delivery and intrauterine fetal demise and gynaecological complications like infertility, endometriosis and chronic pelvic pain. According to American Society for Reproductive Medicine classification, unicornuate uterus is a type 2 mullerian anomaly with unilateral hypoplasia or agenesis that can be further sub-classified into communicating, non-communicating, no-cavity and no horn.

Case Presentation
A 37-year-old woman was presented with two and half years of primary subfertility. Couple had been adequately engaging in sexual intercourse during her fertile period and denied any sexual dysfunction. She also had regular menstrual cycles without heavy menstrual bleeding or dysmenorrhea. She was investigated with a hysterosalpingogram which showed evidence of possible of right hydrosalpinx due to distal isthmic obstruction, while the left fallopian tube was patent. She was incidentally found to have absent right kidney. Then she underwent a laparoscopy and dye test in order to look for tubal patency and to exclude mullerian anomaly. The laparoscopy revealed a left normal size unicornuate uterus with right

non-communicating rudimentary horn which connected to left unicornuate horn by long fibrous band. The right- side fallopian tubes and ovary appeared normal and were attached to right side rudimentary horn. The left ovary and tube appeared, and the latter was patent. The patient was counselled regarding her condition and planned for further fertility treatment.

Discussion

Incidence of this malformation is 0.2% in fertile patients and 0.6% in the infertile. Approximately 90% of these unicornuate uteri with rudimentary horn are non- communicating. When no fusion occurs with the contralateral duct, a fibrous or fibrous muscular band usually connects the two horns. A unicornuate uterus with rudimentary horn is often associated with ectopic pregnancies and with rupture of the rudimentary horn and, although it is unclear whether to remove the rudimentary horn before conception. Laparoscopic resection of rudimentary uterine horn has rapidly become the standard treatment of such mullerian agenesis, to prevent severe complications as ectopic pregnancy or extensive endometriosis. Unilateral renal agenesis is associated with unicornuate uterus. Therefore, in the subfertile patients, both genito-urinary anomalies should be excluded and low threshold for minimal invasive surgery to diagnose suspected mullerian anomalies.

EP/G – 09

CERVICAL HEMANGIOMA – A RARE CAUSE OF ABNORMAL UTERINE BLEEDING

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Introduction

Cervical hemangiomas are an exceedingly rare entity with less than a hundred reported cases. They can present with abnormal uterine bleeding and are often treated surgically.

Case Presentation

Previously well 35-year-old presented with irregular, heavy menstrual bleeding and postcoital bleeding. Examination revealed a vascular cervix and transvaginal ultrasound was normal. Full blood count revealed a normal hemoglobin level. She underwent LLETZ biopsy. During the biopsy procedure excessive bleeding was noted and diathermy and hemostatic sutures were used to arrest the bleeding. A week later, she presented again with heavy bleeding from the cervix. Her hemoglobin level 7.8 g/dl. Bleeding was arrested with tranexamic acid and a temporary vaginal pack, and she was given a blood transfusion. Histology of the biopsy revealed a cervical hemangioma without other abnormalities. Patient opted to have a hysterectomy as she was keen on a permanent cure. Hysterectomy was performed and the histology of the uterus confirmed a cervical hemangioma.

Discussion

Cervical hemangiomas are very rare and predominantly affect women in reproductive age. The mean age of presentation is 35.5 years, as in our patient. Cervical hemangiomas can be asymptomatic and be detected after hysterectomy. Or they can cause abnormal uterine bleeding. This patient had irregular heavy menstrual bleeding and postcoital bleeding which is the typical presentation. She continued to have heavy bleeding and developed anemia even after local excision and ablation of the lesion.

Treatment of cervical hemangiomas can be either conservative or surgical. Hysterectomy is commonly performed as in this patient. Cervical hemangiomas are benign lesions and have good prognosis. Currently our patient is being followed up and has no further complications. Pathogenesis of cervical hemangiomas is unclear. They have been found to have both estrogen and progesterone receptors which seems to explain their predominance in women of reproductive age. The importance of cervical hemangiomas lies as a differential diagnosis of women with abnormal uterine bleeding, particularly in those without any

obvious cause such as other cervical pathologies, leiomyomas, adenomyosis or endometrial pathology. To diagnose the clinician needs a high degree of suspicion, a thorough clinical examination and liaison with histopathologist.

Conclusion
Cervical hemangiomas are a rare pathological cause for abnormal uterine bleeding in women of reproductive age. Diagnosis prior to hysterectomy is unusual and requires awareness by the clinician. Management is often surgical, and hysterectomy is often performed with good results.

EP/G – 10
A RARE CASE OF LEIOMYOMA IN A PATIENT DIAGNOSED WITH MAYOR ROKITANSKY KUSTER HAUSER (MRKH) SYNDROME

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Introduction
Mayor Rokitansky Kuster Hauser (MRKH) syndrome is a congenital malformation involving reproductive, genitourinary, bone, and cardiac systems. Although it is a congenital disorder characterized by the failure to develop the female internal genitalia from the para mesonephric ducts during embryogenesis, the diagnosis is usually made in adolescent women when they undergo the investigations for primary amenorrhoea with normal developing secondary sexual characteristics, as the ovaries are present and functional and is the second most frequent cause of primary amenorrhea. The incidence is 1 in 4000 – 5000 females livebirths. This condition appears as underdevelopment or absence of the upper vagina, cervix, and uterus, but the external genitalia is normal. The development of leiomyoma in the background of aplastic/hypoplastic uterus in the patient with MRKH syndrome is a very rare phenomenon and few cases only described in the literature. The diagnosis and management approach, in this case, is quite challenging.

Case Presentation
A 40-year-old woman who has been diagnosed MRKH syndrome at the age of 17 years, who presented with abdominal pain and later found to be having a leiomyoma on the rudimentary uterus by preforming MRI scan. She underwent laparotomy for the removal of the leiomyoma of the rudimentary uterus. Intra operatively, a solitary leiomyoma measuring 6 cm x 4 cm size was stretching over the rudimentary uterus and it was removed completely. Her both ovaries were normal and post operative period was uneventful.

Discussion
Women with MRKH syndrome who present with abdominal pain and mass, leiomyoma of the rudimentary uterus should be considered as the probable diagnosis, though the differential diagnosis are ovarian fibroma, GIST (gastrointestinal stromal tumor), extravesical leiomyoma of the urinary bladder. Pelvis ultrasonography with both transabdominal and transvaginal route are the first imaging techniques to evaluate the pelvic mass and genitourinary system. Magnetic resonance imaging is a more accurate to assess the soft tissues and to confirm the pelvic mass, and more precisely evaluating the genitourinary system (kidney, ureters, bladder), and may give signs for malignancy tendencies. Complete laparoscopic excision is recommended to manage this case, but laparotomy is preferred if adhesions are anticipated and in low resource settings.

Conclusion
Though the development of leiomyoma from the rudimentary uterus is very rare in a patient diagnosed with Mayor Rokitansky syndrome, the possibility of it should not be neglected and if the history and clinical examinations are suggestive of leiomyoma proper investigations are needed to confirm or refute the diagnosis.

EP/G – 11

BILATERAL OVARIAN SEROUS BORDERLINE TUMORS WITH INVASIVE IMPLANTS- A RARE CASE REPORT

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Introduction

Serous borderline ovarian tumors (SBOT) are low-grade epithelial neoplasms with favorable prognosis. They are serous neoplasms that show epithelial proliferation greater than that are seen in cystadenomas, with cell stratification, epithelial tufting, and nuclear atypia with or without extra ovarian implants. Destructive stromal invasion is absent. Implants have been classified as invasive and noninvasive based on their histological appearance. Characterization of invasive implants from noninvasive is important as the presence of former indicates the need of complete cytoreduction.

Case Presentation

A 47-year-old P3C2 female presented with abdominal distension for 3 weeks. Her ultrasound abdomen showed a mass in right adnexa with moderate ascites. CECT abdomen showed bilateral cystic adnexal masses with moderate ascites, favoring an ovarian malignancy. Her Serum CA 125 was 725 IU/ml and LDH 154 U/ml. She underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy and omentectomy. On macroscopy there were bilateral ovarian masses with irregular capsules. Microscopic examination of both ovarian masses revealed cystic tumors with hierarchically branching papillae lined by a layer of polygonal cells. Nuclear stratification and atypia were noted. Numerous psammoma bodies were present. There was no stromal or vascular invasion by tumor. Surfaces of both ovaries were involved by tumor, but there was no capsular breach. Outer walls of both fallopian tubes and the right parametrial tissue revealed tumor implants of both noninvasive and invasive nature. The omentum was free of tumor involvement. Immunohistochemical studies was performed on the tissue with invasive implants, which revealed diffuse positivity for ER and negativity for HBME-1 and Calretinin, excluding the possibility of a mesothelial hyperplasia. In view of the presence of invasive extraovarian tumor implants the tumors qualified to Low grade serous carcinomas of both ovaries, FIGO IIA. She received 6 cycles of adjuvant chemotherapy (Carboplatin and Paclitaxel). Follow up did not reveal evidence of recurrence up to date.

Conclusion

As SBOTs are commonly seen among young females, mostly conservative surgeries are performed. However, recurrence of tumor is a known complication, and it is significantly higher in the presence of invasive implants as opposed to those with non-invasive implants. The presence of invasive implants is the most important adverse prognostic factor which qualifies a SBOT to a Low-grade serous carcinoma. This case emphasizes the importance of correct pathological assessment and identification of adverse prognostic factors, which are mostly histological, and intern play a vital role in staging of disease and the management plan.

EP/G – 12
A CASE REPORT ON UROGENITAL MYIASIS

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Introduction
Myiasis is the parasitic infestation of a living organism by fly or insect larvae. Myiasis is classified into different types based on the parts of the body involved (cutaneous, subcutaneous, nasopharyngeal, intestinal and urogenital [UGM]) and based on the relationship between the host (obligatory and facultative myiasis). It is usually linked to poor hygiene and sanitary conditions. These larvae feed on the host's dead or living tissues, liquid body substances or ingested foods.

Case Presentation
A 70-year-old patient with a history of 3rd-degree uterovaginal prolapse for 3 years managed with vaginal pessaries, presented following per vaginal bleeding for 2 days and severe genital pain and mass at vulva for past 6 months as the pessary has fallen 6 months ago. Other than these, she suffered from on and off fever spikes, loss of appetite and weight loss during the past few months. On examination, there was an ulcerated mass appearing through the vagina which was not reducible and the mass was infested severely by larvae. The gross anatomy was distorted.

The basic haematological investigations are done, and they showed high WBC with eosinophilia, high CRP and normal liver and renal parameters. On admission, superficial larvae were removed manually using non-toothed forceps and twice a day thereafter. The mass was wrapped with a dextrose-soaked gauze swab daily to attract deeply seated larvae. Same time broad-spectrum intravenous antibiotics, antipyretics, high protein diet were given. A piece of tissue was sent for urgent histology. By one-week time following manual removal, the mass was completely free of larvae but the mass was irreducible. Per rectal examination was unremarkable. Ultrasound abdomen and pelvis were normal. The initial histology came as a benign ulcer with chronic inflammation and negative for dysplasia and malignancy. She underwent a vaginal hysterectomy, and the sample was sent for second urgent histology. The histology came as well-differentiated squamous cell carcinoma of the cervix with tumour extension to cervical resection margin and the uterine corpus and lymphovascular emboli were present. So, the patient was referred to the oncology unit and started on radiotherapy.

Conclusion
Myiasis of the genital organ (UGM) is a rare clinical entity. Good hygiene and proper sanitary conditions are very important for the prevention of myiasis. Vaginal hysterectomy following removal of larvae is the definitive treatment option that can provide immediate relief to the patient. Symptoms of UGM vary according to the organ involved and the severity of the infection. Consequently, a correct diagnosis is necessary to avoid unnecessary treatment.

EP/G – 13
SPONTANEOUS OVARIAN HYPERSTIMULATION SYNDROME WITH HYPOTHYROIDISM: CASE REPORT

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Background
Ovarian hyperstimulation (OHSS) is a rare event which occurs during the luteal phase or early pregnancy. The incidence of the severe form of OHSS is 0.2-1%. The pathophysiology of OHSS is not clearly understood, but vasoactive substance and renin-angiotensin mechanism play a significant role in OHSS. Assisted reproductive technic (ART), molar pregnancy, twin pregnancy, luteal supplementation of hCG, multiple follicles, high level of estradiol, PCOS and primary hypothyroidism are major risk factors associated with it. According to symptoms and signs, OHSS classified as mild, moderate and severe. OHSS is a self-limiting disease. Management should be conservative and manage symptoms with medical treatment sufficient in the most case without surgical intervention. Here in we present a case report of primary hypothyroidism complicated with OHSS. A 22-year-old married woman with primary hypothyroidism and defaulted treatment presented with abdominal discomfort and pain. She had undergone right-sided oophorectomy for a large complex ovarian cyst one year back. This time her pelvic ultrasound revealed a sizeable left ovarian cyst and no free fluid in the peritoneum. Biochemical investigation was HbA1C - 6.2%, FSH - 6.98 mIU/ml normal in range, LH < 0.10mIU/ml, which is low in all stage of menstrual cycles value, β-hCG < 0.100 mIU/ml, 3rd generation TSH >100 μIU/ml, CA-125 - 41.22IU/ml marginally elevated, the histology did not reveal any abnormality. It was suspected of primary hypothyroidism induced OHSS and treated with levothyroxine. Ovarian cysts responded to treatment and gradually shrunk without any surgical intervention.

Conclusion
OHSS is a rare entity which can occur even in non-pregnant women and those who did not undergo assisted reproductive techniques. When investigating multilocular ovarian cysts, the diagnosis of OHSS should be considered, especially in hypothyroidism. Hypothyroidism- induced OHSS can be reasonably managed medically with levothyroxine without any invasive management such as surgery.

EP/G – 14
A CASE OF EPITHELIOID TROPHOBLASTIC TUMOUR

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Introduction
An epithelioid trophoblastic tumor (ETT) is an extremely rare subtype of gestational trophoblastic neoplasia (GTN). It accounts for only 1.0 - 2.0% of all GTN cases, yet, with a mortality rate of 10 - 24%. One-third develop following an antecedent pregnancy event including prior term delivery (43%), molar pregnancy (39%), and miscarriage (18%). Around 25 – 35% of patients present with metastasis, commonly in the lungs. Usually, ETT presents with elevated β-hCG, but in one-third of cases, β-hCG was less than 2500 mIU/ml and rarely negative. The biological behavior of ETT is similar to placental site trophoblastic tumor (PSTT) leading to a dilemma in diagnosis.

Case Presentation
A 38-year-old mother of two, both being term vaginal deliveries who is a known patient with bipolar affective disorder and hypothyroidism presented with gradual onset, foul-smelling yellowish vaginal discharge for one year, preceded by 4 years of secondary amenorrhea. Her second delivery was 8 years prior and used medroxyprogesterone acetate (DMPA) for 5 years as contraception. The transvaginal ultrasound scan was inconclusive and the pipelle endometrial biopsy revealed necrotic tissue. She underwent an abdominal hysterectomy with bilateral salpingectomy. Uterine tissue was found to be extremely friable and bilateral ovaries appeared normal, thus preserved. Her immediate post-operative recovery was un-

complicated. The initial histopathological analysis proved challenging. β-hCG and other serum tumor markers were negative. According to immunohistochemistry studies, AE1/AE3 was strongly positive and PLAP was positive. Ki-67 proliferative index was 24-28% and only weak nuclear staining was present for P63. β-hCG, α-fetoprotein, and CD 30 were negative. The specimen was re-analyzed at the National Cancer Institute and the features were deemed consistent with ETT. The patient was referred to a clinical oncologist.

Discussion

Irregular vaginal bleeding is the commonest presenting symptom. Whereas in the index case, it was an unusual presentation of prolonged amenorrhoea, possibly due to anti-psychotics/DMPA. The Ki-67 of choriocarcinoma tends to be more than 90%, while in ETT it's greater than 10%. Hysterectomy is the primary mode of treatment. If fertility preservation is desired in localized disease, uterine curettage, hysteroscopic resection, and chemotherapy may be considered. The interval from antecedent pregnancy is more than 48 months and Stage IV disease confers a poor prognosis. ETT is less chemosensitive than choriocarcinoma. It is pertinent that the diagnosis of ETT remains a challenge owing to its rarity and diverse presentations, which can lead to potential mismanagement and delay in treatment.

EP/G – 15
OVARIAN HYPERTHECOSIS PRESENTING WITH HYPERANDROGENISM IN A POST-MENOPAUSAL WOMAN – A CASE REPORT

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Introduction

Ovarian hyperthecosis is a condition where there is excess production of androgen from nests of luteinized theca cells scattered in ovarian stroma. Majority of patients are postmenopausal and present with slowly progressive severe hyperandrogenism with virilization at later stage. These women are at risk of developing type 2 diabetes mellitus, endometrial hyperplasia and carcinoma.

Case Presentation

A 69-year-old, mother of three children who attained menopause 19 years ago and a known patient with hypertension, dyslipidemia and generalized anxiety disorder, presented with gradual onset, slowly progressing severe hirsutism over 8 years and recent onset male type baldness. On examination she had excessive hair growth over upper lip, chin, lower abdomen, arms, thighs and back which contributed to Ferriman-Gallwey score of 17. She had frontal baldness but did not have voice change or clitoromegaly. Her serum testosterone level was 13.5 nmol/l, follicle stimulating hormone, luteinizing hormone (LH) and dehydroepiandrosterone sulfate (DHEAS) were within normal range. Low dose dexamethasone suppression test (LDDST) was suggestive of ovarian pathology. Transvaginal scan revealed normal ovaries and contrast enhanced computerized tomography of abdomen and pelvis was normal. She was treated with finasteride and spironolactone, but the response was inadequate. Laparoscopic bilateral oophorectomy was performed, and the histology revealed bilateral ovarian hyperthecosis.

Discussion

Postmenopausal ovaries remain active and secrete significant amount of androgen. Postmenopausal androgen production is LH dependent and gradually decline with age. Causes of postmenopausal hyperandrogenism are diverse and include ovarian hyperthecosis, Cushing's syndrome, androgen secreting ovarian and adrenal tumours. Ovarian hyperthecosis typically present with progressive long-standing history of hirsutism which will eventually become severe and is associated with virilization. These women have high level of testosterone, but not high as androgen secreting tumours. Women with androgen secreting

tumour typically present with abrupt onset and rapidly progressing hyperandrogenism and virilization. They have very high level of testosterone and those with adrenal tumour will have elevated DHEAS as well. LDDST will help to differentiate the origin of testosterone. If testosterone is produced by the ovaries, it will not be suppressed following LDDST. Gonadotropin releasing hormone agonist test and ovarian and adrenal vein sampling will also help in differentiating the origin of testosterone.

Conclusion

Histopathological examination is the gold standard to diagnose ovarian hyperthecosis. Therefore, when ovarian hyperthecosis is suspected in a postmenopausal woman, laparoscopic bilateral oophorectomy is recommended to confirm the diagnosis as well as cure the condition.

EP/G – 16
A CASE OF PELVIC TUBERCULOSIS IN A YOUNG FEMALE

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Introduction

Tuberculosis (TB) is a worldwide prevalent chronic illness. The causative organism is mycobacterium tuberculosis which is an acid-fast bacillus. Tuberculosis of the female pelvis is relatively rare and most of the time it is asymptomatic and sometimes diagnosed during the evaluation of subfertility. Though pelvic TB is rare it has high morbidity and mortality worldwide. often the infection spread to the pelvis and female genital tract via hematogenous spread (in 90%) and descending direct spread or lymphatic spread. Also has a risk of transmission through sexual intercourse by a patient who is having genitourinary TB. Diagnosis of pelvic tuberculosis is challenging. Here the following case report is going to discuss a young girl with extrapulmonary TB resulting from female genital tract tuberculosis.

Case Presentation

This patient is 20 years old unmarried and has on and off lower abdominal pain and irregular menstrual bleeding with dysmenorrhea for 2 months duration. On examination, her body mass index was 17.1 kg/m^2. She was not febrile and not pale. Her hemodynamics were normal, bilateral lungs were clear. There was a right iliac fossa and lower abdominal tenderness. In the transabdominal ultrasound scan, the uterus was normal, endometrial thickness was 8 mm, and there was bilateral adnexal mass with cystic and solid areas with increased vascularity. CA 125 level was high - 566.7 U/ ml. MRI scan of pelvis showed bilateral irregular lobulated enhancing adnexal masses (Right > Left) with cystic and solid components The MRI appearance is more in favor of tubo-ovarian tuberculosis. It's planned for exploratory laparotomy and biopsy. During laparotomy, multiple extensive nodularities were noted over the peritoneum and abdominopelvic organs, and bilateral ovaries were involved with adnexal masses. The omental biopsy was taken for GeneXpert MTB & It was detected with Mycobacterium tuberculosis. The patient was started on anti-tuberculosis treatments.

Discussion

Diagnosis of pelvic tuberculosis is challenging and may need a combination of investigations. Chest X-Ray might be normal in such patients and advanced imaging methods including pelvic ultrasound scan, CT or MRI pelvis, and abdomen may be needed. Diagnostic laparoscopy may help to direct the visualization of tuberculosis lesions. A definitive diagnosis of TB needs isolation of acid-fast bacilli in culture or direct smears. A nuclear amplification test will give results in a few hours and TB PCR is a rapid test and a newer modality of diagnosis of the infection.

The treatment regime for pelvic tuberculosis is similar to the treatment regime for extrapulmonary TB. But it should always correlate with the clinical picture.

Conclusion

The prevalence of pelvic tuberculosis in females is still undetermined. The diagnosis is challenging due to confusion with ovarian malignancies as well as a high proportion of asymptomatic infection. So, it is important to improve the awareness of pelvic tuberculosis in clinicians and start investigations to exclude the disease. Taking expert opinion and starting the antituberculosis and continuation of treatment regime is vital to cure the infection and prevent further damage.

EP/G – 17

A RARE CASE OF DISSEMINATED SUPPURATIVE ABDOMINOPELVIC ACTINOMYCOSIS

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Introduction

Actinomycosis is a suppurative granulomatous infection, caused by actinomyces Israeli, a gram-positive anaerobic rod which exists as normal flora in oral, gastrointestinal and genital tract. Pelvic actinomycosis is a rare but known complication of IUCD which is left for more than 5 years. It always presents with diagnostic challenge as its appearance mimics a disseminated malignancy. Here we present a case of rapidly disseminated actinomycosis following removal of displaced IUCD in peritoneal cavity in a young woman.

Case Presentation

A 28-year-old lady presented with chronic back pain and significant loss of weight for 6 months duration. She denied loss of appetite or evening pyrexia or night sweating. Investigations revealed high inflammatory markers (WBC - 20 x 10^9/l, CRP - 160 mg/l, ESR - 125 mm/hour). Common acquired Immune deficiency diseases were excluded. US scan examination revealed a suspicious adnexal mass with multiple liver lesions suspicious of disseminated malignancy or suppurative actinomycosis. CECT of abdomen and pelvis revealed a large pelvic mass which is infiltrating the uterus and anterior abdominal wall. Tumor markers LDH, AFP and CA-125 were normal. 8 months back she had undergone laparotomy for removal of displaced IUCD and left side salpingo-oophorectomy for a suspicious mass. Histology of ovary revealed ovarian actinomycosis.

Due to high suspicion of disseminated suppurative actinomycosis patient was started on parenteral benzyl penicillin 3 million units 6 hourly for 4 weeks. Patient clinically improved and inflammatory markers dropped significantly. But CECT of abdomen and pelvis did not reveal resolution of the lesion.

Discussion

Actinomyces are low virulence organisms requiring a breach in the mucosa through trauma, surgery or foreign body to cause the formation of abscesses and fistula. The major initiating factor of pelvic infection is the prolong use of IUCD which facilitate the entry of actinomyces into submucosal space where the chronic infection sets and disseminates. In our case, infection had spread from the ovary to upper abdomen within a few months from previous surgery to remove IUCD. Pelvic actinomycosis usually presents in advanced stages due to delayed diagnosis. The appearance of infection often mimics malignancy, since the disease infiltrates the adjacent organs causing diagnostic difficulty. Most patients undergo laparotomy or laparoscopy for resection of suspicious mass and diagnosis of actinomycosis is made postoperatively. Prolong course of antibiotic for 6 -12 months will cure the disease and decrease the risk of relapses. Sur-

gery is recommended to drain abscess and resect injured tissues, when clinical or radiological findings do not resolve after 4 - 6 weeks of antibiotic therapy.

EP/G – 18
CASE REPORT ON ACUTE MYELOID LEUKAEMIA PRESENTING AS ABNORMAL UTERINE BLEEDING

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Introduction
Abnormal uterine bleeding is a common complaint in gynaecology clinics. Careful and systematic assessment is imperative in coming to a diagnosis.

Case Presentation
A 36-year-old nulliparous woman presented with three months' duration of heavy regular menstrual bleeding. She was under treatment for primary subfertility and was treated with ovulation induction agents. On examination she was found to have a normal size uterus with normal adnexa. Bleeding per vaginum was profuse with minimum clotting. On ultrasound scan she was found to have small (2 cm x 2 cm) multiple leiomyomas but they were not in close proximity to the endometrium (FIGO type 4). She underwent full blood count and was found to have pancytopenia (WBC - 1.4 x 10^6/l, Haemoglobin - 5.7 g/l and platelets 194 x 10^6/l). She underwent a blood picture immediately with clotting function assessment (including fibrinogen concentration). Blood picture showed pancytopenia with circulating blast cells suggestive of acute myeloid leukaemia. There was no evidence of DIC but prothrombin time as well as INR was abnormally high. She was treated with intravenous tranexamic acid and was given two consecutive whole blood cell transfusions as well as one adult pack of platelets. Fibrinogen levels were not available immediately and thus cryoprecipitate was not administered. Fortunately, her bleeding reduced but not completely ceased with tranexamic acid. She was immediately transferred to Apeksha Hospital Maharagama for bone marrow biopsy and flow cytometry with immunotyping in view of well discerned oncological treatment.

Discussion
Patient who has any abnormality in menstrual bleeding patterns with clotting abnormalities due to cytopenia might be a presentation of acute haematological malignancies. Having the full blood count assessed promptly might suffice the need for further assessment such as blood picture and clotting profile. Having skilled personnel available or immediate referral to a specialized center is advisable in view of determining the need for specific treatment. Using facilities like TEM/ROTEM in order to treat and control bleeding effectively as well as though rare, using flowcytometry, bone marrow biopsy, immunotyping before unique treatments like chemotherapy, might be very useful. Immediate multidisciplinary team discussion, as in this case could minimize morbidity and mortality.

Conclusion
Assessment of abnormal uterine bleeding systematically (PALM COEIN) is very crucial in the diagnosis of a pathology. However, additional investigations commencing from total blood count, might open new arenas for an uncommon diagnosis, which should be promptly acted upon.

EP/G – 19
EXTRAGENITAL ENDOMETRIOSIS INVOLVING MONS PUBIS

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Introduction
Spontaneous extra pelvic Endometriosis is rare and etiopathogenesis is still uncertain. Endometriosis in mons pubis is even rarer. Only a few cases are reported in the literature. The unusual presentation can make the diagnosis challenging and frequently subjected to mismanagements.

We report a case of deep infiltrated Endometriosis involving Mons pubis.

Case Presentation
33-year-old female presented with excruciating pain at the Right groin and pubic area which worsened cyclically for 4 months. She delivered her child by lower segment caesarean delivery 10 years back. From thereafter she was on combined oral contraceptive pills (COCP) for 7 years. After stopping it with the purpose of conception, she developed the above symptoms. Her menstrual periods are regular apart from this cyclical pelvic, and vulval pain outlasting the menstruation.

She was investigated on several occasions. Treated with attempted surgical excisions, and drainage twice, suspecting it is as an abscess. however, all failed, and histology revealed only the fat tissue. She is having cyclical severe tenderness over Mons pubis. All Other clinical examination was normal. On clinical suspicion of Endometriosis, she was given a trial of COCP back-to-back for 3 months. That improved her symptoms while awaiting the magnetic resonant imaging (MRI) of the lesion.

An ultrasound scan (USS) showed a small multilocular cystic lesion in deep subcutaneous tissue at the Right inguinal region. MRI revealed Endometriotic deposits at the external ring of the Right inguinal canal. COCP withdrew and Surgical exploration was offered when she is symptomatic while having menstruation. We detected a firm nodule situated in deep subcutaneous tissue at the Mons pubis. An altered blood-filled cavity was noted beneath the nodule. All the endometriotic nodules were excised. Histology confirmed endometriosis in the deep subcutaneous tissue in the mons pubis.

Discussion
Extra pelvic Endometriosis can have diverse clinical presentations. Detailed history and clinical examination, a trail of hormonal treatment, and USS would be helpful to come to a diagnosis. 95% of the reported cases of vulval-perineal Endometriosis were following tissue damage. The pathway of implanting Endometriotic tissue in the mons pubis without local tissue damage is unclear. Regurgitated blood through the inguinal canal or abnormal implantation at the time of LSCS are possibilities.

Conclusion
Cyclical Pain in mons pubis or vulvo-perineal pain with or without previous tissue damage warrants the suspicion of Endometriosis. An improvement of symptoms with a trial of COCP will be helpful in a resource-poor setting to come to a clinical diagnosis of the condition. Management should be tailored to individual patients.

EP/G – 20
A CASE REPORT- UTERINE DIDELPHYS WITH COMPLETE LONGITUDINAL VAGINAL SEPTUM

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Introduction
Uterine didelphys is a type of Mullerian duct anomalies (MDA), due to complete failure of the mullerian ducts to fuse, leading to two uterus and two cervices. A longitudinal vaginal septum is also present that

may range from thin and easily displaced to thick and inelastic. A didelphys uterus with complete longitudinal vaginal septum is one of the least common MDAs. Most women are asymptomatic, some are presenting with dyspareunia or dysmenorrhea in the presence of a varying degree of longitudinal vaginal septum. Rarely, hematocolpos, hematometrocolpos, renal anomalies are reported with didelphys uterus.

Case Presentation
A 31-year-old woman presented with six years history of primary subfertility. She had regular menstrual cycles with dysmenorrhea and deep dyspareunia. She has undergone ovulation induction six times which were not successful. She had undergone hysterosalpingography which revealed a single uterine horn with free spillage of contrast into the peritoneal cavity from ipsilateral fallopian tube. Five In-utero-inseminations were done. Then she underwent laparoscopy and found to have two vaginas completely separated with thick septum, two cervixes, two horn of uterus with normal bilateral fallopian tubes and ovaries. MRI pelvis revealed two uterine bodies, two cervixes and possibly two vaginas and no other system abnormality. Vaginal septum resection was performed.

Discussion
The fertility of women with untreated didelphys uterus has better outcome than those with other MDAs, but still less than women with normal anatomy. Ultrasound scan is done followed by an MRI to confirm the diagnosis. When uterine didelphys is diagnosed, further investigation should be done to find renal anomalies to exclude Herlyn-Werner-Wunderlich (HWW) syndrome. Surgical correction (metroplasty) is not usually indicated and there is very limited evidence regarding metroplasty. Excision of longitudinal vaginal septum is considered, if the woman has symptoms, such as dyspareunia or pain from hematometrocolpos due to obstruction. Also, some septa can be easily displaced to the side to facilitate vaginal birth and thick and inelastic septa increase the risks of labour dystocia and, which need excision.

EP/G – 21
LATE PRESENTATION OF MULLERIAN AGENESIS AS PRIMARY SUBFERTILITY: A CASE REPORT

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Introduction
Mullerian agenesis is a rare condition which is characterized by agenesis or underdevelopment of the uterus and vagina or both, with normal ovarian function and normal external genitalia. Vaginal canal may be shortened with blind vagina or appear as a dimple below the urethra. These women have normal secondary sexual characteristics and commonly present with primary amenorrhea.

Case Presentation
A 33-year-old woman presented to clinic with primary subfertility for one year. She had history of primary amenorrhea with cyclical abdominal pain. On examination, she has normal secondary sexual characteristics and external genitalia without vaginal opening. Ultrasound scan revealed as uterine didelphys with absence hematocolpos / hematometra and no other system abnormality. She underwent a diagnostic laparoscopy which revealed rudimentary uterine horn with normal bilateral tubes and ovaries. There is no evidence of endometriosis. After diagnosis, multidisciplinary team (MDT) was involved in her management, including psychosocial counselling and fertility option. Vaginoplasty was performed to achieve her sexual life.

Discussion
Severity of mullerian agenesis is varying from one person to another. In most cases, uterus and/or vagina is not developed; in rare cases have underdeveloped or rudimentary uterus with atresia of the upper vagi-

na. In 90% of cases with mullerian agenesis are found to have rudimentary mullerian structures. During imaging, these structures are difficult to interpret. In this case, she had rudimentary uterus with vaginal agenesis. MDT should involve for management. Due to absence or underdeveloped uterus, these women are unable to conceive. Therefore, options are adoption and gestational surrogacy. There are surgical and nonsurgical option for creating neovagina to have sexual life. Nonsurgical option is vaginal elongation by dilation. Following surgery, patient needs regular manual cervical dilatation or regular sexual intercourse to maintain adequate vaginal length. Psychological support and counselling also have an important role.

Conclusion
Once mullerian agenesis is diagnosed, women should be investigated to exclude other system malformation, especially for renal agenesis.

EP/G – 22
YOUNG WOMAN WITH PERITONEAL TB PRESENTING AS ADVANCED OVARIAN CANCER – A DIAGNOSTIC CHALLENGE

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Introduction
Peritoneal Tuberculosis (TB) is one of the extra pulmonary manifestations of Pulmonary TB complicating 1 - 3% of total TB cases. This is the sixth commonest site of extra pulmonary manifestation. The incidence is higher in developing countries. Although pulmonary TB can be diagnosed by its signs and symptoms as well as laboratory and imaging assessments, peritoneal TB has common symptoms with advanced ovarian malignancy, including pelvic pain, mass lesions, ascites, and elevated serum CA 125 levels. Ambiguity in the differentiation between advanced ovarian cancer and peritoneal involvement of TB before surgery has been reported in literature. Therefore, pre-operative diagnosis between these two distinct pathologies continues to be a dilemma.

Case Presentation
29-year-old unmarried woman was referred from the National Hospital for Respiratory diseases who had been on treatment for Pulmonary TB. She was complaining of progressive abdominal distension with loss of appetite and loss of weight. She also had a pleural effusion, where a thoracocentesis was performed in the chest unit confirming TB. CA 125 level was 185 IU/ml. CECT showed bilateral adnexal masses concerning of advanced ovarian malignancy with moderate ascites and bilateral pleural effusions. There were multiple small volume para-aortic lymph nodes with omental thickening. As the findings were controversial, we performed a diagnostic laparoscopy, which showed whitish miliary nodules over the surface of the peritoneum and ovaries suggestive of peritoneal TB. The Uterus and Ovaries were macroscopically normal. Histological studies of nodules concluded peritoneal TB without evidence of malignancy. She was treated and followed-up further for TB in the chest hospital.

Discussion
Peritoneal TB mimicking advanced ovarian cancer is a diagnostic challenge. Though our index patient with TB developed ascites with elevated CA 125 levels, the relatively slight elevation was controversial with the radiological imaging findings. In such situations clinicians should be suspicious of peritoneal involvement of TB. There is no laboratory investigation nor imaging test to differentiate between the above two pathologies. Therefore, cytological or histopathological verification of the underlying condition before proceeding to an aggressive therapy with complete debulking and adjuvant chemotherapy for advanced ovarian cancer would be essential and beneficial in fertility sparing approach for a young woman as in our case.

Conclusion
In a young patient who is wishing for fertility preservation, laparoscopy will provide benefits of direct visualization and histological confirmation of the underlying pathology, leading to a definitive diagnosis in a dilemma between peritoneal TB and advanced ovarian malignancy.

EP/G – 23
CASE REPORT ON RARE OCCURRENCE OF 45X0/46XY TURNER SYNDROME

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Introduction
Turner syndrome (TS) is the most common form of sex chromosome aneuploidy in females. The disease is due to complete or partial loss of one X chromosome and the incidence is approximately 1 in 2500 live-born females. A 45, X karyotype is observed in 1% to 2% of conceptuses, 10% of miscarriages and 1% of stillbirths. Mosaicism is defined as the presence of two or more cell lines in the same individual derived from a single stem line but with different chromosomal complements. Several mosaic patterns have been identified and 45, XO/46, XY mosaicism accounts for 10-12%.

Case Presentation
A 14-year-old girl, a diagnosed patient with hypothyroidism on thyroxine 75 µg, was presented with concerns about amenorrhoea and short stature. She is the eldest of her family and her younger sister attained menarche at 12 years of age. her school performance was poor with significantly reduced physical activities. There were no other complaints except constipation and poor appetite. On examination, her height was 138 cm (< 5th centile for her age) and BMI was 21.5 kg/m2. Her CVS and RS examinations were unremarkable and there was no thyroid enlargement. Breast buds were seen (Tanner stage ll) and a small amount of pubic hair was seen (Tanner stage ll). External genitalia (vulva) appeared normal, and the hymen was identified. There were no palpable inguinal masses.

Her FSH and LH levels were elevated (183.7 and 32.3 respectively), testosterone level was low (<7) and prolactin level was normal (10.32). following ultrasound examination ovaries and uterus were not seen and there was an oval shape structure (1.9 x 1.0 cm) in the right inguinal region. Karyotype report came as Turner syndrome with mosaicism (45, XO / 46, XY). She underwent laparoscopic surgery and there was no uterus, but only streaky ovaries seen as a thin band. A surgical referral was done for the removal of the inguinal mass, and she was started on oestrogen HRT.

Discussion
The presence of the Y chromosome in TS increases the risk of gonadoblastoma by 7 - 10%. Prophylactic gonadectomy at the time of diagnosis is highly recommended. Turner syndrome patients with any genotype should undergo standard testing and treatment for cardiovascular, renal, metabolic, endocrine, vision, hearing, and bone mineral density abnormalities. Future fertility is an important consideration for patients with Turner syndrome. Accurate and early diagnosis of 45, XO/46, XY mosaicism can allow for counselling about the reproductive potential and pursuing pregnancy with in vitro fertilization with a donor egg and gestational surrogacy.

Conclusion
TS have different cytogenetic and chromosomal subtypes including Y chromosome mosaicism. Y chromosome presence must be investigated in cases suspected clinically and confirmed genetically as TS. As there is a high risk of gonadoblastoma, gonadectomy should be offered and performed on these patients and proper hormonal therapy (Ex: - growth hormone and sex steroids) should be initiated.

EP/G – 24
A CASE REPORT: ENDOMETRIAL STROMAL TUMOURS

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Introduction
Endometrial stromal tumors (ESTs) are rare malignant mesenchymal tumors occurring primarily in the uterine corpus. The WHO in 2003 classified ESTs as endometrial stromal nodule (ESN), endometrial stromal sarcoma (ESS), and undifferentiated endometrial sarcoma. ESS accounts for 0.2% of all uterine malignancies. The annual incidence is 1–2 per million women. It is an indolent tumor.

Case Presentation
A 76-year-old, menopaused for 26 years, presented with bleeding for 1 month. Ultrasound scan showed an enlarged uterus and irregular polypoidal growth spanning the entire uterine cavity, involving the myometrium. On curettage, large, fleshy, tan-yellow polypoidal masses were removed. Histology revealed an EST (ESN or low-grade ESS). Following referral to specialized care she underwent TAH and BSO.

Discussion
ESS affects younger women (42 to 58 years). Only 10 to 25% of affected women are premenopausal, unlike the index case. Our patient had an unusual presentation of post- menopausal bleeding, whereas 90% of women present with abnormal uterine bleeding. Up to 50% have extra uterine spread at the time of the diagnosis. Although the main tumor mass is intramyometrial, most involve the endometrium and uterine curettage aids in preoperative diagnosis. Histologically ESS resembles endometrial stromal cells in the proliferative stage, a distinction between ESN or ESS can typically be made only after hysterectomy. Immunohistochemistry: CD10 expression, positive estrogen and progesterone receptors confers good prognosis. Thus, HRT is contraindicated postoperatively For early disease complete cure is possible with a better prognosis than leiomyosarcomas. Yet, in most cases the diagnosis is confirmed only after hysterectomy.

EP/G – 25
A CASE REPORT ON BLADDER & BOWEL INCONTINENCE FOLLOWING TWO CAESAREAN SECTIONS

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Introduction
Several nerves are severed during caesarean section, and it may take up to six months for the damaged tissues to heal. For months after delivery, some women still feel numbness, tingling, & pains around their scar along with altered bowel and bladder functions. Here, we present a case of altered bladder bowel functions after two caesarean sections.

Case Presentation
A 33-year-old lady of two children presented with the altered bladder and bowel functions for six months. She delivered her first child at the age of 29 years by an uncomplicated caesarean section. Following that she experienced extreme itchiness, altered sensation & numbness over the supra-pubic region. Symptoms were gradually reduced over time. At the age of 32, she delivered her second child by uncomplicated elec-

tive repeat caesarean section. Following the second caesarean section, she complained an altered sensation of the supra-pubic region and altered bladder functions including post-coital dysuria & incontinence, urgency, urge incontinence. Also had bowel symptoms such as on & off cramping severe lower abdominal pain, which relieved soon by the opening of the bowel, remarkably an urgency to bowel opening.
She is having regular periods without AUB, dysmenorrhea or dyspareunia. During either caesarean section, pelvic organs were found to be normal. Medically she was diagnosed with migraine, which is usually exacerbated during the periods.

Discussion
Altered neurology is common following abdominal surgery due to trauma to nerves, burns, drugs (narcotic analgesics, corticosteroids, and Syntocinon etc.), and spinal anesthesia. Ilioinguinal and iliohypogastric nerve injuries are the most common nerve injuries with the incident rate is around 4%. 7% complained of moderate to severe pain. Transaction of the nerves, nerve entrapment may be the causes for this. Urinary incontinence is higher among women who have had c-sections than nulliparous women due to damage to pelvic muscles, tissues or nerves. Scar tissue is formed during the healing process which can penetrate into bladder and bowel causing adhesions may result in bladder bowel dysfunction. Postpartum period shrinkage of organs may facilitate this. Prevalence of anal incontinence is 4.3%. Bowel continence is dependent on factors such as bowel disease, bowel habits, the integrity of the pelvic floor / anal sphincter muscles & psychological factors. However, bowel incontinence resulting from damage sacral plexus is unlikely by caesarean section. The majority, over 90%, of women regain control of their bowels within six months.

EP/G – 26
MIGRATION OF INTRAUTERINE CONTRACEPTIVE DEVICE INTO BLADDER WITH STONE FORMATION

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Introduction
Intrauterine contraceptive devices (IUCD) are widely used reversible contraceptive method and are cost-effective and have low complication rates. Perforation of the uterus and intravesical migration is extremely rare. Once the IUCD has penetrated the bladder, it usually becomes encrusted with calculi and associated with lower urinary tract symptoms. In this report, we present a case in which the IUCD perforated the uterus and migrated to the bladder, which was encrusted with calculi at the time of diagnosis, and the patient presented with lower abdominal pain and on and off urinary symptoms for 1 year duration.

Case Presentation
A 48-year-old female gravid 6, para 5 admitted to the gynecology ward BH Wathupitiwala with 1 year history of pain in Right side lower abdomen with on and off urgency like symptoms. She had recurrent admissions to surgical units which was treated with analgesics. She had undergone ultrasonography to rule out any uterine pathologies which revealed dense acoustic shadows in the urinary bladder suggestive of an IUCD inside the bladder. Uterus and ovaries were unremarkable. Further X-ray pelvis was done, which revealed an IUCD in the anterior pelvic region with well demarcated radio opacity along the margins, thereby suggesting an intravesical IUCD. Her gynecological history revealed insertion of a copper IUCD 25 years back, but was not removed, and during that time she had 3 Normal Vaginal deliveries which were uneventful. Open vesicolithotomy was done and bladder stone + IUCD was removed. Postoperative period was uneventful.

Conclusion
Pregnancy following IUCD insertion should cause high suspicion in the clinicians' mind of uterine perfo-

ration or possible transmigration. Investigations such as Pelvic X-ray or Ultrasound scan by a trained personal is adequate for the diagnosis of intravesical migration of an IUCD. Removal of the IUCD depends on the organs involved.

EP/G - 27
CARCINOMA OF THE CERVIX AND FALLOPIAN TUBE – AN UNUSUALPRESENTATION

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Introduction
Cervical carcinomas often present with abnormal uterine bleeding or postmenopausalbleeding or vaginal discharge. We present a patient who presented with a more unusualpresentation.

Case Presentation

70-year-old multiparous patient presented with a dull abdominal pain for 6 months duration.Examination revealed a 32-week sized intra-abdominal cystic lesion arising from the pelvis.Vaginal examination revealed a normal postmenopausal cervix. She did not havepostmenopausal bleeding or discharge and had never undergone a cervical smear.Ultrasound scan revealed a 32 weeks sized cystic structure with no solid areas and septae andno free fluids in the peritoneal cavity. Origin of the lesion could not be determined. However,ovaries or uterus could not be identified separately. CA125 was 54 IU/ml.

Due to pain the patient underwent an urgent laparotomy. Findings were a fluid filled grosslyenlarged uterus of 32 weeks size. The cervix was hard and bulky. Bilateral tubes and ovarieswere normal.

The patient had a total hysterectomy, bilateral salpingo-oophorectomy and omentectomy withpelvic lymph node sampling.Histology reveled that the cervix had an infiltrating adenocarcinoma of endometroid type. The uterine body had no invasive malignancy, and the right fallopian tube showed a tubalintraepithelial carcinoma. There was no Lymphovascular involvement.

Discussion
Cervical cancers are often diagnosed when they are symptomatic if not detected asprecancerous lesions during cervical screening.This patient however, presented with dull abdominal pain without any vaginal bleeding ordischarge and had a normal looking cervix which is very unusual. She had a grossly enlargeduterus filled with serous fluid which caused her symptoms.

The occurrence of the uterine mass can be explained by the blockage of the cervical canal bythe malignant tumour and blockage of the right fallopian tube by the malignancy. Althoughthe left fallopian tube did not reveal any malignancy it can be assumed that it too was alsoblocked,thereby causing secretions from the malignant tumour to be collected in the uteruscausing it to grossly enlarge and cause symptoms.Due to urgency of patient's clinical situation further imaging, which may have predicted thepathology, was not possible.Patient made a good recovery following surgery and is beingfollowed up.

Conclusion
Non squamous types of cervical carcinomas can present in unusual ways. A clinician musthave due vigilance and awareness about such presentations to manage them appropriately.

ABSTRACTS OF SAFOG – YOUNG GYNAECOLOGIST AWARD

SAFOG YGA 01
THE PSYCHOLOGICAL IMPACT OF COVID 19 PANDEMIC AMONG PREGNANT WOMEN

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Introduction
Corona Virus Disease (COVID 19) is a highly infectious disease firstly identified in China which continued to spread all over the world quickly and emerged as a global pandemic. Pregnancy is an important and challenging phase physically as well as mentally for each woman. Hence, they are vulnerable people to have a psychological impact during this outbreak.

Objective
To assess the psychological impact of the COVID 19 pandemic and associated socio-demographic factors among pregnant women attending ante-natal clinics and delivering in University Unit - Teaching Hospital Jaffna.

Methodology
This was a hospital-based descriptive cross-sectional study that was conducted among 268 pregnant women attending the ante-natal clinic in Teaching Hospital Jaffna from July 2021 to June 2022. An interviewer-administered questionnaire was used as study instrument. SPSS statistical software was used to analyse the data, and the influencing factors were analysed by the Chi-Squared test.

Results
The socio-demographic data revealed that most participants were married and were 20-30 years of age, completed their G.C.E O/L and were unemployed. Nearly 77% of pregnant women had a psychological impact on ante-natal care. Also, 61.3% of pregnant women had a psychological impact on labour & intrapartum care and 46.1% of pregnant women had a psychological impact on post-natal care. Age and educational level had a statistically significant ($p<0.05$) association with psychological impact regarding antenatal care among participants, and educational level had a statistically significant ($p<0.05$) association with the psychological impact regarding labour & intrapartum care as well as regarding post-natal care among participants.

Conclusion
This study revealed that there was significant psychological impact on pregnant mothers due to COVID 19 and this impact affects their antenatal, labour, intrapartum and postpartum care. Hence knowing mothers who are at risk and providing psychological support at the right time is essential to increase the quality of the outcome of their pregnancy. Thus, the healthcare team and family members should be given appropriate health education. Furthermore, this psychological impact in pregnant women needs to be quantified and qualified to provide a better care.

SAFOG YGA 02
ANTILIPID DRUG: IS IT A NEW AMOUR TO TREAT SYMPTOMATIC ENDOMETRIOMA?

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Endometriosis is an estrogen-dependent, chronic, inflammatory disease in women of reproductive age. Endometriosis affects an estimated 10 to 15% of female population characterized by the growth of proliferation of endometrial glands and stroma outside the uterine cavity. It is responsible for various symptoms including chronic pelvic pain, dysmenorrhea, formation of endometrioma and subfertility. It has become a major public health problem associated with high monetary costs and a significantly decline in productivity. Dienogest is a fourth-generation progestin which promotes anti proliferative, immunologic and anti angiogenic effects on endometrial tissue. Due to its antiproliferative and antiangiogenic properties, dienogest received approval for the treatment of endometriosis in the European Union in 2009. Statins are potent inhibitors of cholesterol biosynthesis to reduce serum cholesterol in patients with hyperlipidemia. Statins act by inhibiting 3-hydroxyl 3-methyl glutaryl coenzyme A (HMG-CoA) reductase to block the conversion of HMGCoaA to L mevalonate , a rate limiting step in cholesterol synthesis. Mevalonate, a precursor of cholesterol and monocyte chemoattractant protein (MCP-1), which is an important peritoneal inflammatory factor and stimulates the process of endometrial adhesion and proliferation, as well as neovascularization. Considering the inevitable pros and cons of long term hormonal therapy like anovulation, prompt recurrence and expenses has driven the scientists to search newer drug which act on its molecular target.

There is an ongoing RCT in the department of REI, BSMMU to compare the effects of Dienogest and Dienogest plus Statin in patients with symptomatic endometrioma. Atorvastatin was chosen as the prototype drug from statin family and total patients of symptomatic endometrioma, diagnosed by ultrasound or laparoscopy, fulfilling the inclusion and exclusion criteria will be randomly assigned to receive either Dienogest or Dienogest plus atorvastatin by sequentially numbered sealed opaque envelops. The Dienogest plus Statin group will be receiving tablet Dienogest (2mg) and tablet Atorvastatin (40 mg) daily at evening for 3 months. The Dienogest group will be receiving tablet Dienogest (2 mg) once daily for 3 months. Size of endometrioma will be measured by ultrasound at the beginning and 3months later. Response for pain will be measured on a visual analog scale (VAS) of 0-10 scale, at the beginning of treatment and at interval of 1 months and 3 months. All the patients included in the study will perform S. lipid profile, SGPT, SGOT, CPK, S. Creatinine during the pre and post study period. A total number of 8 patients have already been monitored in this study till date with the expectation that- Change in the size of endometrioma and pain will be more in women receiving Dienogest plus statin (Atorvastatin) than those receiving Dienogest. Detailed result has yet to be confirmed after completion of the monitoring of the sample size. But the result I gained from these 8 women with symptomatic endometrioma (4 treated with Dienogest alone and rest with Dienogest + atorvastatin) among the 4 women of first group shows significant improvement in pain reduction, 2 had well decreased size of endometrioma, 1 had continuous spotting problem. In the second group 3 patients have decreased the size of their endometrioma, 1 has no change in their pain symptom and there was no complain of irregular spotting in this group. Due to time shortage, total sample size has not being monitored yet.

SAFOG YGA 03
VITAMIN D STATUS IN INFERTILE PCOS WOMEN OF RURAL AREA OF BANGLADESH

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PCOS is the most common endocrine disorder and vitamin D deficiency is common in the general population as well as PCOS women in many parts of the world. Vitamin D deficiency is associated with calcium dysregulation, which contributes to the development of follicular arrest in women with PCOS and results in menstrual and fertility dysfunction. This study aims at to detect the status of vitamin D in those infertile PCOS women of rural area of Bangladesh. A total of 101 infertile PCOS women and with an age matched control group of 101 women from Kishoreganj district of Bangladesh were included in this analysis. The mean age of study participants were 24.27±6.49 years, with the median BMI was 22 in cases and 20.5 in control group (15-32 kg/m2). Vitamin D status was found insufficient with the mean of 19.28±11.58 ng/ml among infertile PCOS women whereas the mean vitamin D status among control women was 27.45±5.75 ng/ml which was significantly higher. Vitamin D deficiency was more profound in 20-30 years of age group (48.6%) and was more (48.6%) in overweight PCOS women compared to control group. Earlier observational studies suggested a possible role of vitamin D in an inverse association between vitamin D status and metabolic disturbance in PCOS. We found an evidence from this case control study that there is an association between low vitamin D level and PCOS. Therefore, further research with high quality randomized controlled trials is warranted to establish the impact of vitamin D deficiency in PCOS and it's supplementation on the management of PCOS.

SAFOG YGA 04
TRENDS AND OUTCOMES OF A HYSTERECTOMY DONE FOR BENIGN INDICATIONS AT A NURSING HOME IN URBAN INDIA

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Background
Data on the outcomes of gynaecological procedures from the institutional setup is well published. However, information on gynaecological surgery done in nursing homes are few and far between.

Objectives
To document and analyse operative and postoperative data including morbidities in hysterectomies performed for benign indications at a nursing home in urban India.

Method
This was a retrospective study carried out over a period of 10 years. Medical records of patients who underwent a hysterectomy at this nursing home and with postoperative followup were taken,. The authors included patients who underwent vaginal, abdominal, and laparoscopic hysterectomies consequently from 2012 to 2022. Demographic data including patient's age, parity, previous history, imaging findings, indication for hysterectomy, operative time, intra and post-operative course, and post-surgical morbidity were documented from case records. Data was then compared using Microsoft excel.

Results
A total of 77 hysterectomies (28 vaginal, 35 abdominal and 14 laparoscopic) were included in this study. Patient demographics included mean parity, mean BMI and mean haemoglobin. Most hysterectomies were performed in the 40-50 year age group. The median follow-up was 2.5+/-2.9 years (2 months - 10 yrs). Uterine adenomyosis was the most common indication for hysterectomy followed by uterine fibroid. The average operative time for performing VH, AH and TLH was 46.7+/-12.8 minutes, 64.3+/-19.7 minutes and 94.4+/-28.4 minutes respectively. Postoperative hospital stay was less for TLH (3.5+/-0.5 days vs VH 4.5+/-0.5 days and AH 5.0+/-0.8 days). Postoperative morbidity was more in obese patients and the VH group. The second half of the study (2017-2022) had a higher number of TLH (11 vs. 1). No mortality was encountered.

Conclusions
All methods of conducting hysterectomy for benign pathology are safe and feasible in a nursing home setup.

SAFOG YGA 05
UNDERSTANDING THE PREVALENCE OF HPV AND ITS GENOTYPES AND THE CASE FOR TARGETED UNIVERSAL VACCINATION

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Introduction
Human papillomavirus (HPV) is the most common sexually transmitted, viral infection of the reproductive tract. In few women, HPV infection can persist and progress to cancer. Cervical cancer is one of the most preventable and treatable forms of cancer if detected early and prevented with HPV vaccination. Nearly all cases of cervical cancer (99%) are attributed to high-risk HPV infection. This knowledge has resulted in the development of HPV-DNA testing that detects high-risk strains of HPV and of prophylactic vaccines to prevent HPV infection

Aims and Objectives
We discuss the findings in the population screened for HPV to evaluate the prevalence of HPV and its genotypes in women in an urban setup.

Material & Methods
A retrospective analysis was conducted from July 2017 to August 2022. 2043 women aged 30- 55 years, not previously vaccinated were screened by obtaining cervical swabs. A polymerase chain reaction- based assay was done to detect HPV-DNA in normal cytology and the positive samples were then tested for the genotypes.

Results
HPV infection was found positive in 4.4%. High risk types were found in 85.9%, A rare sub group HPV 53 was found in 1.4%. A combination of High-risk HPV types was found in 8.45%.

Conclusion
Understanding the patterns of HPV infection may help plan appropriate strategies for prevention programs including screening, vaccination and public awareness. Its prolonged negative predictive value can allow extension of screening intervals.Mapping of HPV genotypes among the different population is essential in predicting the efficacy of current vaccines, devising new vaccine strategies and introduction of more affordable vaccines in less developed countries.

SAFOG YGA 06
FREQUENCY OF URINARY TRACT INFECTION IN PREGNANT PATIENTS ATTENDING ANTENATAL CLINIC OF A TERTIARY CARE HOSPITAL

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Introduction
Studies have shown that UTI is common in pregnancy. One recent has shown that 30% of UTI cases were noted in pregnant patients. During pregnancy UTI can occur when bacteria from a fecal source gains access to the bladder by ascending the relatively short female urethra.

Objectives
To determine frequency of urinary tract infection in pregnant patients attending antenatal clinic.

Study Design
Descriptive, Cross sectional study Settings Department of Gynecology and Obstetrics, Jinnah Postgraduate Medical Centre, Karachi. Study duration 12th October 2018 to 11thApril 2019

Materials & Methods
A total of 100 pregnant women of age 18 to 40 years were included. Patients with genital tract trauma, antibiotic therapy taken within two weeks, CKD and pyelonephritis were excluded. Urine sample was obtained from the study subjects using a wide mouth sterile container. All the urine samples were transported to the laboratory and were processed immediately. The plates were incubated in aerobic conditions at 37^{0}C for 24–48 hours and presence or absence of urinary tract infections was noted.

Results
Age range in this study was from 18 to 40 years with mean age of 28.79 ± 3.90 years. Majority of the patients 56 (56.0%) were between 18 to 30 years of age. Mean gestational age was 31.06 ± 1.66 weeks. Mean parity was 3.17 ± 0.99. Mean BMI was 27.61 ± 3.04 kg/m^2. In our study, frequency of urinary tract infection in pregnant women was found in 28 (28.0%) patients.

Conclusion
This study concluded that frequency of urinary tract infection in pregnant women is quite high.

SAFOG YGA 07

COENZYME Q10 SUPPLEMENTATION DURING PREGNANCY REDUCES THE RISK OF PRE-ECLAMPSIA – A SINGLE, CENTER OBSERVATIONAL STUDY

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Introduction
Coenzyme Q10 (Co-Q10) is an antioxidant naturally found in the body and plays an important role in metabolism and growth. Levels of coenzyme Q10 decrease with age and supplementation is necessary to make up for the deficiency. During pregnancies, supplementation with Co-Q10 has been seen to help improve blood pressures and prevent eclampsia in pregnant ladies.

Methods
It was a cross-sectional, descriptive study, conducted at Dept. of Gynaecology and Obstetrics, DHQ Hospital, Parachinar from Nov.2020-Nov.2021. Sampling technique was non-probability, purposeful sampling. Study was done after approval from ethical review board. Informed consent was taken. All patients were started on Neoenzyme Q10 supplementation, one tablet once a day dosage. SPSS Version 25.0 was used to analyze data.

Result
Study included 58 patients, out of which 33 were followed up till delivery. Mean age was 32.3±4 years. Mean gestational age was 18±6.6 weeks. Maternal past history included pregnancy induced hypertension in 37.9%, pre-eclampsia in 34.5%, eclampsia in 6.9% and essential hypertension in 36.2% cases. Mean blood pressure on first visit was 148.5±16.5/93.6±10.7 mmHg, while on follow up visit it was 140.3±19.5/88.7±12.6 mmHg. After supplementation with neo-enzyme Q10, there was a reduction seen in systolic and diastolic BP up to 8.2 mmHg and 4.9 mmHg respectively.

Conclusion
Supplementation with neo-enzyme Q10 during pregnancy helps in keeping maternal blood pressure controlled and favors physiological outcomes of pregnancy.

SAFOG YGA 08

KNOWLEDGE AND ATTITUDE ON MENOPAUSE AND HORMONE REPLACEMENT THERAPY (HRT) AMONG POST-MENOPAUSAL WOMEN PRESENTING TO TERTIARY CARE FACILITY IN SRI LANKA

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Introduction
Menopause is a major milestone in a woman's life where she experience harsh changes in her health due to ovarian failure, which results in various symptoms and signs. These menopausal symptoms can be fairly serious to affect the day-today activities with long term health implications in a post-menopausal woman which leads to poor quality of her life. Hormone replacement therapy (HRT) is a successful treatment option for menopausal symptoms which carries lots of health benefits along with lowering the risk of all-cause mortality in a post-menopausal woman.

Objectives
To assess the knowledge and attitude on menopause and hormone replacement therapy (HRT) among post-menopausal women.

Method
A descriptive cross-sectional study was conducted at Colombo south teaching hospital and Teaching hospital Peradeniya between February 2022 to June 2022. One hundred and sixteen post-menopausal women who came to outpatient gynaecology clinics were interviewed after taking verbal consent. Each woman was interviewed along with a structured questionnaire assessing the socio-demographic data, knowledge on menopause, HRT and their attitude towards it.

Results
The participated women were ranging between 43 to 71 years. The mean age at menopause was 50.6 years. The majority of women participated to the study belongs to low socio-economic class 58.6% (68). 18.1% (21) women did not receive any form of formal education and only 10.3% (12) of women received higher education. 72.4% (84) of women were not sexually active. 98.2% (114) women were aware about the menopause but only 42.2% (49) women were aware about menopausal symptoms. The most commonly perceived symptom was muscle and joint pain 65.5% (76). 11.2% (13) women thought that the menopause can adversely affect on their health. Only 28.4% (33) women were aware about the HRT treatment and majority 66.3% (77) considered menopause as an event which did not require treatments. Among all the participants only 3.4% (4) were on HRT.

Conclusion
Greater number of women did not have adequate knowledge on menopause and HRT. Majority thought that the menopausal symptoms were not to be treated and were unaware about the HRT treatment option. Their knowledge and attitude on menopause and HRT were influenced by cultural background, educational level and other factors.

PROF. SIR SABARATNAM ARULKUMARAN YOUNG GYNECOLOGIST AWARD SLCOG - 2022

SLCOG YGA 01

CARDIOTOCOGRAPHY EDUCATION IN A LOW RESOURCE SETTING: DEVELOPMENT AND PILOT TESTING OF A FREE WEB-BASED TRAINING COURSE IN SRI LANKA

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Introduction and Objectives
Accurate interpretation and action based on cardiotocography (CTG) requires knowledge of various CTG patterns, ability to consider many different parameters, critical thinking, decision making skills to, and ability to communicate appropriately with team members. Inability to accurately identify, classify and respond may lead to unnecessary interventions or management delays. Many countries conduct tailor made training programs to educate caregivers on CTG interpretation. The Sri Lankan health system would benefit from a customized continuing medical education program on this key area. We aimed to develop and pilot test a free web based CTG training course in Sri Lanka.

Methods
A mixed method study in four phases was conducted at the De Soysa Hospital for Women, Colombo. This included: retrospective audit of clinical records of women who had fetal distress; literature review and development of program contents; peer review and optimizing the contents to finalize the curriculum; pilot testing among a variety of end users.

Results
A total of 69 patient records were scrutinized. Major lapses in management identified included poor documentation (n=65, 94.20%), unnecessary intervention for non-pathological CTGs (n=47, 68.12%), inaccurate interpretation (n=45, 65.22%), missing physiological approach of interpreting CTG (n=38, 55.07%) and not considering the clinical picture (n=36, 52.17%). The training program was developed and reviewed based on this needs analysis. Fifty-three participants completed the pilot program, including 17 (32.08%) medical officers, eleven (20.75%) intern medical officers, nine (16.98%) medical students., eight (15.09%) nursing officers, two (3.77%) registrars and a senior registrar (1.89%). Average score of the pre-test was 26.53 out of 100, whereas the average score of the post-test was 67.08 out of 100, showing an average improvement of 40.55 marks (152.84%) out of 100 marks. An additional 60 participants enrolled but did not complete course reported lack of motivation (n=42,70%); time constraints (n=12,20%); lack of proper device or adequate internet facility (n=4,6.6%). Two (3.33%) did not reveal a reason. Overall, participant feedback regarding the course was overwhelmingly positive.

Conclusions
A web based self-learning course is an effective means of improving knowledge on CTG interpretation among caregivers working in maternity services in Sri Lanka. However, implementation and sustaining this type of initiatives has many challenges in this setting. The Ministry of Health is encouraged to make continuing medical education a mandatory requirement and create a learning environment for caregivers which motivates them to continually enhance and update their knowledge.

SLCOG YGA 02

OPERATIVE HYSTEROSCOPY EXPERIENCE AT NATIONAL HOSPITAL KANDY, SRI LANKA; A RETROSPECTIVE STUDY.

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[2]Department of Histopathology, National Hospital, Kandy, Sri Lanka.

Introduction and Objectives

The study was designed to investigate patients' demographics, indications, mode of anaesthesia, operative time, hospital stay, outcomes and complications of operative hysteroscopic procedures performed by gynaecology team of ward 5, National hospital, Kandy, Sri Lanka with emphasis on the need to improve training and facilities.

Method

This was a retrospective descriptive study of hysteroscopic procedures performed from 01st January 2021 to 20th November 2021 . Data was collected from hospital records. Outcomes were evaluated prospectively from questioning and clinical evaluation at subsequent visits.

Results

Mean age of patients was 42.2 ± 7.25 (25-57) and mean parity, 1.7333 ± 1.095 (0.0-5.0") with six being nulliparous (13.3%).Patients with parity ≤2 was28 (62.21%) and parity ≥3 was 11 (24.44%). From total of 45 cases, 14 were diagnostic (31.1%), and 29 (64.4%) therapeutic. Two were abandoned (4.44%), 1 for failed entry (2.22%), 1 for false track formation (2.22%).Indications were abnormal uterine bleeding (AUB) 31, Postmenopausal bleeding 05, subfertility with or without AUB 05 , incidental finding of endometrial pathologies 02 , vaginal discharge 02 .General anesthesia was given to 19 (42.22%) and spinal anesthesia to 26 (57.78%). Nobody had significant discomfort or pain during procedure. Commonest procedure was resection of endometrial polyps in 22 patients (51.16%). Trans-cervical resection of endometrium was performed in seven with generalized thickened endometria (16.28%). Two patients had FIGO type 2 fibroids of 3 cm & 2 cm diameters and one-step resections were performed successfully (4.65%). No hysteroscopic abnormalities detected in 7 (16.28%) for whom only endometrial biopsies were offered.

Mean table time for diagnostic procedures was 39.64 minutes (SD = 11.0) and for resection procedures 55.5 minutes (SD = 14.59). None proceeded beyond 80 minutes. All patients were discharged following 24 hours of post-operative hospital stay except for one, who had post fibroid resection febrile morbidity. None received post-procedure blood transfusions or additional interventions. All 11 patients adhered to follow up over three months showed significant improvement from AUB. Three had atypical endometrial hyperplasia (6.98%) and underwent hysterectomy later. Two (40%) conceived with intrauterine insemination following removal of focal lesions. One was diagnosed with a malignant focus in the polyp and underwent hysterectomy.

Conclusion

Keeping records and analyzing statistics of an institution, particular to a newly implemented procedure, will improve the facility itself by providing measurable data on auditable aspects such as complications, cost, technical issues and patient satisfaction and enabling us to implement changes for improvement. Statistics on patient outcomes will provide feedback on the usefulness and success of the said changes.

SLCOG YGA 03

A RETROSPECTIVE ANALYSIS OF HYSTEROSCOPIC EVALUATION WITH REGARDS TO FINDINGS AND HISTOLOGYAT A TERTIARY CARE HOSPITAL IN SRILANKA

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Introduction

Hysteroscopy is a minimally invasive procedure, which plays an important role in gynaecology. It can be used in either diagnostic or operative purposes. If any uterine abnormality is detected during diagnostic hysteroscopy, operative hysteroscopy can be performed at the same time. According to current data, hysteroscopy reduces the hysterectomy in case of abnormal uterine bleeding. However, availability and accessibility to hysteroscopy is limited in our setting.

Objectives

To review the experience and outcome of hysteroscopy procedure at De Soysa Maternity Hospital, Colombo, in terms of indications, operative and histology findings and complications.

Methods

A retrospective study was carried out at a gynaecology ward of the De Soysa Maternity Hospital- Colombo. Data of 110 patients who underwent hysteroscopy during October 2019 to February 2020 were collected from patients' record and operative notes and were analyzed.

Results

The age of the patients ranged from 33 to 85 years. The most common indication for the procedure was abnormal uterine bleeding 61.81% (68/110). Others were postmenopausal bleeding 14.54% (16/110), subfertility 9.09% (10/110) respectively. The major findings during hysteroscopy were, 50 (45.45%) women had normal uterine cavity, 38 (34.54%) had endometrial polyps, 16 (14.54%) had irregular polypoidal endometrium and 6 (5.45%) has sub mucosal fibroids. No major complication related to the procedure was reported. Histology revealed, 42 (38.18%) women having normal endometrium, 36 (32.72%) having endometrial polyp, 20 (18.18%) having endometrial hyperplasia (simple-17, complex-3), 6 (5.45%) having sub mucosal fibroid and 3 (2.72%) having endometrial cancer.

Conclusion

According to the data analyzed at our unit, hysteroscopy is a safe and effective procedure in management of endometrial pathology. Hysteroscopy is mostly indicated due to abnormal uterine bleeding. A normal endometrium and endometrial polyps are found in most of the cases respectively. Both diagnostic and operative hysteroscopy reduces the hysterectomy rate for benign endometrialconditions. Therefore, availability and utilization of hysteroscopy procedure should be increased in our setting.

SLCOG YGA 04

POSTOPERATIVE CARE IN GYNECOLOGIC ONCOLOGY SURGERY: ENHANCED RECOVERY AFTER SURGERY ERAS PROTOCOL- AN AUDIT

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Introduction
An enhanced recovery is an approach to major elective surgery aimed at minimizing perioperative stress for the patient. 2019 updated "Post-operative Enhanced recovery after surgery ERAS protocol" published by "Enhanced recovery after surgery society" comprised of 9 items aiming reduced hospital stay and perioperative morbidity. Thereby patient satisfaction has improved, and the cost has been reduced.Most of the gynaecological oncology procedures are often complicated and strict post-operative monitoring is maintained. This audit is aimed to improve the quality of patient care following the major gynaecological oncological surgeries according to updated ERAS protocol.

Method
Randomly selected 56 major laparotomies were included. Data on the audit items were checked with bed head tickets and direct questioning from the patient.

Results
For prophylaxis against thromboembolism 47 (85.7%) patients were on thrombo-embolic deterrent stockings and low molecular weight heparin (LMWH) but only 4 (7.1%) patients were discharged with LMWH. Twelve patients (21.4%) were kept nil by oral in the first 24 hours and 44 (78.6%) received balanced crystalloids. Laxatives and gastric prokinetic agents (Domperidone suppositories)were given to 40 (71.4%)and 32 (57.1%) patients respectively for the prevention of postoperative ileus. Postoperative glucose control was maintained below 180 mg/dl in 51 (91%) but no patients were given insulin infusions. Paracetamol (n=52,92.9%), NSAIDs (n=44,78.6%) were used commonly for postoperative analgesia however, there is lower use of truncal nerve (TAP) blocks (n=24,42.9%), fentanyl (n=1,1.5%) and epidural (n=0) within first 48 hours. Opioid use (S/C morphine)is 85.7% . No peritoneal drains were inserted in 47 (85.7%) patients and urinary catheters were removed in 40 (71.4%) patients within 24 hours. Fifty-two patients (92.9%) were mobilized early, and 44 (78.6%) patients were discharged by postoperative day 2.

Conclusions
Currently, the gynaecological oncology unit follows standard post-operative care, and they are individualized accordingly. The current practice of post-operative care was satisfactory overall. However, there are lower rates of intravenous fluid termination, regular diet commencement and higher rates of opioid analgesic use. Glycemic control has been achieved with oral hypoglycemic agents rather than insulin infusions. Data were presented in ward meetings and possible solutions were discussed with the surgical team and ward nursing staff. Arrangements were made to overcome issues during this prevailing drug shortage. A re-evaluation is planned to carry out in 3 months.

SLCOG YGA 05
IS TOT-V A SAFE PROCEDURE IN LOW RESOURCED COUNTRIES? SHARING THE EXPERIENCE IN TRANSOBTURATOR TAPE PROCEDURE (TOT-V) IN STRESS URINARY INCONTINENCE.

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Background
Stress urinary incontinence is a common urogynaecological problem encountered by both premenopausal and postmenopausal women. Burch colposuspension is considered to be the gold standard in management of moderate to severe stress urinary incontinence. Tension free tape procedures are also considered to be an effective method, however complication reported in recent past resulted in its limited use and not recommended in some countries. Tape procedures are still used in low-income countries since it is a low-cost and a simple procedure.

Objective
To evaluate the outcome and patient's satisfaction of TOT-V in regard of stress urinary incontinence.

Method
Patients were assessed preoperatively, before discharge, six-month one year and two years postoperatively. Interviewer administered questionnaire (including Patient Global Impression of Improvement (PGI-I) scale) was used to collect data from the patients who consented for the study. 21 patients participated for the study.

Results
Majority of the patients (76.2%, n=16) were postmenopausal, while 23.8% (n=5) were premenopausal. Most the patients had successful surgical procedure before discharge. 66.7% (n=14) of them had very much better outcome, whereas 23.8% (n=5) of them had much better outcome. Only 9.5% (n=2) had little better outcome. However, 2 (9.5%) patients complained no change in outcome before discharge. One patient had urinary retention following the procedure, however it was settled with conservative management within one week. Groin pain (17%), bleeding from the surgical site (4.7%) were the common acute complications following the procedure, however there were no infections reported. One year and two years follow up showed high patient satisfaction. Regarding long term complications, 2 (9.5%) patients had recurrence of urinary incontinence. During 2 years follow up, there were no reported mesh erosions.

Conclusion
TOT-V is a very effective method in the management of stress urinary incontinence specially at low resource settings. However, it is associated with common acute complications like groin pain and bleeding from surgical site. Long term complications included recurrence of urinary incontinence and tape erosions; however, it was low. The study will be continued to assess the long-term complications at the interval of 5 years.

Keywords- Transobturator tension free tape procedure (TOT-V), Patient Global Impression of Improvement (PGI-I)

ABSTRACTS OF PLENARIES

1. MOLECULAR BASIS OF DIABETES

Prof. Pradeep De Silva
Clinical Professor in Obstetrics and Gynaecology, Colombo North Teaching Hospital, Sri Lanka

How many clinicians are baffled by the unpredictable unexpected outcomes of Diabetes with its glycaemic control and clinical endpoints? An understanding of the molecular basis of diabetes will help to realize, why these situations are challenging the clinicians treating Diabetics.

It is true that obstetricians are dealing with 284 days of a life of a pregnant woman about pregnancy, but Obstetrics is a general field, and the care delivery system is not patient-friendly in poor countries where multidisciplinary teams are needed for care in contrast to socially developed countries in preparing a patient for pregnancy, looking after several years of potential pregnancies. Further preparing gynaecology patients for necessary procedures and looking after holistic care of Polycystic ovarian disease-associated glycaemic derangements make obstetricians and Gynaecologists thorough with the molecular basis of diabetes.

2. WHAT HAVE WE LEARNED FROM THE COVID-19 PANDEMIC AND WHAT SHOULD WE DO NEXT?"

Prof. Kazunori Ochiai
Immediate Past President AOFOG and Executive Adviser, Shin-Yurigaoka General Hospital, Japan

Briefly, the biggest task of my term as AOFOG President, i.e., 2020-2022, was the "fight against COVID-19." Our activities during this period were quite different from those we have done since the founding of AOFOG. AOFOG was founded in Tokyo in 1957 and has conducted 26 conferences through 2019. Under these circumstances, the first thing that welcomed us who starting to row in the rough seas of COVID-19 was the issue of the AOFOG congress, which is usually held every two years.

The momentum of the COVID-19 pandemic at that time was tremendous, and we had to decide to postpone the AOFOG congress 2021 originally scheduled for March 2021 to May 2022. Initially, some said the 14-month postponement was too long, but it ended up necessary and sufficient for global control of this infection.

What have we learned from the COVID-19 pandemic? Here is a list of what I learned.
1. Pandemic is a global issue.
2. Know the enemy you are fighting.
3. Weaknesses appear in the crisis.
4. The blockage of communication forms an isolated society.
5. Trust is one of the most delicate but critical requirements.
6. Obtain an effective weapon and use it correctly.
7. We are human, we have human instincts.
8. Remember basics.

I will discuss each of them and find our way for the new world with COVID.

3. "CESAREAN SECTION RATES IN SOUTH ASIA- A TRAGEDY; WHAT CAN SAFOG DO? by Dr. Rohana Haththotuwa– President SAFOG

Rising cesarian section rates is a tragedy around the globe. At the same time in few countries the rate is unacceptably low. In the SAFOG countries also facea rising cesarean section rate, particularly in the private sector when compared to the public sector and more in the urban areas than in the rural areas. Childbirth itself is a risk to the mother and baby irrespective of the route of delivery but the risk is increased by three-fold when delivered by CS as opposed to vaginal delivery.

WHO without promoting a specific rate recommends providing cesarean section to all those women in need. WHO proposes the Robson classification system as a global standard for assessing, monitoring and comparing caesarean section rates within and between health care facilities. Robson classification shows primary cesarean section as the route cause for the rising caesarean section rates. Labour arrest, non-re-assuring CTG, malpresentations, multiple gestation, & macrosomia are contributory factors for the rise in primary CSs.

Steps towards reducing primary CS includes, Revisiting the definition of labour dystocia, improved fetal heart rate interpretation & management, reconsidering induction of labour, increasing skills of certain procedures such as operative vaginal delivery, external cephalic version, twin delivery and increasing access to non-medical intervention.

It was observed that despite the partograph been widely accepted and used globally for more than five decades, the use of the partograph has not successfully improved birth outcomes in many settings due to several factors such as its incorrect or inconsistent use, time constraints, shortage of skilled workforce and lack of knowledge of the partograph. Further there is increasing evidence that the pattern of spontaneous labour progression may differ considerably from Friedman's reports (the 1 cm/hour rule). Based on the above WHO embarked on the BOLD (Better Outcomes in Labour Difficulty) project. As a part of this project, the patterns of labour progression in a prospective cohort of women in Nigeria and Uganda who gave birth vaginally without adverse birth outcomes following a spontaneous labour onset were examined. The findings concluded that the available averaged labour curves may not truly reflect the variability associated with labour progression, and their use for decision-making in labour management should be de-emphasized. Further studies showed that the active phase does not begin until the cervical dilation is 5cm.

WHO BOLD project revealed respectful care, better communication, labour companion, availability of essential physical resources and a proper information system as what women needed at childbirth in addition to medical care.Taking to account all these emerging evidence and recommendations, WHO has proposed the Labour care guide replacing the traditional partograph.

It is recommended further, to promote the presence of a birth companion. operative vaginal deliveries, twin deliveries when appropriate, better interpretation of CTGs, and improve the skills in breech deliveries in order to reduce unnecessary CSs.

In conclusion we should strive to dispel the image of our profession of solving all the problems by CSs and Regain our role as Obstetricians and maintain our obstetric competencies

4. "STRENGTHENING RESOLVE: LEADING A GLOBAL IMPACT ON REPRODUCTIVE FREEDOM"
- Dr. Jeanne Conry- FIGO President (Virtual)

5. "WOMEN'S RIGHTS TO SAFE AND AFFORDABLE HEALTH CARE"

-Prof. Sir Sabaratnam Arulkumaran- Professor Emeritus of O&G, St George's University of London, Past President of the FIGO, UK

The human right to health was proclaimed in the international human rights treaty. The Economic, Social and Cultural Rights Covenant (Article 12) recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (United Nations, 1996). This right to health needs some clarification. It is not to be understood as a right only to be healthy. The United Nations Committee clarified that, the right to health contains both freedoms and entitlements (United Nations, 2000). The freedoms include the right to control one's health and body. The entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health. As far as women are concerned, in many parts of our world, many women are still denied their right to Sexual & Reproductive health. They neither have the freedom to control their health and body, nor the entitlement to a system of health protection which provides equality of opportunity for them. We will consider why women's rights to safe health care need to be considered as a special entity and how we could make women's health care affordable. Requirements for sexual and reproductive health for women are different from that of men's health. Male dominance denies woman's rights to live, survive & thrive. Globally there is lack of opportunity for Education & Empowerment for women. Domestic & sexual violence still prevail. There are different issues in life & health of women that are not of major concern to men e.g., Female Genital Mutilation, menstruation, Family planning/ contraception, safe miscarriage/ abortion care, prevention and managing STIs, maternity care, breast feeding, child-care, menopause and prevention, early detection & treatment of Cancer of Cervix.

Women's life & Sexual and Reproductive Rights have been denied for centuries. Some have changed & some remain static. Sati – wife being pushed into funeral pyre was stopped. But Sex selective abortion, Female genital mutilation, Honor Killing, Dowry related deaths and Domestic/ sexual violence still prevail. Our profession should make sure their S&R rights to contraception, safe abortion, to avoid STI, safe motherhood and prevention and treatment of cervical cancer should be given priority. On the long run 'RIGHTS TO EDUCATION, NUTRITION & HEALTH CARE' and empowering the girl child and women will help to resolve most of these issues. We can make human rights-based women's health care affordable by including S&R health care available under Universal Health care i.e., by including these within Primary care & Self Care especially in LMICs. In HICs where health care costs are expensive, using modern technology should make it affordable and this can be achieved by embracing the three "D" s of Data, Digital & Devices. Universal health coverage must make sure all people have access to health services they need when and where they need them with no financial hardships. This should include the full range of essential health services; should promote healthy living; prevent from getting ill and offer treatment, rehabilitation & palliative care. Achieving UHC primarily depends on people-centered primary health care underscored by policies, organizational competencies, delivery innovations and appropriate finances. Fundamentally health care delivery requires adequate and competent health workers to provide Universal health care in LMICs and high technology-based care in HICs.

The continual high-quality care can be achieved by good governance & leadership, adequate health work force, medicines & technologies, information, efficient service delivery and proper financing.

ABSTRACTS OF SYMPOSIA

Day 01

SYMPOSIUM 1 - FOGSI Session

"Place of vaginal surgery in the era of laparoscopy" - *Dr. Kawita Bapat - Director, Bapat Hospital, Indore.*

"Liver disorders in Pregnancy"- *Dr. Bipin Pandit* - Practicing Obstetrician & Gynaecologist and Director of Mukund Hospital

"ART of communications of adverse outcomes in Obstetric practice" - *Dr.Madhuri Patel – Consultant Obstetrician and Gynaecologist, India*

SYMPOSIUM 2 - O & G Society of Malaysia–ICOG

Virtual Training of Trainers for SAFOG: The background and lessons learnt? *–Dr. Thaneemalai Jeganathan - Past President of Obstetrical and Gynaecological Society of Malaysia*

Analysis of Virtual Training of Trainers *–Dr. Yong Soon Leong – Consultant Obstetrician and Gynaecologist, Malaysia*

Dr. Zaridah Binti Shaffie - Obstetrician & Gynaecologist based at Hospital Sultanah Bahiyah in Alor Setar, Kedah.

SYMPOSIUM 3 - UNICEF Session - "Think Nutrition First"

Preparing adolescents for wellness; think nutrition first –Prof. Rowshan Ara Begum - Former Head of the Dept. Obs. & Gynae, Holy Family Red Crescent Medical College & Hospital

Managing GDM with Medical nutrition therapy *–Dr. Hema Divakar- Consultant Obstetrician and Gynaecologist and Medical DirectorDivakars Speciality Hospital, Bengaluru*

Post-delivery advice on Nutrition; new mom new baby *–Dr. Farhana Deewan- President Elect, OGSB*

Bangladesh has significantly reduced maternal mortality over the previous few decades and has attained MDG 5. The momentum created by this widely acknowledged advancement offers a chance to speed up these accomplishments. Between 2001 and 2010, Bangladesh made tremendous strides toward lowering the maternal mortality ratio (MMR), which fell from 322 to 194 per 100,000 live births. However, in 2015 and 2022, the MMR became 176 and 163 per 100,000 live births, respectively. Most maternal deaths are due to Haemorrhage (31%) and Eclampsia (24%), followed by obstructed or prolonged labour 3% (BMMS 2016).

Methodology: Two audits were held, first during the intervention pilot and second after the intervention was implemented. Mixed methods design including participant observation, in-depth interviews

and secondary data review was adopted. Measurable structure and process indicators, means of verification and performance thresholds were defined for all activities related to implementation of the study. A feedback system was built into the audit and recommendations were provided to study sites after the first audit, which were evaluated during the second audit.

Results: It was found that quality audit resulted in the following: (i) improved implementation of the study and uptake of care bundle components by study subjects, e.g., constant presence of birth companion during all stages of labour and early initiation of breastfeeding; (ii) improved data validity by innovative data capturing mechanisms and data completeness by the study team; (iii) improved hospital practices with respect to labour management and immediate newborn care.

Conclusion: External quality audit has the potential to improve intervention research outcomes by improving processes related to implementation of research activities.

SYMPOSIUM 4 - SAFOG Maternal & Perinatal Health Committee - Saving Mothers & Babies - Learning From Large Multicenter Studies

E MOTIVE STUDY- Designing and Implementing a large Multicenter study - *Prof. Lumaan Sheikh (Virtual)*

The WOMAN 1 Study - *Prof. Ian Roberts (Virtual)*

External Quality Audit in PREVENT study - *Dr. Rupsa Banerjee*

Improving research outcomes by external quality audits – learnings from PREVENT study

Authors: Rupsa Banerjee, Sutapa Bandyopadhyay Neogi, Anuj Kumar Pandey, Sudhin Thayyil
Presenter: Dr Rupsa Banerjee, Assistant Professor, International Institute of Health Management Research, New Delhi, India

Background: The PREVENT study is a multicentric interrupted time series study which examines whether epilepsy caused by birth related brain injury in neonates can be prevented using a pragmatic care bundle to improve intra-partum care in Indian public sector hospitals. External quality audit of the study was undertaken to assess the extent to which activities under the study are operational as per protocol, identify problems with respect to resources, processes and implementation, prescribe corrective measures and ensure their adoption.

Methodology: Two audits were held, first during the intervention pilot and second after the intervention was implemented. Mixed methods design including participant observation, in-depth interviews and secondary data review was adopted. Measurable structure and process indicators, means of verification and performance thresholds were defined for all activities related to implementation of the study. A feedback system was built into the audit and recommendations were provided to study sites after the first audit, which were evaluated during the second audit.

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Conclusion: External quality audit has the potential to improve intervention research outcomes by improving processes related to implementation of research activities.

Day 02

SYMPOSIUM 5 - UNFPA Session - "Intimate Partner Violence in Pregnancy"

Intimate partner Violence (IPV) : An Overview - *Dr Lakshmen Senanayake – Consultant Obstetrician and Gynaecologist, Sri Lanka*

IPV in pregnancy: Devastating consequences - D*r. Sarada Hemapriya - Consultant Obstetrician and Gynecologist,Sri Lanka.*

Intimate partner violence (IPV) during pregnancy is a serious public health issue with significant negative health consequences for women and children. The majority of research has found that between 3% and 9% of women experience abuse during pregnancy.

An in-depth qualitative study examining abuse patterns during pregnancy suggested that for approximately one-third of battered women, pregnancy was a protective period, while for another group (approximately 15% of those abused during pregnancy), abuse started or worsened during pregnancy. Research has shown women experiencing IPV are also twice as likely to not initiate prenatal care until the third trimester. Poor nutrition and inadequate gestational weight gain have also been associated with experiencing abuse during pregnancy.

IPV was associated with having an unplanned pregnancy or an induced abortion in the majority of studies reviewed. Finally, nearly 80% of those studies examining the association between IPV and sexually transmitted infections or urinary tract infections found an association.

Depression has been identified as the most common mental health consequence of IPV, with nearly 40% of abused women reporting depressive symptomatology. The gravest consequences of IPV during pregnancy include homicide and suicide. Several studies have indicated that maternal injury is a leading cause of maternal mortality. The effects of IPV extend to the consequent health of the neonate. A sizeable body of research supports the role of IPV in low birth weight and increased rates of preterm birth. Several mechanisms for how IPV may influence adverse maternal and neonatal outcomes have been proposed, including direct effects, mental health effects, behavioral effects, and biological effects, all of which offer health care providers opportunities to intervene.

Lessons learnt in addressing IPV: Experiences from India - *Dr. Shantha Kumari, President FOGSI*

Lessons learnt in addressing IPV: Experiences from Thailand - *Prof. Unnop Jaisamrarn - President, Thai Menopause Society*

Violence against women is an important problem globally, including in Thailand. The most common form of this violence is Intimate Partner Violence (IPV). In Thai society, IPV is less visible and unrecognized since this issue is perceived as a private and family matter. Most of the statistics on IPV in Thailand are likely to be underestimated.

It was found in a WHO study that in Thailand, 22.9 - 47.4% of women reported physical and/or sexual violence. A study on domestic violence among pregnant women in one province in Thailand showed that 53.7% , 26.6% and 19.2% reported psychological, physical and sexual violence by their partners, respectively. While in the postpartum period, 9.5 - 35.4% experienced some type of IPV.

A recent study in women aged 20-59 years in 4 regions of Thailand found that 15% had experienced some form of IPV and/or controlling behaviors by their male partners. Among these, psychological violence was the most common, followed by sexual violence and physical violence.

The "Domestic Violence Victim Protection Act" has been launched in Thailand in 2007, to address the problem of IPV. Ministry of Public Health has set up the "One Stop Crisis Center (OSCC)" in government hospitals to help victims of violent situations.

Lessons learnt in addressing IPV: Experiences from Sri Lanka - Dr.Nettanjali Mapitigama– Consultant Community Physician, FHB, Sri Lanka

SYMPOSIUM 6 -MANYATA; Panel Discussion

Panelists: Dr. Shanta Kumari, Dr. H.D. Pai, Dr. Jaideep Malhotra, Dr. Samita Bharadwaj, Dr. Suranjan Prasad, Dr. Rubina Sohail, Dr. Ferdousi Begum, Dr. Asma Rana, Srilanka Representative: Dr. Nishendra Karunaratne

SYMPOSIUM 7 - OGSB Session

OGSB in leadership: MMR reduction- *Prof. Ferdousi Begum- Professor at Ibrahim Medical College and BIRDEM Hospital, Dhaka, , Bangladesh.*

OGSB in combat: COVID-19 - *Prof. Gulshan Ara- Ex Professor & Head of the Department* Enam Medical Collegeand Secretary General-OGSB

Background:
OGSB from very beginning of its establishment in 1972 works hard to improve women's health. Response of OGSB in any disaster in Bangladesh is noteworthy. Corona virus disease (Covid-19) is an infectious disease caused by the SARS-COV-2 virus. Most of the people experience mild to moderate symptoms and recover without special symptoms. The disease spreads between people in several different ways. Basic precautions, guidelines and recommendations about vaccination can reduce the risk of getting Covid-19.

Bangladesh Scenario:
Virus was confirmed to have spread to Bangladesh in March 2020. First 3 new cases were reported on 8th March by the IEDCR. OGSB did several meetings with Director General of Health Service. 2 senior members of OGSB were included as members of National Technical Committee to combat COVID-19 pandemic. This committee advised, recommended & implemented different steps of government to combat pandemic. To protect the people, government declared lockdown from 23rd March to 30th May 2020. On 5th July Bangladesh reach 160,000 cases and 2000 deaths. Initially testing was not enough and was centralized at IEDCR in Capital Dhaka. Gradually testing capacity was increased to every district.

Infection prevention control program of OGSB
OGSB developed a comprehensive guideline "Covid-19 and Women's Health" covering the management of Covid-19 in pregnancy, contraception, sexual and reproductive health, infertility and oncology.

To create awareness program regularly by virtually Talk show with media partner.
IPC for front line fighter.

Training arranged at different hospitals including OGSB hospital.
Poster prepared for meticulous use of PP & mask and distributed.
OGSB declared solidarity with frontline fighters in different aspects.

OGSB visited 72 from June 2020 to till date public & private hospitals virtually in the title of IPC for frontline fighter to facilitate infection prevention and control program of Hospital according to guideline of WHO. Obstetric ICU bed was recommended every Medical College and District Hospital for better management of Obstetric patients. To update the better management of COVID-19 patients OGSB arranged CME, Scientific seminar with different topic virtually.

For better treatment of the people government expanded ICU beds and isolation beds at Dhaka and other parts of the country. Vaccination program was challenging due to disruption of supply initially. In June 2021 program was resumed using Sinopham BIBP, Pfizer Biontech and ModernaTelemedicine.
Our members advised treatment of the patients by telemedicine about 400000 patients.We are mourn & heads of to our 13 beloved frontline fighters who lost their lives during this pandemic period. DGHS, OGSB and National Immunization Technical Advisory Groups (NITAG) recommended vaccination of pregnant Women on as vaccine is safe in pregnancy and lactation. According to recommendation of OGSB Government of Bangladesh started vaccination program for pregnant mothers.

Controversies:
Controversies were about mass gathering fake COVID-19 certificate and Denial Medical treatment.

OGSB in advancement: Infertility - *Prof. Parveen Fatima- Professor & Chairman, Dept. of Gynaecology & Obstetrics, Bangabandhu Sheikh Mujib Medical University (BSMMU)*

OGSB in Quality Improvement: Monitoring & Mentoring - *Prof. Farahana Dewan -President Elect,OGSB*

Bangladesh has significantly reduced maternal mortality over the previous few decades and has attained MDG 5. The momentum created by this widely acknowledged advancement offers a chance to speed up these accomplishments. Between 2001 and 2010, Bangladesh made tremendous strides toward lowering the maternal mortality ratio (MMR), which fell from 322 to 194 per 100,000 live births. However, in 2015 and 2022, the MMR became 176 and 163 per 100,000 live births, respectively. Most maternal deaths are due to Haemorrhage (31%) and Eclampsia (24%), followed by obstructed or prolonged labour 3% (BMMS 2016).

Bangladesh has implemented newer MDG-aligned strategies and policies, established more national and international commitments, and gained fresh insight into the most effective maternal health interventions and policies. The RMNCAH Quality of Care framework has also been developed, and maternal health care standards have been accepted from the global WHO MNH Standards, which follow the WHO Quality of Care framework.

Initiatives have been undertaken in a District Kurigram to introduce MNH quality of care standards at the facility and community level with strong monitoring and mentoring through routine dedicated assessment. Quality Improvement of MNH services through 5S-CQI(PDCA)-TQM, accreditation of facilities through the Women Friendly Hospital Initiative (WFHI) by DGHS, OSGB and UNICEF. Standard-Based Management and Recognition (SBM-R), Maternal and Perinatal Death Surveillance and Response (MPDSR), and Joint Supervisory Visit (JSV) are some of the ongoing Quality Improvement (QI) initiatives for evidence generation and these QI MNH initiatives have been further scaled-up in Moulavibazar, Rangamati, Serajganj, Jamalpur and Patuakhali districts. Hence, OGSB is working hard to ensure Quality improvement in all sectors of Services.

OGSB in Empowerment: Women's Rights - *Prof. Rowshan Ara Begum* - *Professor of Gynaecology & Obstetrics, Bangladesh*

SYMPOSIUM 8 - AOFOG Session - "Evidence based SRH care"

Bringing evidence into SRH practice - *Professor Unnop Jaisamrarn–President, Thai Menopause Society, Thailand*

A number of new findings from research in all medical fields including sexual and reproductive health (SRH) have been published every day, which can contribute to better clinical practice. These research findings can benefit patients if health care providers incorporate them into practice. Factors affecting the adoption of new evidence-based practices include the nature of new knowledge, the capacity of each provider and the organizational factors.

Guidelines and systematic reviews provide the best source of evidence for health care interventions. However, due to a difference in environmental and cultural background, selecting a good and appropriate evidence to change the practice is important. Various approaches for bringing evidence into clinical practice include educational activities, professional interventions, financial interventions, organizational and regulatory interventions. These approaches need to be tailored to suit local circumstances. Although changing professional practice is complex and takes a long time to achieve, the outcome is rewarding, that is better patient care.

Contraception in women with medical conditions *–Prof. Krishnendu Gupta–Professor & Unit Head, Dept of Obstetrics & Gynaecology, Vivekananda Institute of Medical Sciences, Kolkata, West Bengal, INDIA*

Concerns regarding contraception choices is often brought up when women requesting for options have pre-existing medical diseases. It is imperative that when women of the reproductive age are offered birth control options, their past medical history and family history is carefully ascertained. Diseases like uncontrolled hypertension, venous thromboembolism and cancers can limit family planning options especially when considering the hormonal options.

Though in some cases there are risks of using hormonal contraception in women with medical diseases, the risks of an unintended pregnancy may sometimes be of more serious consequence. Therefore, it is prudent to balance the risk and benefits of contraception before offering to women with existing medical disease. Periodic evaluation is also necessary as the risk-benefit balance can alter with time. The WHO Medical Eligibility Criteria (MEC) has been the traditional tool for tailoring contraception methods and guiding health care providers in a variety of medical diseases. Besides medical disease, women with non-modifiable risk factors and lifestyle issues are also listed. Recently in 2019, the WHO MEC has been modified into an app which can be downloaded and kept as a ready reckoner on android smart phones and iPhones. This tool is the digital version of the MEC Wheel. It contains the medical eligibility criteria for starting use of contraceptive methods, based on Medical Eligibility Criteria for Contraceptive Use, 5th edition, 2015, one of WHO's evidence-based guidelines. The tool includes recommendations on initiating use of nine common types of contraceptive methods:

1. Combined pills (COC: low dose combined oral contraceptives, with ≤ 35µg ethinyl estradiol)
2. Combined contraceptive patch (P)
3. Combined contraceptive vaginal ring (CVR)
4. Combined injectable contraceptives (CIC)
5. Progestogen-only pills (POP)
6. Progestogen-only injectables: DMPA / NET-EN (depot medroxyprogesterone acetate intra muscular [IM] or subcutaneous [SC] or norethisterone enantate intramuscular [IM])
7. Progestogen-only implants (LNG / ETG: levonorgestrel / etonogestrel)
8. Levonorgestrel-releasing intrauterine device (LNG-IUD)
9. Copper-bearing intrauterine device (Cu-IUD).

The tool also provides a comprehensive list of medical conditions or characteristics for which all methods of contraception may be safely recommended to women provided there are no additional health concerns. Emergency contraception is also included as part of the "Additional information" section. A graphic representation of the effectiveness of different contraceptive methods is also provided.

Women with medical diseases seeking contraception may present a dilemma to the clinician. The risk of an unwanted pregnancy in the background of the disease needs to be weighed against the risk of contraception methods on the existing medical condition. The WHO MEC is an extremely useful document to facilitate the task of family planning providers in recommending safe, effective and acceptable contraception methods for women with medical conditions or medically-relevant characteristics.

Benefits beyond birth control of contraceptive methods *–Asst. Prof. Susan Logan (Virtual) –Senior Consultant, National University Hospital Systems (NUHS), Singapore*

Most contraceptive methods have benefits beyond contraception yet this aspect is often not discussed. When counselling concentrates on side effects and risks, users lack the information to take a more personised approach to contraceptive choice. The importance of careful personal medical, family and drug history-taking will be emphasised in order to individualise options. Gynaecological conditions such as endometriosis, adenomyosis, primary dysmenorrhoea, fibroids, endometrial polyps and endometrial hyperplasia can be effectively co managed. Non gynaecological benefits will also be highlighted. However, it is cancer reduction which has the greatest potential public health role. This includes risk reduction to both low risk women and those from genetic cancer families. In order to provide holistic care, contraception counselling should include non-contraceptive benefits, gynaecological and otherwise, in order to facilitate disease prevention in the reproductive years.

SYMPOSIUM 9FIGO Session

Welcome and Opening Remarks *– Dr. Jeanne Conry (virtual) – President FIGO*

Violence against women and its impact on women's health *–Dr. Shantha Kumari - President FOGSI, India*

Violence in conflict situations *–Prof. Rubina Sohail -Professor of Obstetrics & Gynaecology & Consultant, Hameed Latif Hospital, Lahore.*

One in three women suffer violence in their lifetime. Situations of conflict and instability exacerbate pre-existing patterns of discrimination against women and girls, exposing them to heightened risks of violence. This includes gender-based violence against women and girls, including arbitrary killings, torture, sexual violence and forced marriage. Women and girls are primarily and increasingly targeted as weapons of war. Gender-based violence also spikes in post-conflict societies, due to the general break down of the rule of law, the availability of small arms, the breakdown of social and family structures and the "normalization" of gender-based violence as an additional element of pre-existing discrimination. Trafficking is also exacerbated during and after conflict owing to the breakdown of political, economic and social structures, high levels of violence and increased militarism. The lack of delivery of essential services to the population experienced during conflict and situations of strife and instability can have a disproportionate impact on specific groups of the population, including women and girls—again, often building on pre-existing situations of discrimination.

Girls can face additional obstacles in accessing education. Access to essential services such as health care, including sexual and reproductive health services can be disrupted, with women and girls being

at a greater risk of unplanned pregnancy, maternal mortality and morbidity, severe sexual and reproductive injuries and contracting sexually transmitted infections, including as a result of conflict-related sexual violence.

The Red Line initiative *–Dr. Jeanne Conry – President FIGO*

Respectful care for all women *–Dr. Jaideep Malhotra - President, ASPIRE (Asia Pacific Initiative on Reproduction), India*

Improving the health and Quality of Life of Women *–Dr. Hema Divakar (virtual) - Consultant Obstetrician and Gynaecologist and Medical Director, Divakars Speciality Hospital, Bengaluru*

Day 03

SYMPOSIUM 10 - UNICEF Session -
"Can improvements in maternal nutrition lead to reductions in LBW in Sri Lanka?"

Trends in Low birthweight and programmatic approaches to LBW reduction – *Dr. Sanjeeva Godakandage - NPM Maternal Care, FHB, Sri Lanka*

Background:
Birth weight is the most important determinant of a newborn's chances of experiencing satisfactory growth and development. Birthweight less than 2500 g is defined as low birth weight (LBW). The immediate complications of low birth weight include neonatal asphyxia, foetal distress, respiratory distress and neonatal deaths. They can also have multiple problems later in the perinatal period, in childhood and even in adulthood.

Trends in low birth weight:
Low birth weight rate is considered a general indicator of health in a country. A steep decline of the LBW rate was observed in Sri Lanka during the last century but has been stagnant in the last two decades. The prevalence was 16.4% in 1999 and 15.8% in 2020. The inter-district variation of LBW prevalence, especially the high rates in districts belonging to the estate sector, is also a concern.

Programmatic Approaches:
Low birth weight is of multifactorial cause, emanating from both maternal and foetal and environmental problems. Ministry of Health, Sri Lanka formulated the National strategic plan on prevention of LBW in 2013. The major strategies therein revolved around improving maternal nutrition, whilst also addressing maternal morbidities, family planning, personal hygiene and sanitation, management of intrauterine growth restriction and premature labour, improving maternal psychosocial status and minimising indoor air pollution. Nearly all the activities coming under above strategies are being implemented by the health sector, albeit with varying coverage.

Conclusions:
Low birth weight remains a priority issue in Sri Lanka despite programmatic interventions, which demands a review of the existing strategies and enhanced focus.

Evidence on programmatic pathways to address the issue of stagnant LBW ; role of maternal nutrition – *Dr. Abner Daniel- Chief of Health and Nutrition, UNICEF Sri Lanka*

Role of the obstetrician in LBW reduction – *Prof. Tiran D. Dias - Professor of Obstetrics, Gynaecology and Fetal Medicine, University of Kelaniya, Sri Lanka*

GESTOSIS SOCIETY SYMPOSIUM

Clinical Risk assessment for HDP Gestosis - *Prof. Girija Wagh - Professor, Obstetrics & Gynecology Bharati Vidyapeeth University Medical College, Pune*

Hypertensive disorders of pregnancy are on the rise and prevention and risk assessment could be the first step in reducing the devastating morbidity associated. This has become important as not only is the woman liable to morbidity in the now but is at high risk of having a lifetime disease. Many factors such as age, nutrition, immunological issues, autoimmune disorders, chronic kidney disorders have been identified to be associated. Clinical risk assessment and Risk Management can help ameliorate the devastating outcomes of this disorder.

Traditional screening for the risk is proposed by many organizations and involves assessment of clinical risk factors and have been found to have 40 percent detection rate while multivariable and competing risk models have found to have better detection rates. However universal acceptability and affordability is contested. Risk assessment paves a way for using low dose aspirin making the patient aware as well as focusing with continued surveillance on these women. But it can also lead to fear. Gestosis Score proposed by the Gestosis India Association is proclaimed to be effective in primary clinical risk assessment and is used as an effective screening tool.

Classically the tools used for surveillance are blood pressure measurement, mean arterial pressure (MAP), proteinuria, dopplers and biomarkers. Maternal ECHO based surveillance is a new concept and helps in better understanding the maternal condition along with risk assessment when the clinical disease occurs by using the biomarkers is a useful strategy. Much evidence has emerged to apply various tools as point of care tests, first contact analytics and can be feasible in remote places.

Recently two large studies using antihypertensive medications early for chronic as well as protein uric hypertension has significantly contributed to a change of approach with which positive outcomes are envisaged. Appropriate diagnosis, risk stratification can help temporize the morbidity to less severe consequences. Delivery decisions also can be better taken with appropriate clinical prediction and clear guidelines and differentiation is available. Use of prophylactic low dose aspirin, antihypertensive medicines and magnesium sulphate can definitely help reduce the severe morbidity and mortality associated with HDP Gestosis and likewise long term surveillance of these mothers adopting appropriate lifestyle change can definitely bring about much respite .

Genetics and Gene engineering Focus Gestosis - *Dr. Sanjay Gupte– Director, GreenArray Genomic Research & SolutionsDirector Gupte Hospital and Center for Research in Reproduction*

Preeclampsia (Gestosis) is a continuing enigma which is researched by scientists and clinicians all over the world. Immune maladaptation, oxidative stress, inadequate placental development, inflammatory cascade all have been identified as possible causative factors. The familial nature of pre-eclampsia (Gestosis) is well known and hence, lately, genetic research is deepening with the hopes of the final solutions. To complicate the matters further, all causative factors mentioned above have their own genetic components. Deciphering the genetic involvement in pre-eclampsia (Gestosis) is challenging, not least because the phenotype is expressed only in parous women. Furthermore, in complex disorders of pregnancy, like preeclampsia (Gestosis), it is necessary to consider two genotypes, that of the mother and that of the fetus, which includes genes inherited from both mother and father. Maternal and fetal genes may have independent or interactive effects on the risk of preeclampsia (Gestosis). In spite of candidate gene studies and linkage analysis, this field of genetic research in preeclampsia

(Gestosis) remains a nascent field worth exploring further. This talk will represent a short review of the recent research in this field.

Critical care in HDP Gestosis *–Dr. Alpesh Gandhi - President, FOGSI-2020*

SYMPOSIUM 11- WHO SESSION
"Countdown to 2030: tracking progress towards reaching SDG targets in maternal mortality reduction"

Are we on track? Global & Regional targets and actions in reducing maternal mortality- *Dr. Anoma Jayathilaka- Medical Officer, Maternal & Reproductive Health WHO-SEARO*

Country Progress & Challenges in achieving SDG targets in maternal mortality and Still Births in a Low mortality setting -Sri Lankan perspective -*Dr. Harendra Dasanayaka - FHB, MOH, Sri Lanka*

Role of obstetricians in reaching maternal and newborn health targets in a country *–Dr. Harsha Atapattu – Consultant Obstetrician and Gynaecologist at De Soysa Maternity Hospital, Colombo, Sri Lanka.*

SYMPOSIUM 12
"FIGO SAFOG Session - "Women's Health in Crisis Situations"

Pakistan floods, Climate change and women in crises *– Prof. Rubina Sohail- Professor of Obstetrics & Gynaecology & Consultant, Hameed Latif Hospital, Lahore.*

Fossil fuel (coal, oil and gas) is by far the largest contributor to global climate change, accounting for > 75% of global greenhouse gas emissions & 90% of carbon dioxide emissions. As greenhouse gas emissions blanket the Earth, they trap the sun's heat. This leads to global warming and climate change. Climate change is already having visible effects on the world. The Earth is warming, rainfall patterns are changing, and sea levels are rising. These changes can increase the risk of heatwaves, floods, droughts, and fires. Climate crisis is likely to have significantly increased rainfall and made future floods more likely. Pakistan floods 'made up to 50% worse by global heating'. The intense rainfall caused devastating floods due to global warming. Around a third of the country has been affected by floods with water covering 1/10th of the country.

The floods have created a humanitarian crisis. Nearly 1,500 people have died, 33 million affected and 1.7 million homes destroyed. According to UNFPA, 73,000 women are expected to give birth this month who would need skilled birth attendants, newborn care, and support. It estimates that almost 650,000 pregnant women in flood-affected areas require maternal health services to ensure a safe pregnancy and childbirth. In addition to the general long term and short-term effects, under the circumstances the women are vulnerable suffering from to lack of reproductive health care and rights and are at risk of facing violence in the refugee camps and lack contraceptive facilities. Pregnant women have nowhere to give birth safely because the floods have washed away homes and health facilities.

The women, girls and other marginalised groups face the biggest challenges, with violence against women on the rise in the aftermath of floods. We need to contribute towards mitigating the impact of disasters through its humanitarian action programs and to ensure setting up safe spaces for women and children in the camps for displaced people.

Protecting autonomy of Rohingya women in sexual & reproductive health *–Prof. Sameena Chowdhry- Past PresidentObstetrical & Gynecological Society of Bangladesh (OGSB)*

Introduction:
Rohingya refugees are still awaiting justice and protection of their rights five yearsafter Myanmar military began a sweeping campaign of massacres, rape, and arson in northern Rakhine State on August 25, 2017. Rohingya refugee women face challenges that need to be acknowledged and addressed to ensure that when they seek sexual reproductive health (SRH) services and reproductive rights, they can act autonomously and decide freely among available options.

Case Presentation:
Rohingya refugee community in Cox's Bazar allows infiltration of male community leaders and husbands into the decision-making on women health and create risks by conditioning women's access to care on male buy-in and diminishes Rohingya women's autonomy over their SRH. Due to cultural and political position of male gatekeepers, religious misconception, and stigma Rohingya women are subject to unique power relations. Gender-based violence (GBV) and reproductive coercion (RC) negatively impact women's health and well-being particularly their care seeking, access to or use of contraception, decisions regarding pregnancy and other reproductive issues. Development workers have made progress in integrating SRH in education, health care, and resources in refugee camps in Cox's Bazar. This includes the introduction of menstrual cleanliness in educational conversations, contraception, abortion, and post-abortion care in health services. However, Rohingya women and male cultural leaders, or gatekeepers, remain reluctant to accept these resources and education.

Conclusion:
Global organizations, Bangladesh, donors, and healthcare providers require to work comprehensively to protect Rohingya women's autonomous choices.

Devastating effects of Srilankan economic crises on vulnerable populations – *Prof. Sanath Lanerolle - President - Sri Lanka College of Obstetricians & Gynaecologists*

This disaster has been few decades in the making. COVID-1 dealt a major blow to the tourism and export (apparel, tea, etc.) industries - Sri Lanka's major sources of income - breaking the camel's back. For the first time in the history, Sri Lanka defaulted on foreign debt! Irrational manipulation of the LKR, untimely tax cuts, unhinged borrowings and the sudden ban on chemical fertilizer imports worsened the effects.

The Russo-Ukrainian War and the Post-Pandemic Recession affecting the whole world means, external help will be few and far between. The rapid depreciation of the LKR coupled with the inability of wages to keep up with inflation have drastically lowered the standard of living.

The current birth rate for Sri Lanka in 2022 is 14.84 births per 1000 people, i.e., 323,989 new babies per year. Maternal nutrition: Unavailability and increased costs of macro and micronutrient supplements, High cost of day-to-day food items, Promotion of cheaper non-nutritious food, Transport: fewer clinic visits, longer hospital stays, Labour companionship, Under-staffing are some of the devastating effects on pregnancy.

SYMPOSIUM 13
SOGP Session

"Strategies to reduce MMR in the region"Prevention and management of PPH a leading cause of MMR in the region - *Prof. General Shehla Baqai - Professor of OBGYN CMH Lahore Medical College and National University of Medical Sciences, Pakistan*

Prevention and management of eclampsia evidence based practice - *Prof. Shabeen Naz - Prof. & Head Department of Obstetrics and Gynaecology, Isra University, Karachi-Campus, Pakistan.*

Globally, it is estimated that hypertensive disease of Pregnancy (HDP) complicates ten million pregnancies, resulting in 70,000 to 80,000 maternal and 500,000 perinatal deaths annually.. The odds of a woman dying from pre-eclampsia and eclampsia is 300 times higher than that for a woman in more developed countries.

MiniPIERS predictive model in hypertensive pregnancy is a demographics, symptom and sign-based model for use in low- resource settings to identify the risk of adverse maternal outcome among women with pregnancy hypertension. POM-guided clinical assessment consisted of: (i) a visual scan, (ii) signs or symptoms suggestive of end-organ involvement (iii) BP measurement; (iv) measurement of dipstick (v) blood oxygen saturation assessment.

The PROGNOSIS Asia study demonstrated the value of sFlt-1/ PlGF ratio cutoff of 38, for the short-term prediction of preeclampsia and fetal adverse outcomes with a greater negative predictive value, facilitating prompt interventions as against the conventional proteinuria and measurement of blood pressure that has low sensitivity and specificity.

Studies suggest that a low maintenance dose of magnesium sulfate is safe and effective for controlling convulsions in women with eclampsia weighing ≤50 kg as compared to Zuspan regimens carried out in western countries where the weight of a woman is much higher than South Asian women.

Introduction of standardized, evidence-based clinical guidelines for the management of patients with preeclampsia and eclampsia has been demonstrated to reduce the incidence of adverse maternal outcomes

Strategies to prevent and treat placenta increta, can we save the uterus? - *Prof. Arshad Chohan - Consultant Gynaecologist, Pakistan*

Sociodemographic characteristics and Three Delays of Maternal Mortality - *Prof. Rubina Sohail-Professor of Obstetrics & Gynaecology & Consultant, Hameed Latif Hospital, Lahore.*

Pakistan is the fifth most populous country of the world, with a population of 207.6 million in 2017 and 220.9 million in 2020, with a growth rate of 1.85% and life expectancy of females at 68.6 years. (2021 estimates) . Fertility rate of 3.47 children born per woman. Pakistan has an average of 6.7 persons per household. 64% population is younger than thirty.

According to maternal mortality survey, Pakistan is 186 deaths per 100,000 live births (2018). The most common cause of maternal death is postpartum haemorrhage, followed by sepsis, eclampsia, rupture of the uterus, and abortions. 21% of married women of reproductive age in Pakistan have an unmet need for contraception while the country's contraceptive prevalence rate (CPR) is only at 30%. The paper aims to discuss the three delays resulting in maternal mortality and the interventions that the government is working upon to reduce maternal mortality. The first delay is the delay in the decision to seek care, the second delay is related to reaching an appropriate health facility, and the third delay occurs once the patient reaches the health facility and waits to be seen by a medical professional. Another delay identified is the fourth delay which deals with taking responsibility of maternal death. Along with this the sociodemographic indicators of maternal health will be discussed and how do they affect maternal health

SYMPOSIUM 14
WHO Session-"Accelerating the elimination of cervical cancer as a public health problem: Towards achieving 90–70–90 targets by 2030"

Are we on track to deliver 2030 targets? Global targets & Regional actions in reaching 90-70-90 targets by 2030 in post COVID era *–Dr. Anoma Jayathilaka(Virtual) - Medical Officer, Maternal & Reproductive Health WHO-SEARO*

WHO recommendation on screening and treatment of pre cancerous lesions in cervical cancer *- Dr. Neerja Bhatla - WHO*

WHO framework for strengthening and scaling-up services for the management of invasive cervical cancer and providing palliative care - *Dr. Cherian Varghese- WHO*

Practical constraints on achieving elimination of cervical cancer 90-70-90 targets by 2030: practical implications in a country situation - *Dr. Suraj Perera*

Sri Lanka is committed to work towards to reach the interim targets of cervical cancer elimination in year 2030. For that National Strategic Plan was developed in year 2021 with the active participation of all stakeholders including different institutes of Ministry of Health, Provincial Ministries of Health, Professional Colleges, Non-Government Organizations etc.

During the Post Covid Pandemic era with the ongoing economic crisis there are several constraints on achieving elimination targets. Continuing school based vaccination programme for HPV vaccination during the limited number of school opening days is a challenge despite the parallel Covid vaccination programme. Ensuring continuous supply of HPV vaccines despite the current global shortage of HPV vaccine is also a real challenge. In addition, securing adequate domestic funding support to continue HPV vaccination programme is also a timely concern.

Currently Sri Lanka also gradually migrating to high quality HPV testing as a primary method of cervical cancer screening. Establishing a system for continuous supply of HPV DNA test kits and other consumables is an essential need to achieve 70% of screening coverage in both 35 year age group & 45 year age group. Establishing an internal and external quality assurance system and ensuring optimal follow up programme for HPV test positive clients are some of the other challenges. Ensuring accessibility for Colposcopy facilities throughout the country for those needed further assessments is another limitation.

Ensuring delivery of optimal mode of treatment despite the availability of management guidelines for both cervical pre cancer and cervical cancer is a challenge considering limited access to pre cancer therapy and cancer therapy including brachy therapy. Also installing inte grated electronic health information system to monitor coverage of treatment and conducting survival analysis is a serious challenge which need to be addressed immediately.

SYMPOSIUM 15 - RANZCOG Session
(Via ZOOM)
Dr. Hasthika Ellepola; Coordinator on behalf of RANZCOG & SLCOG

RANZCOG Strategic Plan - *Dr Benjamin Bopp – President RANZCOG*

RANZCOG Strategic Plan 2022–2024, which will guide the College as it consolidates its position as the peak body for obstetrics and gynaecology and women's health in Australia and Aotearoa New Zealand.

While the delivery of education and training is our core business, RANZCOG will also be focused on several key priorities to support members and trainees deliver the best possible health outcomes for women and their families.

Our strategic priorities are:
- Education and Training
- Member Engagement
- People and Wellbeing
- Sustainable Organisation
- Stakeholder Engagement
- Community, Equity and Advocacy

The COVID-19 pandemic undoubtedly disrupted the well-established, traditional structure of medical education. RANZCOG responded and rose to the challenge, realising the urgency to adapt with rapid and flexible new processes, thanks to the knowledge, skills and dedication of the RANZCOG family.

It is with this same focus we turn our attention to the future, with this Strategic Plan reflecting the continually changing world that RANZCOG works within – a social, political, economic and regulatory environment – both historical and contemporary – that guides its strategic direction and activities. The distinctive capabilities of RANZCOG and what has been achieved in the past by all of us working and striving forward together, are the base from which we can further grow.

The National Preterm Birth Prevention Program in Australia - *Dr. Christoph Lehner - Maternal Fetal Medicine Subspecialist Obstetrician, The Royal Brisbane and Women's Hospital - Clinical Excellence Queensland*

The rate of preterm birth has been rising dramatically in Australia and elsewhere over the last two decades. Being born too early is the single greatest cause of death and disability in young children in developed countries and a major contributor to the global burden of disease. Moreover, caring for preterm infants is very expensive and the socioeconomic impact is immense. A cost analysis model prepared by APTBPA indicates that the annual cost of untimely early birth to the Australian Government is 1.4 billion A$ each year.

Discovering how to safely lower the rate of preterm and early term birth and then evaluating the impact of that effectiveness needs to be one of our highest priorities in contemporary healthcare.

Following the success of a comprehensive and multifaceted preterm birth prevention program in the state of Western Australia in 2014/15 and early successes in other Australian states, APTBPA has partnered with Women's Healthcare Australasia (WHA) and the Institute of Healthcare Improvement (IHI) to roll out the "Every Week Counts National Preterm Birth Prevention Collaborative" across Australia. This is the world's first program to strategically lower the rate of preterm and early term birth on a population level.

A change package comprising key evidence-based interventions will be offered to participating health services. Successful implementation of this package will result in cultural change, prevention of early birth, optimisation of timing of planned birth and ultimately, in improved health outcomes for children and benefits to the nation Australia as a whole.

PERINATAL SOCIETY SYMPOSIUM

Preterm births: Current strategies and way forward *–Dr. Himali Herath – Consultant Community Physician, Sri Lanka*

Preterm birth is defined as all births before 37 completed weeks of gestation. Globally, more than 1 in 10 babies are born preterm amounting to 15 million babies every year. Preterm birth rates are estimated to increase in almost all countries. Many preterm babies require special care in the Neonatal Intensive Care Units and Special Care Baby Units thus having a huge burden on the health system. Inequalities in survival rates around the world as well as within the country in different districts are remarkable. The implications of being born too soon extend beyond the neonatal period and throughout the life cycle. For babies who survive, there is an increased risk of disability, which exacts a heavy load on families and health systems.

Sri Lanka's neonatal mortality rate (NMR) is stagnant around 6 per 1000 live births and prematurity and its complications contribute to nearly one quarter of neonatal deaths in Sri Lanka. Urgent action is essential in order to achieve the Sustainable Development Goal (SDG) target of NMR of 4 per 1000 live births by 2030.

There are strategies aimed at prevention of preterm births as well as strategies that contribute to better outcome of babies born too soon. Prevention of preterm birth must be accelerated and everyone can help to prevent preterm births and improve the care of premature babies, accelerating progress towards the goal of achieving SDG target by 2030.

Management of the newborn delivered at threshold of viability *–Dr. Nimesha Gamhewage – Consultant Neonatologist, Sri Lanka*

Periviability is defined as the earliest stage of fetal maturity where there is a reasonable chance of extrauterine survival. This is generally between 22- 26 weeks of gestation. Significant morbidities comprise of intraventricular hemorrhage, necrotizing enterocolitis, bronchopulmonary dysplasia, severe retinopathy of prematurity and neuro-disability. Gestation, birth weight, gender of the fetus, plurality, growth restriction, antenatal steroids and place of delivery have an impact on the mortality and morbidity.

Management begins antenatally, with antenatal counselling where options regarding resuscitation will be discussed. In-utero transfer to a tertiary center, administration of antenatal steroids and Magnesium sulphate to mother improve the outcome. Minimize trauma to the infant at delivery and facilitate delayed cord clamping in suitable babies. Thermoregulation at birth is extremely important.

Clinician's role is not limited to management of medical complications, but also to take responsibility in adhering to ethical framework to address the relevant management issues, ensuring equal treatment for all periviable infants with similar prognoses.

Below 22 weeks, regardless of other factors, resuscitation is not recommended due to the extremely poor outlook. From the beginning of 22 weeks, individualized decisions are made considering prognostic factors and parental wishes. Resuscitation and critical care are considered obligatory for infants with more than 66% of survival chance. Comfort care must be provided to infants not undergoing resuscitative efforts or has life sustaining therapies withdrawn.

Navigating through the crisis with strategic planning to relieve burden of prematurity
Dr. Surantha Perera – Consultant Paediatrician at Castle Street Hospital for Women, Sri Lanka

Globally, prematurity is the leading cause of death in children under 5 years of age. In almost all countries with reliable data, preterm birth rates are increasing. An estimated 15 million babies are born too early every year in the world: more than 1 in 10 babies. Approximately 1 million children die each year due to complications of preterm birth.

Inequalities in survival rates around the world are starkly evident. In low-income settings, half the babies born at or below 32 weeks die due to even a lack of feasible, cost-effective care, such as warmth, breastfeeding support, and basic care for infections as well as breathing difficulties. In high-income countries, almost all these babies survive. In addition, suboptimal use of technology in middle-income settings is causing an increased burden of disability among preterm babies who survive.

In Sri Lanka, around 350,000 babies are born annually and about 10% of them are preterm. Currently many survive with improvement of perinatal care and quality of services provided over the last few decades. Prematurity related complications are the second commonest cause of death in under five-year mortality rate in Sri Lanka.

Preterm babies comprise a large portion of the admissions to the Neonatal Intensive Care Units. Those who survive are at increased risk of life-long disabilities including cerebral palsy, intellectual and learning disabilities, chronic broncho-pulmonary disease, as well as vision and hearing impairment. These complications exert a huge impact on the affected families, as well as the healthcare and educational systems of a country. It is becoming a huge burden on the health care budget, and it is a real challenge to the policy makers and economists when it comes to decision making on health care priorities. Current political and economic woes in Sri Lanka will make it even a more of a daunting task.

The management of the extreme pre terms and term babies with complications consume a lot of resources and cost is high with depreciation of the rupee against the dollar. Among them expenditure to buy surfactants, parenteral nutrition, nitric oxide, and devices remains high. When we do procurements, we must maintain transparency, accountability, and fiscal responsibility. There is a need for more information and research on the impacts of the current crisis.

Investing in social protection and safety nets for mothers and children is imperative and food security should be integrated into social protection. Vulnerable populations such as pregnant mothers, newborns and pre terms need to be given priority at all levels of decision making and implementation of health care policies.

We do not have many options and we must navigate through the current crisis with optimizing the services to deliver the best possible care with resource limited settings protecting preterm babies. Where intensive optimal neonatal care would fit into the system within the current imbroglio in our country is really a vexed question with unnerving implications.

MENOPAUSE SOCIETY SYMPOSIUM

Cardiovascular Health & Menopause –*Prof. Zinnat Nasreen - Professor & Head (Obs/Gyne) department, ZH Shikder Women's Medical College & Hospital, Bangladesh*

Transition to menopause is associated with an increase in cardiovascular disease (CVD) risk as estrogen deficiency attributes to lipid and glucose metabolism dysregulation & androgenic shift of fat redistribution. 1/3 of all deaths of women after 50 years occurs due to heart disease. Epidemiological evidence suggests that menopause increase 2.6 fold more CVD. Women who have early menopause (EM) and not taking MHT, heart disease is the leading killer of these women. Therefore women need to adopt strategies to prevent CVD and maintain a good healthy heart as soon they a approach towards menopause. Healthy life style, exercise and MHT may reduce the CVD risks. Estrogen is cardio protective, it reduces vascular tone, keeps the blood vessels flexible, increases HDL, decreases insulin resistance, reduces TNF alpha, increase prostacyclin I which reduces oxidative stress and platelet activation thereby reducing the risk of CVD. The Global Consensus statements of 2013 stated standard dose of estrogen alone may decrease coronary heart disease and all cause mortality in women younger than 60 years of age and 10 years of menopause.

Prevention of CVD in women should be started early. Menopause is the time to have assessment of CVD risks and to start a healthy life style. MHT is not be used for primary prevention. But women need to start MHT earlier with in 10 years of menopause in order to get the maximum cardiovascular protection. It is strongly recommended in women with EM and POI, as if they are left untreated, are at risk of CVD, osteoporosis, dementia, depression and premature death.

Prophylactic Oopherectomy - *Dr. Harsha Atapattu – Consultant Obstetrician and Gynaecologist at De Soysa Maternity Hospital, Colombo, Sri Lanka*

Prescribing Hormones in Menopause - *Dr. Diluk Senadeera – Consultant Obstetrician and Gynaecologist, Sri Lanka*

ABSTRACTS OF GUEST LECTURES

1.Global Clinical Guidelines: Challenges in Practice

- Dr Madhuri Patel - Secretary General, FOGSI, India

2.Why Complications Occur in Laparoscopy

- Prof. Laila Arjumand Banu- Past President - OGSB, Bangladesh

Introduction

Laparoscopic Surgery has been widely accepted by surgeons and patients as an effective technique to treat gynecological pathologies. Better recovery, a shorter hospital stay, less post operative pain and lower blood loss are the main arguments in favour of this approach.

Materials and Methods

Laparoscopy is a sophisticated operation –needs skills and organized training. Though it is patients friendly but needs more meticulous watchfulness during the procedure as some of the complications usually are not identifiable; rather problems are revealed in post operative period - like urinary fistula or bowel injury.

We can discuss the complications in the following way-

Surgeons skillness.
Selection of the patients
Faulty ergonomics
Electro-coagulation Hazards
Peroperative complications - overall complications 1.93%.
Intestinal perforations 10%
Bladder perforation 4%
Serious bleeding complications 3.7%

The complications can be discussed in the following way-

Major complications4-3%
Minor complications4.29%

Discussion

The complications are more in patients with previous surgery. Major complications are-intraoperative complications including injury to the hollow organ or the viscera (intestine, bladder or ureter) or bleeding or infection during laparoscopy or the post operative period requiring additional intervention by laparoscopy or laparotomy. Deaths and severe medical pathologies that occurred during the post operative period were also considered as major complications.

Minor complications were recorded when any of the following occurred - anemia, mild bleeding or infection, fever, abdominal wall hematoma, urinary tract infection, post operative urinary retention and ileal paralysis.

It was also found serious complications occur more frequent in patients with prior abdominal surgery. Obesity plays an important role as a risk factor – 7 times more risk.

Conclusion

Laparoscopic surgery is a safe procedure if it is done by an experienced surgeon, proper indication (proper evaluation), precautions in previous surgery patients and obese patients. It is also vital to identify the complications preoperatively and to treat accordingly rather than later postoperative period

3. Dheera -"No to Violence against Women"
-Prof. Shantha Kumari -President FOGSI 2021, India

4. Late Onset FGR Diagnostic Dilemmas
Dr. Ayesha Malik - Assistant Professor and Program Director, Maternal and Fetal Medicine Fellowship, Pakistan

5. Novel Concepts in Preterm Labour -
Prof. Mahbuba Akter Banu, Professor in Obstetrics and Gynaecology, Bangladesh

6. Practices and Possibilities of Evidence Based Medicine in Obstetrics and Gynaecology
-Prof. Shabeen Naz -Professor of Obstetrics and Gynaecology, Isra University, Pakistan

Evidence Based Medicine (EBM) is the integration of best research evidence with clinical expertise and patient values, a process that begins with the patients and ends with the patients. In women with diabetes in pregnancy, almost all aspects of diabetes screening starting from O'Sullivan Criteria up to HAPO study and IADPSG criteria have vast variations in practices between hospitals, individual units globally and even within one hospital. This results in absence of prevalence studies for Hyperglycemia in Pregnancy (HIP) and therefore the care and treatment of women with HIP goes un-diagnosed or diagnosed very late resulting in maternal morbidity and persistently raising perinatal morbidity and mortality, forcing women to keep reproducing and jeopardize their obstetric health, increased risk of conversion to type 2 diabetes over the years and transmission of diabetes to future generations by defective intra uterine programming. EBM helps us set the uniform standards of care whereby all the staff can adhere to evidence-based protocols/treatments in their hospitals/units.

Aggressive marketing of therapeutic agents, analogues and newer longer acting insulins, nutraceutical industry driven antioxidant drug combinations to prevent pre-eclampsia, foetal growth restriction have become a major concern in healthcare settings. Over eight multicenter randomized trials all over the world have shown that this is the appropriate control of Diabetes during pregnancy that will prevent maternal and neonatal morbidity, but the use of newer pharmaceutical agents continues unabated.

Obstetricians are usually too busy in their clinical practice and need to go through the evidence-based literature regularly and diligently.

7. **Genital TB in India**
–Prof. S. P. Jaiswar- Professor and Head Department of Obstetrics and Gynaecology KGMU, Lucknow, India

According to Global Tuberculosis Report (WHO) 2021, 1.7 billion people were infected and 1.5 million died. India accounts for about 26 % of the global burden and estimated incidence was 188 per 100,000 people. FGTB is a relatively rare form of TB, consisting of 9 % of all EPTB and cases are not getting enough attention due to a lack of awareness, nonspecific symptoms, and inadequate diagnostic measures leading to poor uterine receptivity, recurrent implantation failure, and infertility. They present variety of symptoms, ranging from irregular menses to pelvic pain. Diagnosis is challenging because of the paucibacillar nature of Mycobacterium tuberculosis and pathophysiology of the disease which is impacted by genetics, immunological, and environmental factors. It requires multiple diagnostic investigative tools like Bacterial cultures, PCR, and Gene expert-based diagnostic methods. For diagnosis ICMR conducted a study to develop Diagnostic Algorithm as ICMR-TASK force project, our institution was part of this multicentric study. 558 infertile women were screened from which 342 women were further studied who fulfilled inclusion criteria. On the basis of conventional test, AFB 10 (2.92%), LJ culture 4 (1.16 %), MGIT culture 4 (1.16 %), HPE 10 (2.92 %) were found positive respectively. In molecular test 150 were found positive on CB-NAAT. This study showed overall prevalence in infertile women to the extent of 43.8 %. Study shows strong relation between genital TB and infertility. FGTB needs a thorough system-

atic clinical examination with high degree of suspicion and use of intensive investigations to prevent extensive damage and infertility.

8.Prevention of Endometriosis

- Dr. T.Ramani Devi - Vice President FOGSI 2020, India

Endometriosis is a mysterious disease as regards to its etiology, pathogenesis, diagnosis and treatment. As per recent estimates by WHO, about 196 million women suffer from Endometriosis globally. Of these, 50 million women belong to India alone!! Endometriosis causes pain and infertility. Average diagnostic delay may vary from 6 to 8 years. Treatment aims at alleviating the pain, preventing the recurrence and promoting the fertility. Patients need lifelong medical management plan and surgery should be minimized. Diagnosis is based on history, clinical examination, imaging modalities like USG, CECT, MRI, biomarkers and trial of treatment, currently there is no role for laparoscopy to diagnose endometriosis. Prevention of endometriosis could be primordial, primary, secondary or tertiary. This aims at prevention of risk factors for endometriosis and lifestyle modifications play a major role in primordial prevention. Identification of the risk factors and regular screening, non-invasive diagnosis, empirical treatment, regular follow up of the patients and intervention at the right time are the modalities for primary prevention. Secondary prevention includes early diagnosis by symptoms, imaging, biomarkers and, empirical treatment which includes COCs, progestins and GnRH analogues. Tertiary prevention includes prevention and treatment of complications like recurrence and pain. Patients who are high risk for endometriosis should undergo primordial and primary prevention even before the disease manifests. Enhanced awareness, followed by yearly checkup and management may slow or halt the natural progression of the disease. Awareness about endometriosis will improve the sexual and reproductive health, quality of life and overall well-being.

9. FOGSI's way forward for Cervical Cancer Elimination

Dr. Priya Ganesh Kumar- Chairperson ONCOLOGY Committee FOGSI 2021-24, India

FEDERATION OF OBSTRETICIANS AND GYNAECOLOGISTS SOCIETY OF INDIA (FOGSI) is the major professional body of India having around 40,000 members. FOGSI has been very active in setting high standards in healthcare for in various fields pertaining to Women health. It acts as advisory body for GOI in various important Bills and amendments related to women health.

FOGSI has responded very strongly and positively for the WHO CALL for Cervical Cancer elimination by 2030. FOGSI has started SWASTHYA SUNDER NARI – PREVENT THE PREVENTABLE (SSNPP) as a part of FOGSI DRIVE FOR CERVICAL CANCER ELIMINATION.

THEME OF SSNPP

Part 1: Educational Webinars on Cancer Prevention - Covered 178 Societies with 24 Webinars

Part 2: Physical Colposcopy Workshop for Doctors & Public Awareness Program - AV Educational Videos in 8 Regional Languages Developed

Part 3: SSNPP-friendly APP to be used by FOGSIANS - Showcase Actual Pre-cancerous Statistics prevalent in the Community.

The SSNPP Webinars Cover:

Knowledge in the most basic yet not so routinely practiced subject of Screening for Cervical cancer covering the nuances of interpretation of VIA

Understanding various terminologies of Pap test and its relevance as primary screening tool

HPV vaccination

Case based discussions on screen positive what next to clarify the doubts on handling such cases with confidence

GOAL OF FOGSI

FOGSI plays a pivotal role as advocates for CERVICAL CANCER MUKTH BHARATH, thereby showcasing the leadership quality in the global Healthcare arena

SSNPP has been designed to achieve the Cervical Cancer Elimination Goal.

10. Postpartum Intrauterine Contraceptive Uptake; A Cost-effective Family Planning Intervention, Experience in Pakistan -

Dr. Azra Ahsan – Consultant Gynaecologist, Pakistan

Introduction & Objectives

The study was part of an intervention "institutionalization of Immediate Postpartum Family planning (PPFP) services, particularly insertion of Postpartum Intra Uterine Contraceptive Device (PPIUCD)" in selected health facilities across Pakistan. Skilled Birth Attendants (SBAs) conducting deliveries at the selected health facilities were trained to provide PPIUCD services to at least 30% of women delivered.

Method

National Committee for Maternal & Neonatal Health (NCMNH) piloted the PPIUCD intervention in two hospitals of Karachi and scaled up to 52 health facilities in Karachi, Hyderabad, Lahore, Islamabad and Rawalpindi. All cadres of SBAs at the intervention sites were trained, followed by supportive supervision. PPFP counselling was done at ante-natal clinics, labour rooms (women in early labour) and postnatal wards by dedicated counsellors. Contraceptives were available 24/7 in labour rooms and operation theatres. PPIUCD was inserted within 10 minutes of delivery of the placenta after a normal or caesarean delivery, or within 48 hours of normal childbirth. Women were followed up at "6" weeks and "6" months' post insertion.

Results (April 2012- April 2022)

During the intervention 2,713 SBAs were trained, included doctors and midwives. A total of 648,126 women delivered at the intervention sites and 179,508 (28%) had PPIUCD inserted. 47% of the women were followed up at six weeks, the continuation rate was 95%, IUCD was expelled in 3% and was removed in 2% of women. The reason for removal was mainly socio-cultural.

Conclusion

PPIUCD insertion is safe and effective. When counseled appropriately, is acceptable to women and the health care providers. A burgeoning population of 207.7 million and more and more women coming to health facilities for childbirths, (currently 69% childbirths at health facilities), makes PPFP a one stop solution for improving Maternal & Neonatal Health and decelerating the Population Growth. Institutionalization of immediate PPFP, particularly PPIUCD is a step in the right direction!

11. Maternity Care to Minimise Future NCD

- Prof. Kohinoor Begum–Professor in Obstetrics and Gynaecology, Bangladesh

Fetal origins of adult disease, a concept first popularized by Dr David Barker, has subsequently led to many studies which have provided the evidence that certain diseases do have links pointing to fetal origins—adverse influences early in development, and particularly during intrauterine life, can result in permanent changes in physiology and metabolism, which result in increased disease risk in adulthood.

Low birthweight is now known to be associated with increased rates of coronary heart disease and the related disorders stroke, hypertension and non-insulin dependent diabetes. The concept of a fetal origin of adult disease have been extended well-beyond coronary heart disease and being a risk factor for coronary heart disease, and now includes investigations of the development of the central nervous system, early origins of adult mental health and cognitive function. The associations are thought to be consequences of developmental plasticity, the phenomenon by which one genotype can give rise to a range of different

physiological or morphological states in response to different environmental conditions during development.

Nine months of gestation constitute the most consequential period of our lives, permanently influencing the wiring of the brain and the functioning of organs such as the heart, lung, liver and pancreas. The conditions we encounter in utero shape our susceptibility to disease, our appetite and metabolism, our intelligence and temperament.

By understanding fetal origin of adult disease, health care professionals and policy makers will make this issue a high health care priority and implement preventive measures and treatment for those at higher risk for chronic diseases.

12. Novel Concepts in Pre-eclampsia - Prof. Sohana Siddique-

Professor in Obstetrics and Gynaecology, Bangladesh

Preeclampsia is a life-threatening complication of pregnancy where there is maternal blood pressure elevation of ≥140 mmHg systolic or ≥90 mmHg diastolic on two occasions 4 hours apart. Associated features may include any one of proteinuria, thrombocytopenia, renal insufficiency, impaired liver function, pulmonary edema, cerebral or visual symptoms. Preeclampsia complicates 5-7% of all pregnancies and has increased by 25% since 1987. It increases the mortality and morbidity of both the fetus and the pregnant mothers. It has got detrimental effects on the vital organs of the body. The exact etiology of preeclampsia is yet unknown, but growing evidences suggest that abnormalities in the angiogenic factors levels and coagulopathy are responsible for the clinical manifestations of the disease. Although its prevalence is still underestimated in some places due to underreporting, preeclampsia is a disease that health professionals need to know how to deal with and take action. For this reason, the studies about the theme remain along with the advances in their understanding that often implies improvement and change of concepts and conducts. It evolves in 2 stages. Poor placentation before 20 weeks is the first stage, whereas the second stage includes the ability of the maternal vascular endothelium to respond to that poor placentation. There is poor cytotrophoblastic invasion of the spiral arteries which leads to both chronic hypoxia of the placenta and increased stress on the vascular system. The chronic hypoxia causes the endoplasmic reticulum to activate apoptotic pathways releasing particles into the circulation, increasing oxidative stress and causing release of angiotensin II type 1 receptor, soluble growth factor receptor (sFlt-1or sVEGFR-1) and uric acid. Other biochemical markers indicating preeclampsia are pregnancy-associated plasma protein-A (PAPP-A), placental growth factor (PIGF), placental protein 13 (PP13) and s-Endoglin. The aim of this review is to discuss updates on the occurrence, concept, pathophysiology, prevention and prediction of preeclampsia. Specifically, the review highlights the renal manifestations of the disease with emphasis on the involvement of angiogenic factors in vascular injury and how restoration of the angiogenic balance affects renal and cardiovascular outcome of preeclamptic women.

13. Environmental Factors in Infertility

Prof. Rashida Begum- Chief Consultant Infertility Care and Research Centre (ICRC) Ltd, Bangladesh

Environmental factors like smoking, alcoholism, climate change and environmental pollution have different negative impacts on human reproduction. The increased pollution in the world atmosphere is a global concern. Water, air, and soil are polluted by various sources, such as farm fertilizer, sewage industrial waste products, fumes, plastics and which in turn impact human health. Plastics and other mixtures of waste affect lives in the water. Moreover, the ecosystem is disrupted by the use of heavy metal-containing chemicals in agriculture, and those are eventually consumed by humans. The consequences are a significant negative impact on health including reproductive health, which impairs fertility in the human population. Reproductive functions are severely affected by different chemicals which may interfere with hormonal functions. Greater consequences are faced by the women as the number of germ cells present in the ovary is fixed during fetal life, and which are non-renewable. From the production of ovum to fertilization, to implantation, and finally continuation of pregnancy, all are affected by the heavy metals and endocrine disruptors. Similar factors impair spermatogenesis and the quality of sperm. Lifestyle modifications such as avoidance of smoking, alcohol intake, hot temperature, consumption of organic foods,

plastic product avoidance, separation of residential areas from industrial/agricultural areas, proper waste disposal, etc. may help to improve the situation.

14. Fertility Preservation - Prof. Mariam Faruqui

Professor of Obstetricsand Gynaecology, Lab Aid Specialized Hospital, Bangladesh

15. Revisiting Recurrent Pregnancy Loss

Prof. Sehereen Farhad Siddiqua - Specialist in Obstetrics & Gynaecology, Anwer Khan Modern Medical College, Bangladesh

Recurrent pregnancy loss (RPL) is a serious health problem and has both psychological and social impacts. RPL effects approximately 1-2% of all clinically recognized pregnancies either early or late in the gestational period. In some cases, RPL exacts a devastating emotional toll on patients' lives and may lead to divorce or other social problems. The association between thrombophilia and RPL has become an undisputed fact. Development of thrombosis in pregnancy is multifactorial due to the physiologic changes of pregnancy which induce a relative hypercoagulable state as well as physical changes leading to increased stasis and also the effects of both the inherited and the acquired thrombophilias. Inherited thrombophilia includes factor V Leiden (FVL) mutation (C677T), a hyperhomocysteinaemia mutation (A506G), a prothrombin mutation (G20210A) or prothrombin II (PTII) mutation, antithrombin III deficiency, protein S deficiency, protein C deficiency, MTHFR poly morephism, Plasminogen activator inhibitor 1 mutation. In Bangladesh recently, the interest has focused on the increased prevalence of thrombophilic defects in women with RPL. Research works are going on to establish this factor as a cause of placenta mediated pregnancy complications, such as fetal growth restriction, preeclampsia, abruption, and pregnancy loss. An inherited thrombophilia is only one of many factors that lead to development of these diseases and is unlikely to be the unique factor that should drive management in subsequent pregnancies. The paucity of evidence for benefit, coupled with a small potential for harm, suggests that low molecular weight heparin should be considered an experimental drug for these indications until data from controlled trials are published. At present, women with a history of Placenta-mediated pregnancy complications, with or without a thrombophilia, should be followed closely without routine prophylactic low molecular weight heparin other than for prevention of venous thromboembolism in limited circumstances.

16. Menopause, Breast Cancer and HRT

Dr. Edward Morris (Virtual) – President RCOG,UK

17. Understanding Chronic Unexplained Pelvic Pain

Dr. Suchitra Pandit- Gynaecologist and Obstetrician in Santacruz West, Mumbai, India

18. Perimenopausal Bleeding - Role of Hysteroscopy

Dr. Parul Kotdawala - Obstetrician, Gynaecologist, Infertility Specialist & Laparoscopic Surgeon in Ahmedabad, India

19. Endocrine Disruptors & Fertility

Dr. Jaideep Malhotra – President, ASPIRE (Asia Pacific Initiativeon Reproduction), India

20. Challenges in Management of GDM

Dr. Sheuli Kamrunnahar–Assistant Professor in Obstetrics and Gynaecology, Bangladesh

21. Uncommon Ectopic Pregnancies – Challenges in the Management

Dr.*Hiralal Konar - Professor & Head, Department of Obstetrics and Gynaecology, KPC Medical College & Hospital,Kolkata, India*

Background:

The risk factors for ectopic pregnancy are on the rise. Despite the progress (availability of serum βhCG, USG, MRI), there are diagnostic and therapeutic challenges in the management. Up to 50% of ectopic pregnancies go undetected.Furthermore, cases seen as emergency with hemodynamic instability need

urgent intervention with simultaneous arrangement of transport, blood transfusion and at times multidisciplinary team involvement. This is more challenging in settings where resources are limited.

Objective:
To evaluate the outcome of women presenting with uncommon ectopic pregnancies as life threatening emergency. Challenges encountered in diagnosis, preoperative evaluation, decision for surgery and the procedure are presented.

Patients and Methods:
It was a series of sixteen cases of uncommon ectopic pregnancies belonging to twelve different types.

The twelve different types were:

*Cervical	* Secondary abdominal	*Ovarian
*Interstitial ruptured	*Interstitial unruptured	* Cesarean Scar
*Cornual unruptured	*Cornual ruptured (triplets)	*Tubal twins
*Tubal ectopic molar changes	*Recurrent tubal ectopic	
*Familial ectopic pregnancies		

All these cases were faced as emergency. These cases were managed by the author during the period 2002 through 2020. Subjects were analyzed retrospectively.

Results:
Diagnostic dilemma was faced in majority of the cases even with the use of ultrasonography. All the conceptions were spontaneous. Emergency surgical interventions were made on clinical evaluation. Five cases presented with massive hemoperitoneum. Blood transfusion was needed in nine cases. There was no mortality. One woman, with abdominal pregnancy, went home with a live baby, after the second laparotomy.

Conclusion:
Uncommon ectopic pregnancies are life threatening conditions. Clinical acumen and an alert mind are of superior value in diagnosis. Investigations are supportive. Early diagnosis and intervention are life saving

22. Aesthetic & Regenerative Gynaecology

Dr. Narendra Malhotra -Past President - FOGSI, India

23. Tranexaemic Acid & PPH: Alternative Routes

Prof. K. Muhunthan– Professor in Obstetrics and Gynaecology, Sri Lanka

Maternal mortality is one of the dreaded events in the field of medicine where a woman loses her life directly or indirectly as result of a pregnancy.Primary post-partum haemorrhage, usually defined as a blood loss of more than 500 mL within 24 h of giving birth affects about 5% of all women giving birth around the world and is the leading cause of maternal death worldwide, responsible for about 100 000 deaths every year.Most of the deaths occur soon after giving birth and almost all (99%) occur in low-income and middle-income countries.

Unprecedented number of research are being conducted around the world in a quest to search for a solution in terms new and management strategies, drugs, devices and surgical techniques to save mothers.

Recently an old drug called tranexamic acid (TXA) has been shown to be effective in treating postpartum hemorrhage after the WOMEN trial. In the WOMEN trial, tranexamic acid was given by intravenous injection with no published bioavailability studies on tranexamic acid after non-intravenous routes of administration in postpartum women.As a result, the WOMEN group and WHO emphasized on future bioavailability studies on tranexamic acid after non-intravenous routes of administration in postpartum women where intravenous injections might not be feasible as in low-income and middle-income countries.

Based on these recommendations, international collaborative studies by the LSTH on alternative routes

of TXA and a clinical pharmacokinetic study done in Sri Lanka has shed light on the alternative routes of TXA for treatment and prevention of PPH.

24. Non-Clinical Component of PPH Bundle: An Innovation to Improve the Outcome-

Prof. Farhana Dewan - President Elect, OGSB, Bangladesh

Postpartum haemorrhage(PPH) is a leading cause of maternal mortality and morbidity in low- and middle-income countries (LMICs). Common reasons for poor maternal health outcomes are lack of adherence to evidence-based guidelines and delays in care.

Key contributors in the failure to save women with PPH are delays in diagnosis, delays in use of recommended interventions and disorganized use of multiple interventions. PPH EmC Using a Bundle Approach is a different way of conceptualizing PPH emergency response that integrates crucial clinical and systems-based interventions for rapid, effective PPH emergency care. Integral to the program is the understanding that strengthening a clinical response requires more than training providers on clinical skills. It requires continued practice of the emergency response as a team, availability and accessibility of necessary supplies, communication between providers, patients and families, communication between and across networks and commitment to quality improvement. Therefore, this training package addresses both clinical and non-clinical elements, each essential to improving PPH emergency care.

Clinical component includes PPH first response bundle. To provide a quality PPH emergency response, healthcare providers must have the necessary knowledge and competency in relevant clinical skills. However, it is also essential to focus on those key nonclinical elements that help enable and strengthen the clinical response.

Nonclinical modules are leadership, teamwork and communication, facility readiness, network integration, data monitoring and quality improvement.

Teamwork and communication include creating a highly functional obstetric rapid response team and utilizing standardized communication tools. Teamwork and communication are key to having a skilled, professional emergency response. Every facility should create an Obstetric Rapid Response Team and practice with frequent simulations. Team based communication skills are debrief, SBAR, closed loop communication, huddle and board rounds.

Debrief tool is a tool which is used after every case of PPH simulation to discuss in detail the achievements done during management of the case and what were the issues in management and what could have been done better.The debrief tool should be used with each simulation and the team should decide on specific improvements to work on with the next simulation so they can see improvement. SBAR stands for Situation, Background, Assessment and Recommendation. SBAR is a tool which helps in the patient transfer or refer. Closed loop communication is a call back which is very useful on spot management activity.

Conclusion

The non-clinical elements when used singly or in combination in the management of a single case can help in better outcome of cases of PPH.

25. "Role of Progesterone in Threatened Miscarriages"-

Prof. Sir Sabaratnam Arulkumaran - Professor Emeritus of O&G, St George's University of London. Past President of the FIGO (International Federation of Obstetrics & Gynaecology), UK

Progesterone is used prophylactically in cases of recurrent miscarriages &therapeuticallyfor threatened miscarriages. Progesterone support is initially from the corpus luteum andfrom late first trimester it is from the placental unit. Progesterone prepares and maintainsthe endometrium for implantation &maintenance of pregnancy by relaxation of themyometrium. Insufficient progesterone may lead to pregnancy loss and this may happenwith removal of corpus luteum prior to 7 weeks or with the use of mifepristone which disrupts progesterone binding to receptors which may lead to miscarriage. Progestogen shave sim-

ilar activities like Progesterone. Different Progestogens vary in potency, receptor affinity/ selectivity, Bio-availability and route and frequency of administration. They are used to influence the endometrium in cases of infertility due to implantation failure/ incases of IVF? And for prevention of miscarriage threatened/recurrent miscarriage.

Micronized progesterone is bioidentical hormone with molecular structure identical to endogenous progesterone produced by the ovary. Synthetic progestins have a different chemical structure from progesterone. With oral administration – high doses are needed due to variable absorption. This may cause nausea, headaches &drowsiness. With vaginal administration absorption varies, may be washed out with blood and local irritation is a possibility. Micronized progesterone has lower cardiovascular risk and a neutral effect on blood pressure compared with synthetic progestogens, which have androgenic activities. Dydrogesterone – 6 dehydro-retro-progesterone has a bent &retro-structure–stero-isomer of progesterone and has double bond between C6 & C7. It can be administered orally, is highly selective for progesterone receptor / does not bind to androgen receptor and its antiandrogenic effect is less than progesterone. It has no estrogenic, androgenic or glucocorticoid effect. It has higher bioavailability than progesterone (X 6 times) and hence need 10-20 times lower dose of to micronized progesterone.

Two recent trials of the first trimester progesterone use are a) for PREVENTION (PROMISE) to identify the role of progesterone in recurrent miscarriage and b) RESCUE (PRISM) trial to determine the role of progesterone in threatened miscarriage. The PROMISE trial did not show any overall benefit with the use of micronized progesterone pessaries (MPP) but sub analysis showed and increase of live births of +0.5% for those who had three previous miscarriage, 6.4% with four, 7.1% with five and 7.4% with six or more miscarriages. The PRISM study looked at the effect progesterone who presented with bleeding in the first trimester. MPP 400 mg twice aday was given till 16 weeks. Although a previous meta-analysis showed a nearly 40% reduction in miscarriage rates with the use of progestogen the PRISM study showed no advantage. However, sub analysis has shown that women who had one or more previous miscarriages benefited with MPPs if they presented with bleeding with a 5% increase in livebirth rates.

Subsequent Cochrane reviews showed that the prophylactic use of PG for recurrent miscarriage or therapeutic use for threatened miscarriage did not increase the preterm birth rates, still births, neonatal deaths or congenital malformation. A recent meta-analysis showed the effect of oral, IM and intra-vaginal use of progesterone/ progestogen had the same beneficial effect and the route of use could be tailored after discussing with the women. In threatened miscarriage, NICE recommends vaginal micronized progesterone for women with early pregnancy bleeding and 1 or more miscarriages. For recurrent miscarriage (without bleeding), the new draft Green Top guidelines said 'consider'progesterone and final guideline is likely to make it permissive.

26. "Consensus Statements for Assessment, Evaluation and Management of Threatened Miscarriage during the First Trimester in Pakistan"

Prof. Sadia Ahsan Pal - Medical Director & Consultant Concept Fertility Center, & New Beginnings Healthcare Karachi, Pakistan

Objectives

To develop an expert consensus regarding the risk assessment, diagnosis, and management of threatened miscarriage during the first trimester in Pakistan.

Methods

A three-step modified Delphi method was applied to develop the consensus. Eleven specialized obstetricians and gynecologists participated in the development of this consensus. If an agreement level of 75% or higher was attained on each assertion, it was declared a consensus.

Results

Age of 35 or above, previous history of 2 or more previous miscarriages, and direct strong trauma were considered to be risk factors for threatened miscarriage. Infections (Malaria, and COVID-19) included as a risk factor. Unanimous agreement on Endocrine disorders, thrombophilia, and lifestyle variables,

acquired thrombophilia, importance of educating pregnant women about factors which can be modified by changing their behavior. Diagnosis was agreed to be trifold: physical examination, imaging, and laboratory testing. Physical examination included abdominal and pelvic exams but focused more on vaginal examination with speculum to identify the severity and etiology of the bleeding. Transvaginal ultrasound was recommended for uterine structural abnormalities, fetal viability focusing on heartbeat and crown-to-rump length, gestation sac size and emptiness, subchorionic hematoma, and ectopic pregnancy. Laboratory tests indicated; the need for HCG assessment whether serial or once is dependent on the ultrasound findings. Hematologic factor assessment was recommended by complete blood count for anemia, Rh factor for potential bleeding risk and in special cases thrombophilic assessment can be undertaken. The first and foremost aspect of management was follow-up while most management statements were controversial and removed.

Conclusion

These consensus statements aggregated the best available evidence and expert opinion supported statements to improve the risk assessment, diagnosis, evaluation and management of threatened miscarriage during the first trimester in Pakistan.

27. "First Trimester Screening"-Prof. Yousaf Latif Khan

Professor OBS/GYN Department in Rashid Latif Medical College, Pakistan

28. Damage- Control Surgery for Major Obstetric Hemorrhage

Prof. Tazeen Abbas-Head of the Department of Obstetrics & Gynecology KMDC & Abbasi Shaheed Hospital, Karachchi, Pakistan

Major Obstetric Hemorrhage is a nightmare for an obstetrician and is the prime cause of maternal morbidity and mortality. The use of conventional measures to control bleeding frequently results in unnecessary prolongation of operative time, leading to the triad of death.Management of MOH requires a multidisciplinary team and activation of the MassiveTransfusion Protocol.Initial Resuscitation is followed by Damage Control Surgery that consists of initial laparotomy, abdominopelvic packing & Temporary Abdominal Closure. It is prudent to control bleeding sources amenable to surgical intervention (eg, arterial bleeding) at the time of initial laparotomy.This is followed by a period of medical stabilization in the intensive care unit where physiologic derangements should be corrected (temperature, pH, electrolyte anomalies, and coagulopathy).The definitive procedure and the optimal time to remove the pack appears to be between days 2 and 3 postoperatively, provided the patient is stable.Obstetric conditions likely to benefit from damage-control surgery are persistent bleeding from placenta accreta, ruptured liver hematomas associated with preeclampsia, and attempts at placental removal in cases of abdominal ectopic pregnancies.

Conclusion:

In major obstetric hemorrhage, Damage Control Surgery should be considered when arterial bleeding has been controlled, and persistent bleeding is deemed to be secondary to coagulopathy that is refractory to blood product replacement, particularly in the presence of hypothermia, acidosis, and vasopressor requirement.

29. PPH: Role of UBT - Prof. Sayeba Akhter -

Past president of the Obstetrics and Gynaecology Society of Bangladesh

Post-partum hemorrhage is an obstetrical emergency and one of the leading causes of maternal death worldwide. Most of the deaths from PPH occur in low and middle-income countries. Many of these deaths can be avoided using low-cost and widely available products like Uterine balloon tamponade (UBT). The devices have been proven to save lives, lessen the need for blood transfusions and surgical procedures, and avoidable hysterectomies and disability in women. The World Health Organization (WHO) recommended the use of UBT as the second line of treatment for PPH in April 2021. Many low-resource settings like Bangladesh, Indonesia, India, etc. have already introduced UBTs in their national treatment protocol for PPH. The impact of this increased access to the UBTs lowers maternal deaths in line with Sustainable Development Goal 3.

The efficacy and outcome of the UBT have been investigated in several studies and found an 85-100%

success rate. There has been no evidence of genital tract damage, disseminated intravascular coagulation, or retained tissue, according to retrospective research. All prospective studies have proven the effectiveness of UBT in resource-poor settings. The Sengstaken-Blakemore tube, the Bakri balloon, the Rusch balloon, the foley catheter, and the condom catheter balloon are some of the numerous types of balloons that can be used for this method. Estimates of the volume of fluid required to expand the balloon range from 250-1500 ml.

UBT is a simple procedure to treat atonic PPH and has few unfavorable side effects. Hence healthcare providers found UBT as an easy-to-approach and cost-effective way to control PPH and they recommend regular hands-on training to maintain skills. Future research will be needed to investigate any long-term health implications of UBT and its acceptability of UBT among both healthcare providers and patients.

30. Placenta Adhesive Spectrum Disorder

Prof. Fatema Rahman – Professor in Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Bangladesh

Introduction

Specimen of abnormal placental implantation and firm adherence which are classified according to the depth of invasion into the uterus.Placenta Accreta syndrome:

Accreta - Chorionic villi attached to the myometrium, rather than being restricted within the decidua basalis.

Total Placenta Accreta (all lobes involved)
Partial placenta Accreta
Focal Placenta Accreta
Increta- chorionic villi invaded into the myometrium
Percreta-chorionic villi invaded through the perimetrium (uterine serosa)

For major placenta previa- Risk of major hemorrhage 1:5 and Risk of hysterectomy 1:10. Women diagnosed with placenta accreta spectrum should be cared for by a multidisciplinary team in a specialist Centre with expertise in diagnosing and managing invasive placentation.Delivery for women diagnosed with placenta accreta spectrum should take place in a specialist center with logistic support for immediate access to blood products, adult intensive care unit and neonatal intensive care unit by a multidisciplinary team with expertise in complex pelvic surgery.

In the absence of risk factors for preterm delivery in women with placenta accreta spectrum, planned delivery at 35 to 36 weeks of gestation provides the best balance between fetal maturity and the risk of unscheduled delivery.Planning delivery of women with suspected placenta accreta spectrum – once the diagnosis of placenta accrete spectrum is made, a contingency with the women, including the use of an institutional protocol for the management of maternal haemorrhage.

Diagnosis

Although clinical risk assessment may be the most important tool to assess for placenta accreta spectrum, manystudies report very high sensitivity and specificity for obstetric ultrasonography in the diagnosis of placentaaccreta spectrum. Although ultrasound evaluation is important, the absence of ultrasound findings does notpreclude a diagnosis of placenta accreta spectrum, thus, clinical risk factors remain equally important aspredictors of placenta accreta spectrum by ultrasound findings, it is unclear whether MRI improves diagnosis of PAS beyond that achieved with ultrasonography alone.

Management

Cesarean hysterectomy is considered as standard treatment for invasive accreta although high rates of severe maternal morbidity (40-50%) & mortality (7%). Skin incision: low transverse skin incision if the upper margin of placenta does not rise into the upper uterine segment. Midline skin incision if the placenta extending toward the level of the umbilicus.

Uterine incision- Transverse above the upper border of the placenta.After delivery of the fetus- only if

there is no clinical evidence of percreta placentation surgeon may carefully attempt to remove the placenta by CCT and use of uterotonics. Failure to do so suggests the diagnosis of a PAS disorder. Conservative management-All procedures that aim to avoid peripartum hysterectomy & its related morbidity & consequences

Four different primary methods
- Extirpative technique (manual removal of placenta)
- Leaving placenta in situ
- One step conservative surgery (removal of accreta area)
- Triple-P procedure

Additional procedure-
- Methotrexate: not recommended (the risk overweigh potential benefits)
- Gentle attempt of removal of placenta
- Preventive surgical or radiological uterine devascularization
- Hysteroscopic resection of retained tissues.

Evidence based recommendations
- When a conservative treatment is attempted in cases of PAS disorders diagnosed prenatally exact position of placenta should be confirmed by a preoperative ultrasonography.
- Equipment & expert surgical team should be on standby for an emergent hysterectomy
- Leaving the placenta in situ is an option for women who desire to preserve their fertility, agree to continuous long-term monitoring and in centers with adequate expertise.

Preventive surgical or radiological uterine devascularization is not recommended routinely.
The incidence of PAS will be likely to increase further over time. Therefore, clinicians should be aware of the difficulties and challenges associated with the management of this condition.

31. Male Infertility-What Every Gynaecologist Should know
–Dr. Jaydeep Tank- President Elect FOGSI - 2024 –2025, India

32. Day 2 - 2.00pm - 3.00pm - Hall B -

33. Update on PCOS Associated Infertility - *Dr. Mala Banik - Associate Professor of Gynae in Sir Salimullah Medical College, Dhaka, Bangladesh*

Polycystic ovarian Syndrome (PCOS) is a predominant cause of infertility and a common gyne-endocrine disorder affecting 7 to 15% of women in reproductive age. PCOS is defined by two of three features: Oligo or anovulation,clinical or biochemical hyperandrogenism or both, or polycystic ovaries.

Lifestyle modifications(stop smoking,physical exercise and weight loss) are the utmost importance.Metformin as insulin sensitizer has added benefit in achieving ovulation. Vit D, acarbose and myoinositol are just a few of the reciprocal treatment that have been proved to be useful in the treatment of PCOS.

Clomiphene Citrate is the first line of treatment to induce ovulation.But now Aromatase inhibitor like Letrozole is supplanting. Clomiphene as the best option for ovulation. Gonadotrophin and ovarian drilling is the second line therapy. Assisted Reproductive techniqe like IUI, IVF is the third line therapy in women who are not responding or associated with other factors of infertility.

Individualizing treatment according to the different needs of patients is the most important in management strategy of patients with PCOS associated with infertility.

34. Graceful Aging -Prof. Shaikh Zinnat Ara Nasreen -
Professor & Head of Obstetrics and Gynaecology in ZHSWMCH, Bangladesh

Aging is a natural phenomenon with opportunities and challenges. Men & women should have the op-

portunity to live a long, graceful and healthy life. Healthy aging is not merely absence of disease, but it should be graceful which means "showing signs of aging, but still moving forward with life & positive thoughts". But for those with physical challenges, positivity could be euphemism. Yet, aging gracefully is possible for all. Increased life expectancy pushes a huge number of women to live post menopause who deserve graceful ageing. That depends on- health status, mental, psychological wellness, financial sufficiency, social recognition, the residential perspective, and the family structure.Also aged women are emotionally labile, hence tender loving care and respect is required rather than vocal and behavioral abuse.

Harvard Study found "lifestyle factors have a biggest impact on happiness levels than wealth or fame"Therefore, bedrocks of graceful ageing are optimum nutrition, exercise, maintaining BMI, regular health heck up and timed intervention of comorbidities & mental happiness. A positive attitude causes a chain reaction of positive thoughts, It is a catalyst and it sparks extraordinary results." —Wade Bogg.

So mental health matters, being happy and keeping stress down is very important. A strong social network improves mental and physical well-being and longevity. Finding & learning new hobbies, doing meditation, getting adequate sleep, talking to a friend and going close to nature, help us live and age gracefully. We may need to disseminate the information to our aged women. More residential facilities for lonely women are essential. Growing older should continue to have its own rewards.

35. Investing in Adolescent Reproductive Health - *Dr.Marjia Begum*

36. Physical and Psychological Issues in Abortion - *Dr.Dilruba Ferdous*

37. TLH for large Uteri –Dr. Kuiren Joseph - Obstetrician, Gynecologist & Endoscopic Surgeon,
Presently Director – Joseph Hospitals, Chennai, India

The progress of Laparoscopic hysterectomy has been enormous, and more and more uteri are being removed laparoscopically. However, the larger the uterus gets it becomes more challenging to complete it using the scope. We analyzed a series of cases where the uterus was > 500gm and found the problems we faced. This is more pronounced in a small hospital than in a multispecialty hospital.
Despite the problems we could do most cases laparoscopically with few conversions. With careful planning and good teamwork, it is feasible to do so even with limited resources.

38. Tissue Retrieval in LaparoscopicSurgery
-Dr. Rekha Kurian - Director & Consultant at Joseph Hospitals, Chennai, India

Laparoscopic surgery has surged worldwide. From small diagnostic procedures to extensive radical procedures, it has taken the world of gynecological surgery by storm. But as the incisions get smaller and the amount of tissue removed gets larger there are difficulties in tissue retrieval.Initial removal was via the ports but then came mechanical morcellation followed by the electrical morcellators. The sad case of a malignancy being disseminated due to morcellation caused worldwide problems. Today the colpotomy or the contained "in bag" morcellation offer alternatives.

In this brief presentation I hope to discuss the various issues faced at tissue retrieval.

39. Medical and Surgical Management of Endometriosis- Dr. Shyam Desai –
Obstetrician, Gynaecologist and Endoscopic Surgeon, Hinduja Hospital & Nanavati Hospital, India

Approximately one third of women with Endometriosis are symptomatic.Pelvic pain is the most common presenting symptom. Other symptoms include dysmenorrhea, dyspareunia, dyschezia, irregular bleeding, low back pain, hematuria, and dysuria.Several hormonal medications are used in the alleviation of symptoms and suppression of the disease such as OCs Progesterone and progestogens Danazol GnRH analogues, but they cannot be administered indefinitely, and many have undesirable side effects. Dianogest a Progestogen stands out amongst the medications available. The LNG IUS has also been recommended

in a few series.

Surgery is a useful adjunct to the management of endometriosis, It can be carried out in patients who do not respond to the medical management and when medications are contraindicated. Surgery is also preferable in Stage 3 and stage 4 disease. Laparoscopy is well considered to be the approach for a surgical procedure and many Gynaecologists are now proficient in carrying out laparoscopic procedures. The highlighting of such surgeries will be done. Eventually a permanent cure for the disease is hoped for but we are not any closer to such a situation inspire of advances in medical and surgical interventions

40. Adolescent Endometriosis in South Asian Region-

Prof. Sameena Chowdhury - Chairman: OGSB Hospital & IRCH, Bangladesh

WHO defined Adolescents as individual in 10-19 years age group. There are 340 million adolescents in South Asia which is about 30% of the total population in this world. Adolescentgirls are about 190 million.Endometriosis is a chronic inflammatory condition associated with severe dysmenorrhea,dyspareunia, dyschezia, infertility anxiety and depression. The quality of life is seriously affected.

One in ten women & girls are affected by endometriosis. In South Asian context the prevalence of endometriosis among adolescent are increasing day by day. In adolescent it is more challenging to address the situation and to evaluate of this problem. There are diagnostic dilemma and delay makes the debilitating & progressive disease complicated.For creating awareness among the adolescents, parents, health care providers and the broader community is to be included. This will help early diagnosis and treatment to halt the disease process and lead to a tolerable pain free life to enjoy her womanhood.

Intervention & research are needed for culturally acceptable, feasible and quick process to detect endometriosis among adolescent in schoolgirls.Public education initiative on regular and aberrant menstrual health and symptoms are necessary.Promoting health policies that ensure endometriosis sufferers have access to at least a minimum level and support.In the school-based curriculum this problem of endometriosis is to be included.Primary health cares should screen detect and treat endometriosis especially where gynecologist or advanced interdisciplinary experts are unavailable.
So, the South Asian countries together need to make a platform for the awareness and authentic management guideline for the adolescent endometriosis warriors.

41. Island Nation Challenges Around Maternal &Newborn Care- *Dr. Aseel Jaleel*

42. SRH: Bangladesh Perspective -

Dr. JoysreeSaha- Associate Professor , OBGYN, Popular Medical College, Dhaka, Bangladesh

Reproductive health approach implies to those people who have the ability to reproduce and regulate their fertility; women who are able to go through pregnancy and childbirth safely; the outcome of the pregnancy is successful in terms of maternal and infant survival; and couples who are able to have sexual relations free of fear of pregnancy and contracting disease.

The reproductive healthcare or the primary healthcare is provided in a three-tiered system: at district level, at upazila level and at the Union level. In Bangladesh at the district level 93 (Maternal and Child Welfare Centers (MCWCs), at the upazila level at present 349 Maternal and Child Health (MCH) units and at the Union level almost 3000 Union Health and Family Welfare Centers (UHFWC) are providing reproductive healthcare services. Moreover, countrywide at the Union level, about 30,000 Satellite Clinics are organized every month to provide doorstep services.

According to the International Technical Guidance on Sexuality Education (ITGSE), Comprehensive Sexuality Education (CSE) is an 'age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information (UN Women & UNICEF, 2018).
Bangladesh population policy and adolescents' reproductive health strategy recommends effective cir-

culation of knowledge and information regarding adolescent reproductive health through school syllabuses in secondary and higher secondary school (MoHFW, 2017). Due to socio-cultural and religious challenges, there are considerable barriers, taboos and resistance to share information on sexuality in the secondary and higher secondary schools in Bangladesh (Bhuiyan, 2014). The evidence from Bangladesh and other regional studies' findings suggests that improving existing CSE programmes, scaling up, and effective uptake requires adaptability of CSE content, relevant to social, and cultural contexts. This adaptability should involve introducing sexuality as a part of life while simultaneously keeping in mind the cultural sensitivity around gender, sex and sexuality as well as the adolescents' capacity to assimilate these concepts.

While Bangladesh has made gains in providing support services in maternal, neonatal and children's health (MNCH) and family planning (FP), there are still considerable gaps and unmet need. An estimated 5,200 mothers die each year due to pregnancy-related causes as high maternal mortality and morbidity remain serious concerns in the country.

43. Prenatal Diagnosis - Prof. S. H. Dodampahala

– Professor of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo, Sri Lanka

44. Electronic Fetal Monitoring- Beyond Conventional Interpretation

–Prof. Chaminda Kandauda- Head/Professor/Consultant Gynecologist and Obstetrician,Department of Gynecology and Obstetrics, Teaching Hospital Peradeniya, Sri Lanka

Anaemia in pregnancy is mainly due to iron deficiency and it is the commonest nutritional deficiency among pregnant women worldwide. The WHO estimates IDA to affect approximately 42% of pregnant women. Since it is highly prevalent and associated with major health concerns to both the mother and the baby, the NICE guidelines recommend that women are screened for anaemia at booking and again at 28 weeks. A trial of oral iron therapy is both diagnostic and therapeutic.

Although oral iron therapy has its own set of drawbacks, pharmacological management of iron deficiency anaemia in the Sri Lankan context is majorly based on oral iron therapy. Intra Venous iron therapy is becoming more popular worldwide, and it's being adopted as a safe and effective method of treatment for IDA in during the second and third trimesters of pregnancy.Many analyses have been conducted comparing the oral and IV iron therapies, and it has shown that, compared with oral iron, intravenous iron is associated with a higher hemoglobin level following therapy, higher neonatal birth weight and higher neonatal ferritin levels. All of the analyses found that adverse effects and discontinuation of therapy were less frequent with intravenous iron. Although IV iron eliminates many shortcomings of oral iron therapy, maternal and neonatal outcomes were not significantly different between the two types of therapies. Considering the advantages to both the pregnant women and the healthcare providers, it would be highly beneficial if intra venous iron therapy could be introduced into the Sri Lankan practice whenever and wherever its use is recommended based on the latest and concrete evidence.

45. Adenomyosis: A Challenge to Fertility Treatment

- Dr. S.Raguraman – Consultant Obstetrician and Gynaecologist, Sri Lanka

Adenomyosis is defined as endometrial glands and stroma being present within the myometrium and leading to hypertrophy of the surrounding myometrium. The epidemiological profile of adenomyosis has been changing due to the role of imaging studies in diagnosis andextensive workup of subfertile women. It is classified according to location, size, extent, and distribution pattern (focal or diffuse), which is essential in fertility treatment. Clinical assessment along with imaging studies are sufficient to diagnose adenomyosis, especially in subfertile women to achieve an optimal outcome.

Adenomyosis has an impact on fertility, fertility treatment and pregnancy outcomes. Abnormal utero-tubal transport and altered endometrial function and receptivity lead to implantationfailure are affect natural fertility. The optimal outcome of basic fertility treatment and assistedreproductive technology is low compared to same-aged non-adenomyotic women. In adenomyotic women, there is an increased risk of

early pregnancy loss, preterm delivery, pre-eclampsia, caesarean section, fetal malpresentation, small for gestational age and postpartum haemorrhage. Management of adenomyosis comprises expectant, medical and surgical options.Early adenomyosis is treated conservatively, along with fertility treatment. Medical management is usually used following surgery or before assisted reproduction. Surgical management remains the mainstay of treatment with challenges and limitations. There are several surgical methods available to manage adenomyosis. In that, surgical excision of adenomyosis with various techniques has shown reasonably improved outcomes in fertility treatment.

Subfertile women should be assessed in view of the effects of adenomyosis on fertility treatment, plan appropriate management without reducing fertility potential and counselling couples about treatment outcomes could aid in overcoming the challenges.

46. Electronic Fetal Monitoring- Beyond Conventional Interpretation

–Prof. Lanka Dasanayake - Professor in Obstetrics & Gynaecology and Head of the Department of Obstetrics & Gynaecology, Faculty of Medicine, University of Ruhuna, Galle, Sri Lanka

Conventionally electronic fetal monitoring is done with cardiotocographs (CTGs) based on pattern recognition, with set parameters and time limits as normal, suspicious and pathological. This interpretation does not take into account the wider clinical picture including the background risk factors, pregnancy complications and varied response to hypoxia of fetuses. Furthermore, it has been shown that conventional CTG interpretation has significant observer errors and false positive rates resulting in poor perinatal outcomes and as well maternal litigation.

Human fetuses are exposed to both hypoxic and mechanical stresses during labor. A fetus is equipped with physiological reflex and endocrine responses to ensure that the fetal central organs are protected from hypoxic ischemic injuries during labour. These physiological attempts at compensation varies from one fetus to another and can easily be identified on the CTG trace. Thus, understanding the physiology of the fetus in labour allows confident prospective prediction of fetal hypoxia. The international Consensus Guideline on physiological Interpretation of CTG developed by 34 CTG experts from 14 different countries in 2018 recommend the "hybrid" Intrapartum Fetal Assessment Tool for physiological CTG Interpretation. The aim of incorporation of fetal pathophysiology whilst interpreting CTG traces is to achieve a reduction in unnecessary intrapartum operative interventions and their resultant complications such as postpartum haemorrhage and perineal tears, whilst at the same time to reduce the incidence of fetal hypoxic-ischaemic encephalopathy (HIE) and perinatal deaths. Current evidence shows that physiological CTG interpretation significantly improves perinatal outcomes.

47. Early Management of Miscarriages

Dr. Rajeev Vithanage - Consultant Obstetrician and Gynaecologist at Ashraff Memorial Hospital Kalmunai, Sri Lanka

Pregnancy is a natural process, but when occurring in a previously compromised woman, it may lead to untoward outcomes which may require additional medical interventions. But even in a previously healthy woman there are many unforeseen occurrences that could lead to major health issues during the pregnancy.

In this regard, identification of the abnormal from the normal pregnancy features is rather important. This may be of utmost value because the signs and symptoms of a normal pregnancy may mimic many disease conditions when taken individually or sometimes in combination. Pregnancy causes physiological changes in almost all organ systems in the body resulting in a wide variety of signs and symptoms, for example mild abdominal pain and spotting, excessive tiredness, increased sleep, morning sickness, frequent micturition, light headedness, gastritis and constipation. Skin changes; spider naevi, breast changes; tenderness and swelling, vaginal changes; thin whitish discharge with thickening and reduced sensitivity of the vaginal walls are some of them. So correct diagnosis is mandatory to reduce over-investigation and unnecessary treatment. At the same, time sinister features suggestive of early pregnancy complications should not be overlooked. Vaginal bleeding, excessive nausea and vomiting, fever with or without rashes, joint pain,

vaginal dryness and itchiness, dysuria, swelling of one leg with leg or calf pain and severe headache can be some of them. Attention should be given to flare ups of chronic diseases such as thyroid dysfunctions, diabetes and other autoimmune diseases e.g., SLE. In this presentation management of miscarriage will be discussed in detail including clinical assessment with history and clinical signs, patient information and support, when to refer and using ultrasound scan for diagnosis. As discussed above, timely identification and management of early pregnancy disorders will ensure a positive outcome for the mother and consequently the family as well as the community at large.

48. Optimizing the Outcome of SLE in Pregnancy

- Dr. Punsiri Gunathilaka– Consultant Obstetrician and Gynaecologist, Base Hospital Kinniya, Sri Lanka

Systemic lupus erythematosus (SLE) is a rare chronic, multisystem autoimmune condition mainly affecting women of childbearing age. It provides challenges to obstetric teams in managing the pre-pregnancy, antenatal, intra-partum, and postpartum periods for a better maternal and neonatal outcome. This could be obtained with a planned pregnancy and a multidisciplinary team involvement.

Effective pre-pregnancy risk assessment and counseling includes exploration of factors for poor pregnancy outcome, discussion of risks and appropriate planning for pregnancy such as initiating interventions to optimize disease activity and adjusting medications to those that are least harmful to the fetus. In pregnancy, early referral for hospital-coordinated care, involvement of obstetricians and rheumatologists (and other specialists as required), an individual management plan, regular reviews, and early recognition of flares and complications are all important. A cesarean section may be required in certain obstetric contexts (such as urgent preterm delivery for maternal and/or fetal well-being), but vaginal birth should be the aim for the majority of women. Postnatally, an ongoing individual management plan remains important, with neonatal management where necessary and rheumatology follow up.

The presentation explores the challenges at each stage of pregnancy, discusses the effect of SLE on pregnancy and vice versa, and reviews medications with the latest guidance about their use and safety in pregnancy. Such information is required to effectively and safely manage each stage of pregnancy in women with SLE.

49. Outcome Assessments in Obstetrics & Gynaecology - Dr. Chanil Ekanayake–

Senior Lecturer / Consultant Obstetrician and Gynaecology, General Sir John Kotelawala Defence University, Sri Lanka

Emory Codman, an orthopedic surgeon was the first to objectively assess patient outcomes. Since then, quality assessment in health care has become increasingly important as health care providers need to minimize errors and improve patient care in order to overcome litigation. Universally applicable outcome assessments also facilitate comparative research.

There are several methods to assess outcomes; clinical outcomes, patient reported outcome measures (PROMs) and the societal perspective. Clinical outcomes include hospital stay, operative time and complication rates etc. Selection of outcomes to reflect the true clinical picture is a challenge. Core Outcome Measures in Effectiveness Trials (COMET) is an agreed standardized set of outcomes that should be reported, as a minimum, in all clinical trials in specific areas of health or health care. Patient reported outcome measures (PROM) are generally regarded as 'soft data' as they are reported by patients themselves and may account for confounders. The societal perspective is based on the opinion of the general public and although acting as a summary of the above two methods, is difficult to measure and can be prone to bias. Cost-effective analysis (CEA) is a new method of assessing outcomes but is often complicated and will change from one setting to another as the cost will differ from centre to centre.

Gross clinical indicators in obstetrics and gynaecology include maternal mortality and morbidity, perinatal mortality which are accepted indices worldwide. Specific PROMS and CEA can be applied to individual clinical scenarios depending on the need.

50. Ventral Suspension, an Innovative Operation for Uterine Prolapse in Young Women

–Prof. Azizunnisa Abbasi- President SOGP, Professor of Obstetrics & Gynaecology and head of the International Medical College Abbottabad, Pakistan

Surgical management of uterine prolapse in young women, where it is needed to conserve the uterus is a challenging task. Manchester repair is becoming obsolete because of its complications associated with fertility and pregnancy. Other option is sacral hysteropexy. For sacral hysteropexy mesh is used to suspend the cervix to presacral facia, procedure is difficult to learn and is associated with mesh related problems. Meshes are not widely available and also are costly. Ventral Suspension is a new innovative operation, where isthmic part of the uterus is pulled up and stitched to the lower cut edge of the rectus sheath.Operation is easy to learn, with minimal side effects and excellent long-term success rate. Video of the original operation will be shown.

51. "Adolescent TB:Future Cause of Infertility"

Prof. Sangeeta Sharma - Prof and HeadDept of Pediatrics, National Institute of Tuberculosis and Respiratory Diseases, New Delhi, India

52. Female Urinary Incontinence:Evidence Based Treatment Pathway -

Dr. Kajendran Jogarasah- Consultant Obstetrician and Gynaecologist at Base Hospital Thellippalai, Sri Lanka

Urinary Incontinence (UI) is a highly prevalent condition amongst women affecting approximately 50% of women aged > 50years.In Sri Lanka a diverse range has been reported with the highest prevalence being 54.8; such diversity is mainly due two reasons, it is either that the women are embarrassed to talk about their condition, or they deem it to be a normal occurrence not requiring medical attention. Along with the increase in the aging population and obesity this is expected to eventually result in a public health issue when the economic, psychosocial, and physical burdens of UI are concerned, necessitating a focused management pathway.

It is vital to develop a management pathway that integrates recent evidence-based management with screening and diagnosis, ensuring that the barriers faced when seeking medical advice are circumnavigated, thus improving patient and provider knowledge. This facilitates shared decision making about treatment options in line with professional guidelines. A thorough subjective history followed by symptom evaluation and risk assessment using any validated surveys where necessary should be done. At times evaluation and care should be done by specialists/subspecialists in cases such as congenital, neurological/ metabolic conditions, fistula, prolapse, urinary retention or prior pelvic surgeries. After the cause has been identified UI should be classified into stress, urgency, or mixed type prior proceeding to initial treatment recommendations. First line treatment includes pelvic floor training and behavioral modifications then progress onto advanced therapies. Evidence based infographics positively impact patient knowledge, treatment and supplements counselling and decision-making.

53. Pelvic Floor dysfunction; Impact on quality of life

Dr. J. B. Sharma – Professor, Department of Obstetrics & Gynaecology, All India Institute of Medical Sciences, Ansari Nagar, New Delhi, India

The inseparable relationship between structure and function in living organisms is one of the common themes found in biology. The normal functioning of the pelvic floor is responsible for proper functioning of lower urinary tract. The structure of pelvic floor relates to micturition, continence and pelvic organ support.

Pelvic floor disorders, including urinary and anal incontinence, pelvic organ prolapse (POP), sexual dysfunction, and pelvic pain consist of an array of functional and anatomical diseases that significantly impact the quality of life (QOL) of women. As pelvic floor disorders are largely functional problems that cannot be diagnosed by objective testing. Questionnaire transform "subjective" information into "objec-

tive" measures of the presence and severity of symptoms as well as their effect on QOL. Unlike many diseases, pelvic floor dysfunction has a huge impact on Quality of life. Here comes the role of patient reported outcome measures. They are assessed with help for various Questionnaire. Various Questionnaire are used to assess for urinary incontinence, sexual function, bowel function, pelvic organ prolapse and to screen and measure satisfaction, expectation, and Goal achievement. POP, urinary incontinence, anal incontinence and other pelvic floor dysfunction have a huge implication on financial, physical, emotional, psychological, and social aspects, and they are demoralizing and distressing. The probability of incontinence increases with age, and the nature of incontinence also changes with increasing age. This is due to an increased prevalence of multiple disorders and organ dysfunction in the elderly. This change has significant implications for clinical management. Pelvic floor problems bring stigmatization, social embarrassment, loss of self-esteem, and loss of face, all of which prompt widespread underestimation and underdiagnosis among patients. Though, there is lot of scope for preventive Urogynecology, and pelvic floor health needs to be restored.

54. Updates of Management of Isthmocele/ Caesarean scar defects –

Dr. Prabhath Jayanga Randombage – Acting Consultant Obstetrician and Gynaecologist, Sri Lanka

Caesarean scar defects (CSD)/ isthmocele/ niche/ diverticulum is a wedge-shaped defect in the anterior uterine wall following caesarean section. The obstetric sequalae of CSD are well described which includes abnormal placentae and scar break down. Gynaecological symptoms and sequalae include post menstrual spotting, infertility, dysmenorrhea, chronic pelvic pain, and scar ectopic. CSD are possibly associated with an increase in risk of complications during some gynecologic procedures like uterine evacuation, endometrial ablation, and insertion of an intrauterine device. Rarely, it can lead to formation of an abscess and fistula. Currently there are no established diagnostic criteria for CSD where majority being asymptomatic. This can be identified by transvaginal ultrasound, saline infusion sonohysterography (SIS) and pelvic MRI. The prevalence of an isthmocele as diagnosed by TVUS ranges from 24 to 70% but, most women being asymptomatic.

Though medical treatment may be tried with LNG IUS, surgery is the most common choice of treatment. Approaches include hysteroscopy, laparoscopy (including robotics assisted), vaginal repair, laparotomy, and combined techniques. Surgery should be only offered for symptomatic patients. There is insufficient evidence to offer surgery to prevent obstetric complications like uterine rupture. Meanwhile, new terminology like LapNiche and HysNiche have been introduced to the gynaecology literature. With the growing number of cesarean sections, the sequalae and complications of CSDs are more likely to be encountered. However, more studies need to be done to establish the diagnostic features of CSDs and the optimal routes and steps of management.

55. Changing Scenario in C-section in Sri Lanka -

Dr. Apputhurai Sritharan – Consultant Obstetrician and Gynaecologist, Teaching Hospital, Jaffna, Sri Lanka

Caesarean section is the time-honored approach to shorten or avoid labour when the woman, the child or both are in danger. It is the most commonly performed major abdominal surgery in women all over the world. The rate of Caesarean section is rising globally. Sri Lanka is not an exception to the world trend. Caesarean sections are effective in saving maternal and fetal lives when they are performed for medically indicated reasons. Antepartum haemorrhage, hypertensive disorders, maternal illness like heart disease, fetal distress and failure to progress are few such indications.

However, globally and in Sri Lanka Caesarean section for non-medical indications are rising exponentially. Maternal request is an important non - obstetric cause for this rise. Increasing maternal age, mater-

nal obesity, urbanization, assisted reproduction, multiple pregnancies are few other attributable causes. Fear of labour pain, the belief that C –section prevents trauma and damage to the pelvic floor and is less traumatic to the baby are also considered as reasons for the rising C-section rate. Fear of litigations and improper use of social media are other important causes for the increase in C-section rate.

Preventing the primary C–section would be the key step to reduce the C-section rate in Sri Lanka. Realistic and candid explanation to pregnant women and their families regarding the benefits of vaginal birth to the mother and baby should be an integral part of the well-structured antenatal care in Sri Lanka.

56. Robsons TGCS -

Prof. Shahanara Chowdhury - Professor and Advisor, Marine City Medical College, Bangladesh

Cesarean section (CS), a potentially life-saving procedure is on the rise worldwide. This rising trend become a cause for great public health concern as it not only increases the CS related maternal and neonatal mortality and morbidities, also have a negative impact on health-related costs and medical resources. The overall CS rate differs significantly between regions, countries and even different institutions of the same country and many of them may not be medically indicated. Variations to CS rates can be explained with some related issues like, inherent differences in patient characteristics, institutional labor management protocols, available resources, internal audit and monitoring systems. Whatever may be the cause, the challenge is to keep CS rates as low as possible without imposing any extra risk to the mother or the infant or both. It requires implementation of effective strategies to optimize CS rates, continuous auditing of CS, improvement in clinical practices and quality care to patients. Lack of an internationally accepted standardized classification system is one of the factors preventing a better understanding of this trend and the underlying causes. Policymakers, program managers, clinicians, and administrators need a standardized and internationally accepted classification system to monitor and compare CS rates in a meaningful, reliable and action-oriented manner.

In 2011, a systematic review and critical appraisal of available CS classification system concluded that, women-based classifications in general and the Robson's Ten Group Classification System (RTGCS) in particular, would be the most suitable framework to optimize CS rates according to the current international and local needs. WHO in 2015 and FIGO in 2016 recommends the use of RTGCS as a global standard for assessing, auditing, monitoring and comparing CS rates between different health care facilities, across countries and regions overtime. Robson's classification is simple, can be applied prospectively, reproducible, clinically relevant and its categories are totally inclusive, mutually exclusive. Every woman who is admitted for delivery can be immediately classified into ten groups based on few predefined obstetric parameters, such as gestational age, parity, fetal presentation, onset of labor, previous CS, and number of fetuses. They also consider the comparison between CS done before the onset of labor and those after spontaneous and induced labor. Each Robson group can be further analyzed to assess its relative size to the obstetric population, its contribution to the overall CS rate, and the CS rate within the group. It has been suggested that, if used on a continuous basis, this classification system can provide critical assessment of care at delivery, able to give overall information of each category, can identify the areas of default or problems. It can also be able to identify where corrective remedial action can be taken and can be used to change practice. The 10-Group Classification System is a simple method providing a common starting point for further detailed analysis within which all perinatal events and outcomes can be measured and compared.

57. Triad of PCOS

Dr. Champika Gihan – Senior Lecturer / Consultant Obstetrician and Gynaecologist, University of Peradeniya, Sri Lanka

PCOS is the commonest endocrine disturbance in women accounting for a prevalence of 8 o 13%. Even though it has higher chance of medical comorbidities, up to 70% of affected women remain undiagnosed. Pathophysiology of the disease is multifactorial and polygenic. It carries both intra-uterine and post-natal environmental risk factors, and the disease may express in circumstances like weight gain. PCOS is a heterogenous collection of symptoms and signs gathered to form a spectrum of a disorder. Expression of PCOS may begin early and it varies across the life span of an individual.

The triad of PCOS includes endocrine, reproductive, and metabolic dysfunctions whilst ovarian dysfunction is central. Endocrine dysfunction is the insight into the pathogenesis of PCOS and it is an association between insulin resistance, compensatory hyperinsulinemia and hyperandrogenism. PCOS women have high LH level, and it correlates with the ovarian volume. Higher the LH level, higher the risk of subfertility. Reproductive dysfunction includes menstrual irregularity, subfertility, and recurrent implantation failure. Intra-ovarian increased androgens arrest follicular development by upregulating the level of AMH. AMH can be used as a biomarker to assess the risk and monitor the prognosis. Metabolic dysfunction includes obesity, type 2 diabetes mellitus, dyslipidemia, hypertension, and cardiovascular diseases. Visceral adiposity is correlated with insulin resistance and metabolic dysfunction. Psychological morbidity and malignancies associated with PCOS also cannot be underestimated.

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