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11th to 13th of August 2023

"Advancing Women's Health with Good Governance"

Abstracts

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ORAL PRESENTATIONS – OBSTETRICS

OP/O – 01
POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME IN THE LATE POSTPARTUM PERIOD

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Objectives
Posterior reversible encephalopathy syndrome (PRES) is known to have a heterogenous aetiology and has known associations with gestational and chronic hypertension and renal disease.

This particular case of PRES which occurred in the late postpartum period has had an uneventful normotensive antenatal period. She presented with bilateral vision loss after two weeks of delivery. PRES is a rare entity in pregnancy and usually occurs in late antenatal or early postpartum periods. But the presented case here is a prime example to state that PRES can even occur in the late postpartum period with subtle blood pressure elevations.

Case report
A 34-year-old lady in her second pregnancy from a suburb of Kandy, who had delivered her baby by elective caesarean section 2 weeks before, presented to the Preliminary Care Unit with two episodes of generalised tonic-clonic seizures, altered behaviour, bilateral vision loss and persistent headache. There weren't any previous episodes of similar nature, high blood pressure readings or proteinuria in the antenatal period.

Her blood pressure was 161/90 mmHg without clonus and normal reflexes. GCS was 15/15 without any focal neurological deficit. Cranial nerves were normal, except for the optic nerve. The seizure was treated, and she was alert afterwards with mild headache and drowsiness, but the vision loss persisted.

Evaluation with CT Brain and CECT brain was done at the presentation and revealed non-specific findings. Further evaluation with MRI revealed changes specific to PRES.

Discussion
A patient presenting with bilateral vision loss is alarming to the clinician. Considered differential diagnoses at the presentation were intracranial haemorrhages, retinal detachments, cerebral venous thrombosis, encephalitis, ischemic stroke and PRES.

PRES is a radiological–clinical diagnosis, and vasogenic edema in the white matter of parieto-occipital region is the currently accepted pathophysiology. Diagnosis of PRES is by clinical findings with the typical radiological findings of subcortical white matter changes in the occipito - parietal region. The prognosis of PRES is usually reassuring despite of its devastating symptoms at the time of diagnosis.

Conclusion
PRES presenting in the late postpartum period without a significant hypertensive history is a rarely encountered entity. It is pivotal to have the necessary awareness and knowledge about

the condition as it is a completely reversible condition given the prompt diagnosis at the time and treatment of the underline causative condition.

OP/O – 02
A CASE OF SUCCESSFUL PREGNANCY IN A TRANSFUSION DEPENDENT BETA - THALASSEMIA MAJOR WOMAN

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Objective
Pregnancy in a transfusion-dependent beta Thalassemia woman is rare due to subfertility (30%-80%) and life expectancy of beta thalassemia major patients ranges around 15-20 years; rarely do these women live long enough to become pregnant.

Case presentation
A 19-year-old primigravida was referred from the haematology clinic in her 19th week of gestation for further management and follow-up. She was diagnosed patient with beta-Thalassemia major at the age of 10 months by HPLC and has been on monthly regular blood transfusion and iron chelation with oral deferasirox. Splenectomy was done at the age of 13 years, and Hib and pneumococcal vaccination was given. She had an unplanned pregnancy, diagnosed at 19 weeks. Thalassemia screening of her spouse was negative. At the booking visit all baseline investigations were done, including FBC, ECG, Thyroid function test, Renal function test, Liver function test, Ultrasound abdomen,2D Echocardiogram, and OGTT. All other investigations were normal except for low Hb and high platelet count. Ultrasound scan parametric were compatible with the period of gestation, and the Doppler study was also normal. She was started on low-dose aspirin while continuing her monthly regular blood transfusion and iron chelation with IV desferrioxamine. Repeat cardiac evaluation, and OGTT were done at 28 weeks of gestation and found to be normal. Two weekly growth scans were done 28 weeks onwards, which were normal. She was admitted for confinement at 39 weeks of gestation but underwent category III caesarean section due to failure to progress in labour. She was discharged from the ward with low dose s/c Enoxaparin for six weeks postpartum, and a haematology clinic follow-up was arranged.

Discussion
The cornerstone of modern treatment in thalassemia major is blood transfusion and iron chelation therapy. In most instances, multiple blood transfusions cause iron overload resulting in hepatic, cardiac and endocrine dysfunction. Improved transfusion techniques and effective chelation protocols have improved the quality of life and survival of individuals with thalassemia major. Pregnancy in women with transfusion-dependent Thalassemia major should be considered as high risk, and close monitoring is needed. Proper and timely assessment and adjustment of hepatic, cardiac and endocrine function in conjunction with prophylactic anticoagulation to reduce thrombotic risk will lead to a successful pregnancy outcome.

Conclusion
Proper assessment and management with a multidisciplinary team lead to successful pregnancy in women with transfusion-dependent thalassemia major.

OP/O – 03
PREVENTION OF SEPSIS: EARLY INDUCTION IN TERM PRELABOUR RUPTURE OF MEMBRANES - AUDIT

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Introduction
Pre-labour Rupture of Membranes (PROM) is defined as the rupture of membranes occurring prior to the onset of labour. Depending on its occurrence being prior to or after 37 completed weeks of gestation, it is further classified as Preterm PROM (PPROM) or Term PROM, respectively. PROM is mainly a clinical diagnosis; however, supportive investigations may play a role when the clinical findings are equivocal. Management modalities of PROM depend on the gestational age of the fetus and the relative maternal and fetal risks associated with the pregnancy. PROM is a major contributory factor for early neonatal sepsis; hence the optimum management modality of PROM is of paramount importance in reducing overall perinatal morbidity and mortality.

Objectives
To determine the effectiveness of early induction over watchful waiting in women presenting with PROM at term in preventing early neonatal sepsis.

Methods
A single-centre retrospective cohort study was performed involving 18 study participants who presented to the Obstetric Ward at DGH Mullaitivu Sri Lanka from February 2022 to May 2022. Women with live singleton pregnancies at term (37 – 42 weeks of gestation) with PROM for less than 12 hours were recruited for the study. Based on the ACOG guidelines, expectant management was carried out, and the incidence of neonatal infections among the study participants was assessed.
During the next four months (from June 2022 - September 2022), a prospective cohort study was conducted using 17 study participants who presented to the same unit, and fulfilled the same criteria as per the retrospective cohort. Upon confirmation of PROM, a ward-based protocol was introduced for those participants aiming for early induction. Protocol included administering intravenous antibiotics and early induction using prostaglandin tablets as soon as the diagnosis of PROM was made. The incidence of neonatal infections within this cohort, too, was assessed.

Results
Considering the newborns of women in the retrospective cohort, 55.55% of newborns were affected by neonatal infections, possibly due to ascending infections. The same investigations carried out for the prospective cohort revealed only 29.41% of newborns to be affected by neonatal infections. So, a 50% reduction in neonatal infections was noted following the introduction of the ward-based protocol on early induction.

Conclusion
Early induction following term PROM can result in a significant decline in ascending infections. Therefore, early induction may be preferred over expectant management in the prevention of early neonatal sepsis following term PROM. The necessity to use intravenous antibiotics upon induction needs further evaluation.

OP/O – 04

OXIDANT-ANTIOXIDANT IMBALANCE IN SRI LANKAN GESTATIONAL DIABETIC WOMEN: A PILOT STUDY

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Background and objectives
Gestational diabetes mellitus (GDM) has several adverse consequences for maternal well-being and fetal development. Oxidative stress, resulting from an imbalance between pro-oxidants and antioxidant defenses, has been suggested as a potential contributor to these complications. Yet, the understanding of oxidative stress and antioxidant status in GDM remains obscure. This study aimed to fill this knowledge gap by investigating serum levels of oxidants and antioxidants to predict oxidative stress in pregnant women with GDM in a Sri Lankan context.

Design and Methods
This case-control study enrolled 30 women with untreated GDM and 30 age-matched controls (healthy pregnant women) in their second or third trimesters. After obtaining demographic and anthropometric data, blood samples (3 ml) were collected from both groups. Nitric oxide derivative (NOx) concentration, lipid peroxidation (LPO) level, total antioxidant capacity (TAC), and catalase enzyme (CAT) activity of serum were measured using colorimetric assays. Pro-oxidant: antioxidant ratio was used to evaluate the presence of oxidative stress. The CombiROC web tool assessed the diagnostic accuracy of the best combinations of markers for GDM.

Results
Pregnant women with GDM had significantly higher levels of serum NOx and LPO than the control group ($p<0.001$; $p<0.01$, respectively). TAC and CAT activity was significantly lower in GDM-afflicted women than in controls ($p<0.001$; $p<0.05$, respectively). Significantly higher LPO: TAC and LPO: CAT activity ratios were observed in the GDM group compared to controls ($P<0.001$; $P<0.001$, respectively), indicating elevated levels of oxidative stress among women with GDM. The CombiROC analysis identified five potential diagnostic marker panels with the most robust discriminatory power for GDM from the control group. These panels consisted of four biomarkers (NOx, LPO, TAC, CAT activity) and BMI, which was also found to be an important marker. The five combinations were (NOx-TAC-LPO), (BMI-NOx-TAC-LPO), (BMI-NOx-LPO-CAT), (NOx-TAC-LPO-CAT), and (BMI-NOx-TAC-LPO-CAT) with an area under the curve of 1.000, sensitivity of 1.000, and specificity of 1.000.

Conclusions
This pilot study evidently demonstrated higher levels of oxidative stress and lower levels of antioxidant defences in Sri Lankan women with GDM than in controls. The findings suggest that administering antioxidant therapy to pregnant women with GDM could be beneficial in mitigating oxidative stress. Additionally, the identification of potential diagnostic markers may contribute to improved and more efficient diagnosis of GDM in the future.

OP/O – 05

PREGNANCY OUTCOMES OF COVID – 19 POSITIVE PREGNANT MOTHERS AT A TERTIARY CARE CENTRE

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Introduction
COVID – 19 pandemic has affected almost all aspects of health. The Delta variant appears to cause even more morbidity and mortality in Sri Lanka, especially among pregnant women during the 3rd wave.

Objective
The aim of this study was to determine the maternal and neonatal outcomes in mothers who were tested with active COVID-19 infection and admitted to the maternal isolation ward and those who had been positive for COVID-19 at any point of the gestation and came for delivery to the professorial unit Obstetrics ward in Colombo South Teaching Hospital.

Design
A cross sectional descriptive study among 59 mothers who were admitted to the maternity COVID ward with active COVID-19 infection and mothers who were positive for COVID-19 at any point of gestation and came for delivery to the obstetric ward of the professorial unit, Colombo South Teaching Hospital.

Method
This study was done over a period of 3 months during the 3rd wave of the COVID-19 pandemic. Details regarding the socio-demographic status, current or past pregnancies, vaccination status against COVID-19 and ward management were collected using Interviewer Administered Questionnaire, and clinical records were analysed using the Statistical Package for the Social Sciences (SPSS – 23) software.

Results
The majority of our study population belonged to the age group of 20 – 24 (33.9%). A majority of 55.9% experienced mild symptomatic disease without pneumonia, 42.4 % were asymptomatic, and one (1.7%) developed COVID-19 pneumonia. Cough, myalgia, arthralgia and fever were the commonest presentations. The association to the severity of the disease was studied with the trimester of contractions of COVID-19, vaccination status, past medical conditions, mode and timing of delivery, intrapartum and postpartum complications, which showed no statistically significant association. 80.7% of the mothers who delivered during active disease underwent Lower Segment Caesarean Section (LSCS). A significant percentage (18%) delivered preterm, where 77.8% of them had active disease. Neonatal COVID-19 status was negative in all tested neonates. Low birth weight was reported in 22.7% of the newborns.

Conclusion
The highest proportion (71.7%) of the study sample underwent LSCS, out of which most number of patients had active disease at the delivery (80.7%). All newborns who were investigated for COVID-19 status were negative. An increased percentage of preterm delivery

and low birth weight was observed when compared to the Sri Lankan newborns in the normal population, with no statistically significant associations.

OP/O – 06
PSYCHOLOGICAL OUTCOMES IN COVID – 19 POSITIVE PREGNANT WOMEN AT A MATERNITY ISOLATION UNIT

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Introduction
The current pandemic has significantly affected the mental well-being of pregnant mothers owing to the fear of being infected and, thus, the fear of having an unsafe pregnancy. Also, various restrictions imposed to curtail the spread of COVID-19 have become detrimental to their mental well-being.

Objective
To determine the level of anxiety and depression in mothers who had an active infection and were managed at the maternity isolation ward and to compare the difference in the level of their anxiety and depression upon their discharge from the isolation ward after being treated. To determine the association between levels of anxiety, depression and obstetric factors.

Design
A cross-sectional descriptive study, done over three months duration, recruited a maximum number of possible mothers (79) who were admitted to the maternity isolation ward at Colombo South Teaching Hospital (CSTH) after being tested positive for Covid-19 by any accepted mode of testing.

Method
Details about socio-demographic status, current and past pregnancies, COVID-19 vaccination status and ward management were collected via Interviewer Administered Questionnaire. Psychiatric assessment was done via Hospital Anxiety Depression Scale (HADS) upon admission and discharge of these COVID-19 positive mothers. Data analysis was done using Statistical Package for the Social Sciences (SPSS – 23) software.

Results
Most of the patients were not anxious (72.2%) and were normal for depression (78.5%) upon admission to the isolation ward. Only 6.3% were depressed upon admission. However, none of the parameters, such as the age, severity of illness, associated medical disorders, blood group of patients, showed any significant association with the level of anxiety. This anxiety didn't persist in patients who remained at the isolation ward till the completion of their quarantine period because 97.8% on discharge were not at all anxious. None of the obstetric or socio-demographic factors showed a statistically significant association except for anaemia during pregnancy ($p=0.028$).

Conclusion
The majority of the study sample was normal for anxiety and depression according to the HADS at admission and as well as throughout the admission. This can be explained by the naturally strong mentality of the patients due to the trust in good patient care at tertiary hospitals or inadequate knowledge of patients on the severity of COVID-19 and its fatality. There was a statistically significant association between the level of depression and anaemia in pregnancy. However, further study on this is required to explain the association.

OP/O – 07
AUDIT ON DETERMINING THE CAUSATIVE FACTORS FOR EPISIOTOMY ASSOCIATED INFECTIONS AND ASSESSMENT OF METHODS TO PREVENT INFECTIONS

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Introduction
Episiotomy is an incision made during normal vaginal delivery to protect the maternal pelvic floor from lacerations. In the early days, it was performed as a standard practice in all vaginal deliveries, but in the current clinical context, the advantage of it had become questionable as the natural tears occurring during the delivery process were found to be less significant than the incidence of surgical site infections associated with the episiotomy. Investigating the causative factors and taking necessary measures to prevent such infections is of great importance as it will have direct and indirect effects on the mother and the newborn during the early postpartum period.

Objectives
To determine the causative factors for episiotomy-associated infections and assessment of methods to prevent infections.

Methods
A single-centre retrospective cohort study was performed involving 207 study participants who underwent vaginal deliveries at DGH Mullaitivu, from 1st May – 1st July 2022. The incidence of episiotomy site infections in this cohort was analysed. During the next three months (from 1st August 2022 – 1st October 2022) a prospective cohort study was conducted using 254 study participants who underwent vaginal deliveries at the same unit. A ward-based protocol was introduced for those participants aiming reduction of episiotomy site infections, following which episiotomy site infections.

Protocol included a one-day training programme for all the health care staff at the ward on proper aseptic episiotomy suturing techniques, administration of oral cefuroxime 500mg bd for five days for all mothers who underwent episiotomy, prescription of Lactulose for all the mothers who underwent instrumental deliveries, displaying of educational videos and posters on proper perineal hygiene in the ward and clinic premises and conducting health education sessions to mothers by the midwifery team.

Results
Considering the vaginal deliveries performed in the retrospective cohort, 182 (87.9%) were normal vaginal deliveries, 25 (12.1%) were instrumental deliveries, out of which 8 (3.9%) were

performed using forceps while 17 (8.2%) were performed using the vacuum cup. In this cohort 22 (10.6%) mothers presented with episiotomy site infections.
Considering the prospective cohort, 28 (11.0%) were instrumental deliveries, out of which 12 (4.7%) were performed using forceps while 19 (7.4%) were performed using the vacuum cup. In this cohort 5 (2.0%) mothers presented with episiotomy site infections. So, 8.1% reduction in episiotomy site infections was noted following the introduction of the ward-based protocol on episiotomy care.

Conclusion
Based on our study, a significant reduction in episiotomy site infections was noted following the introduction of a ward-based protocol to address the above deficiencies. Hence the importance of these measures in reducing maternal morbidity as well as the economic burden cannot be over-emphasized.

OP/O – 08
TIMING OF REFERRALS TO FETAL MEDICINE UNIT AT COLOMBO NORTH TEACHING HOSPITAL.

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Introduction
Ultrasound plays a vital role in prenatal care, enabling the assessment of fetal growth, evaluation of fetal anatomy, and management of multiple pregnancies. A first-trimester ultrasound conducted between 11 + 0 to 14 + 0 weeks gestation is used to screen for chromosomal abnormalities and detect major structural anomalies. The mid-trimester ultrasound scan, typically performed between 18 to 24 weeks gestation, focuses on the detailed evaluation of fetal anatomy, allowing skilled professionals to identify clinically significant structural anomalies.

Objective
This article aims to review the timing and indications of referrals made to the Fetal Medicine Unit of the Professorial Obstetric Unit at Colombo North Teaching Hospital.

Design
A retrospective institution-based audit was conducted in the Fetal Medicine Unit of the Professorial Obstetric Unit at Colombo North Teaching Hospital, Ragama. Data were collected from the FMU registry, including all referrals received from June 2022 to June 2023.

Methods
A total of 333 referrals were received by the FMU during the one-year duration from June 2022. The reasons for referrals were categorised into five main categories: exclusion of anomalies, assessment of fetuses with isoimmunisation, assessment of twin and higher order pregnancies and their complications, routine growth scans, and assessment of placenta accrete spectrum disorder. Data were entered and analysed using an Excel spreadsheet.

Results
Out of the 333 referrals, a total of 297 data were analysed. Among these, 181 (61%) referrals were intended for excluding anomalies, while 116 (39%) were for other reasons, including the assessment of fetuses with isoimmunisation (8 cases), assessment of twin and higher order pregnancies and their complications (25 cases), assessment of routine growth scans (82 cases), and assessment of placenta accrete spectrum disorder (1 case).

Within the 181 referrals aimed at excluding anomalies, 45 were for the routine anomaly scan, while 123 were for confirming suspected anomalies. Among the group scheduled for the routine anomaly scan, 60% (27/45) attended within the suitable time frame for an anomaly scan, while only 37% (46/123) attended from the group seeking confirmation of anomalies.

Conclusion
Fetal Medicine Unit plays a significant role in diagnosing and managing fetal conditions. Timing of referrals for anomaly assessment is essential to optimise the detection of fetal anomalies and provide optimal care to both the fetuses and mothers. First-trimester anomaly scans are best performed between 11 and 14 weeks of gestation, while mid-trimester anomaly scans are best performed between 18 to 24 weeks of gestation.

OP/O – 09
ACUTE PANCREATITIS IN PREGNANCY: A RARE ENCOUNTER

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Background
Acute Pancreatitis can complicate 3 in 10 000 pregnancies. The aetiology of pancreatitis is different in pregnancy compared to non-pregnant women. Common Causes of acute pancreatitis in pregnancy include gallstones (over 65%), alcohol and hypertriglyceridemia. Rarely, it can be associated with hyperemesis gravidarum, acute fatty liver in pregnancy, and HELLP syndrome. Acute pancreatitis is more common with advancing gestational age and postpartum, which coincides with the increase in the frequency of gallstones in pregnancy.

Diagnosis of acute pancreatitis is also difficult during pregnancy due to non-specific symptoms. Two out of three criteria must be met for diagnosis of pancreatitis in pregnancy as in non-pregnant women. Diagnostic criteria include abdominal pain, typically epigastric pain radiating to the back, raised serum amylase or lipase levels (more than three times the upper limit of normal) and imaging characteristics that are typical of pancreatitis.

Case report
A 24-year-old female in her first pregnancy at the gestation of 29 weeks presented with severe epigastric pain radiating to her back. This was associated with fever, nausea and vomiting of 2 days duration. On examination, she was febrile, tachycardic and found to have epigastric tenderness. Further investigation found high serum amylase level (968 U/L). Above findings lead to the suspicion of acute pancreatitis, which was further supported by ultrasound scan findings. A multidisciplinary team was involved in the management. Conservative management was done with intravenous fluid, pain relief, antibiotics, antiemetics and close observation. The patient was encouraged on enteral route of nutrition. She made a full recovery

without any short-term sequelae. She had a vaginal delivery at 39 weeks gestation. Mother and baby were discharged home without any complications.

Discussion
The diagnosis of acute pancreatitis in pregnancy is based on the combination of the clinical manifestations, laboratory findings and radiological investigations. Treatment in pregnancy should be carried out by a multidisciplinary team, as in our case. Management can be either conservative management or surgical intervention according to the severity of presentation and the general maternal and fetal condition.

Conclusion
Early detection and appropriate therapy of acute pancreatitis will reduce the maternal mortality rate and prevent catastrophic outcomes.

OP/O – 10
DYSTROPHICA MYOTONIA - A CHALLENGING DIAGNOSIS UNVEILED IN PREGNANCY, WITH CONFIRMED FETAL AFFECTION

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Objective
We present a case report of a pregnant woman in whom the challenging diagnosis of Dystrophica Myotonia (DM) was unveiled during pregnancy. This case highlights the complexity of diagnosing DM during pregnancy and underscores the importance of comprehensive prenatal care, genetic counselling, and multidisciplinary management in such cases.

Case report
A 33-year-old, a primigravida, presented to the obstetrics clinic at 20 weeks with complaints of muscle stiffness, weakness, and respiratory difficulties. She reported experiencing these symptoms intermittently since her teenage years but attributed them to muscle fatigue. At the age of 20, she underwent bilateral cataract surgery. The woman doesn't have a family history of muscular dystrophy. However, she was never evaluated for the condition prior to her pregnancy. Upon examination, wasting and weakness of limbs with reduced reflexes, percussion myotonia, and bilateral foot drop were elicited. Electromyography showed characteristic myotonic discharges, confirming the diagnosis of DM1. Genetic testing (Fragment Analysis) subsequently revealed an abnormal expansion of CTG trinucleotide repeats in the *DMPK gene*. Given the autosomal dominant nature of DM1, genetic counselling was provided to the patient and her partner. Prenatal testing was recommended to determine the status of the fetus. Prenatal testing was not performed. An antenatal ultrasound scan revealed polyhydramnios, the extended attitude of the fetus, and fetal foot drop. An emergency cesarean section was performed due to fetal distress. The baby was delivered with Apgar scores of 2 and 4 at 1 and 5 minutes, respectively. The infant required immediate resuscitation and was transferred to the neonatal intensive care unit. Despite intensive medical interventions, the neonate experienced rapid deterioration in respiratory function and succumbed to respiratory failure at four days of age. The patient experienced worsening muscle weakness, myotonia, and respiratory difficulties during immediate postpartum and required close monitoring in ICU with respiratory support and adjustments in her daily activities.

Discussion
The diagnosis of DM during pregnancy presents numerous challenges. The variability in symptom onset and presentation, coupled with its rarity, often leads to delays in diagnosis. Furthermore, the potential implications of DM on maternal and fetal health necessitate comprehensive prenatal care and multidisciplinary management.

Conclusion
This scenario emphasises the importance of early recognition, genetic counselling, and multidisciplinary management for individuals and families affected by this rare genetic disorder. Further research is needed to better understand the impact of DM1 on pregnancy outcomes and to develop effective interventions to improve.

OP/O – 11
PREGNANCY IN A TRANSGENDER MALE: A CASE REPORT

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Introduction and Objectives
Transgender men are individuals who are genetically females, born with female sexual organs but identified as males. These individuals are considered to have gender dysphoria, which is a mental health disorder. The right to change gender is legal in Sri Lanka. However, there is no legal protection against discrimination for the transgender population. There is inadequate research and guidelines on the fertility and pregnancy-related needs of the transgender population.

Case Report
A 31-year-old transgender man who is in the process of gender transformation was referred with unintended pregnancy at the period of gestation of 12 weeks. Following the diagnosis of pregnancy, he was depressed and wanted to terminate the pregnancy. However, as termination is illegal, the pregnancy was continued after meticulous counselling. He had multiple social problems and stayed at the National Institute of Mental Health (NIMH) and antenatal ward throughout his pregnancy. His pregnancy continued until term, and he was induced with a Foley catheter following the detection of late-onset fetal growth restriction. He underwent an emergency caesarean section due to fetal distress and delivered a 1.935-kilogram baby girl. He chest-fed the baby, developed strong bond with his baby and decided to raise the baby. Jadelle was inserted as postpartum contraception. He was transferred to NIMH mother-baby unit and later discharged with the baby under the care of his mother once all the legal procedures were completed. His pregnancy, delivery, postpartum care, newborn care and birth registration were associated with psychological and legal issues and managed by a multi-disciplinary team.

Discussion
The incidence of transgender pregnancy is increasing worldwide. One-third of pregnancies are unplanned. Transgender men have difficulty in making life choices of carrying a pregnancy, barriers to respectful maternity and labour care, physical and psychological issues with chestfeeding, legal conflicts in the birth registration process, constrain in continuing testosterone supplementation and vulnerability to major depressive disorder. These problems

could be overcome only by proper counselling and the provision of compassionate multi-disciplinary care tailor-made for the transgender population. Unfortunately, the health care staff do not possess adequate knowledge and training on transgender health, and there are no guidelines on the management of transgender pregnancy.

Conclusion
Transgender men have specific needs related to fertility, conception, pregnancy, delivery and post-partum management. Education on transgender health and pregnancy should be incorporated into medical and nursing curriculum. Guidelines on the management of pregnancy in the transgender population should be created by relevant authorities.

OP/O – 12
A CLINICAL AUDIT ON APPLICATION OF THE MODIFIED BISHOP'S SCORE

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Introduction
The Modified Bishop's Score is a widely used pelvic scoring system to assess pre-induction readiness in pregnant women. However, studies have shown that healthcare professionals often fail to fully consider all the parameters of the Bishop's Score during vaginal examinations. To address this issue, an audit was conducted to evaluate the routine checking of five parameters (dilatation, consistency, position, length, and station) in vaginal examinations and to assess the impact of introducing a seal for quick and accurate documentation.

Objectives
The aim of this audit was to determine the frequency of checking the five parameters of a vaginal examination and to examine the effect of implementing a seal for documentation on the Modified Bishop's Score.

Design
A prospective analysis was conducted involving 100 antenatal mothers admitted for delivery in ward 21 of THA.

Method
The initial audit collected data on the checking of dilatation, consistency, position, length, station, Bishop Score, and the conclusion derived from the Bishop score. Following this, the Bishop score chart was displayed near the examination bed, and a seal was introduced to facilitate efficient documentation. A re-audit was then performed to assess any improvements in parameter checking in 3 months.

Results
The initial audit revealed that dilatation and length were consistently checked in all cases (100%), while consistency, position, Bishop score, and conclusion were rarely or never checked, almost less than 2%. The re-audit showed an increase in the checking of consistency (88%), position (74%), Bishop score (44%), and the drawing of a conclusion (54%) significantly increased.

Discussion
The findings indicate that the implementation of the seal led to improved checking of

consistency, position, Bishop Score, and conclusion. The Bishop's Score is crucial in determining the need for induction of labour, and it is essential to ensure consistent and accurate assessment of all parameters.

Conclusion
While the introduction of the seal resulted in improved documentation of the Bishop's Score parameters, the overall checking and conclusion drawing remained sub-optimal. Further efforts in education and reinforcement are necessary to enhance the scoring and decision-making process for the induction of labour. By addressing these limitations, we can improve the management of labour induction and ensure optimal care for pregnant women.

OP/O – 13
POSTPARTUM ASCITES CAUSED BY HELMINTH INFECTION: A CASE REPORT

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Introduction and Objectives
Helminthic infection is the most common cause of peripheral eosinophilia. Eosinophilic ascites is a rare condition, and it can be caused by invasive helminthic parasites; *Ascaris, Trichuris, Ancylostoma, Strongyloides, Trichinella and Toxocara.* These parasites invade the bowel and cause subserosal inflammation, resultingng in eosinophilic ascites.

Case Report
A 28-year-old mother who underwent elective caesarean section presented with abdominal pain, bloating, abdominal distension, vomiting and diarrhoea 7 weeks after delivery. On examination, there was non-tender gross ascites. There is no history of cardiac, renal and liver disease and pre-eclampsia during pregnancy. During the caesarean section ovary appeared normal, and there was no free fluid. An ultrasound scan abdomen revealed gross ascites containing turbid fluid with no other abnormalities. Her CA 125 was 87.28 units/milliliters. Contrast-enhanced computer tomography of the abdomen and pelvis revealed ascites and mild hepatomegaly with no structural abnormality. Her FBC showed a marginally elevated white cell count with eosinophilia (40.1%). All blood investigations, including liver function test and stool full report, were normal. Her immunoglobulin E level was 288.5 IU/ml and filarial immunoglobulin M and G were negative. Helminthic infection was suspected, and she was treated with mebendazole followed by albendazole. Her symptoms improved with treatment; a repeat ultrasound scan performed after one month revealed minimal free fluid in the pouch of Douglas, and peripheral eosinophilia has resolved.

Discussion
Postpartum ascites could be due to pregnancy-related and unrelated causes. Eosinophilic ascites can be idiopathic or associated with abdominal lymphoma, peritoneal dialysis, vasculitis, eosinophilic gastroenteritis, hypereosinophilic syndrome and migrant parasites. Its pathogenesis is poorly understood. A negative stool full report does not exclude the diagnosis of parasitic eosinophilic ascites. Peritoneal irritation due to ascites can result in elevated CA 125 levels, and it is not specific to eosinophilic ascites. Diagnostic aspiration and analysis of

ascitic fluid will show exudate with marked eosinophilia. Histology of biopsy from the gastrointestinal tract will show eosinophilic colitis. Eosinophilic infection due to parasites is reversible with anti-helminthic therapy, and some may require steroids.

Conclusion
When ascites is associated with features of gastroenteritis and peripheral eosinophilia, eosinophilic ascites should be always suspected. As helminthic infection is common in Sri Lanka, it should be considered in the absence of any other cause. High suspicion is necessary for the diagnosis of this condition.

OP/O – 14
AUDIT ON ASSESSING VISUAL ESTIMATION OF BLOOD LOSS FOLLOWING VAGINAL DELIVERIES AT DISTRICT GENERAL HOSPITAL MATALE AND DRILL ON MANAGEMENT OF POSTPARTUM HAEMORRHAGE AND VISUAL ESTIMATION OF BLOOD LOSS

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Introduction
Postpartum haemorrhage is a major cause of maternal morbidity and mortality worldwide. It can lead to hypovolemic shock, acute kidney injury, disseminated intravascular coagulation and heart failure, like life-threatening complications. Thus, visual estimation of blood loss following delivery is extremely important in guiding the critical management of postpartum haemorrhage. It is usually underestimated due to the use of incorrect techniques and lack of awareness.

Objectives
To audit the proportion of correct documentation and measurement of visual estimation of blood loss following vaginal deliveries at the labour room, District General Hospital, Matale.

Method
Data collection was done at the labour room, District General Hospital Matale from June 2022 to September 2022, over 15 weeks duration. Visual estimation of blood loss and correct documentation were entered into the study proforma. A drill on emergency management of postpartum haemorrhage and a workshop on visual assessment of blood loss had been conducted. Posters on visual estimation of blood loss and emergency protocol for postpartum haemorrhage were displayed in the labour room. Re-audit conducted one month after the drill and workshop, from October 2022 to December 2022. Data analysis was done using SPSS statistical software.

Results
An audit was conducted before the drill and workshop, among 232 vaginal deliveries showed, 71 (30.6%) deliveries were documented on blood loss and out of that, only 27 (11.6%) correctly estimated the blood loss. After the intervention, a re-audit was conducted among 191 deliveries and out of those, 170 (89.4%) deliveries were documented on estimated blood loss and 151 (79.1%) deliveries correctly estimated the blood loss.

Conclusion
Correct assessment and documentation of blood loss following delivery is an extremely important thing which should be done by labour room staff. Postpartum drills and workshops helped to improve the correct assessment and documentation of blood loss following vaginal deliveries.

OP/O – 15
PREGNANCY COMPLICATED WITH CHRONIC IMMUNE THROMBOCYTOPENIC PURPURA AND DENGUE HAEMORRHAGIC FEVER IN THE THIRD TRIMESTER.

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Introduction
Immune thrombocytopenic purpura (ITP) is a chronic condition leading to low platelet count with an incidence of 0.1-1/1000 pregnancies. Thrombocytopenia occurs due to antibody-mediated platelet destruction and concomitant suppression of platelet synthesis from bone marrow. It is a diagnosis of exclusion, but it can co-exist with other pathologies leading to thrombocytopenia. In the given scenario, relapse of ITP co-existed with dengue haemorrhagic fever.

Case report
A 38-year-old third para mother with chronic ITP and defaulted follow-up developed fever associated and headache for 3 days. She was admitted to a local hospital and found to have positive dengue NS-1 antigen, platelet count 55,000/µl, positive dengue IgG and IgM antibodies. She was transferred to an intensive care unit at a tertiary care centre. On admission, she was clinically stable without bleeding manifestations, but her platelet count was 13,000/µl. Her ultrasound scan revealed early leaking and dengue critical phase monitoring was started. Her blood picture revealed thrombocytopenia secondary to viral infection and immune thrombocytopenia. An urgent haematological consultation was sought, which recommended augmenting the dose of oral prednisolone and maintaining vigilance in monitoring the critical phase of dengue fever. She completed her dengue critical phase without significant complications. However, her platelet count remained below 10,000/µl persistently. She was transfused with six units of platelets and started on intravenous immunoglobulin (IV Ig) according to haematology opinion. Her platelet counts gradually increased up to 100,000/µl after the completion of her IV Ig regimen for five days. At the same time, her foetal well-being was monitored, and foetal growth was adequate for her period of gestation. On day 9 of the illness, she was transferred to an obstetric ward and discharged with oral prednisolone on day 11 of the illness after the haematology opinion. She delivered a healthy baby at 38 weeks of gestation, weighing 2.9kg.

Discussion
Dengue haemorrhagic fever in pregnancy is associated with very high perinatal morbidity and mortality. Management of dengue haemorrhagic fever in pregnancy consists of critical monitoring, supportive measures for maternal comfort and assessment of foetal wellbeing. Delivery is delayed until the completion of critical phase, irrespective of the outcome of the baby to safeguard the maternal life. In the given scenario, management was extremely challenging due to relapse of ITP. Treatment of choice for ITP is intravenous immunoglobulin

and it may respond to steroids. In severe-refractory cases, splenectomy is indicated but it is technically difficult during the third trimester. The target platelet count during pregnancy is more than 50,000/µl. ITP carries 15% risk of developing neonatal thrombocytopenia due to transplacental transfer of antibodies.

Conclusion
Management of relapse of ITP with concomitant dengue haemorrhagic fever in late pregnancy is an extremely challenging condition. Prompt interventions, provision of intensive care, involvement of a multidisciplinary team, patient counselling and debriefing contributed to improve the pregnancy outcome.

OP/O – 16
SUCCESSFUL PREGNANCY OUTCOME FOLLOWING FLARE OF PSORIASIS COMPLICATING PREGNANCY - CASE REPORT

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Introduction
Psoriasis is a chronic immune-mediated dermatological condition with multi-system involvement. Plaque psoriasis is the commonest type which accounts for 80-90% of cases. Psoriatic arthritis is seen among 10-20% of psoriatic patients. The prevalence of the disease is nearly 1% with equal gender distribution. Psoriasis has 10-20% risk of exacerbation during pregnancy. Common pregnancy complications associated with psoriasis are low birth weight, preterm birth, gestational diabetes, gestational hypertension, preeclampsia and emergency caesarean section.

Case report
A 32-year-old mother of second para and known patient with plaque psoriasis presented at 18 weeks of gestation with exacerbation skin rash with itching, scaling, redness and swelling while on tropical emollients and steroids and multiple painful joints, which was associated with restricted movements, difficulty in walking and standing. On examination, she had raised areas of inflamed skin covered with silvery white scaly plaques. It was distributed on the elbows, knees, scalp, abdomen, chest and back. Furthermore, she had pitting nails and dry reddish eyes. Her inward ultrasound scan revealed a single live foetus with maturity compatible with the period of gestation. Her complete blood count showed neutrophil leucocytosis, ESR was 77mm/hr, and CRP was 81mg/dl. Urgent dermatology and rheumatology opinions were taken. She was started on oral prednisolone, topical steroids, phototherapy and physiotherapy. The patient was closely followed up at joint obstetric, rheumatology and dermatology clinics. She was well responded to the above medications, and her symptoms improved by 24 weeks. But her oral corticosteroids tailing off regimen was continued. At 28 weeks, she was diagnosed with gestational diabetes and started on metformin for glycaemic control. Foetal wellbeing, growth, liquor volume was closely observed. She delivered a healthy baby by 37 weeks, weighing 3.2kg, via an elective caesarean section due to past section.

Discussion
Managing the flare of psoriasis, monitoring maternal and foetal wellbeing, and early identification of pregnancy complications are the main challenges associated with the above scenario. Multidisciplinary management aided in timely inventions and management. Even

though psoriasis is well controlled during pregnancy, there is still a 10 to 20% risk of flare-up during pregnancy. In severe cases, patients may need systemic corticosteroids, including methylprednisolone; immunosuppressive agents, including cyclosporin A, biological agents like Etanercept, infliximab, adalimumab and phototherapy with ultraviolet A and B. Termination of pregnancy may be needed in severe uncontrolled psoriasis with resistance to treatment. Maternal psychological support plays a crucial role in management as it can lead to increased psychological morbidity in pregnancy and postpartum.

Conclusion
Managing a flair of psoriasis during pregnancy is an extremely challenging condition. Multidisciplinary team management, timely interventions, close monitoring and follow-up, helped to improve the pregnancy outcome.

OP/O – 17
ACCURACY OF SONOGRAPHIC ESTIMATION OF THE FETAL WEIGHT FOLLOWING A TRAINING PROGRAMME: AN AUDIT

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Introduction
The assessment of fetal growth is a critical component of prenatal care, enabling the identification of fetuses at risk of perinatal morbidities or mortality. Recognition of both fetal growth restriction (FGR) and large-for-gestational age (LGA) fetuses is essential to plan appropriate care. FGR, referring to fetuses with a birth weight plotting below the 10th percentile, is the single strongest risk factor for stillbirth. LGA fetuses, those with a birth weight greater than the 90th percentile, are at risk of shoulder dystocia and thus increased emergency caesarean section rates.

Ultrasound growth scan incorporates the performance of three fetal biometry measurements – head circumference (HC), abdominal circumference (AC) and femur length (FL). Specific standards and landmarks required for each measurement are stipulated by the International Society of Ultrasound in Obstetrics and Gynaecology (ISUOG) to ensure accuracy and reproducibility and reduce both inter- and intra-operator variability. (Figure1)

Objectives
Assessment of the improvement of accuracy in estimating the fetal weight ultrasonologically by trainees following providing proper teaching and guidance.

Method
50 Bed Head tickets of mothers who delivered were analyzed. The inclusion criteria were trainee should have performed the ultrasound scan, and at least head circumference, abdominal circumference, and femur length should have been measured to estimate the fetal weight. Tabulation was done of the following data. The discrepancies between the estimated fetal weight and birth weight of each mother were calculated. Educating and training of the trainees for a period of one week was performed under direct supervision according to the ISUOG Practice Guidelines. In addition, the printed document was displayed in the scan room to make the process more feasible. Following one week of training, weight discrepancies in hundred cases were collected and analysed. Pre-audit and post-audit data were charted in a bar chart to compare and contrast.

Results and Discussion
Data were analyzed using the pooled t-test, which revealed a significant improvement in estimation of the fetal weight ultrasonologically by trainees following the training session.

Conclusion
Introduction of proper training sessions to trainees and supervising them according to ISUOG guidance is the cornerstone in achieving an accurate Estimated Fetal Weight. Thus, conducting training sessions, and updating the knowledge and skills of the trainees, including in-course assessments, are of utmost importance in order to achieve a successful outcome from both trainees' and patients' perspectives.

OP/O – 18
A CASE OF HYPERREACTIO LUTEINALIS IN A SPONTANEOUSLY CONCEIVED PREGNANCY

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Introduction
Hyperreactio Luteinalis (HL) is a rare benign condition in pregnancy that is caused by high β-human chorionic gonadotropin (β-hCG) levels or abnormal sensitivity of the β-hCG receptor leading to multicystic enlarged ovaries. It is mostly seen in patients with trophoblastic disease, multiple pregnancies or after fertility treatment. We are reporting a case of HL in a spontaneously conceived multiple pregnancy.

Case report
A 23-year-old primi at a period of gestation 13 weeks + presented with excessive vomiting and mild abdominal pain to the gynaecology ward. She didn't have a history of fertility treatment or ovulation induction. Her clinical examination was normal. Investigations revealed hypokalemia 2ry to Hyperemesis Gravidarum and β-hCG levels were compatible with her pregnancy. Ultrasound assessment revealed monochorionic monoamniotic viable twin pregnancy with both ovaries grossly enlarged with a multicystic appearance (right side -13cm *9cm & left side 10cm*8cm) with minimum free fluid in the peritoneum. Her tumour markers were negative. She was managed symptomatically. However, her pregnancy ended up as a 2nd-trimester (19 weeks) complete miscarriage and her ovaries gradually returned to normal over four months period. There were no significant clinical complications that occurred during recovery.

Discussion
HL is a benign condition with spontaneous resolution in postpartum. Pathophysiology similar to ovarian hyperstimulation syndrome, which is mainly iatrogenic, but HL is spontaneous. Our patient didn't have a very high level of hCG which suggest HL may be due to β-hCG receptor hypersensitivity. HL may mimic ovarian malignancy, but cysts will be thin-walled and lack solid components. HL can be differentiated from malignancy by clinical history and tumour markers. Correct diagnosis Careful follow-up will have a favourable outcome.

Conclusion
HL is a rare but benign condition that is important in differentiation from other critical conditions to prevent unwanted complications for patients. Analytical clinical assessment and investigation are vital in diagnosis.

OP/O – 19
DOES MATERNAL VITAMIN D DEFICIENCY INCREASE THE RISK OF GESTATIONAL DIABETES MELLITUS?

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Introduction
Gestational diabetes mellitus (GDM) has become a common metabolic disorder during pregnancy leading to serious adverse effects both in the mother and the offspring. The relationship between maternal vitamin D deficiency and the incidence of developing GDM has gained global attention in recent years.

Objective
To describe the association between maternal vitamin D deficiency and GDM among pregnant mothers attending antenatal clinics at Colombo South Teaching Hospital (CSHT)

Method
A case-control study was conducted among pregnant mothers attending antenatal clinics at Colombo South Teaching Hospital (CSTH), Sri Lanka. 58 pregnant mothers with GDM (Cases) and 80 pregnant mothers without GDM (Controls) at 24-28 weeks of gestation were recruited to the study based on their OGTT values in the antenatal record, according to the IADPSG criteria for diagnosis of GDM (Fasting ≥92 mg/dl, 1- hour≥180 mg/dl, 2 hour- 153 mg/dl). About 3.0ml of venous blood sample was collected from the participants to analyse serum 25(OH)D level. Maternal serum 25(OH)D level was analysed using a Liaison analyser via chemiluminescent immunoassay method. According to the international guidelines, maternal vitamin D status was classified as <10 ng/mL as deficient, 10-20 ng/mL as insufficient and >20 ng/mL as sufficient level. Descriptive statistics, Chi-Squared Test and Independent Samples T Test with the SPSS version 23.0 were used to analyse the data. Ethical approval was obtained from the relevant authorities.

Results
The mean age of the case and control groups were 30.2±4.7 years and 28.5±4.9 years. Mean maternal serum 25 (OH)D levels of the case and control groups were 15.3±4.9 ng/mL and 20.0±5.7 ng/mL respectively. Accordingly, maternal 25(OH)D level was significantly low among pregnant mothers with GDM (p=0.000). Also, the percentage of pregnant mothers with vitamin D deficiency and insufficiency were lower among pregnant mothers with GDM

compared to the control group (13.8% and 70.7% vs. 2.5% and 56.3%). While, the percentage of pregnant mothers with vitamin D sufficiency was higher in the control group than the GDM group (41.3% vs. 15.5%).

Conclusion
Maternal vitamin D level was significantly low among pregnant mothers with GDM, and pregnant mothers with vitamin D deficiency/ insufficiency are at 2.315 times risk for developing GDM ($p<0.05$). Therefore, vitamin D supplementation during pregnancy should be considered to reduce risk of developing GDM.

OP/O – 20
OGTT IN PREGNANCY, ARE WE DOING IT RIGHT? AN AUDIT

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Introduction
One in four live births in Southeast Asia is complicated with hyperglycaemia in pregnancy. Nearly 7 % of pregnancies in Sri Lanka are thought to be affected by GDM, and Sri Lankan women are at high risk of having GDM. Therefore, the correct identification of GDM is of utmost importance. The oral glucose tolerance test (OGTT) has been the mainstay for diagnosing GDM and performing it adhering to universal protocols is essential.

Objectives
To identify and improve the knowledge gaps among healthcare workers on correct preparation and method of performing OGTT for pregnant women.

Design
A Complete audit cycle was conducted over three months of time and included 60 Healthcare workers who were involved in advising for OGTT.

Method
A web-based questionnaire including 20 multiple-choice questions on the correct method of performing OGTT for pregnant women was given to all participants, and responses were automatically recorded. A poster on the correct preparation and method of performing OGTT was introduced to the ward, and a lecture was conducted for all healthcare staff in the ward. The re-audit was conducted one month after the intervention.

Results
35% of participants were not aware that the woman should take a normal diet unrestricted of sugar for 3 days prior to the test, and more than 50% were unaware that she should not exercise prior to the test. Although the majority were aware of the minimum number of fasting hours, they were not aware of the exact maximum fasting duration. Only 55% of them were aware that water is allowed during fasting. Nearly 65% of participants did not know that patients should be at rest during the test period. Knowledge of methods that can prevent vomiting of glucose drink was poor, and after the implementation, there was a significant improvement in the knowledge, and almost all questions were answered correctly.

Conclusion

Even one value above the cut-off in OGTT is considered abnormal, and the woman is diagnosed as having a high-risk pregnancy complicated with GDM, which ultimately results in increased healthcare cost. If the false negatives are increased, it can result in adverse pregnancy outcomes related to Diabetes. Adhering to the universally accepted protocol in performing OGTT would prevent such false positives and negatives. Clinical audits to assess adherence to accepted protocol improves the outcome.

OP/O – 21
ANTENATALLY DIAGNOSED DUODENAL ATRESIA LEADING TO SEVERE POLYHYDRAMNIOS: A CASE REPORT

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Introduction

Duodenal atresia is a common cause of intestinal obstruction with an incidence of 1in 5000 to 10000 pregnancies with female predominance. It can be diagnosed using antenatal ultrasound scanning in the presence of a double bubble appearance and polyhydramnios. It carries a good prognosis with a survival rate of 90%.

Case report

A 24-year-old third para with a background history of hyperthyroidism was referred at 36 weeks of gestation from a local hospital due to polyhydramnios with suspected bowel pathology. This was an unplanned pregnancy, and she had taken carbimazole three years prior to conception. Her thyroid functions were within the normal range, and she continued carbimazole during her first trimester. She presented to the booking visit at 12 weeks and then she defaulted her antenatal follow-up and presented at 36 weeks of gestation to the local hospital were found to have her fundus more than dates. She had undergone an inward ultrasound scan which showed increased liquor with a suspected bowel pathology. Then she was referred to the tertiary care unit for further evaluation and neonatal care. She had undergone a detailed department ultrasound scan which showed severe polyhydramnios with duodenal atresia. Neonatology and pediatric surgical referrals were done. Dexamethasone was given for lung maturation. She was observed in the ward for fetal and maternal well-being. During her hospital stay, she had a pathological CTG and undergone an emergency cesarean section at 37 weeks of gestation. She delivered a healthy baby weighing 2.6kg and handed over to the neonatology team. The baby had undergone duodenoduodenostomy at three days following birth and started on oral feeds 12 days after the surgery.

Discussion

Failure to recanalise the lumen of the duodenum at earlier gestation is the main pathophysiology behind the duodenal atresia. Nearly half of the cases are associated with other pathologies, including Down syndrome, annular pancreas, congenital heart disease and malrotation of the gut. It should be managed with a multidisciplinary team involving a neonatologist, paediatric surgeon, fetal medicine specialists, obstetricians and radiologists, ideally at a tertiary care centre. Due to co-existing polyhydramnios, duodenal atresia complicating pregnancies are at a high risk of developing preterm labour, malpositions, placental abruption, postpartum haemorrhage and umbilical cord prolapse. Neonatal and prenatal genetic testing need to be considered to rule out underlying genetic abnormalities.

Conclusion
Multidisciplinary team involvement with timely interventions leads to improve neonatal outcome. Duodenal atresia may be associated with Carbimazole therapy during preconceptional period.

OP/O – 22
ADVANCED ABDOMINAL PREGNANCY: A CASE REPORT

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Introduction and Objectives
Abdominal pregnancy is a rare type of ectopic pregnancy with an incidence of 1 per 10000 live births in which the embryo implants within the peritoneal cavity. Its diagnosis and treatment have significant challenges. Advanced abdominal pregnancy is associated with significant maternal and fetal morbidity and mortality.

Case report
A 20-year-old primipara with suspected abdominal pregnancy was transferred to our hospital at 28 weeks of gestation for further evaluation and management. She conceived spontaneously and a dating scan done at 12 weeks of gestation was reported as live intra-uterine pregnancy in the bicornuate uterus. She has had multiple admissions with abdominal pain during the second trimester and was treated for gastritis. An ultrasound scan confirmed advanced live abdominal pregnancy with a placenta attached to the bladder and uterine wall. Magnetic Resonance Imaging (MRI) was arranged for placental mapping and revealed placental attachment to the bowel. She was kept in the ward and monitored until 34 weeks of gestation. Midline Laparotomy was arranged with multi-disciplinary team input, and a live baby of 2.31 kg was delivered. Placenta was attached to the bladder surface, uterus, parietal peritoneum and omentum. Placenta was left inside after achieving haemostasias, and she was started on antibiotics. She developed mild paralytic ileus which was resolved with conservative management. Ultrasound scan done at 2 weeks post-partum revealed placenta with vascularity attached to bladder and uterus.

Discussion
During an early pregnancy scan, if the gestational sac is seen adjacent to the uterus with an empty uterine cavity, should look for thick myometrium surrounding the sac, bowel loops surrounding the sac and fluctuation of the sac with pressure applied to the pouch of Douglas to correctly identify the pregnancy location. Advanced abdominal pregnancy should be managed in a tertiary care centre with multi-disciplinary input. It can be safely prolonged up to 34 weeks of gestation with meticulous monitoring. Midline laparotomy enables better visualisation of placental attachment. In the absence of heavy bleeding, delivery of the placenta should not be attempted if the placenta is attached to a vascular structure. Methotrexate in early postpartum may cause rapid placental necrosis, massive bleeding due to placental detachment, infection and interference with breastfeeding. Systemic methotrexate can be considered later to hasten placental degradation when its vascularity is reduced.

Conclusion
It is crucial to perform an early pregnancy scan to confirm the location of the pregnancy. In case of any suspicion, an MRI should be performed or a second opinion from an expert should be obtained in a low-resource setting.

OP/O – 23
MATERNAL AND NEWBORN OUTCOMES RELATED TO WEIGHT GAIN DURING PREGNANCY

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Background
Weight gain during pregnancy is an important indicator in the prediction of morbidity and mortality in infants and mothers. The objective of this study was to determine the patterns of weight gain and the maternal and newborn outcomes related to weight gain during pregnancy among pregnant women admitted for delivery at a tertiary care facility in Southern Sri Lanka

Methods
A cross-sectional study was carried out in a consecutive sample of 300 pregnant women admitted to Teaching Hospital, Mahamodara for delivery whose period of gestation was 37-40 weeks with documented evidence on weight gain during pregnancy. A self-developed, pre-tested, interviewer-administered questionnaire was used for data collection. Pre-pregnancy nutritional status was categorized according to Body Mass Index (BMI) and recommended weight gain for each BMI category was considered in determining the adequacy of weight gain. Chi-square test was used to assess the association between variables and followed by a multivariate analysis of variance.

Results
The mean age (SD) of the pregnant women was 29.04 (5.08) years. The majority (81.7%) were Sinhalese and 57.4% were primi mothers. Over 70% of the sample had received secondary education or beyond. According to pre-pregnancy BMI, only 3.8% of the pregnant women belonged to underweight category (BMI<18.5), 52.1% to normal category (BMI=18.5-24.9), 32.1% to overweight category (BMI=25-29.9) and 9% to obese category (BMI≥30). Of the women, 48.3% had an optimum weight gain and 48.3% had inadequate weight gain and 3.14% had excessive weight gain during pregnancy. Over 40% of the women had adequate diet during pregnancy and no statistically significant association was found between the dietary intake and adequate weight gain during pregnancy.

The mean birth weight (SD) of the neonates was 2.983 (0.42) kg and the majority (61.7%) were uncomplicated deliveries. Over 39% of the women had morbidities acquired during pregnancy and gestational diabetes mellitus was the most prevalent (21%) condition.
No statistically significant association was found between the presence of morbidities during pregnancy (p=0.45), the mode of delivery (p=0.57) and the birth weight of the baby (p=0.88), the presence of antenatal (p=0.93) or postnatal complications (p=0.86) and the weight gain during pregnancy.

Conclusion
Further studies are recommended in this area to explore the associations between weight gain during pregnancy and maternal and newborn outcomes.

OP/O – 24

OBESITY IN PREGNANCY AND ITS RELATIONSHIP TO BODY ESTEEM AMONG EXPECTANT MOTHERS

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Introduction
Obesity is a growing health concern that significantly increases complications during pregnancy. The number of overweight women entering pregnancy has increased over the past decade. Emerging research evidence suggests body esteem as an important indicator of mental health. However, the possible relationship of maternal obesity with body esteem has not been adequately investigated.

Objectives
The present study aimed to report the prevalence of maternal obesity and examine the relationship of pregnancy Body Mass Index (BMI) and body esteem.

Design
A descriptive cross-sectional study was conducted at University Hospital Kotelawala Defence University, Navy General Hospital, Teaching Hospital Jaffna, and two antenatal clinics in Gamapaha.

Method
A general information sheet and body esteem scale for adolescents and adults were self-administered to two hundred and eighty two expectant mothers (N=282).

Results
Among the respondents, 46 (16.3%) were in their first trimester, 123 (43.6%) were in their second trimester, and 113 (40.1%) were in their third trimester. Pregnancy weight ranged from 30 to 108 Kg with a mean of 64.57± 13.01. Pregnancy BMI ranged from 12.81 to 43.81 Kg with a mean of 26.53± 5.25. Body esteem ranged from 17 to 84 with a mean of 60.09± 14.16. During pregnancy, 13 (4.6%), 101 (35.8%), 103 (36.5%), and 65 (23%) were respectively underweight, normal weight, overweight, and obese. Spearman rank order correlation revealed a statistically significant strong, negative correlation between BMI and body esteem which was r_s= -0.224, n=282, p<0.005.

Conclusion
Nearly 60% of expectant mothers acquired more weight than recommended during pregnancy, with nearly one-fourth being obese. Body esteem of expectant mothers decreased with increasing BMI. Interventions that target weight reduction and prevention of excessive gestational weight gain must commence in the preconception period. Expectant mothers may benefit from improved mental health if they receive effective nutrition advice and are encouraged to adopt weight-restrictive behaviours.

OP/O – 25

THE RELATIONSHIP BETWEEN BODY ESTEEM, PSYCHOSOCIAL STRESS AND PSYCHOLOGICAL DISTRESS DURING PREGNANCY

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Introduction
Pregnancy being a time of rapid changes in a woman's body weight and size, is associated with an increased vulnerability for the reduced body esteem. Low body esteem has been linked to adverse mental health outcomes for the mother which eventually can trickle down to her infant both before and after birth. However, the nature of the relationship between body esteem and psychological implications continues to be debated by researchers and clinicians alike.

Objectives
The present study aimed to examine the relationship of pregnancy body esteem with antenatal psychosocial stress and psychological distress.

Design
A descriptive cross-sectional study was conducted at the University Hospital Kotelawala Defence University, Navy General Hospital Welisara, Teaching Hospital Jaffna, and two antenatal clinics in Gamapaha.

Methods
Self-administered measures included a general information sheet, body esteem scale for adolescents and adults, Kessler psychological distress scale, and stress scale for pregnant women in the South Asian context: the A-Z stress scale. Two hundred eighty-two (N=282) expectant mothers participated in the survey.

Result
Among the respondents, 46 were in their first trimester (n=46,16.3%), 123 were in their second trimester (n=123,43.6%), and 113 were in their third trimester (n=113,40.1%). The age ranged from 18 to 42 with a mean of 29.01 ± 5.25. Spearman rank order correlation revealed a strong, negative correlation between antenatal psychosocial stress and body esteem (rs= -0.344, n=282, $p< 0.005$) and psychological distress and body esteem (r_s = -0.212, n=282, $p<0.005$).

Conclusion
Psychological distress and antenatal psychosocial stress are strongly inversely related to body esteem. Body-esteem should be a focus of mental health promotion initiatives for expectant mothers. Understanding the mechanisms through which women can achieve higher body esteem during pregnancy is crucial for enhancing mental health during pregnancy.

OP/O – 26

ATYPICAL PRESENTATION OF PREECLAMPSIA AND HELLP AT 19 WEEKS OF GESTATION- A CASE REPORT

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Abstracts
Hypertensive disorders of pregnancy affect 10% of all pregnancies, which carries high morbidity and mortality. Preeclampsia accounts 3-5% of all pregnancies. The HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome a sequalae of hypertensive disorders of pregnancy which carries increased maternal and fetal complications.
We present the case of atypical presentation of preeclampsia and HELLP at 19 weeks gestation.

Introduction

Gestational hypertension is new onset hypertension without significant proteinuria developing after 20 weeks of gestation and resolving within 42 days of delivery. The initiating event in Gestational Hypertension appears to be reduced uteroplacental perfusion as a result of abnormal cytotrophoblast invasion of spiral arterioles, which result in systemic hypertension. maternal mortality 20 times higher in early severe preeclampsia compared to PE after 37 weeks. Pathophysiology of HELLP includes endothelial damage in multiple organs, such as the liver, the kidney, and the placenta, results platelet activation, the release of thromboxane A2, and reduced prostacyclin production all leads to worsened platelet agglutination and aggregation. Besides immediate delivery of the fetus, there is no specific treatment for either pre-eclampsia or HELLP.

Case report

42 years old, 2nd pregnancy, conceived while on DMPA presented with positive Urine HCG and abdominal pain. On admission, her BP was 210/120mmgh, urine albumin +1, and ultrasound revealed single live intrauterine pregnancy compatible with 19 weeks of gestation. Her blood pressure was controlled with IV Labetalol and IV Hydralazine, then stable with oral antihypertensives. Her investigation shows Low platelet, Increasing Liver Enzymes with evidence of Hemolysis in the blood picture which is suggestive of HELLP syndrome. Her clotting profile was normal without evidence of DIC. Emergency hysterotomy followed by ICU monitoring. Jadelle was inserted and discharged on Day 6 with Prazocin and Enalapril once blood pressure was stable and investigations returned normal. There was a slight drop in Haemoglobin from 10.1 to 9.5, and the platelet count, initially 64000 picked up to 143000 following hysterotomy indicating the resolution of HELLP following delivery of the placenta. SGOT and SGPT which was 78 and 64, respectively initially dropped to 46 and 41 respectively, following delivery. Renal function and clotting profile were within normal limits

Discussion

In the current case, her 1st pregnancy was also complicated by preeclampsia at 34 weeks, but her blood pressure was not evaluated in the post-partum and prior to this pregnancy. She may have been a chronic hypertensive. She presented with very high blood pressure at 19 weeks, with headache and abdominal pain, which are the symptoms of preeclampsia. Considering a positive urine Albumin, low platelet, rising liver enzymes and evidence of hemolysis, we decided on termination by hysterotomy, which saved a maternal life.

OP/O – 27
KNOWLEDGE AND PATTERN OF ANTENATAL CARE SERVICES UTILIZATION AMONG PRIMIPAROUS WOMEN

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Introduction
Antenatal care is the service given to a pregnant woman or an adolescent girl by a skilled healthcare professional to ensure the health and well-being of the mother and the newborn. Availability and utilisation of antenatal care services play a key role in good pregnancy outcomes.

Objectives
The objective of the study was to assess the knowledge about the antenatal care services provided by the health care system and determine the pattern of utilisation of antenatal care services among primiparous women attending the antenatal clinics at Castle Street Hospital for Women.

Method
A descriptive cross-sectional study was conducted among 108 primiparous women in their 3rd trimester attending the antenatal care clinics at Castle Street Hospitals for Women in Colombo. A pre-tested questionnaire, developed by researchers and reviewed by experts, was administered by the interviewer. Data regarding knowledge and patterns of utilisation of antenatal care facilities were obtained and assessed using a scoring system to determine the adequacy of knowledge and the pattern of utilisation.

Results
The study reveals that about 48.1% of women had adequate knowledge regarding antenatal care, and 53.7% had a good pattern of antenatal care utilisation. Although most of the study population had a good pattern of utilization, they lacked adequate knowledge regarding antenatal care services. However, an appeasable number of pregnant women had adequate knowledge of antenatal check-ups, screening tests, maternal health concerns, and maternal supplements and vaccination.

Conclusion
The overall knowledge on ANC services of the participants was inadequate, but they showed a good pattern of ANC service utilisation. Even though the participants were using ANC services, they had a poor understanding of the wide variety of services that are available for them. And majority of the participants had utilized government care system to fulfill their ANC requirements.
It is recommended that awareness programs regarding different ANC services for couples during eligible couple registration by PHMs at field level. PHMs should identify pregnant women showing poor utilization of ANC services and encourage them. And also, to improve the accessibility to government ANC facilities both qualitatively and quantitatively

ORAL PRESENTATIONS - GYNAECOLOGY

OP/G – 01
PUBLIC PERSPECTIVE ON THE USES AND INDICATIONS OF SURROGACY WITHIN THE SRI LANKAN CONTEXT

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Background
Although surrogacy is a relatively controversial Assisted Reproductive Technology (ART), there is an abundance of locally and internationally affiliated platforms in Sri Lanka that advertise surrogate mothers under anonymous names for needful couples. Thus, it is necessary to gauge the public perspective on indications of surrogacy within the current legal framework, which isn't either regulated or up to satisfactory standards.

Objective
To describe attitudes and factors associated with surrogacy among 20 - 40-year-old adults in Sri Lanka.

Method
This descriptive cross-sectional study was conducted among men and women aged 20 - 40 years currently residing in Colombo District. The study instrument was an online questionnaire with close-ended questions conducted via a snowball sampling method.

Results
Participants, in general, preferred the usage of surrogacy in women unable to have children due to medical conditions over the other instances provided (83.30%). However, in the instance of same-sex couples opting for surrogacy, non-heterosexuals (n = 22, 88.00%), Buddhists (n = 202, 58.21%), respondents with more liberal religious beliefs (n = 78, 63.93%), and those without children (n = 233, 58.54%) showed significantly higher levels of acceptance of surrogacy. Heterosexuals (n = 165, 40.64%), non-Buddhists (n = 40, 57.14%), and respondents with more firm religious beliefs (n = 59) had significantly higher rejection rates for the use of surrogacy to circumvent the effects of pregnancy. Participants who had positive attitudes towards having children also depicted higher acceptance rates for both of these scenarios (p = 0.001 each).

Conclusion
Non-heterosexuals, Buddhists, and respondents with more liberal religious beliefs were deemed more open-minded about using surrogacy in various instances as opposed to their counterparts. This may have a significant socio-cultural impact on the acceptance and normalisation of third-party reproduction methods like surrogacy, even if properly regulated.

OP/G – 02

KNOWLEDGE AND WILLINGNESS FOR POST-PARTUM CONTRACEPTION IN BASE HOSPITAL DAMBADENIYA – A CLINICAL AUDIT

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Introduction

Contraception is an essential component of postpartum care as it helps to avoid unplanned pregnancies. It helps to enhance maternal well-being as well as the stability of the family.

Objective

To evaluate the service provision and knowledge about postpartum contraception among post-partum women in Base Hospital Dambadeniya.

Method

An interviewer-administered questionnaire was used on 50 post-partum women delivered in the maternity unit from the 01st of March to the 22nd of March 2023. The gold standard was used as 100%. The questionnaire included demographic data, willingness for contraception, type of contraception selected, reasons for not selecting a contraception method, and information on the provision of counselling on contraception. Data were analyzed using Microsoft Excel version 2021.

Results

19 nulliparous and 31 multiparous women were included in the audit. Only 40% of participants selected a contraceptive method. Progesterone implants (43%) were the most frequently chosen method, followed by intrauterine devices (25%), progesterone injections (25%), female sterilisation (18%), and combined oral contraceptive pills (12%). Most women (40%) have selected a method after the counselling they received in the antenatal period. 31% of women selected a method based on their previous experience.

Public health midwives (36%) and ward nurses (47%) provided most antenatal counselling. Counselling by the medical officers was very low. (9%)
Among women who haven't decided on contraception, fear of delay for another pregnancy (39%) was the most common reason for not choosing. 25% of women have not decided on a method as they never received counselling. Fear of side effects (11%) was the next common reason for non-uptake of a method.

Most (61%) of the participants answered yes to receiving counselling and 69% of them preferred antenatal counselling in clinics and the antenatal ward. Twelve women (24%) agreed that counselling should be given to all women before planning a pregnancy.

Conclusion

The uptake of contraception was low. The importance of proper counselling, especially during the antenatal and pre-conception period, was highlighted as most reasons for non-uptake were not receiving counselling and perceived myths and side effects of previous use. Healthcare providers should incorporate contraceptive counselling as a routine, and a separate individualised session on contraceptive counselling during the antenatal period would improve the uptake among users. We plan to re-audit in six months after implementing this into our antenatal clinic.

OP/G – 03

C-INDEX: A PRACTICAL MEASURE TO ASSESS SURGICAL MORBIDITY IN OBSTETRIC AND GYNECOLOGICAL SURGERY

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Introduction

There is a need to develop a method of assessing outcomes that is as accurate as studying complications, more objective than patient-reported outcome measures (PROMs), and easier than CEAs (cost-effective analysis). The C-index was proposed to assess surgical outcomes instead of studying complications that require large sample sizes. It is a suitable index to achieve this goal using intensive care unit (ICU) stay in relation to major surgeries.

Objectives

Evaluate the applicability of the C-index to assess surgical morbidity in obstetric and gynaecological surgery.

Design

A retrospective case series study

Method

A retrospective case series study included all patients who underwent major surgery in obstetrics and gynaecology at University hospital-KDU for a period of one year from July 1st, 2021, to June 30th, 2022. Outcome measures were; degree of difficulty, ICU stay, and complications. The C-index was calculated as; C-index = (sum of ICU stay – sum of ICU stay≤24 hours)/total major surgeries.

Results

The c-index for cesarean sections (n=731) and gynaecological surgery (n=284) was 0.0519 and 0.1092 respectively. In terms of cesarean sections, an emergency procedure was associated with a higher risk of ICU admission [$p<0.01$, OR=6.25 (1.63-23.97)]. The ICU stay > 24 hours was increased by; the total number of complications in a patient [$p<0.01$, OR=3.04 (1.34-6.88)] and age [$p<0.05$, OR=1.151 (1.006-1.317)]. Regarding gynaecological surgery, the degree of difficulty was associated with ICU admission [$p<0.001$]. The ICU stay > 24 hours was increased by total complications in a patient [$p<0.001$, B=1.70 (1.37-2.03)], and reduced by increasing the severity of the worst complication in a patient [$p<0.001$, B=-0.38 (-0.53—0.22)].

Conclusion

The ICU stay > 24 hours is related to total complications in a patient for both cesarean sections and gynaecological surgery. As such, the C-index offers an objective picture of surgical outcomes. It offers a new dimension for quality control, risk management, and benchmarking using routinely available data in any setting.

OP/G – 04

SURGICAL SITE INFECTION FOLLOWING CAESAREAN SECTION IN ANURADHAPURA, SRI LANKA

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Introduction

Surgical site infection (SSI) is one of the common hospital-acquired infections and the incidence following caesarean section is around 3-15%. It is responsible for significant maternal morbidity and economic burden to the health care system. This study is aimed to identify the associated risk factors for post-cesarean surgical site infection in Teaching Hospital Anuradhapura.

Method

A retrospective audit and case note review were done for all caesarean deliveries at Teaching Hospital Anuradhapura in units A & B from 1st June 2022 to 31st November 2022. For women who developed a surgical site infection, details of pre-and post-operative management were recorded. The rate of surgical site infection and risk factors were identified.

Results

A total of 880 caesarean deliveries was studied and the incidence rate of surgical site infection was 3.8% (34/880). There 76.5% (26/34) cases presented within 2 weeks of surgery. Out of the total cases, 47% (17/34) had wound gaping with infection and 70% (24/34) of cases were managed with intravenous antibiotics and secondary suturing. The majority of SSIs were associated with emergency labour room sections, vaginal examinations of more than three times, more than 48 hours of hospital stay, and induction of labour with Foley catheters. Anaemia, antepartum or postpartum fever, diabetes, and more than 500 ml of blood loss during surgery were not prevalent among the cases. Antibiotic prophylaxis and preoperative skin preparation were done for all cases. In almost all cases there was no proper documentation about the post-operative wound care & wound inspection at the discharge of the patient.

Conclusions

Surgical site infections significantly affect the health care burden & maternal morbidity. Emergency caesarean deliveries, number of vaginal examinations, induction of labour, and postoperative hospital stay were more prevalent among the reported cases. Appropriate preventive measures help to lower Surgical site infections and proper documentation & provision of wound care is major deficiency-related postpartum care.

OP/G – 05

HOW COVID-19 PANDEMIC AFFECTED CLINICAL EXPOSURE OF MEDICAL STUDENTS: A COMPARISON STUDY

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Introduction

Online learning has evolved during the pandemic, and in the medical field, the level of clinical exposure is equally as important as the theory knowledge. Thus, the clinical training received by the medical students amidst the restrictions is questionable.

Objective

The main objective of this study is to compare the clinical exposure of the final year medical students who are engaged in studies at the professorial unit for Obstetrics and Gynaecology of Colombo South Teaching Hospital, Kalubowila amidst the COVID-19 pandemic, with those who attended clinical training before the pandemic.

Design

A cross-sectional study was conducted by analyzing the data collected from the portfolios maintained by medical students, during and before the pandemic. The portfolio is a multifaceted record of clinical exposure with case presentations and procedures completed.

Method

The study was conducted with a systematic sampling of 66 final-year medical students belonging to two groups, who completed their professorial Obstetrics and Gynaecology appointment for 7 weeks, using their student portfolios that were completed based on the clinical skills and procedures performed during the appointment. The pre-COVID data was gathered from a previously done study based on the same unit in 2018. Data analysis was done using Statistical Package for the Social Sciences (SPSS – 23) software.

Results

The majority had presented both the Gynaecological and Obstetrics mini Clinical Evaluation Exercise-CEX (62.1% and 56.1% respectively) but the percentages of those who have presented only one case or none is higher than the pre-COVID-19 situation. All of them completed the Objective Structured Assessment of Technical Skills (OSATS) in episiotomy suturing (100%) while 90.9% have performed Artificial Rupture of Membranes (ARM) but only 36.4% have got the exposure to obtain a PAP smear independently. The majority (95%) of the cases were presented to the registrars attached to the unit with fewer encounters of students being evaluated by a consultant. The Obstetric and Gynaecological clinical procedures and skill acquisition reported a slightly lesser percentage than in pre-COVID-19 period with the means and the medians lying in between the 1st and 2nd quartiles of the distribution. On average one reflective writing was completed per student.

Conclusion

The clinical exposure to procedures and skills remains slightly reduced on average during the COVID-19 outbreak compared to the non-COVID-19 period and the opportunity for the medical students to be supervised under a consultant Obstetrician and Gynaecologist had reduced drastically during the pandemic.

OP/G – 06
UNMET NEED FOR FAMILY PLANNING AND CONTRACEPTIVE FAILURE: PREGNANCY COHORT IN ANURADHAPURA

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Objectives
In Sri Lanka, recent evidence suggests a reduction in contraceptive prevalence and an increased rate of induced abortions; thus, an in-depth analysis of unmet needs (UMN)for family planning and contraceptive failures is timely. This study aimed to describe the prevalence of UMN and contraceptive failures among pregnant women in Anuradhapura district.

Method/Design
A mixed-method study was conducted within a large maternal cohort, Rajarata Pregnancy Cohort, which included pregnant mothers registered in field antenatal clinics in 22 Medical Officer of Health areas in the Anuradhapura district. Interviewer-administered questionnaires and focus group discussions were used to collect quantitative and qualitative data.

Results
Among 3,404 pregnant women, the prevalence of UMN was 9.6% (n=290). Out of the 914 (26.8%) unplanned pregnancies,88(8.8%) were on modern contraceptive methods and the common reasons for getting pregnant were “missed-pills” (n=13), delayed DMPA injection(n=8) and unavailability of condoms(n=8). Contraceptive failure was noted in 31 mothers and 48.4% were on oral contraceptives. Six mothers reported emergency contraceptive failures. Qualitative data from a sub-sample revealed that pregnancy due to contraceptive failure is a distressing experience. Mothers were embarrassed due to inadequate spacing between childbirths. Further, these mothers expressed a negative impact of the pregnancy on the household economy. Some mothers have made up their minds to ‘accept’ the pregnancy, while some were contemplating adopting the child.

Conclusion
The prevalence of UMN in the pregnancy cohort in Anuradhapura is higher than the national figure. Unplanned pregnancies due to contraceptive failure are associated with negative health and economic outcomes.

OP/G - 07
AWARENESS OF BREAST CANCER AMONG SCHOOL GIRLS IN KANDY DISTRICT. A SCHOOL-BASED STUDY

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Objective
Breast cancer (BC) is a leading cause of cancer deaths globally. Schooling girls are the first-level target group in many public health interventions. Hence the purpose of this study was to determine the awareness of BC among schoolgirls residing in the Kandy district of Sri Lanka.

Method/design
A descriptive cross-sectional study was conducted among schoolgirls of the age group 13-18in four randomly selected schools in Kandy district and data were collected using a self-administered questionnaire.

Results
There were 406 participants and of them, 402 (99%) heard about BC. The main resource of information was television/radio (n=283) (69.7%). Only 138 (34%) were aware that it's a leading cause of cancer deaths, while only 28 (6.9%) were aware that men get the disease. Most aware clinical features were lump in the breast (n=231)56.9%, skin dimpling (n=131) 32.3%, nipple discharge (n=115) 28.3%. Also171 (42%) thought the pain was a clinical feature.

A low number of participants were aware that past history (n=157) (38.7%), family history (n=129) (31.8%), early menarche (n=30) (7.4%), late menopause (n=38) (9.4%) and nulliparity (n=49) (12.1%)as risk factors. Although 206 (50.7%) were aware of early detection, only 40 (9.9%) knew the steps of self-examination of the breast (SEB). The rural group has significantly less awareness about the steps of SEB (Chisquare=3.95/p=0.047). While 334 (82.3%) definitely would consult a doctor, 25 (6.2%) will still neglect any abnormality of the breast.

Conclusion
Though the awareness of BC is satisfactory the knowledge of preventive methods was unsatisfactory. BC awareness programs can be initiated at the school level as an early preventive strategy.

OP/G – 08
ASSESSMENT OF KNOWLEDGE AND ATTITUDES OF SRI LANKAN POST-INTERN DOCTORS ON OBSTETRICS AND GYNECOLOGICAL EMERGENCIES

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

Method/Design
A descriptive cross-sectional study was conducted using a self-administered close-ended questionnaire based on RCOG guidelines. The study was conducted among 200 randomly selected volunteer post-intern doctors who have done a 6-month internship in an obstetrics and gynecology unit within the last year. Data was collected and analyzed using the Beta version of SSPS.

Results
Of 200 doctors, 10.3% don't like to think or speak about obstetrics and gynecological emergencies. Adequate knowledge of gynecological emergencies is shown by 88.5% of participants and for obs emergencies it is 85.2%(n=115). During the internship, 99% of participants, have faced postpartum hemorrhage(PPH), while 878.9% and 94% of them experienced antepartum hemorrhage(APH) and pre-eclampsia(PE) respectively. Of those exposed, the most commonly encountered gynecological emergency was miscarriage 197

while 98% actively participated in the management of those miscarriages. 100% knew basic drugs in emergencies. Competency in communication (84.8%) and skills in handling the situation (77.7%) were low among post-intern doctors. 95% requested modified teaching methods while 98.8% requested to involve them in emergencies and 99.5% requested skills development programs in emergencies.

Conclusions
Post-interns show adequate theoretical knowledge of management and use of drugs in emergencies but lack active participation, positive attitudes, competency in communication, and skills for handling emergencies. Active involvement in managing emergencies, modified teaching methods, and skills development programs are suggested to improve the skills and attitudes of Post interns in managing emergencies to improve the quality of Srilankan healthcare.

OP/G – 09
RETROSPECTIVE OBSERVATIONAL STUDY ON ENDOMETRIAL BIOPSY TECHNIQUES; EXPERIENCE IN A TERTIARY HOSPITAL

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Introduction
Endometrial biopsy is a frequently used technique to evaluate the endometrium of patients with abnormal uterine bleeding. It is the way to sample the endometrium to allow for direct histological evaluation of the endometrium detecting endometrial hyperplasia and endometrial malignancy. It can be performed by an Endometrial suction catheter (Pipelle aspirator), traditional dilatation and curettage (D&C) technique, and hysteroscopic endometrial sampling.

Objective
This retrospective observational study aimed to assess the diagnostic efficacy and outcomes of three different endometrial biopsy techniques used in a gynecology clinic. The study analyzed data from 101 participants, evaluating the prevalence of malignancy, benign findings, and non-diagnostic results in endometrial samples obtained via Dilatation and Curettage (D&C), hysteroscopy, and Pipelle® aspiration methods.

Design & Method
Medical records of patients who underwent endometrial biopsy between January 2023 and June 2023 at the professorial unit of the Colombo North Teaching Hospital were retrospectively reviewed. The study cohort consisted of women aged 35 to 85 years, with a mean age of 49 years. Endometrial biopsy techniques were categorized as follows: 53 patients (52%) underwent Pipelle® aspiration, 33 patients (33%) underwent D&C, and 15 patients (15%) underwent hysteroscopy. Histopathological analysis was performed on collected samples to determine the prevalence of malignant, benign, and non-diagnostic outcomes.

Results
Among the 101 participants, 4% of endometrial samples were malignant, 70% were benign, and 25% were non-diagnostic due to procedural failure or inadequate samples. In the Pipelle®

aspiration group, 35% of patients had negative endometrial samples, while 65% had positive samples. Out of the positive samples, 5.8% were non-diagnostic. In contrast, the D&C and hysteroscopy groups exhibited higher rates of successful sample acquisition, with 85% and 100% of patients, respectively, obtaining sufficient endometrial tissue for diagnosis.

Conclusion
This retrospective observational study highlights the utility of different endometrial biopsy techniques in a gynecology practice and their diagnostic outcomes. The Pipelle® aspiration method was the most commonly used technique, demonstrating acceptable diagnostic yield with a low rate of non-diagnostic samples. However, D&C and hysteroscopy exhibited higher rates of successful sample collection, leading to enhanced diagnostic accuracy. The findings underscore the importance of tailoring the choice of biopsy technique to each patient's clinical characteristics and the clinical indication. Further prospective studies with larger sample sizes are warranted to validate these results and refine clinical guidelines for endometrial biopsy in gynecology practice.

OP/G – 10
TOTAL LYMPH NODE YIELD AND VAGINAL CUFF LENGTH IN THE LONG-TERM SURVIVAL OF PATIENTS FOLLOWING RADICAL HYSTERECTOMY

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Introduction
Radical hysterectomy and pelvic lymph node reresection are the mainstay of treatment for early-stage cervical and endometrial cancer. Data on long-term follow-up including survival, adequacy of dissection, and quality of life are not available for Sri Lanka.

Objectives
Assess the long-term survival of patients following radical hysterectomy (RH) for patients with early-stage endometrial and cervical carcinomas.

Design
A case series study

Method
A case series of 21 patients who underwent total RH with pelvic lymphadenectomy at university hospital-KDU from 2019 February to 2022 November were followed-up. Outcome measures were; stage, nodal status, number of lymph nodes, vaginal cuff length, recurrences, and quality of life. Quality of life was assessed using EQ-5D-3L.

Results
The median (IQR) age of patients was 60 (53.5-65.5). The total follow-up period was 315 months (n=13). The median (IQR) lymph node (LN) yield was 21 (14-37.5) with positive nodes

in four patients. The median (IQR) vaginal cuff length was 22 (20-44) mm. None of the 13 contactable patients had a recurrence. The mean (SD) EQ-5D-3L score was 0.78 (0.20).

Conclusion
The LN yield and vaginal cuff length in this sample of patients appear to be adequate in the short term considering the follow-up period, lack of recurrences, and quality of life assessment. However, a longer follow-up with a larger cohort of patients would be necessary for wider conclusions to be made.

OP/G – 11
AUDIT OF GYNAECOLOGY OPERATIVE NOTES AT A TERTIARY CARE HOSPITAL, SRI LANKA

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Introduction
Standard medical record-keeping is of paramount importance for effective patient management. Maintaining a comprehensive record of operative notes is the professional responsibility of every gynaecologist. Quality of the operative notes influences not only patients' immediate post-operative care but also health-related decision-making later onwards as well. In 2019, the Royal College of Surgeons of England introduced the "good surgical practice guidelines", which outline the criteria that should be present in operative notes. The purpose of this audit was to evaluate the gynaecology operative notes against this recognized standard in view of improving the quality of documentation and care.

Method
This audit was conducted in the Department of Gynaecology at University Hospital, Kothalawela Defense University, Werahera from April to June 2023. All data were collected prospectively using a checklist that evaluated 25 parameters, based on the 2019 Royal College of Surgeons of England's good surgical practice guidelines. Data extracted from the pro forma were in the form of present, absent, or not applicable. Data were analysed using Microsoft Excel.

Results
Sixty-nine operative notes were analysed prospectively. The majority of the operative notes contained the patient's identifiable details such as name 100%, age 98%, and bed head ticket number 100%. Although the recording of the date was 100%, the time of commencement of the procedure was not recorded in any of the notes analysed. Only 7.2% contained information as to whether the surgery was an elective or emergency surgery. Although documentation of the name of the surgeon 100%, the name of the assistant 85%, name of the anaesthetist 100% were satisfactory, documentation of the name of the theatre assistant and the signature of the record keeper were absent in all of the operative notes. Recording of the remaining surgery details was as follows: type of anaesthesia 94%, operating procedure 98%, the incision 76%, operating diagnosis 100%, operative findings 98%, problems/findings 98%, extra procedures 98%, details of tissues removed 100%, any prosthesis used 100%, closure technique 71%, blood loss 86%, antibiotic prophylaxis 98%, DVT prophylaxis 100%, post-operative instructions 100%.

Conclusion
Gynaecology operative note record keeping was overall satisfactory; however, deficiencies were noted in documenting certain categories in the operative notes. These shortcomings in the existing proforma require revision and re-audit to improve the quality of gynaecological surgery documentation.

OP/G – 12
A RETROSPECTIVE OBSERVATIONAL STUDY ON URODYNAMIC STUDIES IN THE MANAGEMENT OF URINARY INCONTINENCE IN A TERTIARY CARE HOSPITAL IN SRI LANKA

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Introduction
Urinary incontinence is the involuntary leakage of urine that usually occurs with increased intra-abdominal pressure or with the urge to pass urine. It may be present as a combination of urological symptoms where diagnosing becomes complex. Urodynamic studies consist of both the filling or the storage phase and the voiding phase of the bladder, which gives us the measurements to assess the function and dysfunction of the Lower Urinary Tract (LUT).We have been performing urodynamic studies to improve the outcome of management in women with urge-predominant mixed urinary incontinence or urinary incontinence in which the type is unclear, Symptoms suggestive of voiding dysfunction, anterior or apical prolapse, and a history of previous surgery for stress urinary incontinence. Therefore, auditing the urodynamic practice in the management of urinary incontinence is important to improve patient outcomes.

Objectives
To measure the number of women with urodynamically confirmed urinary incontinence and how the definitive management has been changed according to the study result.

Method
The study was done retrospectively with patients attending urodynamic studies from November 2022 to May 2023 at Sri Jayewardenepura General Hospital, Kotte. The patients were given the consent form and symptom assessment questionnaire and asked to fill the bladder diary, which was assessed before the study. The data were collected by tracing the urodynamic test results of 25 patients of which two urodynamic traces were discarded from the audit due to machine errors. Patients with uncontrolled diabetes and urinary tract infections were not included in the audit. The simple proportion was used to analyse the data.

Results and the Discussion
Patients were included from the age of 41 years to 79 years. After analysis of the symptoms and bladder diary, there were 12 patients (52%) with mixed incontinence with urge predominant incontinence and 2 patients (8.6%) in which the predominant symptom was not clear. Five patients (21%) had an apical or anterior wall prolapse associated with stress incontinence, two patients (8.6%) had undergone surgery for uterovaginal prolapse, and two patients (8,6%) had voiding dysfunction. However, only six patients (26%) had detrusor over-activity, but seven patients (30%) had urodynamic stress incontinence among them, only

2(8.6%) had a prolapse and only one patient (4.3%) demonstrated voiding dysfunction during the substraction cystometry and uroflometry. The study revealed that further assessment with ambulatory urodynamics and video urodynamics would provide better results in women who had symptoms but were negative in urodynamic assessment. Standards described by the ICS were maintained during the assessment. Patients with detrusor overactivity were treated with Solifenacin and the bladder drill before planning the corrective surgery (Burch Colposuspension) for stress incontinence in patients with mixed incontinence. Patients with voiding dysfunction were referred for cystoscopy, and patients with stress incontinence were given lifestyle modification, pelvic floor exercises, and surgical options.

Conclusion
The urodynamic assessment provides a more objective assessment of symptoms which helps to improve management decisions and patient outcomes.

OP/G – 13
CLINICAL CASE OF FATAL PULMONARY EMBOLISM IN A WOMAN WITH UTERINE LEIOMYOMA WITHOUT ANY RISK FACTORS

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Introduction
Deep venous thrombosis (DVT), which leads to pulmonary embolism (PE) caused by pelvic vein compression, is a rare and life-threatening complication of leiomyoma of the uterus. Uterine leiomyomas, the most common benign tumour of the uterus, the incident is 30% among reproductive-aged women. Rarely large leiomyoma presents with oedema of the lower extremity and DVT. PE is a common life-threatening sequelae of DVT, occurring about 23-69 per 100,000 population and it carries 25% mortality. Almost 80% of patients with PE were diagnosed with DVT prior to or at the time of PE. Acute DVT and PE have several predisposing factors, such as inherited or Acquired thrombophilia, hypercoagulable states caused by cancer, pregnancy, trauma, oral contraceptives, and major surgery.

Case report
A 42-year-old woman with diagnosed Uterine leiomyoma awaiting myomectomy, presented with abdominal pain. She didn't have any symptoms of dyspnea or pleuritic chest pain, and not have any risk factors for either DVT or PE and was not on any hormonal contraceptives. On physical examination, she had a non-tender abdomen with a 16-week size fibroid uterus without any clinical evidence of DVT. Ultrasound Imaging revealed intramural fibroid with degenerative changes without any detectable abnormality in the abdomen or pelvis. Her urine HCG was negative and all other Blood and Urine investigations were also within normal range. the patient was symptomatically managed with analgesia, and her all parameters were normal. The patient suddenly collapsed and passed away despite continued Resuscitation. Postmortem revealed intramural leiomyoma with degenerative changes, pelvic vein DVT, and a large clot within the heart towards the pulmonary trunk suggestive of pulmonary embolism.

Discussion
Uterine leiomyomas are the most common benign pelvic tumour in reproductive age. Most of them are asymptomatic, but some are symptomatic. Symptoms depends on the size and site of the leiomyomas of the Uterus. Pressure effects of leiomyomas due to compression of the

surrounding anatomic structures, which causes pain, intestinal Obstruction, urinary symptoms like retention, frequency, and incontinence, and rarely oedema of lower-extremity and DVT due to vascular compression. In cases with DVT and PE, the use of appropriate anticoagulant agents, inferior vena cava filters & Thrombolysis, and Surgical Embolectomy in acute cases together with hysterectomy or myomectomy depends on who wants to preserve their fertility is the criterion standard treatment.

Conclusion
In this case, either she didn't have any risk factors or any signs and symptoms of DVT or PE. Her only complaint was abdominal pain and which was well correlated for the Ultrasound appearance of degenerative changes of Leiomyoma, which was also confirmed by postmortem examinations. PE commonly originates from DVT, which rapidly results in death. High degree of clinical suspicion, early appropriate treatment can reduce the risk of mortality, but despite the optimal therapy, it carries a high mortality.

OP/G – 14
AUDIT ON INTRA-OPERATIVE AND POST-OPERATIVE COMPLICATIONS FOLLOWING TOTAL LAPAROSCOPIC HYSTERECTOMIES

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Introduction
The laparoscopic route for hysterectomy has many advantages over open abdominal hysterectomy when performed with the availability of good surgical expertise.

Objective
The objective of the audit is to assess the rate of intra and post-operative complications and the duration of postoperative hospital stay following total laparoscopic hysterectomies in Teaching Hospital Anuradhapura Sri Lanka.

Method
The audit was performed on a sample of patients who underwent total laparoscopic hysterectomies during the period of 1st of January 2022 to 30th April 2022. Data on preoperative co-morbidities, intraoperative complications, post-operative complications, and duration of hospital stay were obtained from hospital records. Thirty-six records were analysed. According to the available evidence, the rate of intestinal injuries (0.4/100), urological injuries (1.3/100), and vascular injuries 0.1/1000), and the usual post-operative hospital stay is 24 hours for laparoscopic hysterectomies.

Results
From the 36 records studied, one patient (2.7%) suffered a bladder injury. 2 (5.5%) needed intra-operative blood transfusion. There were no cases of intestinal or vascular injury. One patient (2.7%) suffered an anaesthetic complication. Post-operatively, four patients were observed for abdominal pain and two patients developed fever. Out of them, 1 had a surgical site infection. There were no cases of postoperatively detected bowel or urinary tract

complications. 19 patients (52%) were discharged from the ward within the first 24 hours following the surgery, and 13 patients (36 %) on day 2 (24- 48 hours). Three patients (8 %) who suffered either from fever or abdominal pain had a hospital stay between 3- 5 days. 1 (2.7%) patient with surgical site infection was treated inward for eight days.

Discussion
One case of intraoperative bladder injury, 2 cases needing a blood transfusion, 4 with post-operative mild abdominal pain, 2 with fever, and one patient with surgical site infection were the only complications noted in the selected sample. 88% of patients were discharged by post-operative 48 hours. Out of them, 52% were discharged within 24 hours. Only one patient had a prolonged stay which was due to a surgical site infection. Duration of hospital stay should be minimised by adherence to the enhanced recovery pathway and should target reducing the post-operative stay to less than 24 hours for more patients. A re-audit should be planned following optimising the care pathway.

OP/G - 15
DYNAMICS OF SURGICAL MANAGEMENT OF ECTOPIC PREGNANCY IN A BASE HOSPITAL IN SRI LANKA: AN AUDIT

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Introduction
Ectopic pregnancy is a common cause of morbidity and mortality in early pregnancy, with an incidence of around 2-3%. Surgical management is the mainstay of treatment for patients not suitable for conservative or medical management of an ectopic pregnancy.

Objectives
To review the patient, practitioner, and system-related factors involved in the surgical management of ectopic pregnancy and to identify ways to reinforce and improve the relevant standards of care.

Design
A retrospective audit via a case notes review.

Method
Case notes of 34 patients who underwent surgical management for ectopic pregnancy in District Base Hospital, Theldeniya, from January 2022 to January 2023, were reviewed for data collection in this audit. Data were analysed by SPSS version 24 and described using percentages and frequencies.

Results
The mean age of the study group was 28.1 years (SD±5.17), with a mean gestational age of 6.3 weeks (SD±2.86) at presentation. Abdominal pain (91.2%) and vaginal bleeding (35.3%) were the most frequent presenting symptoms. The majority have initial medical review (94.1%) and ultrasound (70.6%) within 2 hours. The main indications for surgery were free fluid in the scan (82.6%), deteriorating clinical status (61.8%), and elevated/rising B-hCG (29.4%). The mean Decision-to-Surgery interval was 64.4 minutes (SD±24.32). Laparotomy was the only

available route of surgery. 97.1% (N=33) were in the fallopian tube, while one case of ovarian ectopic was noted. Ampulla was the commonest tubal site (78.8%), while 12.1%, 6.1%, and 3% were in the isthmus, fimbria, and interstitial parts, respectively. Most patients had a leaking (64.7%) or ruptured (27.3%) ectopic, and over 500 mL haemoperitoneum was noted in 38.2%. Blood transfusion was required for 20.6% during the hospital stay. The majority (88.2%) were discharged by postoperative day 2, and none had a major intra- or post-operative surgical complication.

Conclusion
Prompt initial assessment, triage, and decision making, access to ultrasound/blood bank/theatre facilities, and good surgical training are important aspects of proper surgical management of ectopic pregnancy. The availability of laparoscopy would facilitate quicker post-operative recovery while minimising surgical morbidity.

OP/G – 16
AWARENESS OF THE GENERAL PUBLIC ON THE CONCEPT OF SURROGACY AS AN ASSISTED REPRODUCTIVE TECHNOLOGY

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Background
Currently, there is a growing demand and a market for surrogacy as a method of Assisted Reproductive Technology (ART), especially due to the lack of legal provisions to acknowledge or regulate this practice in Sri Lanka. Within this context, ascertaining the awareness of the public with regard to this ART is essential.

Objective
To describe knowledge and factors associated with surrogacy among 20 - 40-year-old adults in Sri Lanka.

Method
This was a descriptive cross-sectional study conducted among men and women aged 20 - 40 years currently residing in Colombo District. The study instrument was an online questionnaire with close-ended questions. Data collection commenced via a snowball sampling method through common online platforms.

Results
The larger proportion (65.89%) had an average level of knowledge, while only a meagre percentage (9.51%) exhibited poor or very poor levels of knowledge of the concept of surrogacy. The majority of participants (>80%) had awareness about ART in general and one of its subsets, surrogacy. Additionally, 89.10% had heard of the concept of surrogacy before the questionnaire. However, only 22.51% acknowledged the use of surrogacy in Sri Lanka. A significant difference in the level of knowledge between males and females was observed ($p = 0.019$), as well as between those who had undergone higher education and those who hadn't ($p = 0.022$).

Conclusion

Due to the meagre levels of comprehension of the legal ramifications and status quo with regard to surrogacy in Sri Lanka, especially within the current socio-cultural context, it is recommended that subfertility clinics held in government and private hospitals in Sri Lanka have health promotion activities to enhance awareness of surrogacy, with special attention on legal context to prevent illegitimate institutions from taking undue advantage. Concerned subsectors of professionals should also be addressed.

OP/G – 17

A CLINICAL AUDIT ON LAPAROSCOPIC SURGERY FOR ECTOPIC PREGNANCY IN GYNECOLOGY AND OBSTETRICS UNIT B TEACHING HOSPITAL, ANURADHAPURA

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Introduction

Ectopic pregnancy (EP) is a potentially life-threatening condition that requires prompt diagnosis and management. Laparoscopic surgery has emerged as a preferred approach due to its numerous advantages over open surgery. This retrospective audit aims to evaluate the management of women with a diagnosis of ectopic pregnancy at Gynecology and Obstetrics Unit B, Teaching Hospital Anuradhapura, over one year from May 2020 to February 2022.

Objectives

The primary objective of this audit is to determine the management strategies employed, including the utilisation of laparoscopic surgery. The findings of this audit will provide valuable insights into the current practices and potential areas for improvement in the management of EP. According to the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines EP surgical management should be by laparoscopy.

Design

A retrospective audit was conducted. The medical records of those diagnosed with tubal EP were reviewed. The audit period spanned from May 2020 to February 2022, covering a total of 32 cases.

Method

Data collection involved a comprehensive review of medical records and were analysed using descriptive statistics, providing a quantitative overview of the diagnostic and management approaches used.

Results

During the audit period, transvaginal ultrasound was the primary diagnostic method, accounting for 93.5% of all diagnoses, while trans-abdominal scans alone did not yield any positive cases. Surgical management was the first-line approach for all women diagnosed with tubal EP. Laparoscopic surgery was performed in 87.5% of cases, while the remaining 12.5% underwent laparotomy. The reasons for opting for laparotomy included a lack of expertise to perform laparoscopy (50%), anaesthetic concerns (50%), and one patient's diagnosis of COVID-19 infection coupled with hemodynamic instability (25%). The majority of cases (78.1%) underwent salpingectomy, while the rest underwent salpingostomy.

Conclusion
This audit highlights the predominance of transvaginal ultrasound in diagnosing tubal EP and the utilisation of laparoscopic surgery, although favourable, is limited by factors such as lack of expertise, anaesthetic concerns, and COVID-19-related challenges. Enhancing facilities and organising proper training programs for medical officers in Gynecology units can potentially lead to increased adoption of laparoscopic interventions in line with the standards set by RCOG.

OP/G – 18
PATIENT WITH CONGENITAL ADRENAL HYPERPLASIA WITH PERSISTENT UROGENITAL SINUS: A CASE REPORT

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Introduction and Objectives
Congenital adrenal hyperplasia (CAH) is an autosomal recessive disorder caused by defects of enzymes in the adrenal steroidogenesis pathway resulting in excessive androgens, which lead to disorders of sex development (DSD). Persistent urogenital sinus (PUGS) occurs in 1 in 100000 female births. It can be an isolated anomaly or associated with DSD.

Case report
A 16-year-old, 46 XX male with classical CAH presented to surgical casualty with acute abdomen and septic shock. He was diagnosed with salt-losing CAH when investigated for ambiguous genitalia with hypospadias. Their parents decided to raise him as a boy. He was started on steroid replacement therapy and underwent hypospadias repair with urethroplasty. He was on monthly Gonadotrophin-releasing hormone (GnRH) analogues for nine years and testosterone replacement for thirteen years. He was diagnosed with hydrocolpos at the age of 11 years, and an ascending and descending urethrogram revealed urethrovaginal communication indicative of PUGS.

He was referred to the gynaecology clinic for total abdominal hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO). While waiting for surgery, he underwent laparoscopic drainage of hydrocolpus. In a few months, he was admitted with high spiking fever, acute abdomen, tachycardia, and hypotension. After starting intravenous antibiotics and haemodynamically stabilising him, a midline laparotomy was performed. It revealed a large pyometrocolpus and pus inside the peritoneal cavity with distorted anatomy. Hysterectomy and BSO were performed. A few weeks later, he again presented with abdominal pain and hydrocolpos, and the histology report revealed incomplete resection of the cervix. Ultrasound-guided aspiration was done. Repeat laparotomy and excision of the residual cervix and upper vagina were performed, and he is awaiting correction of PUGS.

Discussion
As he has been on GnRH analogues for nine years, his hypothalamus-ovarian axis is suppressed. He has not experienced cyclical haematuria. Although the fluid within the uterus

was repeatedly aspirated, it has refilled within a short time. Therefore, the collection of fluid within the vagina and uterus is likely to be urine which has passed through the PUGS into the genital tract, and the pyometrocolpos is probably caused by urinary tract infection.

Conclusion
The presence of PUGS should always be confirmed or excluded in patients with DSD with imaging and cystoscopy. In a genetic female with PUGS who is reared as male, TAH and BSO alone are inadequate, and the PUGS should be surgically corrected. Unfortunately, this surgical procedure is difficult as the vagina is blind-ended and cannot be manipulated from the perineum.

OP/G – 19
ASSOCIATION OF KARYOTYPE ABNORMALITIES IN SUB-FERTILE COUPLES WITH RECURRENT MISCARRIAGES.
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Introduction and objectives
Miscarriage is the spontaneous loss of pregnancy before its viability. Recurrent miscarriages include more than two or three consecutive miscarriages, which is about 1-3 %. About 4% of recurrent miscarriages may have chromosomal abnormalities. The most common being the balanced translocations in either parent or both. The retrospective study was conducted to find the association of karyotype abnormalities in a subfertile couple with recurrent miscarriages.

Method
The study population was the couples referred to the Human Genetic Department, Faculty of Medicine, University of Colombo, over a three-year duration to conventional karyotype for recurrent miscarriages around the country. Data were extracted retrospectively from previous records and reports in the genetic department. Couples' demographic data, clinical history, and investigation results were recorded with conventional karyotype findings. The percentage of karyotype abnormalities associated with these couples was analysed.

Results
A total of 49 patient data were analysed. The mean ages of females and males are 33 and 35 years, respectively. They were with five years of mean age of marriage. Patients with two or three miscarriages were 45%, and 55% of couples had more than four miscarriages. Ninety-five per cent of patients were present after the exclusion of possible thrombophilias. Of all the couples, 6.2% had clinically significant karyotype abnormalities that can result in miscarriage. Those include balanced translocations, chromosomal inversions, and Turner mosaicism. In this cohort of patients, 12.5% were with a normal polymorphic variant with either partner and commonly with a female partner (80%). Both partners with polymorphic variant was 6.5%. Seventy-five per cent of couples had normal karyotypes.

Conclusion
Karyotypes have been conducted towards the later part of the reproductive age of the women, and the majority of the patients who underwent karyotypes after a fourth miscarriage would have limited or delayed the possible fertility options for the couple. Early referral for genetic

assessment with the initial diagnosis of recurrent miscarriage will be helpful in the early diagnosis of karyotype abnormalities and better reproductive management.

OP/G – 20
CYTOGENIC EVALUATION OF AMENORRHOEA DUE TO PRIMARY OVARIAN INSUFFICIENCY

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Background and Objectives
Amenorrhea is defined as the absence of menstruation in a reproductive-age woman. There is a strong correlation between the X chromosome with the physiology of menstruation and reproduction. Therefore, it warrants early referral for the identification of cytogenetic abnormalities in amenorrhoeic patients. This study aims to estimate the frequency and types of chromosomal abnormalities in both primary (PA) and secondary amenorrhoea (SA) due to ovarian insufficiency in Sri Lanka and correlate their hormonal profile and sonographic findings with chromosomal reports.

Design and Method
A retrospective study, where the data was collected from records of the Human Genetic Department, Faculty of Medicine, University of Colombo, over a three-year duration. Clinical features of 76 patients, referred from all over the country, along with their hormonal profile and sonographic findings with their cytogenic report, were recorded. G- banded chromosomes were karyotyped, and chromosomal analysis of all patients was recorded.

Results
The results revealed 28 cases (48%) had normal female karyotypes (46XX) among all cases of PA due to primary ovarian insufficiency (58), and 30 case (52%) with different abnormal karyotypes. Among the abnormal karyotype constituents, 46.6% (14) had Turners (45X), 40% (12) had 46XY, and 4 cases had other cytogenic abnormalities. Among 18 cases of secondary amenorrhoea due to ovarian insufficiency, 12 cases (66.6%) had normal female karyotype, and 6 (33.3%) cases had Turner mosaic karyotype.

Conclusion
This study emphasises the need for cytogenetic analysis as an integral part of the diagnostic protocol in the cases of PA and SA, especially due to ovarian insufficiency. It will guide the clinician in the precise identification of chromosomal abnormalities and for appropriate reproductive management. Early detection is necessary to proceed with reproductive options and genetic counselling.

OP/G – 21
PREVIOUS CAESAREAN SECTION SCAR ENDOMETRIOSIS. A RARE OBSTETRIC SURGICAL IMPEDIMENT

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Objective
Obstetric surgical Scar endometriosis is a rare occurrence with a challenging diagnosis.

Case report
Scar endometriosis after Obstetric surgery is conceivably increased due to an upsurge in caesarean sections in Sri Lanka. A Case of scar endometriosis extending to the rectus sheath following repeat Caesarean section was diagnosed at the teaching unit Hospital.

Discussion
The patient's symptomatology is abundant on meticulous history details and, through clinical examination, is adequate to diagnose the condition. Imaging is a supplementation and non-specific for definite diagnosis. Wide clear margin resection is the preferred choice of management in this symptomatic patient, whilst GnRH analogues may offer transient improvement of clinical symptoms.

Conclusion
Frequent occurrence of caesarean scar endometriosis warrants measures and adopt protocols at Caesarean section to prevent scar endometriosis in the future.

OP/G – 22
CASE REPORT OF TWIN PREGNANCY COMPLICATED WITH COMPLETE HYDATIDIFORM MOLE AND CO-EXISTING LIVE FETUS

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Abstract
Complete hydatidiform mole (CHM) with a live fetus is a rare and high-risk pregnancy usually seen with ovulation induction. These pregnancies are complicated with life-threatening complications with the risk of gestational trophoblastic neoplasia (GTN) and the necessity for a hysterectomy. This was a spontaneous pregnancy. The decision of continuation or termination of pregnancy was left to the mother after counselling. Unfortunately, the pregnancy had to be terminated at 23 weeks of POA due to profuse vaginal bleeding (VB).

Introduction
CHM with live fetuses is an extremely rare phenomenon, occurring in approximately 1-5/100,000 pregnancies. These pregnancies cause considerable anxiety as they are likely to be associated with an increased risk of life-threatening complications such as haemorrhage, uterine perforation, pre- eclampsia, and malignant change requiring chemotherapy.

Case report
A 28-year-old lady in her second pregnancy. Her first pregnancy ended in a first-trimester miscarriage. Her dating scan at nine weeks of POA & revealed a single live fetus (SLF). However, follow-up USS at 16 weeks demonstrated a SLF compatible with gestation with a large hydatidiform mole was noted, and it was completely covering the os. Serial β-HCG levels were performed, and they were elevated.

The patient was extensively counselled about the risks of continuing the pregnancy. Despite all the advice, she was determined to continue the pregnancy. She had been kept under close observation. Repeat USS performed one month later shows significant enlargement from 12*12cm to 20*20cm but no features of invasion.

Eventually, she had profuse VB at 23 weeks & emergency hysterotomy was carried out. A live fetus was delivered & a large volume of molar tissue was removed. Histopathology confirmed the finding of both a CHM and a normal placenta. PP, the neonate, was admitted to the neonatal ICU and expired within a few hours. Her β-HCG became normal at eight weeks of PP.

Discussion
A CHM with a live fetus is a separate special entity. Clinically, VB remains the most common presenting symptom. Parents who choose to continue the pregnancy should be counselled about the risk of possible maternal complications. Based on the limited studies and guidelines, we tried to continue the pregnancy. However, she developed one of the well-known complications and ended up with an emergency hysterotomy.

Conclusion
The management varies depending on the POA, size, and the site of trophoblastic mass and complications arising from it.

OP/G – 23
LAPAROSCOPIC RESECTION OF NON-COMMUNICATING UTERINE HORN WITH THE FUNCTIONAL ENDOMETRIUM

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Introduction
A unicornuate uterus with a non-communicating uterine horn is a rare uterine anomaly that occurs by aplasia or atresia of one of the paired Müllerian ducts. This is either diagnosed incidentally or while investigating an obstetric or gynaecological problem in the patient. Dysmenorrhea, ectopic pregnancy, abdominal mass, subfertility, and recurrent miscarriages are the commonest presentations.

Case report
A 25-year-old recently married female presented with progressive dysmenorrhea of 4 years duration. She attained menarche 13 years ago, with regular monthly cycles established since the age of 20. Ultrasonography revealed a right-sided adnexal mass suggesting a pedunculated fibroid. She underwent a diagnostic laparoscopy, and a unicornuate uterus with a right-sided uterine horn was noted. Later, she underwent hysterosalpingography, and the right-sided non-

communicating uterine horn was diagnosed. As the best treatment option, the non-communicating uterine horn and the right fallopian tube were resected, and the right-sided round ligament was attached to the uterus to maintain the uterine support under laparoscopy. The right ovary was preserved. Histology of the resected rudimentary horn revealed functional endometrium. Renal anomalies were excluded by ultrasonography before surgical resection.

Discussion

Uterine anomalies are a rare presentation, with difficulty ascertaining incidence since the majority of patients remain asymptomatic. Unicornuate uterus may develop with or without a rudimentary horn. This rudimentary horn can be communicating or non-communicating and functional or non-functional. According to the European Society of Human Reproduction and Embryology (ESHRE)/European Society for Gynaecological Endoscopy (ESGE) classification system for Müllerian anomalies, a unicornuate uterus with functional endometrium is classified as class U4(a). The presence of functional endometrium in the non-communicating horn is the precipitating factor for severe dysmenorrhea due to the distension of the rudimentary horn with menstruation. MRI is the gold standard investigation for the diagnosis of Müllerian anomalies in suspected cases, as the diagnosis is difficult with conventional ultrasonography. Non-communicating rudimentary horn with functional endometrium is treated by excision of the horn laparoscopically or by laparotomy to prevent complications like dysmenorrhea, ruptured horn, and infertility. However, renal anomalies should be excluded before surgical interventions as unicornuate uterus is associated with renal tract anomalies.

Conclusion

When a young female presents with progressive dysmenorrhea, a rudimentary horn with functional endometrium should be one of the differential diagnoses. The definitive diagnosis is made through an imaging or diagnostic laparoscopy. Removal of the rudimentary horn with its connecting fallopian tube is the treatment of choice for younger women to prevent future gynaecological and pregnancy-related complications.

OP/G – 24
PREVALENCE OF SEXUAL DYSFUNCTIONS IN PATIENTS WITH DELUSIONAL JEALOUSY

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Introduction

There is evidence supporting the idea that pathological jealousy may result from diminished sexual function. Similarly, it has been observed that sexual problems are sometimes the consequence of dysfunctional or dissatisfying relationships. Cultural values have a substantial impact on attitudes toward sex and the perceived function of sexual activity. Sexual problems and dysfunctions have been markedly under-researched, especially from the perspective of mental health. Limited studies have investigated the prevalence of sexual dysfunction in clinically jealous patients.

Objectives

The aim of the present study was to determine the frequency of sexual dysfunctions in patients with delusional jealousy and the frequency of their occurrence.

Design
Twenty-three (N=23) patients with delusional jealousy participated in a descriptive cross-sectional study. Respondents came from four settings: the National Institute of Mental Health (NIMH), the University Psychiatry units of National Hospital Sri Lanka (NHSL) and Teaching Hospital Karapitiya (THK), and Noris Clinic, a private mental health clinic.

Method
Male and female versions of the Questionnaire of Cognitive Schema Activation in Sexual Context (QCSASC) were self-administered to the participants. Participants responded in relation to their sexual relationship with their current partner.

Results
Desire disorder had been experienced by 8 (34.78%) men and women. Four (17.4%), 2 (8.7%), and 2(8.7%) males and females had experienced desire disorder, respectively, rarely, sometimes, and moderately. Erectile dysfunction had been experienced by 4 (28.57%) men at some stage in the current relationship. Three (21.4%) and 1 (7.1%) men had experienced erectile dysfunction, respectively, sometimes and moderately. Premature ejaculation had been experienced by 6 (40%) men. Three (20%), 2 (13.3%), and 1 (6.7%) men had experienced premature ejaculation rarely, sometimes, and moderately respectively. Eight (36.36%) men and women had experienced orgasmic difficulties. Three (13.6%), 3 (13.6%), and 2 (9.1%) males and females had respectively experienced orgasmic difficulties rarely, sometimes, and often. One (12.5%) female experienced subjective arousal difficulties moderately. Out of the females who responded, 4 (57.14%) had experienced vaginismus. Two (28.6%), 1(14.3%), and 1 (14.3%) had experienced vaginismus rarely, moderately, and often respectively.

Conclusion
Sexual dysfunctions are notably commoner among patients with delusional jealousy. The commonest sexual dysfunction among men was premature ejaculation, whilst vaginismus was the commonest among females. In evaluating, treating, and educating patients about sexual dysfunction, there is a need for collaboration between healthcare professionals from various disciplines. There is a need for research to identify effective integrated and or combined interventions for sexual dysfunction.

OP/G – 25
HISTOPATHOLOGICAL SPECTRUM OF ENDOMETRIUM IN ABNORMAL UTERINE BLEEDING

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Background
Abnormal uterine bleeding (AUB) is a common presentation in gynaecological practice. Histopathological evaluation of the endometrium plays a significant role in the management of AUB. This study was carried out to determine the histopathological spectrum of the endometrium seen in women presenting with abnormal uterine bleeding.

Objectives
To describe the histopathological spectrum of the endometrium in patients presenting with abnormal uterine bleeding at a tertiary care unit in Colombo, Sri Lanka.

Method
A descriptive cross-sectional study was carried out on a total of 227 consecutive endometrial biopsies reported from 01. 01. 2019 to 31. 12. 2019. Socio-demographic data were obtained from the request forms. All the routine Haematoxylin and Eosin-stained paraffin sections were reviewed at the conference microscope by the principal investigator and a consultant Histopathologist.

Results
The commonest clinical presentation of AUB was heavy menstrual bleeding (60.7%), followed by post-menopausal bleeding (29.5%). The majority (69%) of the samples were from pre-menopausal women. The mean age was 48.66 years. 97.6% (n=202) of the biopsy samples were adequate for histological examination. A pathological cause of AUB was detected in 29% of the cases, while 4.4% of the cases were premalignant or malignant.

The most prevalent histological finding was endometrial polyps (18.5%, n=42). In postmenopausal women, endometrial polyps were the commonest histological finding (23.2%, n=16), followed by inactive endometrium (13%,n=9) & glandular and stroma breakdown of inactive endometrium (10.1, n=8). The majority of premenopausal women were found to have normal cyclical endometria in the secretory (19.2%, n= 29) and proliferative (18.5%, n=28) phase, while endometrial polyps were found in 17.2%, n=26. Five cases of endometrial hyperplasia were detected (without atypia = 2, with atypia =3). All of these cases were from pre-menopausal women.

Endometrial carcinoma was present in 2.2% (n=5) of patients. All of these were endometrioid-type carcinomas. Four of these were FIGO grade 1 tumours, while one carcinoma fulfilled the criteria for FIGO grade II. Two out of 5 cases of endometrial carcinoma were from pre-menopausal women. Exogenous hormone-induced changes of the endometrium were present in 13.5%, n=19 cases. 2.9% (n=3) of these cases were in post-menopausal women.

Conclusion
The detection of pathology in the endometrium in more than $1/4^{th}$ of the cases in this stud re-emphasizes the importance of evaluating the endometrium in patients presenting with AUB. Administration of exogenous hormone prior to endometrial sampling was detected in a significant number of cases which could potentially mask an existing endometrial pathology.

OP/G – 26
AN AUDIT ON THE EFFECTIVENESS OF VAGINAL MISOPROSTOL IN THE MEDICAL MANAGEMENT OF FIRST-TRIMESTER MISCARRIAGES IN A TERTIARY-LEVEL HOSPITAL

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Introduction
The majority of first-trimester miscarriages occur below 12 weeks gestation, with an overall rate of around 20%. Ultrasound has a pivotal role in the diagnosis of miscarriage. Management options fall into three groups: expectant, medical, or surgical. Medical management of miscarriage involves the use of misoprostol; the dose and frequency may vary depending on the type of miscarriage.

Objective
In the literature survey, the overall success rate of medical management ranges from 72 to 93%. The aim of this study was to assess the success rate of medical management in the tertiary level hospital.

Method
A retrospective cross-sectional study was conducted with data collected from patients who were admitted to ward 09 Sri Jayewardenepura General Hospital for medical management from October 2022 to March 2023. All the women who got admitted with missed miscarriages and incomplete miscarriage in the first trimester were administered vaginal misoprostol 800 mcg and 600 mcg, respectively. The repeat dose was given 24 hours later if the first dose was not successful. The efficacy of misoprostol was considered to be a complete miscarriage when the ultrasonic endometrial thickness was 15mm or less after completing the course.

Results
A total of 27 patients were included in the study. Among them, 24 (88.8%) were missed miscarriages, while three (11.11%) were incomplete miscarriages. 20 (74.07%) women were treated with a single dose of misoprostol, while seven (25.92%) women required a second dose 24 hours later. 19 (70.37%) women successfully completed the evacuation with a single dose of misoprostol, while 03 (11.11%) patients required two doses. 05 (18.51%) women required suction evacuation of retained products under anaesthesia. Among them, 04 (14.8%) women were given two doses of misoprostol, and 01 (3.70%) women underwent evacuation after a single dose. Only 01 (3.70%) woman developed severe bleeding after the medical management and required uterotonic to control the bleeding. None of them have developed features of sepsis. The mean duration of hospital stay was 1 to 2 days.

Discussion and Conclusion
SLCOG recommends using two doses of 800 mcg vaginal misoprostol three hourly for missed miscarriage and a single dose of 600 mcg for incomplete miscarriage with a follow-up review 1 to 2 weeks later. In our study, we found that the success rate of medical management was 81.48% which is compatible with NICE recommendation.

OP/G – 27
COMPATIBILITY OF CONTRACEPTIVE CHOICES OF PERI-MENOPAUSAL WOMEN IN RURAL SRI LANKA WITH GLOBAL STANDARDS

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Introduction
Fertility and probability of conception decline by half as early as the mid-forties; however, women during perimenopause still need effective contraception. Reports worldwide have indicated that the use of contraceptive methods in the perimenopausal age group is inconsistent. UKMEC and WHOMEC are two globally adopted guidelines to decide the best possible contraceptive method depending on a multitude of factors.

Method
An audit was conducted among perimenopausal attendees of the gynaecology clinic at Mahaoya Base Hospital, Ampara, on contraceptive practices, and they were compared with the UKMEC and WHOMEC standards.

Results
Even though a considerable proportion of women were sexually active (82.4%), the usage of contraception was only seen among (54.1%) of the participants. Permanent sterilisation with LRT (30%) was the most common method employed, followed by DMPA (25%), IUCD (22%), Jadell (13%), COCP (5%), and condom (5%) usage. Of the women using reversible or long-term contraception (n=28), 42.9% had been employing the best possible contraceptive method (Category-01), followed by Category-02 (17.9%), where advantages outweigh the theoretical or proven risks. A significant 39.8% (n=11) were employing contraceptives belonging to Category-03, where risks outweigh the advantages and use only recommended with specialist advice and when other options are not amenable. None of the women were using contraceptives that were contraindicated for them (category-04). Out of the women belonging to Category-03, the majority (81%) had multiple cardiovascular risk factors, of which most were not under proper control and were using DMPA. There was one patient with a history of cerebrovascular accident currently using a progesterone-only implant (Jadelle) and two patients with a history of ischemic heart disease currently on DMPA.
When inquired further on contraceptive choices, most women have not been consulted by a doctor prior to making the choice. Most have been employing a method that had been recommended to them years before developing any comorbidities.

Discussion & Conclusion
Only half of the perimenopausal women were on a contraceptive method, and around 40% of them were using contraceptive methods that were less than suitable for their comorbidities according to recommended medical eligibility criteria (UKMEC / WHOMEC). Despite services being provided free of charge at government hospitals and MOHs, the use of contraception and obtaining advice on contraception remains at a low level among rural women in Sri Lanka.

OP/G - 28
OFFICE HYSTEROSCOPY FINDINGS AND PATIENTS' EXPERIENCE AT A SRI LANKAN TERTIARY CARE CENTER.

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Introduction
Outpatient (office) hysteroscopy is a minimally invasive approach to common gynaecological problems at a relatively low cost with satisfactory results. The procedure involves the use of miniature endoscopic equipment to directly visualise and examine the uterine cavity without the need for formal theatre facilities or general or regional anaesthesia.

Methodology
The study was conducted as a prospective observational study at the professorial unit of Colombo South Teaching Hospital among women who underwent outpatient hysteroscopy for all indications from January 2020– August 2022.

Results
Three hundred fifty-two women underwent hysteroscopy, and simple analgesics were offered to all women prior to the procedure. Vaginoscopic entry was preferred to overcome pain. The age of patients ranged from 20-79 years, with a mean age of 42.6 years. Major complaints

included heavy menstrual bleeding (n=229,65.1%), spotting (n=74,21%), post-coital bleeding (n=76,21.6%), peri-menopausal bleeding (n=16,4.5%), post-menopausal bleeding (n=66,18.8%), dysmenorrhea (n=210,59.7%) and subfertility (n=145,41.2%). Most hysteroscopies were performed by postgraduate trainee registrars (n=268,76.1%), followed by senior registrars (n=45,12.8%) and 11.1% (n=39) by consultant gynaecologists. Most hysteroscopies were performed within 05 minutes (n=271,77%) with a mean time duration of 6 minutes and 41 seconds.

On examination of the female genital tract, the vulva and vagina appeared normal in all women. The cervical canal appeared normal in most patients (n=287,81.5 %). Some of the abnormalities noted in studies include endo-cervical stenosis (n=46,13.15 %), enlarged uterine cavity (n=10, 2.85 %), abnormal uterine cavity shape (n=13,3.7 %), and abnormal (closed) tubal ostia (right- 4 %, left-1%).

The observed changes in the endometrial cavity included hyperplastic endometrium (n=96,27%), multiple polyps in the endometrium (n=90,26%), single polyp (n=58,16%), atrophic endometrium (n=46,13%) and suspicious endometrium (n=13,4%). Simultaneous pap smears were taken during procedures in 5.7% (n=20) of patients and pipelle biopsy in 19.3% (n=68) of women. Patient's perception of pain during hysteroscopy was assessed after the procedure using the Wong-Barker FACES pain rating scale, and a majority of women expressed that they have experienced uncomfortable, troublesome pain / score-4 (n=204/352, 58%) followed mild annoying pain / score-2 (n=119/352, 33.8%). About 81.3% (n=286/352) of women expressed that they experienced pain less than what they expected the procedure to ensue. Most women (n=316,89.8%) have said they would recommend this procedure to other patients awaiting outpatient hysteroscopy. No immediate or late complications were noted following the hysteroscopy procedures.

Discussion & Conclusion
Outpatient hysteroscopy is a well-tolerated, low-cost, well-established procedure with a low complication rate that has many applications.

OP/G – 29
THE IMPORTANCE OF THE WHO CHECKLIST: A SYSTEMATIC APPROACH TO IMPROVE PATIENT OUTCOMES

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Introduction
Patient safety is a critical concern in healthcare settings worldwide. To address this issue, the World Health Organization (WHO) developed a comprehensive checklist to enhance the quality and safety of patient care for patients who are preparing for surgical procedures. This abstract aims to highlight the importance of the WHO Checklist in improving patient outcomes and reducing preventable errors.

Objectives
The primary objective of this paper is to examine the impact of the WHO Checklist on patient safety. The major hypothesis tested is that the implementation of the checklist leads to a reduction in adverse events and improves overall patient outcomes.

Design
A retrospective clinical audit was conducted to assess the effective usage of the WHO Checklist in theatres in THA.

Method
Selected the patients who underwent surgical procedures in the first two weeks of April 2023 in THA Theaters. Then traced their bead head tickets (BHT) from the record room. A total of 134 BHTs were observed on the WHO checklist in every ticket, and recorded data has been analysed.

Results
Findings suggest that the implementation of the WHO Checklist has not been used properly, and the data which had to include were missing. When considering all theatres, 95% of WHO checklists were not filled or not attached to BHTs. Partially filled WHO checklists were found in 2%, and completed checklists were found only in 3%. In gynaecological theatre, 84.8% of WHO checklists were not filled or not attached to BHTs**.** Partially filled WHO checklists were found in 8.7% % and completed checklists were found only in 6.5 %.

Conclusions
The study concludes that the WHO Checklist is a valuable tool for enhancing patient safety. But its usage has been neglected. Need to understand the importance of the WHO checklist for all healthcare workers involved in theatres. Its implementation contributes to a systematic and standardised approach to care, reducing preventable errors and improving patient outcomes. Future research should focus on further refining and adapting the checklist to different healthcare contexts and exploring its impact on long-term outcomes, cost-effectiveness, and patient satisfaction.

OP/G – 30
IMPORTANCE OF PUBLIC PERCEPTION ON THE GENETIC LINK BETWEEN PARENTS AND OFFSPRING IN THE DETERMINATION OF ATTITUDES TOWARDS SURROGACY.

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Background
Surrogacy is a relatively unknown albeit discreetly commodified Assisted Reproductive Technology (ART) in Sri Lanka. Controversies may arise due to it being a third-party reproductive method, therefore, ascertaining the public perception of surrogacy with regards to the genetic link between parent and child is important if surrogacy is allowed to be continued as an ART option in the country.

Objective
To describe attitudes and factors associated with surrogacy among 20 - 40-year-old adults in Sri Lanka.

Method

This descriptive cross-sectional study was conducted among men and women aged 20-40 years currently residing in Colombo District. The study instrument was an online questionnaire with close-ended questions conducted via a snowball sampling method.

Results

Acceptance of traditional surrogacy was lower among participants with positive attitudes towards the presence of a genetic link between the parents and offspring (n = 168, 54.02%). In comparison, those who claimed that a genetic link was not of notable importance showed a significantly higher acceptance of the traditional form (n = 80, 66.67%, p = 0.017). A similar pattern in attitudes was observed in the acceptance of gestational surrogacy among the participants. However, the proportion of respondents who claimed that a genetic link was important and who also accepted the gestational form was higher (n = 245, 78.78%) than the proportion who accepted traditional surrogacy (p = 0.012). Disapproval rates of gestational surrogacy among those who did not find a genetic link between parents and offspring dropped to a mere 10.83% (n = 13) when compared to the traditional form.

Conclusion

The need for genetic ties that link a parent to their children played a significant role in the formation of attitudes for and against surrogacy in general, as well as between the two formats of the ART.

E-POSTERS – OBSTETRICS

EP/O – 01
USE OF ROBSON CLASSIFICATION IN REDUCING CAESAREAN RATES – A CLINICAL AUDIT

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Introduction
The Caesarean Section (CS) rate is on the rapid rise globally as well as in Sri Lanka. This is a source of concern because of the higher risk of maternal morbidity and mortality associated with a high Caesarean rate and the economic burden on the public health system. The rate of CS reached 43.1 % in Sri Lanka in 2021, surpassing the global recommendations. The rise of CS is due to a multitude of factors, out of which some are preventable. Robson classification is a WHO-proposed standard system for monitoring and comparing the rates of CS. It classifies all the women who undergo CS into one of ten categories which are mutually exclusive. These categories are based on basic obstetric characteristics, including age, parity, onset of labour, previous CS and fetal presentation.

Objective
To analyse the CS rates, indications and assess the suitability of in-cooperating the Robson classification to optimize the CS rates.

Method
This retrospective audit was carried out using Colombo North Teaching Hospital records of randomly selected 100 CS during January - June 2023.

Results
None of the CS were classified according to the Robson classification system, but most had applied the NICE guidelines, and the indications were mentioned clearly. Among the selected, 72.5% of CS belonged to CAT 3 and CAT 4. A minority of 5% of CS had intraoperative or postoperative complications, including PPH, ICU admissions or wound infections.7.5% of babies were admitted to NICU due to a multitude of reasons. 80 % of mothers were discharged within the first 48 hours.
When it was incorporated into the Robson classification system, group 5 (35 %) was the most common reason for CS, followed by groups 2 and 4 collectively contributing 25%. Group 1 was the next commonest, contributing to 13 %. The leading causes of CS were previous CS, fetal distress, lack of progression, unsuccessful induction and malpresentation.

Discussion & Conclusion
Detailed analysis of Robson classification reveals that proper intrapartum monitoring, minimising the induction of labour, waiting for spontaneous onset of labour in suitable mothers, judicial use of syntocinon and encouraging the mother for a trial of labour (TOLAC) in suitable pregnancies will help to reduce the rate of CS. Based on the findings, education of staff on how to reduce the rate of CS and implementing the Robson classification system will be done, followed by a re-audit after 3-6 months.

EP/O – 02

KNOWLEDGE AND PRACTICES ON DELAYED CORD CLAMPING AMONG OBSTETRIC STAFF

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Introduction

Delayed cord clamping is proven to be beneficial in term and preterm deliveries. These advantages include an increment in haemoglobin levels and improvement in iron stores in term infants, and in addition, a reduction in the risk of necrotizing enterocolitis and intraventricular haemorrhage is noted among pre-term infants. There is abundant evidence to suggest that delayed cord clamping, either alone or in combination with other techniques, results in 50% higher neonatal blood volume than early clamping, by the 80–100 ml blood transferred through the placenta within the first three minutes. Obstetric staff attending to the delivery should adhere to certain techniques during delayed cord clamping to maximise the benefits and avoid any issues. This includes positioning the infant in a way that gravity facilitates the flow of blood, and simultaneously, early care of the newborn should be initiated, including skin-to-skin contact and clearing out secretions, among others. Instances where delayed cord clamping should not be practised, include instances where there is maternal or fetal compromise.

Objectives

The objectives of the study are to assess the knowledge on delayed cord clamping and deficiencies in practice among the obstetric staff.

Design & Method

A self-administered questionnaire encompassing the advantages, disadvantages, contraindications, methods and practices of delayed cord clamping was provided to various categories of antenatal ward staff, including doctors, nurses, and midwives who attend deliveries at Ragama Teaching Hospital.

Results

The total number of responses was 52, of which the majority were nurses (52%), followed by midwives (28%) and doctors (20%). Among the participants, only 54% knew the correct definition of delayed cord clamping. Even though 94 % of them had gained some knowledge about delayed cord clamping through various sources, including lectures, guidelines and presentations, overall knowledge was not satisfactory. A majority of 65 % of the participants did not have adequate knowledge of the advantages of delayed cord clamping. Only 45% of the antenatal staff are practising delayed cord clamping despite the recommendations, and of the remaining, 62% were practising umbilical cord milking as an alternative.

Conclusion

According to this audit, the practice and overall knowledge on delayed cord clamping is unsatisfactory. Based on these findings, educational activities are to be arranged to improve the knowledge among staff and encourage practice. A re-audit in three months will evaluate the improvement.

EP/O - 03

AN AUDIT ON KNOWLEDGE AND PRACTICES ON MATERNAL RESUSCITATION AMONG OBSTETRIC HEALTHCARE STAFF

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Background
Maternal collapse is a rare but life-threatening event which needs prompt intervention as early as possible, and the outcome primarily depends on the effectiveness of resuscitation. Even though it is rare, the consequences are devastating. So it is important that the clinical team should have adequate skills for this life-saving procedure.

Essentially, the cause of maternal collapse should be identified and investigated to start appropriate management. Obstetric staff should undergo adequate training in the resuscitation of a pregnant mother to prevent potential complications.

Objectives
This audit was performed to identify the current status of effective maternal resuscitation among obstetric staff, to identify deficits and correct them for better outcomes.

Methods
54 obstetric staff, including doctors, nurses, and midwives from the antenatal staff at Ragama Teaching Hospital, were included in this audit. A web-based questionnaire containing questions regarding their knowledge, experience and practices were evaluated.

Results
Among all the staff, 53% of participants have witnessed a maternal collapse and have been involved in management in the past. But a majority of 89% of participants didn't have any training programme in maternal resuscitation. 35% of participants had basic knowledge about maternal resuscitation, and only 12 % had adequate knowledge of perimortem caesarean section. None of the participants had undergone a regular training programme in maternal resuscitation, and none had a complete understanding of the equipment and medications needed to be in a resuscitation trolly.

Conclusion
Overall, the preparation of the obstetric staff to manage maternal collapse was not satisfactory. There is a critical need for organising comprehensive training programmes regularly and updating their knowledge from time to time. We plan to arrange training sessions with the input of the anaesthetic team and plan to re-audit after three months.

EP/O – 04
"ECLAMPSIA IN DISGUISE" - RECURRENT SEIZURES FOLLOWING DELIVERY IN A NORMOTENSIVE MOTHER

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Background & Objectives
Eclampsia remains one of the leading causes of maternal and perinatal morbidity and mortality. It may occur even without any preceding classical features. Postpartum hypertension is common, particularly in the early postpartum period, especially in women who suffer from gestational hypertension during the antenatal period.

A physiological rise in blood pressure (BP) is expected following delivery, and hypertensive mothers must be monitored closely until 3–6 days postpartum. Although normotensive immediately following delivery, women with gestational hypertension may become hypertensive again within the first week of postpartum.

Case report
We report a case of post-partum eclampsia immediately following delivery in a normotensive mother in the absence of proteinuria. She was an 18-year-old primigravida admitted for confinement at a POA of 40+3 weeks with a relatively uncomplicated antenatal history except for anaemia (Hb- 8.3 g/dl) which was treated with oral iron. This was an unplanned pregnancy, but her booking visit blood pressure (BP) was 90/60 mmHg and had been normotensive until 27 weeks POA, when she defaulted on her clinic visits.

On the day of admission for confinement, her BP was 140/90 mmHg. She didn't have clinical evidence of preeclampsia, and urinalysis was negative for albuminuria. Her haemoglobin was optimised with blood transfusion, and labour was allowed to progress. Her vital parameters were stable, including normal blood pressure values throughout the labour process. Instrumental delivery was performed due to delayed second stage, resulting in a successful instrument delivery.

Around fifteen minutes following delivery, she developed recurrent episodes of generalised seizures, with each episode persisting for about two minutes. She was started on MgSO4 infusion, for which her seizures settled. A slight rise in her BP was noted on the following day, which was managed with oral antihypertensives. An MRI was performed after multidisciplinary input, which excluded structural abnormalities. Apart from the seizure episodes, her neurological status was normal throughout.

Discussion & Conclusion
Eclampsia is one of the leading causes of maternal morbidity and mortality. Timely detection and management will prevent adverse consequences. Eclampsia should be considered an essential differential diagnosis in mothers with seizures, even in the absence of clinical features and proteinuria.

EP/O – 05
ANENCEPHALY ASSOCIATED WITH OMPHALOCELE – A CASE REPORT

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Introduction
Anencephaly is a lethal neurological malformation which occurs during the third to fourth weeks of gestation due to failure of closure of the cranial end of the embryonic neural tube. It is commonly seen in females and manifests as the absence of brain hemispheres and the cranial arch. The overall prevalence of anencephaly worldwide is around 5 per 10,000 live births. It is associated with a widespread of concomitant anomalies, among which omphalocele is one such association where there is a congenital defect in the abdominal wall of the fetus, out of which abdominal contents protrude to the external environment. Omphalocele is commonly associated with trisomy 18, and it was found that around 65% of fetuses diagnosed with omphaloceles during early pregnancy was subsequently diagnosed with anencephaly.

Case Report
Herein we report a case of a male neonate, born at 23+4 weeks POA with a weight of 350g. The mother was a 21-year-old primi with diabetes mellitus diagnosed at the booking visit at six weeks of POA. She was on medical nutrition therapy up until delivery with good control of her glycaemic status. Anomaly scan, which was performed at 22 weeks of POA, revealed a fetus with anencephaly and a small omphalocele with consistent growth parameters for dates and an adequate amount of liquor. The mother had a history of preconceptual folic acid intake, and no family history of similar illnesses was noted. Following fetal medicine input, the diagnosis was confirmed. The mother went into spontaneous onset of labour at 23+4 weeks, but the neonate succumbed 20 minutes after birth despite resuscitation.

Discussion
Anencephaly has a multifactorial pattern of inheritance, and the etiological factors contributing to its occurrence include genetics, maternal diabetes mellitus, inadequate folic acid intake etc. Yet the majority of cases are found to be idiopathic. The prognosis of anencephaly is extremely poor. Most cases are stillborn or aborted spontaneously. Few cases like ours will be born alive, but their life span may be limited to minutes to hours due to severe brain deformities, and death will be inevitable.

Conclusion
Proper pre-conceptional counselling, optimum glycaemic control, and preconceptual folic acid supplementation are of utmost importance in reducing the incidence of congenital malformations.

EP/O – 06

CLINICAL AUDIT TO DETERMINE THE EFFICACY OF PROPER BREAST-FEEDING TECHNIQUES TO PREVENT NEONATAL JAUNDICE

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Introduction

Neonatal jaundice results from elevated total serum bilirubin (>5mg/dl) and clinically manifests as yellowish discolouration of the skin, sclera and mucus membranes. In most neonates, it's a physiological phenomenon occurring 24 hours after birth, commonly due to problems with breastfeeding, and it resolves spontaneously. Pathological jaundice usually occurs within the first 24 hours after birth and is mainly due to sepsis, hereditary haemolytic anaemias and haemolysis due to Rh, ABO or minor group incompatibilities.

Objective

To determine the effectiveness of proper breastfeeding techniques in reducing the incidence of neonatal jaundice.

Method

A single-centre retrospective cohort study was performed involving 165 newborns admitted to the post-natal ward at DGH Mullaitivu from 1st August – 31st September 2022. The incidence of neonatal jaundice among the study participants and causative factors for jaundice was assessed using laboratory investigations, interviewer-based questionnaires, and clinical examinations.

During the next four months (from 1st October – 23rd November 2022), a prospective cohort study was conducted using 174 newborns admitted to the same unit. After the introduction of a ward-based protocol, the incidence of neonatal jaundice, along with causative factors for jaundice within this cohort, was assessed in a similar manner. The ward-based protocol included educating mothers on the proper breastfeeding techniques using visual aids, frequent assessment of breastfeeding by trained health staff, provision of medical and psychological support etc.

Results

In the retrospective study, total live births were 165. Out of it, 72(43.6%) had neonatal jaundice. 5(6.9%) neonates developed infection. 3(4.1%) cases were due to ABO incompatibility. 26(36.1%) cases were due to physiological jaundice. 38 (52.7%) were because of lactation failure. 5 of the mothers had cracked nipples and engorged breasts. In the prospective analysis, the total number of live births was 174. Out of which, 49(28.1%) were diagnosed with neonatal jaundice. Out of these, 5(10.2%) were due to ABO incompatibility. 7(14.2%) had infection. 25(51.0%) cases were due to physiological jaundice. Rest of the cases, 12(24.4%) were due to lactation failure. Out of them, three mothers had cracked nipples, and one had inverted nipples. There is a 52.2% to 24.4% reduction in Neonatal jaundice following intervention.

Conclusion

With the improvement of breast-feeding technique via frequent assessment, supporting the mother to properly breastfeed and use of visual aids, a significant reduction in neonatal jaundice in the early newborn period can be achieved.

EP/O – 07

VENOUS THROMBOEMBOLISM STICKER FOR POSTPARTUM THROMBOPROPHYLAXIS: SINGLE UNIT EXPERIENCE

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Introduction and Objectives
Risk stratification and thromboprophylaxis prevent venous thromboembolism (VTE) associated maternal deaths. Identifying women who require postpartum pharmacological thromboprophylaxis and administering the correct dose and duration of low molecular weight heparin (LMWH) is crucial in preventing postpartum VTE. The RCOG guideline stratifies women at risk for thromboembolism based on pre-existing, transient and obstetric risk factors and recommends thromboprophylaxis based on their risk scores. This audit evaluated compliance with the RCOG guideline about postpartum risk stratification and thromboprophylaxis in a tertiary hospital in Sri Lanka.

Method
Data were collected retrospectively from hospital records of all postnatal women regarding VTE risk assessment, dose and duration of thromboprophylaxis for three consecutive months. A VTE prophylaxis sticker was designed and introduced to postpartum women, followed by a prospective re-audit over two months. Risk stratification and thromboprophylaxis were evaluated per the RCOG guideline.

Results
The initial audit included 90 postnatal women, and the re-audit following the introduction of the VTE sticker included 60 women. 37, 24, 18 and 16 women scored 0, 1, 2, and ≥ 3, respectively, in the initial audit; however, none had their risk scores documented objectively. 5.4% (2/37) with a score of 0, and 100% (24/24) with a score of 1 received LMWH, although not indicated. 72.2% (13/18) scoring 2 received LMWH, albeit only for two days, while 68.7% (11/16) women with a score of ≥3 received LMWH, with nine women receiving for the recommended duration of 6 weeks. Following the re-audit, 14, 17, 16 and 13 women scored 0, 1, 2 and ≥3, respectively, with 100% documentation of risk scores. Among those with a score of 0 and 1, 100% complied with the RCOG guideline and did not receive pharmacological thromboprophylaxis. For women with a score of 2, 87.5% (14/16) received LMWH, albeit only for two days, and 100% of those with a score of ≥3 received LMWH for six weeks complying with the guideline.

Conclusion
A decrease in unnecessary pharmacological thromboprophylaxis in postpartum women at low risk for VTE and an increase in the percentage of women with scores of ≥2 receiving pharmacological thromboprophylaxis was observed following the introduction of the VTE sticker. Financial constraints accounted for women discontinuing thromboprophylaxis early. The VTE sticker helped maintain acceptable levels of clinical accuracy in risk stratification and targeted pharmacological thromboprophylaxis per the RCOG guideline.

EP/O – 08
A CASE REPORT IN THE RARE CASE OF TORSION OF THE PREGNANT UTERUS

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Objectives
We describe a rare case of torsion of the pregnant uterus during the third trimester, which mimicked placental abruption.

Case report
The patient, a 38-year-old gravida 2 para 1 at 33 weeks and three days gestation with a singleton pregnancy, was admitted to the obstetrical unit with continuous uterine cramping and decreased fetal movement. Her prior obstetrical history included one elective caesarean delivery due to breech presentation, and the current pregnancy had been uncomplicated until the date of presentation. After 3 hours of observation, uterine cramping and tenderness increased, and fetal tachycardia developed. The presumptive diagnosis was a concealed placental abruption. The patient was not in labour, so an emergency Caesarean section (CS) was carried out. At the time of CS, the diagnosis of 180-degree uterine torsion was made. Detorsion failed, and the baby was delivered via the lower segment of the posterior uterine wall. The patient recovered, and the baby was treated at NICU for a few days.

Discussion
Uterine torsion is observed in all age groups of the reproductive period, in all parity groups, and at all stages of pregnancy. Rotation of the gravid uterus is a normal finding in the third trimester of pregnancy. However, a pathologic rotation of the uterus beyond 45 degrees-torsion of the entire uterus is rarely seen in obstetrical practice. We report here a case of uterine torsion from our obstetrical practice and a review of reported cases.

Conclusion
Uterine torsion is an infrequently reported and potentially dangerous complication of pregnancy that occurs mainly in the third trimester with adverse maternal and neonatal consequences.

EP/O – 09
CASE REPORT: A SUCCESSFUL PREGNANCY OUTCOME IN A PATIENT WITH NON-MOSAIC TURNER SYNDROME (45, X) VIA IN VITRO FERTILIZATION

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Objectives
We describe a successful pregnancy outcome in a patient with non-mosaic Turner syndrome (45, XO) via in vitro fertilisation using donor eggs.

Case report
34year old, having primary subfertility, had a successful IVF at the 7th attempt with donor eggs. Phenotypically characterised by short stature, webbed neck, and cubitus valgus. She started our antenatal care at 24 weeks, had hyperthyroidism on thyroxine 200mcg daily, GDM

on insulin, and had a serial scan due to IVF pregnancy and SGA. Attempted trial of vaginal delivery at 38+3ds and ended up with category 2 caesarean section due to failure to progress of labour. The baby was phenotypically and genetically normal.

Discussion
One in every 2500 female newborn infants has Turner syndrome. TS is the second most common cause of chromosomal abnormalities that results in miscarriage. A common symptom of this syndrome is infertility due to ovarian dysgenesis. So, fertility in cases of 45-XO-Turner's syndrome is extremely rare. In cases of pregnancy, spontaneous abortions, stillborn and chromosomal defects are frequently diagnosed.

Conclusion
However, some of these patients can have successful pregnancy outcomes following in vitro fertilisation using donor eggs.

EP/O – 10
EFFECT OF BMI ON THE SUCCESS OF FOLEY CATHETER INDUCTION

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Introduction
The Foley catheter has been shown to be a safe, effective, and relatively feasible mechanical method of cervical priming in the induction of labour (IOL). High Body Mass Index (BMI) at the booking visit is thought to be associated with failed IOL with a Foley catheter. But the association between BMI at the time of induction of labour and the success of the Foley induction is not assessed yet.

Objectives
Our study objective was to assess the association of on-admission BMI with the outcome of IOL using a Foley catheter for cervical ripening in a tertiary care centre in Sri Lanka. Assessing whether high BMI associated with failed Foley catheter induction requiring emergency caesarean section was a secondary objective.

Design
A prospective cohort study was designed at the Professorial Unit of the De Soysa Maternity Hospital, Colombo. Each participant was monitored for their interventions during labour and mode of delivery.

Method
All the women who had induction of labour using a Foley catheter for cervical priming during the study period were selected for the study. The mode of induction, height and weight at the admission and mode of delivery were recorded. Calculated BMI and its association with the mode of delivery were analysed using SPSS software version 22.

Results
A total of 85 women had labour induction using a Foley catheter. The mean BMI of the sample was 28.03 kg/m^2. Out of the 85 women induced, 48(56.47%) underwent emergency caesarean

section, and 37(43.53%) delivered vaginally. The mean BMI of women who underwent emergency caesarean sections was 28.85 kg/$m^{2,}$ while the women with normal vaginal deliveries had a BMI of 26.94 kg/m^2. There was no statistically significant difference between the means of the two groups (p=0.0824). There were 26 women with BMI ≥ 30kg/$m^{2,}$ and 16 of them (61.5%) had caesarean sections compared to 34 (54.8%) women who had a BMI < 30 kg/m^2.

Conclusion
Although statistically not significant, there was a trend towards a higher risk of emergency LSCS with a higher BMI at the time of induction. This trend should be further explored with an appropriately powered prospective study.

EP/O – 11
INDUCTION OF LABOUR WITH FOLEY CATHETER IN A TERTIARY CARE UNIT- A DESCRIPTIVE STUDY ON CERVICAL AND LABOUR OUTCOME

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Introduction
Induction of labour is the initiation of labour by artificial means, which is indicated for various reasons, including past dates, small for gestational age, and other obstetric and medical complications. It is achieved through various mechanical, pharmacological, and surgical methods. A Foley catheter inserted through the cervix kept for a maximum of 48 hours for cervical ripening, and improvement of bishop score is a common mechanical method of IOL.

Objective
To study cervical and labour outcomes following induction of labour with a Foley catheter in a tertiary care unit.

Design
A prospective cohort study was designed at the professorial Unit of the De Soysa Maternity Hospital, Colombo. Each participant was monitored for their interventions during labour and delivery.

Method
We prospectively collected data on all labour inductions using a Foley catheter for consecutive 4 months and compared labour outcomes with a matched control group of spontaneous onset labours. All Foley inductions were carried out according to the unit protocol.

Results
We analysed a total of 88 women who underwent Foley insertions. We matched with 88 in the spontaneous onset of labour (SOL)group. For Foley inductions, the median gestation was 38 weeks and for SOL group, 39 weeks. 95 % of all inductions were decided by the consultant. The mean Bishop score at initial insertion was 4. The main reasons for IOL were past dates, small for gestational age and GDM on MNT. There were no statistically significant differences between induction outcomes and indications for IOL. At 48 hours, 69.4% ended in LSCS for failed induction, and 7.4% had PGE2 insertions. For the PG group outcome of EM/LSCS was

60%. 20% of spontaneous onset labours ended up with EM/LSCS. The median time for cervical preparation with Foley was 10 hours.

Conclusion
Compared with spontaneous onset of labour, induction of labour in women at term with a single fetus in cephalic presentation is associated with an increased risk of caesarean delivery, predominantly related to an unfavourable Bishop score.

EP/O – 12
INDUCTION OF LABOUR WITH FOLEY CATHETER INSERTION- THE EFFECT OF "UNFAVOURABLE CERVIX"

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Introduction
The Foley catheter has been shown to be a safe, effective, and relatively feasible mechanical method of cervical priming in the induction of labour (IOL). IOL is perceived to increase the risk of Caesarean section. However, this perception may be due to differences in the cervix of women going on to post-dates compared to women delivering before 40 weeks.

Objectives
The study objective was to compare the mode of delivery with IOL using a Foley catheter for cervical ripening in women who are post-dates and women who are induced between 37-40 weeks of gestation due to other reasons. The research question was whether IOL with Foley catheter of an unfavourable cervix at past dates would increase the risk of caesarean section.

Design
A prospective cohort study was designed at the Professorial Unit of the De Soysa Maternity Hospital, Colombo. Each participant was monitored for their interventions during labour and mode of delivery.

Method
All the women who had induction of labour using a Foley catheter for cervical priming during the study period were selected for the study. The mode of induction, indication for IOL, and mode of delivery were recorded. The mode of delivery of women who were induced due to post dates and women who were induced before 40 weeks due to other reasons was analysed using SPSS software version 22.

Results
A total of 95 women had labour induction using a Foley catheter. Out of which, 24(25.3%) were induced due to post-dates, and 71(74.7%) were due to other reasons. Of women who were induced due to post-dates, 17(70.8%) had to undergo emergency caesarean sections, whereas 7(29.2%) delivered vaginally. Of the women who were induced for other indications before 40 weeks, 36(50.7%) had emergency caesarean sections, and 35(49.3%) had normal vaginal deliveries. There was no statistically significant difference($p=0.085$) between the two groups in terms of emergency caesarean section rates.

Conclusion
Although statistically not significant, there was a trend towards a higher risk of emergency LSCS in normal post-date women compared to women who were undergoing IOL for Obstetric reasons before 40 weeks. This trend should be further explored with an appropriately powered prospective study.

EP/O - 13
CLINICAL CASE OF GROSS ASCITES PLEURAL EFFUSION AND VULVAL SWELLING DURING POSTPARTUM PERIOD IN PATIENT WITH PRE-ECLAMPSIA

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Abstract
Preeclampsia is a multi-system disorder unique to human pregnancy characterised by hypertension and proteinuria or involvement of one or more other organ systems and/or the fetus. Pathophysiology is the vascular endothelial dysfunction, which leads to increased vascular permeability and vascular spasm, resulting in fluid leakage and effusion into the body cavity, which can result massive ascites and pleural effusion during pregnancy.

Introduction
Ascites is rarely observed in Pre-eclampsia (PE), and vulval swelling is very rarer. Ascites is associated with poor maternal and neonate outcomes, and incidence was 1.9 out of 1000 all PE cases, and the rate increases to 21.6 out of 1000 in severe PE patients. Ascites also can be seen in conditions such as portal hypertension, inflammatory diseases, malignancies, and diseases associated with low hypo albuminemia.

Case report
A 32-year-old in her 2nd pregnancy, normotensive until 32 weeks, presented with high blood pressure, ++ positive Urine albumin and Small for Gestational age fetus with reversed end diastolic flow in Umbilical artery Doppler. Her blood pressure was controlled with oral labetalol, and she had no symptoms of pre-eclampsia. Investigations revealed features of HELLP, with elevated liver enzymes but normal platelet count and haemoglobin without evidence of hemolysis. Following a multi-disciplinary discussion, an emergency caesarean section was performed after completion of steroid and MgSO4, and a 1.2 kg baby was delivered, and post-op ICU care continued.

Liver enzymes were raised on 3rd postoperative day. Her renal function, coagulation profile, platelet count and haemoglobin levels remained stable without evidence of hemolysis. The patient developed gross ascites & B/L Pleural effusion on day 3 with marked Labial swelling.

Ultrasound confirmed clinical ascites and Pleural Effusion. Total Protein and Serum albumin were only slightly reduced. Considering the clinical picture and investigations, two units of albumin were transfused, ascites together with pleural effusion responded early, but labial swelling continued for one week. Post-operative ICU care continued for six days. Blood pressure was controlled initially with Nifedipine & Enalapril and then without medication.

Discussion
Preeclampsia is a life□threatening disorder that often progress in the last trimester and can be complicated with eclampsia or HELLP syndrome. In our case, considering the deterioration of her liver function and reversed end diastolic flow in the Umbilical artery, timely delivery at 32 weeks and continuity of ICU and NICU care improved maternal and neonatal outcomes.

EP/O – 14
AUDIT: KNOWLEDGE AND ATTITUDE OF LABOUR ROOM STAFF AT COLOMBO NORTH TEACHING HOSPITAL REGARDING PAIN RELIEF IN LABOUR

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Introduction
The audit was conducted to evaluate the current practices and identify any gaps in knowledge and attitude related to pain relief during labour. The findings and recommendations provided in this report are intended to improve the quality of care provided to labouring women at the hospital.

Method
The audit was conducted using a combination of qualitative and quantitative methods. The following steps were undertaken. a). Review of existing protocols, guidelines, and literature on pain relief in labour. b). Direct observations of the labour room staff during actual patient care. c). Structured questionnaires were distributed to the staff members. d). Analysis of collected data to identify knowledge and attitude gaps. A structured questionnaire (n = 60) was distributed to healthcare providers working in the antenatal ward, Labour ward, and post-natal wards in Colombo North Teaching Hospital. Descriptive analysis was performed using Excel 2013 and google forms.

Results
Forty-eight questionnaires were filled out, representing an 80% response rate. The majority of respondents, 89%, acknowledged that women could experience moderate to severe pain during labour, and 87% agreed that labour pain should be alleviated. The labour room staff demonstrated a satisfactory level of knowledge regarding pain relief methods in labour. Most staff members were familiar with common pain relief medications, such as epidural anaesthesia and intravenous analgesics, and understood their indications and contraindications. However, there were instances where some staff members lacked detailed knowledge about alternative pain relief techniques. The overall attitude of the labour room staff towards providing pain relief in labour was positive and patient-centred. Staff members exhibited empathy and compassion towards labouring women, addressing their concerns and providing emotional support. However, there were a few instances where staff members appeared rushed or failed to provide adequate explanation and reassurance during the pain relief process.

Conclusion
The audit findings indicate that the labour room staff at Ragama Teaching Hospital possesses a satisfactory level of knowledge and a generally positive attitude towards pain relief in labour. However, there are areas for improvement in both knowledge and attitude, particularly regarding alternative pain relief techniques and ensuring consistent empathy and communication.

EP/O – 15
DIAGNOSTIC DILEMMA AND MANAGEMENT CHALLENGES IN A SCAR ECTOPIC PREGNANCY: A CASE REPORT

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Objective
This case report aims to highlight the diagnostic challenges associated with scar ectopic pregnancy, particularly the misinterpretation of ultrasound findings, and to discuss the implications for clinical practice and management strategies.

Case Report
A 34-year-old parous woman with a history of previous Caesarean section presented with mild vaginal bleeding at 6+ weeks amenorrhea. Serum beta-human chorionic gonadotropin (HCG) levels were elevated at 27,285 IU/L. Initial ultrasound revealed a pregnancy located at the previous Caesarean scar, in close proximity to the internal cervical os. However, a subsequent scan suggested a cervical pregnancy, leading to the administration of intramuscular methotrexate. Despite a slight decline in HCG levels after the first dose, subsequent levels fluctuated and remained elevated. One month later, a repeat ultrasound revealed a viable fetus at 11 weeks gestation positioned over the Caesarean scar. Laparotomy confirmed an amniotic sac protruding through the scar, and the fetus was surgically removed.

Discussion
This case highlights the diagnostic dilemma associated with scar ectopic pregnancies, emphasising the potential misinterpretation of ultrasound findings, particularly distinguishing between a scar ectopic and a cervical pregnancy. The misdiagnosis led to unsuccessful treatment with methotrexate, which is generally effective for treating ectopic pregnancies with lower HCG levels. Clinicians should exercise caution when interpreting ultrasound findings and consider obtaining additional imaging, such as MRI, to confirm the diagnosis.

Conclusion
Accurate diagnosis of scar ectopic pregnancies remains a challenge, and misinterpretation of ultrasound findings can lead to inappropriate management decisions. In cases where ultrasound findings are inconclusive or atypical, clinicians should consider additional imaging modalities, such as MRI, to aid in accurate diagnosis. Furthermore, the administration of intramuscular methotrexate may be less effective in scar ectopic pregnancies with significantly elevated serum HCG levels. Future research should focus on refining diagnostic approaches and developing tailored management strategies for scar ectopic pregnancies.

EP/O – 16
LAPAROSCOPIC MANAGEMENT OF ADNEXAL TORSION IN A PREGNANT PATIENT: A CASE REPORT

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Objective
This case report aims to highlight the management of adnexal torsion in a pregnant patient and discuss its implications on clinical practice.

Case report
We present the case of a 27-year-old primigravida with 12 weeks of gestation who experienced left adnexal torsion. The patient was initially diagnosed with a 6cm cyst during the 5th week of pregnancy. However, at the 12th week, she presented with acute pain in the right hypochondrium, along with nausea and vomiting. Physical examination revealed a palpable mass, and ultrasound confirmed the presence of a 10cm ovarian cyst on the right side. Doppler examination showed no pathological changes. Laparoscopy was performed, revealing a triple-torsioned ovarian cyst that had displaced the left ovary into the right hypochondrium. Detorsion of the ovary and cystectomy was successfully carried out. Histopathological examination confirmed the cyst as a benign serous cyst. The patient's pregnancy is currently being followed up, and she was delivered normal vaginal delivery by 39w gestation. A healthy baby boy of 3.1kg weight was discharged on day two with the mother.

Discussion
This case highlights the challenges associated with the management of adnexal torsion during pregnancy. Surgical intervention is generally considered safe; however, abdominal surgery poses risks for both the mother and the fetus. Therefore, the decision regarding the choice of management should be based on a careful assessment of the gestational age and the characteristics of the adnexal mass. In this case, laparoscopic surgery proved to be a viable option, leading to a successful outcome.

Conclusion
Adnexal torsion during pregnancy necessitates a balanced evaluation of the risks and benefits associated with surgical intervention. Laparoscopic management can be a safe and effective approach for pregnant patients with adnexal torsion, provided that appropriate precautions are taken. Further research is needed to establish clear guidelines and optimise the management of adnexal torsion in pregnancy.

EP/O – 17
SUCCESSFUL VAGINAL DELIVERY IN A CHALLENGING OBSTETRIC CASE: HOLOPROSENCEPHALY AND CONGENITAL ANOMALIES WITH PAST THREE SECTIONS

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Objective
This case report aims to highlight a rare and challenging obstetric scenario involving a 30-year-old woman in her fourth pregnancy with a diagnosis of holoprosencephaly and polyhydramnios. The report discusses the management of a non-viable fetus with breech presentation, absent brain matter, absent liquor, and an anterior placenta, emphasising the successful trial of labour and subsequent delivery of a baby girl with multiple congenital anomalies.

Case report
A 30-year-old woman with a history of three previous lower-segment caesarean sections presented at 33 weeks of gestation with dribbling and abdominal pain. Ultrasound examination revealed a non-viable fetus with the absence of brain matter, breech presentation, longitudinal lie, and anterior placenta with absent liquor. The cervical assessment indicated a Bishop's score greater than six. A trial of labour was initiated with careful monitoring, resulting in a normal

vaginal delivery. The baby girl weighed 1.7 kg and exhibited well-developed limbs but had six fingers in both upper and lower limbs, along with Cyclops.

Discussion
This case highlights the challenges faced when managing pregnancies complicated by holoprosencephaly and polyhydramnios. Despite the adverse fetal findings and previous caesarean sections, a trial of labour was considered, given the favourable cervical assessment. The successful vaginal delivery demonstrates the importance of individualized management and careful evaluation of each case.

Conclusion
This case report emphasises the significance of individualised management in complex obstetric scenarios, such as pregnancies with holoprosencephaly and polyhydramnios. While vaginal delivery can be a viable option under careful monitoring, the presence of congenital anomalies, including cyclopia and limb abnormalities, requires appropriate counselling and support for parents. Further research is warranted to explore optimal management strategies for similar cases and to improve our understanding of the aetiology and outcomes associated with holoprosencephaly.

EP/O – 18
POLYARTERITIS NODOSA IN A PRIMIGRAVIDA: A CASE OF FETAL GROWTH RESTRICTION COMPLICATED WITH SUBCUTANEOUS BREAST NODULES

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Objective
This case report aims to present a unique case of polyarteritis nodosa (PAN) in a primigravida, highlighting the diagnosis and management challenges, as well as the implications for fetal growth and delivery outcomes.

Case report
A 27-year-old primigravida with a diagnosis of PAN presented at 38+6 weeks of gestation. The patient was investigated for subcutaneous breast nodules, which were found to be benign upon biopsy. Treatment for PAN included azathioprine and prednisolone with rheumatology follow-up. Fetal growth restriction was observed, indicated by an abdominal circumference below the 3rd centile and an estimated fetal weight below the 10th centile. Foley induction was done, leading to an uncomplicated vaginal delivery of a baby girl weighing 2.3 kg.

Discussion
This case highlights the complexity of managing PAN in pregnancy and its impact on fetal growth. The use of azathioprine and prednisolone in this patient successfully controlled the maternal disease, but the fetus experienced growth restriction. The decision to proceed with vaginal delivery, considering the fetal weight and associated risks, was guided by a multidisciplinary approach involving obstetricians, rheumatologists, and neonatologists. The successful outcome of an uncomplicated vaginal delivery in the setting of PAN demonstrates the importance of individualised management strategies.

Conclusion

This case underscores the need for close monitoring of fetal growth in pregnant patients with PAN, as fetal growth restriction can occur despite optimal control of the maternal disease. Multidisciplinary collaboration between obstetric and rheumatology teams is crucial in tailoring management strategies and optimising outcomes for both the mother and the fetus. Further research is warranted to explore the long-term effects of PAN on fetal growth and to determine the most appropriate delivery approach in similar cases.

EP/O – 19
SYSTEMIC LUPUS ERYTHEMATOSUS AND PREGNANCY: A CASE REPORT WITH UNIQUE FEATURES

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Objectives

This case report aims to highlight the special features and implications of systemic lupus erythematosus (SLE) during pregnancy. The objective is to discuss the clinical course, management, and outcomes of a patient with SLE, focusing on the challenges encountered and the implications for clinical practice.

Case report

A 23-year-old pregnant woman, diagnosed with SLE and followed up in a rheumatology clinic presented for her first antenatal clinic visit at 12+6 weeks of gestation. The patient was positive for anti-dsDNA antibodies and negative for lupus anticoagulant. She had a history of normal renal and liver function. Anomaly scan at 20 weeks of gestation was normal. At 26 weeks, she was evaluated for gestational hypertension and had multiple admissions for cystitis. Generalised lymphadenopathy was observed, and a left-sided cervical lymph node biopsy revealed reactive lymph nodes. Chest X-ray showed a left-sided pleural effusion. Blood analysis indicated normochromic normocytic anaemia and the antinuclear antibody test was positive. The patient was managed with medications, including Azathioprine, Hydroxychloroquine, Nifedipine, and Prednisolone. She delivered a 2.7 kg baby boy at 37+4 weeks by elective lower segment caesarean section due to fetal distress.

Discussion

This case report emphasises the challenges of managing SLE during pregnancy. The patient experienced multiple complications, including gestational hypertension, cystitis, generalized lymphadenopathy, and pleural effusion. The successful management of lupus nephritis during pregnancy, close monitoring of renal and liver function, and appropriate use of medications contributed to favourable outcomes. The use of Ecospirin for anticoagulation and the delivery mode chosen due to fetal distress were critical decisions. The case highlights the need for interdisciplinary collaboration involving rheumatology, nephrology, obstetrics, and ophthalmology to optimise maternal and fetal outcomes.

Conclusion

This case report demonstrates the complex management of SLE during pregnancy, emphasising the importance of multidisciplinary care and close monitoring of maternal and fetal well-being. It underscores the need for individualised treatment plans and careful consideration of potential complications associated with SLE. Further research is warranted to better understand the pathophysiology, optimise therapeutic approaches, and improve outcomes for pregnant women with SLE.

EP/O – 20

MATERNAL AND FETAL COMPLICATIONS IN A PREGNANT WOMAN WITH CHRONIC KIDNEY DISEASE FOLLOWING NEUROGENIC BLADDER: A CASE REPORT

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Objectives

This case report highlights the challenges faced by a 35-year-old woman with multiple comorbidities during her pregnancy. The patient presented with chronic kidney disease (CKD), neurogenic bladder, hydronephrosis, hydroureters, hypothyroidism, anaemia, and diabetes.

Despite a long-term urinary catheter and prophylactic antibiotics, her renal function deteriorated, increasing the risk of renal damage following genitourinary (GU) sepsis. This case report aims to emphasise the unique aspects of this complex pregnancy and its implications for clinical practice.

Case report

The patient, gravida 2, para 1, with a previous uncomplicated normal vaginal delivery, had a long pregnancy interval of over ten years. She had a low body mass index (BMI), hypothyroidism managed with thyroxine, and CKD due to a neurogenic bladder. Long-term urinary catheterisation was necessary, resulting in recurrent infections.

Furthermore, she developed anaemia, requiring erythropoietin injections. The patient also had diabetes and managed her blood glucose levels with insulin therapy. She delivered a baby boy by elective lower segment caesarean section (1.7 kg) at 33 weeks of period of gestation. Baby was admitted to the Neonatal unit. Mother followed up by nephrology clinic.

Discussion

This case report underscores the vulnerability of pregnant women with multiple comorbidities and poor socioeconomic conditions. The patient's compromised renal function, in combination with neurogenic bladder, hydronephrosis, and hydroureters, posed significant challenges during pregnancy. Additionally, her susceptibility to GU sepsis and recurrent infections further complicated her condition. The absence of normal physiological adaptations of the renal system during pregnancy heightened the risk of renal damage.

Conclusion

This case emphasises the need for comprehensive monitoring and multidisciplinary management of pregnant women with complex medical histories and multiple comorbidities. Improved understanding of the implications of chronic kidney disease, neurogenic bladder, and other comorbid conditions on maternal and fetal outcomes is crucial. Strategies for preventing and managing genitourinary infections should be implemented to minimise the risk of renal damage. Further research is warranted to explore similar high-risk pregnancies.

EP/O – 21
OGILVIE'S SYNDROME IN A TRIPLET PREGNANCY: A CHALLENGING CASE REPORT

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Objective
The objective of this case report is to highlight the unique challenges and implications associated with Ogilvie's syndrome in a triplet pregnancy, emphasising the importance of early recognition and prompt management.

Case Report
We present the case of a 36-year-old primigravida mother who underwent in vitro fertilisation following seven years of subfertility. The patient was admitted at 23+6 weeks of gestation due to dribbling, and persistent tachycardia was noted. Given the cervical assessment Bishop's score of less than six, an emergency lower segment caesarean section (LSCS) was performed, resulting in the birth of triplets who were subsequently admitted to the neonatal unit.

On post-LSCS day 3, the mother developed abdominal distension. X-ray abdomen revealed dilated small and large bowel loops, while the abdominal scan was unremarkable. Elevated C-reactive protein (CRP) levels were observed, while serum electrolytes remained within the normal range. The patient was kept nil by mouth, underwent gastric decompression, and received intravenous Meropenem. Although the bowel opened, the distension persisted. Antibiotics were initiated on the second day, leading to the resolution of abdominal distension. Normalisation of serum electrolytes and CRP levels was also achieved. Oral intake was resumed, and the patient recovered. This presentation was managed as Ogilvie's syndrome.

Discussion
Ogilvie's syndrome, also known as acute colonic pseudo-obstruction, is a rare condition characterized by massive colonic dilation without mechanical obstruction. This case report emphasises the complexity of managing Ogilvie's syndrome in the context of a high-risk triplet pregnancy. The prompt recognition and intervention were crucial in preventing potentially life-threatening complications and ensuring a positive outcome for both the mother and the neonates.

Conclusion
This case report highlights the importance of considering Ogilvie's syndrome as a potential diagnosis in postpartum patients presenting with abdominal distension. Early identification, close monitoring, and timely intervention are essential for the successful management of this challenging condition. Further research is needed to explore risk factors, preventive measures, and optimal treatment strategies for Ogilvie's syndrome in the obstetric population.

EP/O – 22
SUCCESSFUL ELECTIVE LOWER SEGMENT CAESAREAN SECTION IN A DOUBLE UTERUS PATIENT WITH VAGINAL SEPTUM: A CASE REPORT

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Objective
This case report aims to highlight the successful management of a patient with a double uterus and vaginal septum who underwent elective lower segment caesarean section (LSCS) and delivered a healthy baby boy.

Case Report
A 32-year-old gravida 2, para 1 woman with a known double uterus and vaginal septum presented for elective LSCS due to her previous complicated vaginal delivery. Her previous delivery resulted in an extended second stage of labour and fetal distress, necessitating an emergency caesarean section. In the current pregnancy, the patient opted for an elective LSCS to minimize the risk of complications associated with a vaginal delivery. During the procedure, the vaginal septum was excised, allowing access to both uterine cavities. The surgery was uneventful, and a 3.1kg baby boy was successfully delivered via LSCS.

Discussion
This case emphasises the importance of careful management and individualised decision-making in patients with uterine anomalies. The presence of a double uterus with a vaginal septum increases the risk of obstetric complications such as malpresentation, prolonged labour, and obstructed labour. Elective LSCS can be a safe and effective option for women with this condition, offering a controlled delivery environment and reducing the risk of potential complications.

Conclusion
This case report demonstrates the successful management of a double uterus patient with a vaginal septum through elective LSCS. The excision of the vaginal septum during the caesarean section procedure allowed for a safe delivery and a positive postpartum outcome. Further research is needed to establish guidelines for the optimal management of patients with uterine anomalies, ensuring the best maternal and fetal outcomes.

EP/O – 23
TAKAYASU'S ARTERITIS PRESENTING IN PREGNANCY: A CASE REPORT

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Introduction & Objectives
Takayasu's arteritis (TA) is a rare, chronic vasculitis of unknown aetiology characterised by inflammation of the aorta and its main branches. It commonly affects women of reproductive age, and active disease can result in adverse feto-maternal outcomes. Undiagnosed or poorly controlled disease can lead to pre-eclampsia, eclampsia, prematurity, intrauterine growth restriction, perinatal mortality, miscarriages and major maternal cardiovascular complications.

Case report

Twenty-four-year-old previously healthy primigravida with an uncomplicated antenatal history at the 25th week of gestation presented with a one-month history of progressive severe left-sided headache associated with sudden onset and self-remitting visual disturbances. This was associated with generalised body aches, proximal muscle pain in the upper limbs during rest, inflammatory-type lower back pain and intermittent evening pyrexia. On examination, both radial pulses were normal in volume & in character with no tachycardia and normal blood pressure with no discrepancy of the limbs. The precordial examination was normal, but the left carotid pulse was weak with a bruit on auscultation.

Haematological investigations revealed anaemia (Hb-10.2g/dl) with normal liver-renal functions and no evidence of proteinuria. Significantly elevated ESR of 140 mm/h and CRP of 49mg/dl were noted. The 2D echocardiogram, ophthalmological assessment, investigation for tuberculosis (Mantoux & chest-Xray), and auto-immune antibody was found to be normal. Carotid doppler revealed intimal thickening of the left common carotid artery and right brachiocephalic trunk. With the above findings, an initial suspicion of TA was raised, and further management decisions were made through the collaboration of a multidisciplinary team (MDT). An MRA was conducted based on the MDTs' recommendation and discovered a pseudoaneurysm and thickening of the proximal half of the left common carotid artery, which led to the confirmation of clinical suspicion of Takayasu's arteritis.

The patient was started on oral prednisolone and hydrochlorothiazide, following which she had rapid clinical improvement, resolvent of fever with reduction of inflammatory markers. The rest of the pregnancy was uncomplicated, and she delivered a healthy baby at term. The rheumatology team is mediating the postpartum management of TA.

Discussion & Conclusion

Planning of pregnancy, achieving disease remission before conception, managing existing complications, and changing medication to a pregnancy-compatible regimen is essential to achieve a favourable outcome. In most pregnancies, the prognosis for TA is favourable if managed appropriately. Pregnancies occurring in the presence of TA should be regarded as high-risk, necessitating strong coordination between experts and the obstetric team.

EP/O – 24
ATYPICAL PRESENTATION OF EARLY-ONSET HELLP SYNDROME IN A BACKGROUND OF CHRONIC KIDNEY DISEASE

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Introduction

HELLP syndrome is a rare obstetric complication. It is characterised by haemolysis, elevated liver enzymes and low platelet count. It occurs in 0.1 to 1% of pregnancies. Usually, it develops during the third trimester, sometimes during the 1st week of the postpartum period. It is extremely rare to develop before 20 weeks of gestation. Chronic hypertension or diabetes, chronic kidney disease, advanced maternal age, multiple gestations and previous history of preeclampsia are the known risk factors for HELLP syndrome. The overall perinatal outcome will be poor with the early development of HELLP syndrome.

Case report

Thirty-two years old, second para mother with a past history of emergency hysterotomy due to pre-eclampsia at 31 weeks of gestation, transferred from a local hospital at 22 weeks of gestation due to uncontrolled high blood pressure, proteinuria, elevated liver enzymes, deranged clotting profile and high LDH levels for one-week duration. On admission, her blood pressure was 170/110mmHg without impending eclamptic symptoms, urine albumin was 2+, AST 123U/l (<40U/l), ALT 110U/l (<40U/l), serum creatinine 201μmol/l, PT/INR 1.35, LDH 405U/l, and her blood picture showed thrombocytopenia with evidence of haemolysis. Therefore, she was managed at the ICU setting due to suspected HELLP syndrome and on the 3rd day of admission, the patient developed moderate ascites and mild bilateral pleural effusion with proteinuria and poorly controlled hypertension.

The patient underwent emergency hysterotomy due to worsening of maternal parameters and a 560g weighing baby was delivered and handed over to the neonatology team. At the time of surgery, nearly 750ml of ascitic fluid was drained, and an abdominal drain was kept in situ for monitoring purposes. After the delivery patient gradually improved, her blood pressure normalised, on the 5th day postpartum her biochemical investigations become normalised except for serum creatinine which was persistently elevated above the range of 170 μmol/l. Her abdominal drain removed at postoperative day 5. Chest physiotherapy and ventilatory support were given as she was in respiratory distress due to bilateral pleural effusion. She was discharged on postoperative day 12 without any antihypertensives and advised to be followed up at the haematology and nephrology clinic for chronic kidney disease. On discharge, she was advised regarding risk of recurrence in her future pregnancies. A reliable contraceptive method was arranged, and she was directed to postnatal, nephrology and haematology clinics for follow-up.

Discussion

HELLP syndrome is a life-threatening obstetric complication with 10.0-60.0% of perinatal mortality rate and 1.0% of maternal mortality rate. Therefore, early diagnosis and early intervention play a crucial role in managing patients with HELLP syndrome. This patient was managed at ICU in a maternity hospital where her vital parameters, biochemical investigations including full blood count, clotting profile, liver and renal functions closely monitored during acute stage.

Her pregnancy was terminated due to multisystem involvement with ascites, pleural effusion, poorly controlled blood pressure and deranged biochemical parameters. Her immediate postpartum period was the most challenging period of her management because it carries an increased risk of complications such as acute kidney injury, disseminated intravascular coagulation, acute liver failure, acute respiratory distress syndrome, eclampsia, cerebral oedema and even maternal death due to postpartum hemodynamic alterations. The patient was managed with the assistance of anaesthesiology, nephrology and haematology teams. Psychological support and counselling, DVT prophylaxis, chest and limb physiotherapy, hydration and nutritional support were continued throughout the management.

Conclusion

Even though HELLP syndrome is an obstetric complication with increased mortality, early diagnosis, timely interventions, multidisciplinary team approach and teamwork helped to optimise the perinatal outcome and to save the maternal life.

EP/O – 25

SUCCESSFUL PREGNANCY OUTCOME FOLLOWING APPLICATION OF TWO RESCUE CERCLAGES IN SECOND TRIMESTER

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Introduction

Cervical cerclage is a surgical procedure in which sutures or synthetic tapes are used to reinforce the cervix. It is done through transvaginal or transabdominal route under spinal or general anaesthesia. Rescue cerclage is an emergency procedure which is applied to the cervix as high as possible. It delays delivery, on average, by 34 days and reduces preterm birth before 34 weeks of gestation by two folds. It provides a structural support to the weak cervix, a mechanical barrier to ascending infections and it helps to maintain the cervical length and the mucus plug. Cervical cerclage is usually applied between 14 to 24 weeks of pregnancy. There are no data in the literature regarding application of 2 cervical cerclages when the first one is failed or unsuccessful.

Case report

A 34-year-old mother with a history of primary subfertility for 7 years, conceived following intrauterine insemination, presented at 14 weeks of gestation with lower abdominal pain and mild vaginal spotting. On examination her cervical os was dilated up to 6cm and rescue cerclage was inserted under spinal anaesthesia. She was discharged on progesterone supplements and advice given regarding bed rest.

Four weeks later, she presented again with abdominal pain. On vaginal examination she had bulging membranes with dilated cervical os up to 5cm and the knot of the cervical cerclage was visible. She was observed in the ward for 2 days. As her vaginal examination findings remained the same, obstetric team decided to apply another cervical cerclage in the presence of the previous cerclage. The second cervical cerclage was inserted above the first cerclage, under spinal anaesthesia. During the procedure membranes were carefully reduced to prevent rupture of membranes. She was observed in the ward for 3 days after the procedure. With the absences of complains she was discharged with the progesterone supplements and was closely followed up at the clinic to assess foetal and maternal wellbeing.

At 28 weeks of gestation, she was diagnosed with gestational diabetes and was managed with medical nutrition therapy. Apart from that, her pregnancy was uneventful. At 37 weeks gestation, she underwent elective caesarean section due to breech presentation. She delivered a healthy baby weighing 2.9kg and both cervical cerclages were removed at the time of surgery. Her postpartum period was uneventful.

Discussion

Rescue cerclage is applied when there is premature cervical dilatation with exposed foetal membranes in the vagina. It can be considered up to 27+6 weeks of gestation. It is a highly individualised decision according to risks and benefits to both mother and baby. Advanced cervical dilatation of more than 4cm and prolapse of membranes through external os are associated with a high risk of cerclage failure. Active preterm labour, evidence of infection, continuous vaginal bleeding, preterm prelabour rupture of membranes, lethal foetal anomalies, foetal compromise and foetal death are contraindications for cervical cerclage. Emergency

cervical cerclage is associated with an increased risk of bladder injury, chorioamnionitis, cervical trauma and rupture of membranes during the procedure. Cervical cerclage should be removed between 36 to 37 weeks of gestation before labour or after caesarean section. Early removal may be considered in active preterm labour and preterm prelabour rupture of membranes. Following cervical cerclage, prolonged bed rest, abstinence from sexual intercourse, progesterone supplementation, serial sonographic surveillance of cervical length and monitoring foetal fibronectin levels are not routinely recommended.

Conclusion
Rescue cervical cerclage is a safe emergency surgical procedure which prolongs the pregnancy in advanced cervical changes. Even though data is not available in the literature regarding the application of second cervical cerclage after the failure of the first cervical cerclage, this case scenario shows there is still a possibility of prolongation of the pregnancy with the use of second cervical cerclage.

EP/O – 26
NEONATAL DEATH FOLLOWING ANTENATALLY DIAGNOSED GASTROSCHISIS COMPLICATING PREGNANCY

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Background
Gastroschisis is a congenital defect of the anterior abdominal wall leading to protrusion of abdominal viscera to the outside of the body without covering the membrane. It is a paraumbilical defect commonly seen on the right side of the abdominal wall. It is a rare condition with an incidence of 1 in 2000 live births. Even though the exact aetiology is unknown, it occurs due to multiple genetic and environmental factors. Low maternal age, use of tobacco, alcohol, cigarette smoking, and recreational drugs are known risk factors for developing gastroschisis.

Case report
A 23-year-old primi mother presented to the antenatal clinic at 13 weeks of gestation, in which her dates were confirmed, no gross anomalies were noted in the ultrasound examination, and no background risk factors were identified. Her routine booking investigations were unremarkable, and she had taken rubella and covid vaccines prior to the pregnancy. At 20 weeks of gestation, her routine anomaly scan was done, which revealed liver, gastric bubble, and bowel loops outside the abdominal cavity, which are covered with membrane features, are more in favour of omphalocele. Both partners were informed and counselled regarding the condition of the foetus. At 28 weeks of gestation, she was diagnosed with gestational diabetes and started on medical nutrition therapy.

At 30 weeks of gestation, she was admitted to the ward with reduced foetal movements; during the admission, she was started on metformin due to high blood sugar values. A neonatology referral was done and planned to deliver at 37 weeks of gestation by an elective caesarean section. Paediatric surgical opinion taken regarding surgical correction following birth. At 33 weeks of gestation, the mother presented with labour pains; on vaginal examination, the cervix was fully effaced with 6cm dilatation with bulging membranes. Ultrasound scan showed the baby in a transverse lie with bowel loops at the lower pole. The baby was delivered by an

emergency caesarean section and handed over to the neonatal team; on neonatal examination found to have gastroschisis with multiple gross fetal anomalies. The baby died a few hours after active neonatal resuscitation.

Discussion

Management of antenatally diagnosed gastroschisis based multidisciplinary team approach, involving obstetrician, foetal medicine specialist, neonatologist, paediatric surgeons, radiologists, psychiatrists, specially trained nursing, and midwifery staff. During the antenatal period, both partners should be counselled regarding the condition and available treatment options. Mode and time delivery, neonatal care and paediatric surgical referral, intrapartum and postpartum care should be planned and arranged during the antenatal period.

Regular monitoring of biophysical profile and fatal growth is recommended due to the increased risk of foetal growth restriction. Mode of delivery is decided according to the foetal lie and presentation, severity of the anomalies and obstetric indications. There are no added maternal and neonatal advantages of performing elective caesarean delivery for gastroschisis, which may associate with increased maternal morbidity. During the postnatal period, psychological support and counselling, suitable contraception, breast milk suppression, and pathological post-mortem should be offered apart from routine postnatal care.

Conclusion

Management of antenatally diagnosed major congenital anomalies is a challenging situation for both the obstetric team as well as to the parents. A multidisciplinary team approach helped in the management of that critical incident.

EP/O – 27
SEVERE UPPER LUMBAR ROOT LESION LEADING TO WALKING DIFFICULTY IN LATE PREGNANCY - CASE REPORT

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Introduction

Compression neuropathies are common in pregnancy due to associated soft tissue swelling, fluid accumulation, mechanical compression and obstetric interventions. Carpal tunnel syndrome, femoral neuropathy, obturator neuropathy and post-partum foot drop are the common compression neuropathies. Very rarely, it may involve spinal nerve root canals. Patients may develop clinical features according to the involving spinal nerve roots. Most of pregnancy-associated neuropathies may settle after childbirth. The incidence of obstetric neurological injuries is 1 in 25,000.

Case report

A 36-year-old primi mother presented at 35 weeks of gestation due to gradual onset loss of sensation over the lateral aspect of the left lower limb with pain and tingling sensation over two weeks duration and difficulty in walking for three days duration. Her bladder and bowel functions were intact. On examination, she had left lower limb proximal muscle weakness with grade III muscle power and foot drop with intact tone, reflexes, and sensations. The rest of her neurological examination was unremarkable.

Apart from advanced maternal age, her antenatal period was uneventful. Her complete blood count, inflammatory markers, clotting profile, and renal and liver functions were normal. A duplex ultrasound scan for a lower limb for deep vein thrombosis was negative. Urgent medical and neurological opinions were taken. Nerve conduction study of the left side lower limb revealed severe acute on chronic degenerative changes in the left quadriceps muscle, suggestive of severe upper lumbar root lesion. She was started on analgesics, limb physiotherapy and oral steroids. An anaesthesia opinion was taken, and her delivery was planned to be done at 37 weeks under general anaesthesia. She delivered a healthy baby weighing 3.1kg. She continued on analgesics, physiotherapy and local applications. The patient improved after five days of postpartum.

Discussion

The lumbosacral trunk arises from L4 and L5 spinal nerves, which run along the pelvic brim and ala of the sacrum. It is commonly compressed between the foetal head and sacral bone. The main risk factors are cephalopelvic disproportion and foetal malposition. It can lead to foot drop, difficulty in walking, paraesthesia and loss of sensation along the lateral aspect of the calf and foot. The prognosis is excellent and has a quick improvement after the delivery. Physiotherapy, neuropathic medications and analgesics may be helpful in supportive treatment.

Conclusion

Compression neuropathies in pregnancy can lead to a wide spectrum of clinical manifestations. They are often self-limiting and resolve after delivery. Multidisciplinary team management helped to improve the clinical outcome.

EP/O – 28
POSTPARTUM GESTATIONAL DIABETES INSIPIDUS RELATED TO HELLP SYNDROME: A CASE REPORT

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Introduction

Gestational diabetes insipidus (GDI) is a rare complication of pregnancy and typically occurs at the end of the second or third trimester and very rarely during the postpartum period. This can be associated with pre-eclampsia or HELLP syndrome. Early recognition and close monitoring are important to mitigate possible life-threatening consequences. This report describes a case of gestational diabetes insipidus associated with HELLP syndrome.

Case report

This patient is a 31-year-old primigravida diagnosed to have gestational hypertension at a gestation of 29 weeks, which was under satisfactory control with oral labetalol. She was admitted to the ward with a blood pressure (BP) of 150/94mmHg and mild headache at 34 weeks. She was asymptomatic, and investigations, including renal and liver functions and platelet count, were normal, with no evidence of proteinuria. Blood pressure was optimised using oral anti-hypertensives. Ultrasound showed a well-developed fetus with normal Doppler values.

She developed severe antepartum haemorrhage due to placental abruption on the second day of in-ward care, which warranted emergency hysterotomy. After six hours of LSCS, she

complained of blurring of vision and BP was found to be 170/90mmHg with significant proteinuria. Repeated investigations showed thrombocytopenia (55000/mm^3), low Hb (7.7g/dl), marginally elevated liver enzymes and elevated LDH.

She was found to be polyuric during the immediate post-partum period, with urine output reaching up to 7.5 l/day with mild hyponatremia (Na+ 130mmol/l). She was managed conservatively with adequate fluid support with the guidance of the nephrology team. Her BP was under control with enalapril in one week of postpartum, and polyuria completely resolved within ten days.

Discussion and conclusions

Gestational diabetes insipidus (GDI) can occur rarely in pregnancy due to high levels of vasopressin activity, particularly in the presence of hepatic dysfunction and placental abruption. It typically resolves by 4-6 weeks postpartum, and the chance of recurrence in future pregnancies is rare. In our patient, GDI was associated with mild hepatic dysfunction (AST 32 IU/l and ALT 52IU/L), placental abruption and polyuria, resulting in mild hyponatremia. Our patient improved without the need for desmopressin, which is the mainstay of the treatment if the condition worsens. Undiagnosed GDI can lead to serious consequences. Therefore, the clinician should suspect GDI in any woman with risk factors & suggestive history.

EP/O – 29
DOCUMENTATION PRACTICES IN ELECTIVE CAESARIAN DELIVERY CONSENT: COMPLETE AUDIT CYCLE IN DE SOYSA HOSPITAL FOR WOMEN

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Introduction

The flow of information between the doctor and the patient is critical to the treatment process. The consent is a representation of this connection and, from a legal point of view, a fundamental ethical principle which is the declaration of the patient's will. The decision-making must be approached thoroughly and firmly to gain informed consent. Before requesting consent, the doctor should make sure the patient is fully informed about the procedure for which it is being proposed, its prognosis, likely consequences, the risks of not receiving treatment, and any alternatives. The inaccuracy of the consent can lead to litigation, especially in Obstetrics and Gynaecology.

Method

A complete audit cycle was conducted in Ward 16 De Soysa Hospital for Women in 2022. RCOG Consent Advice No 14, "Planned Caesarean Birth" (August 2022), was used as the standard review tool. Only consent taken from elective LSCS was included, and components regarding tubal sterilisation or PP-IUCD were not considered. After the retrospective preliminary audit, a new consent form was introduced for ELSCS to the unit. The re-audit was conducted three months following implementation. Descriptive statistics were used to summarise the data, and the Fishers exact test was used for analysis.

Results

Initially, consent of 123 cases and in the re-audit, 93 cases were included. Documentation of all the components of consent has improved. Documentation of date, time, and patient information was 100% in the preliminary audit. Age was only documented in 15.4% of cases.

The intended surgical procedure was documented in 92.6% of cases, but the indication was only in 23.5%. Components of the procedure and possible complications were mentioned in 7.3% and 4% of the cases, respectively, but factual accuracy was poor. Mode of anaesthesia was mentioned in 45.5% of cases, but complications were not mentioned. Patients have signed 94.3% of the consents, but the medical officer who took the consent hasn't signed any of the consents. Evident in the re-audit, in 96.7% of cases, all the above components were documented. There was a statistically significant difference in proper consenting after the implementation. But poor knowledge of indication was highlighted. Significance is taken as an alpha value of 0.05.

Conclusion
Utilising a proper consent form for medical procedures will reduce the risk of litigations in the future. The patient is empowered to take more informed decisions regarding the surgery, and they are involved in the decision-making process, which is the ultimate goal.

EP/O – 30
SIRENOMELIA: A CASE REPORT OF A RARE CONGENITAL ANOMALY IN A TWIN PREGNANCY FOLLOWING IVF

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Objectives
Sirenomelia (The Mermaid Syndrome), is a rare congenital anomaly characterized by a fusion of lower limbs, resembling a mermaid's tail, accompanied by gastrointestinal and urogenital anomalies and the presence of a single umbilical artery. The etiology and pathogenesis of sirenomelia remain unclear, but certain risk factors such as gestational diabetes mellitus, maternal age extremes, and exposure to teratogens have been identified. Early detection through prenatal ultrasound is crucial for appropriate management and counseling.

Case report
A 27-year-old, primiparous woman with pre-existing diabetes mellitus and a dichorionic diamniotic twin pregnancy conceived through in vitro fertilization presented at 35+1 weeks of gestation with preterm prelabour rupture of membranes (PPROM). Her antenatal ultrasound scans revealed grossly absent liquor in one twin and the anomaly scan revealed agenesis of the left kidney and gross hydronephrosis of the right kidney with an absent bladder. The first twin showed no gross anomalies in USS.

The woman delivered by a caesarean section due to grade II meconium-stained liquor, PPROM, presenting twin was in breech & the complex nature of IVF pregnancy. The second twin exhibited fused lower limbs, characteristic of sirenomelia. The head, face, neck, upper body, and upper limbs appeared to be normal. Lung expansion was poor and bilateral air entry was poor due to hypoplastic lungs. The abdomen was rigid but not distended. The umbilical cord had one artery and one vein. Six toes were connected anteriorly to fused feet. Genitalia was absent & anus was not seen. The baby expired within one hour of life due to respiratory arrest. The parents declined a post-mortem examination.

Discussion

Sirenomelia is an extremely rare anomaly with only approximately 300 reported cases worldwide. The incidence is 1 in 100,000 births. The most noticeable feature is the presence of a mermaid's tail-like structure due to the fusion of lower limbs. It's characterized by severe urogenital abnormalities & presence of a single umbilical artery. Even though Sirenomelia has no exact causative factor, few strong associative factors have been identified such as Gestational diabetes mellitus, women's age of less than 20 years or more than 40 years, exposure to teratogenic factors (Air pollution, Cocaine, Tobacco, alcohol, cigarettes, drugs such as Cadmium, Lithium, Phenytoin, Sodium valproate, carbamazepine, warfarin, etc.). Ultrasonography can aid early detection by revealing fused lower limbs, single lower limbs, renal agenesis, single umbilical artery & oligohydramnios.

Conclusion

Sirenomelia is a rare and devastating congenital anomaly. Our case report underscores the importance of early prenatal diagnosis and appropriate counseling for parents. Preventive measures such as achieving good glycaemic control in pregnancy, avoiding exposure to teratogens, and considering optimal maternal age for pregnancy should be emphasized. Further research is needed to unravel the underlying etiology and pathogenesis to improve management and potential interventions to enhance outcomes.

EP/O – 31

EFFECTIVE USE OF ROBSON CLASSIFICATION IN A LOW RESOURCE SETTING – AN AUDIT FROM MAHAOYA, SRI LANKA

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Introduction

Cesarean Sections (CS) rates are on the rise in Sri Lanka (most recent rate) and exert a considerable weightage on the free health care system, in an era of financial difficulties apart from the known morbidity on the mother. A significant number of CS are avoidable with meticulous clinical handling. The introduction of Robson criteria by the WHO is expected to provide a systematic way of categorizing the indications and thereby reduce unnecessary CS. This audit was conducted with the intention of ascertaining the effectiveness of Robson criteria in a low-resource setting.

Method

This audit was conducted at Mahaoya Base Hospital from mothers who had undergone CS within this period. Relevant clinical data were collected from BHTs.

Results

During this time period, 35 mothers had undergone CS with the majority (n=15, 42.8%) being primigravidae. Out of the rest of the mothers, 70%(n=14) had already had one or more CS during previous pregnancies. All were single pregnancies with 7 (20%) having breech presentation while the rest had a cephalic presentation with a longitudinal axis. The average period of gestation was 38 weeks and 3 days (36+2 – 39+6). In 11 (34.2%) mothers, labour was induced. The majority of the CS were emergency LSCS (n=19, 54.3%), which included all the induced labours. Of the elective CS six mothers (37.5%) were primigravidae.

Major indications for CS included fetal distress (n=8, 22.9%), past CS with unfavorable cervix (n=8, 22.9%), lack of progression (n=7, 20%), and primi breech (n=5, 14.3%). All the CS in our cohort were divided into five categories of the Robson classification and their percentages in descending order are, Robson 02 (n=12, 34.3%) - Nulliparous single cephalic, ≥37 weeks induced labour or CS before labour, Robson 05 (n=12, 34.3%); multiparous with one previous CS, single cephalic pregnancy ≥37 weeks; Robson 6 (n=4, 11.5%); Primi breech; Robson 07 (n=4, 11.5%); multiparous single breech including previous CS and Robson 04 (n=3, 8.6%); multiparous with no previous CS with single cephalic pregnancy ≥37 weeks gestation.

Discussion & conclusion
Robson classification provides a more comprehensive yet clear idea of what the indications are for CS. This uniformity allows for clearer comparison between maternity units, and local & international data, thus allowing to identify instances where CS could be avoided.

Suggestions
Implement the Robson criteria in the same setting and analyze the data to confirm the effective use in a low-resource setting.

EP/O – 32
A NEAR MISS! ACUTE FATTY LIVER OF PREGNANCY (AFLP)

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Introduction and Objectives
AFLP is a fatal disorder. The reported incidence and stillbirth rates are 1/7000–1/16000 and 9% respectively. Nulliparous, low Body Mass Index (BMI), and Multifetal pregnancies are identified as risk factors. We report a case of AFLP complicated with intrauterine fetal death (IUD), coagulopathy, post-partum haemorrhage (PPH), Acute Kidney Injury (AKI), Macroangiopathic haemolytic anemia (MAHA), and post-partum psychosis.

Method
A 30-year-old primigravida at 35 weeks of gestation was admitted with malaise, vomiting, and jaundice. She didn't have a fever or skin eruptions. Cardiotocograph showed features of severe fetal acidosis and fetal heart sounds were absent by the time she transferred to the tertiary care centre. Her BMI was 18kg/m^2 and she was afebrile, icteric, and had a normal Blood Pressure (BP) of 110/70mmHg.The Ultrasound Scan (USS) confirmed IUD with an EFW of 2.9kg.

ABG showed severe metabolic acidosis with a pH of 7.1. Elevated K^+ (5.57mmol/l), blood urea 88 mg/dl, and serum creatinine 302 µmol/l revealed an AKI. Urine albumin was negative. Her Hemoglobin(HGB) was 11.8 g/dl, PLT 54000/µl and WBC was 22000/µl. Liver function tests showed ALT 288 U/L, AST 332U/L, ALP 519 U/, Total serum bilirubin of 11.8 mg/dl. Serum uric acid was 15.7mg/dl and LDH was 1212U/L.INR was 1.6, APPTT was 45.9 (control 30.5 Sec), and PT was 16.3 (Control 14 sec). She was normoglycemic throughout.

Multidisciplinary team (MDT) involved. Hemodialysis is done due to severe renal impairment. The dead fetus was delivered on day 3 which was complicated by PPH.APTT risen to 100 Seconds and INR was 1.8. ROTEM confirmed impaired Intrinsic pathway of clotting. Blood products & Factor Vii concentrate transfusion, uterotonics, and Bukry balloon catheter successfully arrested the bleeding. Grade 1 hepatic encephalopathy was diagnosed on day 5.

Her HGB and PLT were dropping. The blood picture revealed MAHA. 7 cycles of Plasma exchange were done. She was having disturbed behavior and labile mood despite improving biochemical parameters and post-partum psychosis was diagnosed. The patient was discharged on day 19 with a stable biochemical and mental state.

Results
AFLP makes a diagnostic dilemma with other liver diseases which can share most of the clinical features. The Swansea criteria guides to diagnose AFLP where this patient had 8 of the features. Despite multiple complications, the quick diagnosis and aggressive treatment saved the life of this young girl.

Conclusion
AFLP is an obstetric emergency. Diagnosing as early as possible, aggressive management with MDT involvement, expedited delivery, and careful follow-up are the four main rules in management.

EP/O – 33
SUCCESSFUL PREGNANCY IN AN END-STAGE RENAL FAILURE PATIENT WITHOUT INITIATION OF DIALYSIS: A RARE CASE REPORT

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Abstract
Pregnancy in patients with end-stage renal failure (ESRF) poses significant challenges due to the complex interplay between pregnancy-related physiological changes and compromised renal function. While dialysis is the standard treatment for ESRF, some patients may choose to forgo or delay dialysis during pregnancy due to concerns regarding potential risks to the developing fetus.

Pregnancy in ESRF patients without dialysis is associated with increased risks for both the mother and the fetus. Maternal complications observed included worsening of renal function, hypertension, pre-eclampsia, and infections. Fetal complications comprised prematurity, low birth weight, intrauterine growth restriction, and neonatal mortality. However, it is important to note that the outcomes varied among the studies due to the heterogeneity in patient populations, study designs, and management strategies.

Case Discussion
42 years old membranous proliferative glomerulonephritis end-stage renal failure patient (booking visit creatinine 309 micromol/l) presented to us at 16 weeks of gestation. She had multiple risk factors including GDM, Anaemia, Fibroid complicating pregnancy, Class 2 Obesity, Advanced maternal age, and primary subfertility for 15 years. She was managed with inputs from a multi-disciplinary team input including Obstetrician, Nephrologist, haematologist, Neonatologist, and Anesthetist. The patient refused hemodialysis during pregnancy. At each visit(every 2 weeks) BP, urine albumin, RFT, and ABG were performed. Fetal biometry, UADF, and MCADF were checked every 2 weeks. She was treated with nifedipine, methyldopa, soluble insulin, prednisolone, NaHCO3, Cyclosporin, Aspirin, Vitamins, and minerals. At 34+2 weeks POG she underwent CAT 3 LSCS due to rising levels of uric acid and acidaemia. She delivered a baby weighing 1.78 Kg and was discharged on postpartum day 33. Long-term nephrology follow-up was arranged.

Conclusion
Pregnancy in patients with ESRF without dialysis is associated with significant maternal and fetal risks. However, the available evidence is limited to abstracts, and further research is warranted to establish comprehensive guidelines for managing this unique patient population. Clinicians should carefully consider the potential risks and benefits of dialysis initiation or continuation during pregnancy on a case-by-case basis, taking into account the individual patient's medical history, renal function, and fetal well-being. Several management approaches were identified in the reviewed abstracts, including close monitoring of renal function, blood pressure control, dietary modifications, and the use of medications to support renal function. Some studies also reported the successful use of intermittent hemodialysis during pregnancy to manage worsening renal function in select cases.

EP/O – 34
SUCCESSFUL OUTCOME OF THE SURVIVING TWIN IN DICHORIONIC TWIN PREGNANCY INVOLVING A SINGLE FETAL DEMISE: A SINGLE UNIT EXPERIENCE

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Introduction
Death of one twin after 20 weeks of gestation can be 0.5-6.5%of all pregnancies.[1] Although one twin demise is common in mono chorionic placentation it can also occur in Dichorionic placentation. Dead twin due to compression will mummify and eventually will be made fetus papyraceous. It causes an immense psychological impact on parents.

Case Presentation
28 years old G1P0C0 mother was diagnosed with DCDA twin pregnancy at 12+2 weeks of gestation. This was a spontaneous pregnancy and there was no family history of twin pregnancy. She was started on aspirin 150mg nocte dose. Her booking investigations were normal. At 19+6 weeks during the anomaly scan one twin fetal demise was noted. IM dexamethasone 12mg 2 doses were administered at 20+ 2 weeks. The patient was advised to get admitted if any episodes of fever spike, symptoms of DVT, or coagulopathy. She was diagnosed with GDM at 26 weeks of gestation and was started on insulin and metformin.

Umbilical artery and middle cerebral artery dopplers were normal at 28 weeks. there was slow resorption of the dead fetus noted. Weekly FBC, CRP, and coagulation profile were done. At 32+2 weeks she had uncontrolled sugar control and was admitted to hospital. CRP was high at 16mg/dl on admission.CAT 02 LSCS was done in view of intrauterine infection. The patient started on IV antibiotics. The first twin weighing 1.75 Kg was delivered in breech presentation. A dead fetus weighing 300g was delivered next. The patient received antibiotics for 7 days. The baby was discharged on day 07 after a course of antibiotics.

Conclusion
In dichorionic twins, management depends on gestational age and coexisting underlying pathology (Eg - preeclampsia). Delivery should be delayed until 34 weeks. The route of delivery depends on the presentation of the leading twin. Steroids should be administered if LSCS planned (before 38+6 weeks) and vaginal delivery (before 35+6 weeks). Umbilical artery Doppler and middle cerebral artery Doppler will reassure fetal well-being. Although

coagulopathy is rare clotting factors should be monitored carefully.[2] It is not so common within 4 weeks of one twin's demise. On a weekly basis fibrinogen levels, PT/INR, aPTT, and platelets should be monitored. A review showed out of 77 dichorionic one twin demise 1.3% stillbirth,5.2% neonatal death,1.3% premature brain damage, and a total adverse outcome of 7.8% noted. A successful outcome depends on chorionicity, gestational age, underlying pathology, and psychosocial factors.

EP/O – 35
SUCCESSFUL POST-MENOPAUSAL IVF PREGNANCY: A RARE CASE REPORT

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Introduction
There has been a growing interest in utilizing IVF technique in post-menopausal women. This case report provides a brief overview of the considerations, challenges, and outcomes associated with this approach. The decision to pursue IVF after menopause raises several ethical, medical, and social considerations. Firstly, it is essential to evaluate the overall health and fitness of the post-menopausal woman to ensure she can withstand the physical demands of pregnancy. Comprehensive medical assessments, including cardiovascular and endocrine evaluations, are crucial in determining candidacy for IVF. Additionally, psychological counseling and support may be necessary to address the emotional aspects associated with later-life pregnancies.

One of the primary challenges of post-menopausal IVF is the availability of viable eggs for fertilization. Maternal risks include gestational diabetes, high blood pressure, preeclampsia, and cesarean section delivery. Fetal risks may include chromosomal abnormalities, preterm birth, and low birth weight. Despite the challenges and risks, successful post-menopausal IVF pregnancies have been reported. Advanced techniques such as preimplantation genetic testing (PGT) can be employed to screen embryos for chromosomal abnormalities before transfer.

Case Discussion
54 years old G3P2+1C1 post-menopausal women presented to us at 13 weeks of POG after successful IVF pregnancy post-endometrial preparation. First pregnancy underwent CAT 4 LSCS (I-FGR+Oligohydroamnios.) The first child had cerebral palsy and now bed bound. She had a T1 miscarriage in her second pregnancy.5 years back she reached menopause. Now she opted for an IVF pregnancy and succeeded during the second attempt. Endometrial preparation is done with higher doses of per vaginal and oral progestogens. Then embryos were transferred. She had dichorionic diamniotic twins.

Problems encountered were: multiple pregnancy (DCDA), Past one section, IVF pregnancy, Advanced maternal age, and age-related comorbidities, inter-interval pregnancy of more than 10 years, and threatened miscarriage during T1. She was screened with ECG, cardiac 2D echo, RFT, LFT, and OGTT. Followed up every 2 weekly (BP, urine albumin, Fetal biometry, Doppler studies) until delivery. She had two inward admissions during the antenatal period due to constipation. At 36+6 she underwent CAT4 LSCS and she delivered babies weighing 2.1 Kg/1.9 Kg. Both babies were discharged on post-partum day 9.

Conclusion
Post-menopausal IVF pregnancy is a complex and controversial topic that involves numerous considerations and challenges. While it can offer the opportunity for women to experience pregnancy later in life, it requires careful assessment, thorough counseling, and the use of donor eggs. Medical and ethical guidelines should be followed to ensure the well-being of both the mother and child throughout the process.

EP/O – 36
A CASE OF GIANT CERVICAL POLYP IN PREGNANCY

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Introduction
A cervical polyp is a focal hyperplasia of the endocervical epithelium; it's uncommon in pregnancy. Most of them are managed conservatively and polypectomy indicated for symptomatic cases outweighs the risk of bleeding and preterm delivery.

Case presentation
A 34-year-old lady in her 3rd pregnancy with two children by caesarean delivery presented at 33 + 5 weeks of gestation with an irreducible lump at the vulva for around 6 hours. The cervical polyp was detected following the second pregnancy and it was there for nearly 2 years. She conceived while awaiting polypectomy and that was managed conservatively. The polyp prolapsed through the vagina from 29 weeks but it was reducible with digital pressure. At 34 weeks the polyp was irreducible and the size was further enlarged up to 10* 7 cm with venous engorgement. The foetus was in cephalic presentation with an estimated foetal weight of 1.6 kg and posterior upper placenta. The corticosteroids were given to the mother to achieve fetal lung maturity with suspected preterm labour. The size of the polyp was not reduced with simple measures like the hypertonic saline pack. After 24 hrs, the polyp showed evidence of necrosis. There the joint decision was taken by the neonatal and obstetric teams to deliver the baby. So, the 1.7kg baby was delivered and cervical polypectomy was done vaginaly. Postoperatively the maternal condition was stable, and the baby was admitted to the neonatal ICU. The mother and baby were discharged on postpartum day 12.

Discussion
Cervical polyps are common in multiparous women with an unknown incidence in pregnancy. Few cases reported in the literature of giant cervical polyps > 4 cm in size in pregnancy. The polyp in pregnancy can present with vaginal spotting or bleeding, vaginal discharge with or without foul smelling, mass per vagina, preterm delivery, and chorioamnionitis. Most obstetricians prefer conservative management in pregnancy unless the polyp is symptomatic or suspicious of malignancy. The need for cervical cerclage for Polypectomy beyond the second trimester decides on an individual basis considering cervical changes and other risk factors for preterm labour. In conclusion, Giant cervical polyp in pregnancy is a rare condition. The conservative management offered most of the time with closed follow-up due to the risk of preterm delivery. Polypectomy indicated polyp with symptoms and suspicious features of malignancy.

EP/O – 37

AN UNUSUAL CASE OF UNCORRECTED TOTAL ANOMALOUS PULMONARY VENOUS DRAINAGE TO CORONARY SINUS IN PREGNANCY

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Objective

Total anomalous pulmonary venous drainage (TAPVD) is a rare form of congenital heart disease, where there is an absence of direct communication between pulmonary veins and the left atrium, resulting in a mixture of oxygenated and deoxygenated blood in the right atrium.

Uncorrected TAPVD rarely survives up to adulthood and pregnancy is very rare unless surgically corrected in childhood. It often requires termination of pregnancy in the first trimester as the heart cannot withstand the hemodynamic changes associated with pregnancy.

Case report

22 years old primi gravida, transferred from a peripheral hospital to our tertiary care hospital for further management for her at 19 weeks of gestation. She has been diagnosed patient with total anomalous pulmonary venous drainage into the coronary sinus in her neonatal period and planned surgery for correction at the age of 10 months, but defaulted. When she was presented to us at 19 weeks of gestation, she was asymptomatic and clinically stable with a saturation of 86% with room air, the 2D Echo cardiogram shows TAPVD, ostium secundum ASD with balanced shunt (Right to left), severe pulmonary hypertension with preserve LV function.

With the multidisciplinary team input, the pregnancy was continued up to 28 weeks of gestation for fetal maturity, with the close monitoring of the maternal condition and regular assessment of fetal growth and well-being, and the baby was delivered by lower segment caesarean section under regional anaesthesia at 28 weeks and 5 days with the birth weight of 890g. Postoperative care was given to the mother in Intensive Care Unit and Neonatal intensive care was given to the baby.

Discussion

TAPVD is a rare congenital anomaly of the heart in which there is an absence of direct communication between pulmonary veins and the left atrium, resulting in a mixture of oxygenated and deoxygenated blood. The factors determining the severity are the severity of pulmonary venous obstruction and restriction of interatrial communication. Uncorrected TAPVDs do not survive till adulthood and pregnancy in patients with this condition is extremely rare and often an indication for termination of pregnancy since hemodynamic changes in pregnancy. Our case survives up to adulthood and is delivered successfully at our hospital.

Conclusion

The multidisciplinary team approach helped in successful management and delivery without complication in our tertiary care hospital.

EP/O – 38
SUCCESSFULLY MEDICALLY MANAGED AN UNUSUAL ECTOPIC PREGNANCY- A CASE REPORT

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Objectives
As the commonest cause of maternal mortality in the First trimester, the surgical procedure has become the first line of treatment for ectopic pregnancies. Surgical procedures carry their own set of complications and salpingostomy increases the risk of persistent trophoblastic disease, which needs chemotherapy. Once the salpingectomy is done, management options for the next ectopic pregnancy leaves the patient have limited options for her fertility wishes. Whereas medical management would allow to keep the fallopian tube unharmed.

Case report
27-year-old primi with a POA 5 weeks +2 days presented with lower abdominal pain for a day. She was hemodynamically stable, on Trans vaginal scan (TVS), no Intra Uterine Pregnancy (IUP), no free fluid, no adnexal masses, Right side (R/s) Corpus luteum was seen. Serial βhCG Days 1, 3, and 5 had risen from 721 IU/ml, 951 IU/ml to 1622 IU/ml, respectively. Diagnostic laparoscopy on Day 7 was inconclusive thus we followed up with Serum βhCG Day 9, which was 4926 IU/ml and TVS showed R/s small suspicious mass of 1.5cm on adnexa, but no free fluid. As she was asymptomatic, we decided on medical management.

Intramuscular methotrexate 50mg/m^2 was administered on Day 11. βhCG on Days 13 and 15 had risen from 10437 IU/ml to 14796 IU/ml respectively. She was hemodynamically stable. The size of the suspicious mass in R/S adnexa stayed the same, there was no free fluid, thus the second dose of methotrexate was given on Day 17. βhGC on Day 19 was 7969 IU/ml and on Day 23 was 3547 IU/ml. The patient was kept in the ward and monitored regularly for the signs and symptoms of leaking or rupture of the ectopic. On Day 37, the βhCG had dropped to 150 IU/ml.

Discussion
The most common site for ectopic pregnancy is the ampulla of the fallopian tube (80%), and the majority is visualized on TVS, with high sensitivity and high specificity. Systemic methotrexate as medical management can be administered for carefully chosen cases according to nice guidelines. Which includes, gestational sac <35mm, β hCG <1500 IU/ml, no fetal heartbeat, minimal free fluid, and being hemodynamically stable. Even though her βhCG was 14796IU/ml, as she had the above clinical criteria; the medical management was carried out and it was successful.

Conclusion
Successful medical management will rather depend on the clinical status of the patient and the sonographic appearance of ectopic than the level of βhCG values.

EP/O – 39

FIBROID COMPLICATED CAESAREAN SECTION USING PFANNENSTIEL INCISION AND TRANSVERSE UTERINE INCISION – A CASE REPORT

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Objective

Fibroid-complicating pregnancies can be difficult to manage during delivery. Surgical technique plays a key role in a caesarean section. Standardizing the Perioperative period and enhancing recovery after caesarean section plays a basic role with benefits for maternal wellbeing.

Case report

37 years on her 1st pregnancy was admitted to Castle Street Hospital Sri Lanka at 37+3 weeks of period of gestation and she had a history of lower uterine fibroid which was diagnosed in 1st trimester. The last growth scan confirmed that it was a large lower anterolateral intramural fibroid (FIGO 4) measuring 13cm*12cm*10cm at the lower segment. The fetal presentation was breech and the placenta was anterior.

Elective cesarean section was done under combined spinal epidural anesthesia, with a Pfannenstiel incision and transverse uterine scar above the upper pole of the fibroid without breaching the capsule, and delivered a baby girl with a weight of 2675g. Manual rotation is done and fetus is delivered by the head, perioperative and post-operatively periods are unremarkable.

Discussion

In obstetrics usually surgeons are using supra pubic transverse incisions than vertical incisions. Delivery of a fetus with a lower-segment fibroid is always challenging. The surgeon usually preferred to use a midline vertical incision for that kind of surgery, with greater ease of access to the pelvis and lower abdomen. lower or upper segment caesarean sections are preferred to vertical incisions over the uterus for delivery of a fetus. A transverse incision over the uterus will reduce blood loss more than a vertical incision, with better healing, and reduced adhesion formation. The presenting case was a lower fibroid uterus and a breach presentation which need more space to deliver the fetus. But we mapped the fibroid and placenta and planned a transverse incision for delivering this breached fetus after manual rotation.

Conclusion

Early planning of a difficult surgery, using routine, correct surgical techniques with good surgical manipulations helps to make a successful outcome of a surgery. Proper analgesics and enhance recovery protocols are the basic requirement for quick recovery from a difficult surgery. Proper follow-up and interval myomectomy for complicated uterus must be encouraged.

EP/O – 40
POST-OPERATIVE LOCAL INFILTRATION OF ANALGESICS AND THE CLINICAL OUTCOME OF CAESARIAN DELIVERIES: CASE SERIES

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Objective
Satisfactory pain relief with perioperative local infiltration of analgesics following the caesarean section is a method to optimize somatic pain. Assessing the positive outcomes of this method in the early postpartum period has not been evaluated among postpartum mothers in Sri Lanka.

Case report
20 cases of category 4 elective caesarean sections done at Teaching Hospital Anuradhapura were selected. Indications for all 20 caesarean sections were elective repeat caesarean sections (ERSC) and select randomly. Out of 20, ten randomly selected cases were infiltrated with peri-operative local analgesics with plain lignocaine (4ml/Kg dose) followed by routine post-operative NSAIDs (Non-steroidal anti-inflammatory drugs). Oral feeding started after 4 hours. Assess pain, mobility, and bowel opening after 6 hours. The average visual analog scale of pain is less than 2 among the 10 cases after 6 hours. Early mobility was achieved in all 10 cases, that is by 6 to 8 hours. All cases had their bowel opening within 8 hours. No allergies or reactions were noted in any of the cases. The other 10 cases were not infiltrated with local analgesics, only post-operative NSAIDs were given. The average pain score is 3-4 after 6 hours. Early mobility achieved only 7 cases by 6 to 8 hours. All had bowel openings by 8 hours.

Discussion
Maternal morbidity and mortality are major health issues in developing countries. post-operative pain management and ambulation are key associations for enhanced recovery following lower segment caesarean section.

Conclusion
Lignocaine infiltration will improve post-operative pain, and mobility without any important side effects. Need large comparative studies to evaluate more local analgesics infiltration.

EP/O – 41
CORTICAL BLINDNESS IN POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME (PRES) – A CASE REPORT

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Objective
PRES is a clinical condition related to pre-eclampsia and is associated with ophthalmic and neurological symptoms. This is a clinicopathologic entity characterized by altered mental status.

Case report
34 years G3P3C3 had an uncomplicated vaginal delivery at term and was admitted to Kurunegala Hospital on postpartum day five. Presenting complaint was refusing the baby for 2 days. admission blood pressure was 138/90 with trace albumin of urine. Pre-eclamptic toxemic investigations were normal. The metabolic screen was negative. Provisional diagnosis made as eclampsia. The ophthalmic assessment showed bilateral blindness which make her refuse the neonate. The radiographic analysis made, the oedematous area around the occipital and parietal brain regions. Magnesium sulphate started, and the patient was managed at ICU and kept under observation. Recovered in 5 days. Follow-up MRI was normal.

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Discussion
Pathophysiology of PRES not fully understood. Cortical blindness is caused by a dysfunction in the visual pathway associated with eclampsia. Early detection is important as it will help minimize long-term complications.

Conclusion
Early suspicion of eclampisa with cortical blindness is important as we can minimize maternal morbidity and mortality by giving magnesium, antibiotics, and diuretics. Ophthalmic assessment and radiological assessment is recommended.

EP/O – 42
ACUTE ON CHRONIC PANCREATITIS IN PREGNANCY – A CASE REPORT

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Objective
Acute pancreatitis is a rare condition seen in up to 3 in 10000 pregnancies with high mortality and morbidity. Early detection with proper investigations will support the diagnosis. Managing pancreatitis in pregnancy consideration for the fetus poses an extra challenge. Mode of delivery can be considered according to the gestational age, severity, and complications. There is the greatest danger to the mother and fetus from pancreatitis in pregnancy, understanding the disease is particularly important to manage this condition.

Case report
25 years old in her second pregnancy with one living son was admitted to Castle Street Hospital at 33+3 weeks of period of gestation with an acute abdomen. Diagnosed with chronic pancreatitis in 2021 and was investigated for etiology and found to be hyperlipidemia. Left-sided sharp abdominal pain associated with nausea and vomiting without fever for one day was the complaint during her hospital admission. BMI 28.9 kg/m2 of BMI. She was mildly dehydrated. Hemodynamically stable and Basic investigations have normal limits. The serum amylase value was 2028 and the triglyceride level was 735mg/dL.

Resuscitated with intravenous crystalloids, antiemetics, antibiotics, prokinetics, and with analgesics. Monitoring started and she was kept fasting and bowel rest. Conservative management was decided as she is hyperlipidemic with a 4-fold triglyceride level. Repeat amylase values showed 1708, and 139 consecutively, and the patient was clinically improved, within one-week oral feeding was started. Planned induction of labor was done at 37+0 weeks of gestation with prostaglandins and she delivered a baby boy with a weight of 2480g. Basic investigations before discharge were normal and she was asymptomatic after delivery.

Discussion
Hyperlipidemia is known to occur in pregnancy up to 4-fold rising triglyceride level, which is the maximum cut-off, rising more than that associated with acute pancreatitis or relapse in chronic pancreatitis patients. Hyperlipidemia is a reversible cause with a poor outcome, that needs an early delivery as our initial management was successful and delivery of the fetus was done after induction at term.

Conclusion
The Obstetrics team must be aware of the maternal and fetal complications of pancreatitis. Proper investigations, initial resuscitation, and timely delivery will minimize the negative outcome of the pregnancy. Proper follow-up must be encouraged to minimize the relapses and improve the quality of the patient.

EP/O – 43
MEGA URETER IN PREGNANCY – A CASE REPORT

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Objective
The mega ureter can be divided into Primary and secondary mega ureter (PMU & SMU). Rarely PMU can present during pregnancy as non-obstructed, non-refluxing, or as refluxing obstructed mega ureter. We report a case of mega ureter which was incidentally found during pregnancy.

Case report
23yr old, previously healthy primi gravida presented for the routine dating scan at 12th weeks of gestation and was found to have a right-sided unilocular large retroperitoneal cystic lesion filled with anechoic fluid. The rest of the scan findings were normal. She was asymptomatic except for usual pregnancy symptoms. She didn't have features of urinary tract infection (UTI), haematuria, or previous history suggestive of chronic kidney disease. She denied any past ultrasound examination. Further evaluation confirmed the presence of the right-sided mega ureter. Her urine culture and renal function tests were normal. She was managed conservatively together with the Genitourinary surgical team. She was induced at term and had to undergo emergency caesarean delivery due to fetal distress. The mega ureter was noted right lateral to the uterus. Her recovery was uneventful. She was planned to review with CT-IVU after six weeks.

Discussion
Crucial point in management is to differentiate PMU from SMU. PMU or congenital mega ureter may associate with congenital mega calyces and ipsilateral renal dysplasia. As this patient didn't have features of bladder outflow tract obstruction or neurogenic bladder which suggests SMU, it had to be considered as previously undiagnosed PMU. The presence of retroperitoneal cystic lesions below the level of linea terminalis up to the bladder can be used to differentiate this from physiological hydro-ureter in advanced pregnancy.

Differential diagnoses are ceripelvic cysts, congenital megacalices, calyceal diverticula, and capacious extrarenal pelvis. Ordinary IVU or CT-IVU, MCUG will help to demonstrate reflux

of urine at the vesico-ureteral junction but can't be done during early pregnancy due to radiation to the fetus. Functional assessment of the affected kidney is unreliable with serum creatinine due to compensation by the other. And also, creatinine level falls during pregnancy.

Proper management should be done once the body physiology normalizes following delivery. Management of PMU has been changed recently. Even though ureteral re-implantation was the treatment of choice previously, conservative management is the accepted mode of treatment now with 85 to 90% success. Minimally invasive methods like endoscopic balloon dilatation have become more popular. Patients should be regularly screened and advised on the prevention of UTIs. With the advancement of pregnancy, the gravid uterus can compress the mega ureter. Delivery should be planned via a multi-disciplinary team discussion.

Conclusion

Even though an asymptomatic mega ureter in pregnancy doesn't need treatment, patients should be kept under careful surveillance for the complications. Definitive treatment should be offered following delivery.

EP/O – 44
A CASE OF POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME COMPLICATED WITH SEIZURES

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Introduction

Posterior reversible encephalopathy syndrome (PRES) is a rare presentation of pre-eclampsia. It is an acute neurological condition that may present as headache, vomiting, altered mental status, seizures or visual disturbance, and blindness. Furthermore, they might present with focal neurological signs dysphasia, or hemianopia. PRES is most commonly associated with pre-eclampsia or eclampsia which is more common in intra-partum or post-partum rather than antenatal period. It can also present with other predisposing risk factors such as immune suppression, sepsis, and renal disease.

Case report

A 26-year-old woman, a mother of two, who had an episode of convulsion during the postpartum period of her first delivery which was an emergency caesarean due to fetal distress. She was diagnosed as having generalized seizure disorder following EEG and started on levetiracetam. However, the woman had defaulted to the treatment after three weeks. She delivered her second baby by elective repeat caesarean section due to a past section following an uncomplicated antenatal period and developed a headache in the mid-night of post-partum day 5, which was responded initially to paracetamol, but she had a severe headache during the night with two episodes of vomiting, for which she had come to the hospital in the morning. Since her headache presentation was unusual, she had undergone an NCCT brain at the ETU which was interpreted as normal by the neurology team.

However, the blood pressure at the ETU was 177/92mmHg and 2+ proteinuria was detected during the dipstick test. On examination she was found to have exaggerated reflexes with no clonus, nor did she have neck stiffness. She was started on enalapril 2.5mg BD dose with a quarter-hourly blood pressure monitoring chart. In the afternoon, she had a GTC fit lasting for about 5 minutes in the ward, which was managed with IV Midazolam 5mg and IV $MgSO_4$

bolus of 4g over 20 minutes given. Her blood pressure dropped drastically to 70/40 mmHg, and she was transferred to ICU for further management.

IV MgSO4 infusion was not continued due to low blood pressure, and she was started on Levetiracetam 2g BD, IV Mannitol 250mg TDS and IV Dexamethasone 8mg TDS. She was stable and the blood pressure picked up within a few hours. The woman was transferred to the ward, the following day as she was stable, and the mannitol was discontinued. Furthermore, she became drowsy with a severe headache and a blood pressure of 150/100mmHg two days later, for which she was re-transferred to ICU for an impending convulsion. As expected, she developed another GTC fit that lasted for two minutes in the ICU at 1 pm.

MgSO4 bolus followed by 1g per hour infusion was continued for 24 hours with IV mannitol, Dexamethasone, and levetiracetam. Meantime her MRI showed the changes of posterior reversible encephalopathy syndrome (PRES) and EEG was suggesting BL fronto- temporal seizure disorder. The woman recovered during the next two days and the antihypertensives were omitted as the blood pressure became normal.

Discussion

The pathophysiological mechanism underlying PRES is still vague. It may be related to disordered cerebral autoregulation and endothelial dysfunction. The combination of acute hypertension and endothelial damage can lead to vasogenic edema elicited by the forced leakage of serum through capillary walls and into the brain interstitium. The reason for the primary involvement of posterior brain regions is not well understood. One possibility may be the regional heterogeneity of the sympathetic innervation of the intracranial arterioles. This is explained by better autoregulation of the anterior circulation due to better sympathetic innervations as compared to the posterior circulation.

Conclusion

Diagnosis of PRES depends on clinical and radiological findings. Early identification and meticulous management with supportive treatment including anticonvulsant therapy and antihypertensive treatment will prevent residual brain damage and help quick recovery.

EP/O – 45
RARE BUT POTENTIALLY FATAL POSTPARTUM HEADACHE - INFERIOR SAGITTAL SINUS THROMBOSIS

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Objective

Cerebral venous sinus thrombosis (CVST) is a rare but potentially fatal cause of headaches of which pregnancy and puerperium are recognized risk states. Early diagnosis and timely interventions will reduce maternal mortality and morbidity.

Case report

Here we report a case of 32year old primi mother, with a severe headache on postpartum day one. She was a known patient with iron deficiency anaemia and gestational diabetes mellitus on medical nutrition therapy. She complained of severe generalized headache from day 1 which was aching in nature, which was not relieved by NSAIDs, or opiate analgesics were given. She had associated photophobia; the pain was more significant towards the L/S peri orbital region

on day 2 with associated excessive tearing from the L/S eye. There were no other associated features, relieving or aggravating factors. Her blood pressure was within normal limits and her neurological examination unremarkable. MRI (magnetic resonance imaging), and MRV (magnetic resonance venography) showed filling defects in the inferior sagittal sinus, Cerebral Venous Sinus Thrombosis (CVST) involving the inferior sagittal sinus was diagnosed. Anticoagulation with LMWH (low molecular weight heparin) started and symptoms improved gradually within three days' time. She was planned to continue anticoagulation for a minimum of 3 months, with repeat MRI, and MRV assessment in four weeks' time.

Discussion

Perhaps the risk is related to prothrombotic changes in pregnancy. Dehydration, caesarean section, anaemia, and systemic infections increase the risk. Nevertheless, seen throughout pregnancy, it is most common in the third trimester and during the second and third week of postpartum. Incidence of CVST in Western countries range from 1:2500 -1:10000 deliveries. Commonly present with headache (80%-90%) & seizures (40%), some may present with focal neurological deficits, visual disturbances, and aphasia. 80% of cases involve the superior sagittal sinus, and only 20% involve the inferior sagittal sinus. MRI with T2 weighted imaging and magnetic resonance venography is the imaging modality of choice. Which will exhibit filling defects. Management involves a multidisciplinary team involving neurology and hematology input. Treatment involves long-term anticoagulation and a follow-up MRV.

Conclusion

CVST of the inferior sagittal sinus is a rare occurrence, the case highlights the need of a high index of suspicion in patients presenting with post-partum headaches. Early diagnosis & early commencement of anticoagulation will prevent further neurological deterioration.

EP/O – 46
MAJOR MATERNAL MORBIDITY FOLLOWING HETEROTROPIC PREGNANCY

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Objective

Heterotopic pregnancy is a rare condition where one embryo implants in the uterine cavity and another embryo implants on a site other than the uterine cavity. The extrauterine pregnancy can be ruptured and present with clinical manifestations of acute abdomen. In the presence of intrauterine pregnancy, initial diagnosis makes it difficult that may lead to delayed interventions causing major maternal morbidity.

Case report

26 year of patient who is in her third pregnancy with a period of amenorrhea for eight weeks presented to the emergency treatment unit with abdominal pain for 1-day duration. This pregnancy was conceived following ovulation induction with letrozole. On admission, she complained of right-sided lower abdominal pain but no per-vaginal bleeding, vomiting, or fever. Her hemodynamic parameters were within normal limits. There was mild tenderness in the right lower abdomen but no guarding or rigidity. A bedside transabdominal ultrasound scan was performed, live intrauterine pregnancy at eight weeks was identified. She was transferred to gynecological ward.

After six hours, her abdominal pain increased and complained of faintishness, and dizziness. Blood pressure was slightly low range with tachycardia. Abdominal examination revealed significant tenderness. Repeat scan was performed and revealed a large amount of free fluid in the abdominal cavity.

Emergency laparotomy was performed. There were nearly 2.5 liters of fresh and clotted blood noted in the peritoneal cavity. On further examination, the right side ruptured tubal ectopic pregnancy was detected. Right-side salpingectomy was performed. During the intraoperative and postoperative period three pints of pack red cell, fresh frozen plasma was transfused. Following surgery patient's conditions was improved. Oral progesterone was started, and she was discharged postoperative day four with live intrauterine pregnancy.

Discussion

During natural conception, the risk of heterotopic pregnancy rate is 1:30000 pregnancies while in assisted one it is about 1:100. Following ruptured extrauterine pregnancy patient can present with signs and symptoms of acute abdomen but usual diagnostic tools like serum B HCG, ultrasound scans may not be very helpful to get accurate diagnosis. In this instance, a diagnostic delay can occur that is associated with significant morbidity to the patient's life. therefore, clinicians should have a high degree of suspicion regarding heterotopic pregnancy when a patient presents with the above symptoms, specially who has a history of assisted reproductive treatments even in the presence of intrauterine pregnancy.

Conclusion

While managing acute abdomen in early pregnancy, the Presence of intrauterine pregnancy does not exclude extrauterine pregnancy. Clinical pictures combined with ultrasound findings should be used to exclude heterotopic pregnancies.

EP/O – 47
HYPERHAEMOLYSIS IN A PATIENT WITH HAEMOGLOBIN E DISEASE DURING THE POST-PARTUM PERIOD

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Objectives

Haemoglobin E (Hb E) disease is an inherited variant of hemoglobin A that results from an amino acid substitution. It's most frequently seen among the southeast asian population. Hb E disease is considered benign. Most individuals with the disease are asymptomatic. Hyperhemolysis syndrome (HHS) is a complication that affects patients with underlying haemoglobinopathies. HHS is a rare haemolytic transfusion reaction where severe anaemia occurs paradoxically following blood transfusion causing post-transfusion haemoglobin to be less than pre-transfusion haemoglobin. Haemodynamic changes and fluid shifts that occur during the post-partum period, pose a challenge in managing severe anemia in HHS.

Case report

A 34-year-old woman with a diamniotic dichorionic twin pregnancy presented at 31 weeks of gestation with signs of preterm labour. She is diagnosed with Hb E disease and her pregnancy was complicated by gestational anaemia and gestational diabetes mellitus. Two days prior to current admission she was transfused with 1 unit of packed red cells (PRC) which raised her haemoglobin to 9.5 g/dl. She had an uncomplicated delivery with a blood loss of 400ml. She

developed symptomatic anaemia during the immediate post-partum period with a haemoglobin of 6.6 g/dl. She was transfused with 4 units of PRCs which failed to raise the haemoglobin above the pre-transfusion value. Following the fifth transfusion she became jaundiced, passed dark urine and her haemoglobin dropped to 5.4 g/dl. A presumptive diagnosis of antibody-mediated acute haemolysis was made without an identifiable cause. Administration of intravenous immunoglobulin (IVIG) and systemic steroids failed to produce a successful outcome. She was also started on high-dose erythropoietin, folic acid, and vitamin B12. She was given supportive care, without further PRC transfusion in the intensive care unit. Oxygen requirement and patient's symptoms steadily improved and haemoglobin raised to 7.5 g/dl.

Discussion
HHS is a rare life-threatening complication which occurs following a blood transfusion. The acute form of HHS is a diagnostic challenge since alloantibodies at an early stage are often absent. Therefore, a high index of suspicion is important. Use of IVIG should be selective as it is associated with thrombosis, especially during the postpartum period with reduced mobility. Use of Erythropoietin warrants further exploration. It may correct anemia in HSS either by directly stimulating erythroid precursors or by preventing neo-cytolysis.

Conclusion
Our patient had severe anemia and was managed with a transfusion-free approach with a favourable outcome. This case highlights the importance of early recognition of HHS to avoid erroneous PRC transfusion.

EP/O – 48
MESENTERIC VENOUS THROMBOSIS IN A PREGNANT WOMAN AT 32 WEEKS OF GESTATION

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Objectives
Mesenteric venous thrombosis (MVT) is a rare thrombotic event which leads to intestinal hemorrhagic necrosis, sepsis, and demise. Occurrence of MVT in pregnancy is extremely rare which is associated with pregnancy-related prothrombotic state. MVT presents with a sudden onset of nonspecific symptoms like abdominal pain, nausea, and vomiting. MVT represents a diagnostic and therapeutic challenge as symptoms are erroneously interpreted as common pregnancy complications such as placental abruption, and uterine rupture.

Case report
A 33-year-old mother of one child at 32 weeks of gestation presented with generalized abdominal pain and vomiting for 2 days. Her antenatal period was uneventful. She had no significant medical, family, or history of thromboembolism. Upon admission she was tachycardic, and tachypneic however had no fever or hypotension. Physical examination revealed generalized abdominal tenderness without guarding. Fetal tachycardia was noted along with gestational age-compatible fetal biometry. Investigations revealed neutrophil leukocytosis, elevated C-reactive protein, and lactic acidosis. Ultrasound abdomen was inconclusive. Despite the improvement of haemodynamic parameters following initial resuscitation abdominal pain was intensified and fetal tachycardia persisted. Emergency laparotomy was performed following a multidisciplinary discussion. Corticosteroids were

given to promote fetal lung maturity along with magnesium sulphate for fetal neuroprotection preoperatively. Gangrenous cecum with blood-stained ascitic fluid was noted. The baby was delivered by transverse lower segment caesarean section and right hemicolectomy and ileostomy were performed. The postoperative period was uneventful. The histopathological report revealed evidence of ischaemic haemorrhagic necrosis without prominent transmural inflammation.

Discussion
MVT is a rare and poorly understood potentially life-threatening condition in pregnancy. Since the symptoms are nonspecific and there are no distinct physical examination findings or laboratory abnormalities, the diagnosis is rendered difficult. Abdominal pain is a frequent antepartum complaint and is a diagnostic challenge. Imaging is imperative at minimal clinical suspicion. Patients without suspected bowel necrosis can be managed with fluid resuscitation, broad-spectrum antibiotics, bowel rest, and systemic anticoagulation. If bowel necrosis or perforation are suspected, immediate exploration with either an open or laparoscopic approach should be performed. It is prudent to deliver the baby during the third trimester following multidisciplinary input to improve maternal and fetal morbidity.

Conclusion
Timely and accurate diagnosis of MVT requires a high index of clinical suspicion. Persistent fetal tachycardia can be a reliable indicator of maternal and fetal morbidity. This case highlights the importance of early imaging and surgical intervention in MVT to reduce morbidity and mortality.

EP/O – 49
A CONSERVATIVE MANAGEMENT APPROACH FOR SPINAL TUBERCULOSIS CAUSING CAUDA EQUINE SYNDROME IN PREGNANCY - A CASE REPORT.

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Background& Objectives
Spinal tuberculosis in pregnancy leading to neurological sequelae is rare and a challenging condition to manage. The usual approach is to perform urgent decompression surgery, but patients with a more stable course of the disease may benefit from a conservative approach with anti-tuberculosis (ATT) therapy.

Case presentation
A pregnant mother in her second trimester presented with a history of chronic backache exacerbated by right-sided foot drop, L5 root sensory loss, and intermittent urinary retention. MRI revealed L5 vertebral collapse with para-vertebral collection causing cauda equine compression at the L5-S1 level. High ESR, strongly positive tuberculin test, and the clinical and radiological findings were compatible with a diagnosis of spinal tuberculosis.

Based on the multi-disciplinary team's decision, a conservative management approach with ATT and supportive therapy was initiated with close observation. The patient showed a remarkable response to ATT with clinical and radiological improvement. She underwent an elective caesarean section at 37 weeks and delivered a healthy baby. On the fourth week postpartum, she underwent decompressive surgery with complete neurological recovery.

Discussion
Lower back pain is the universal symptom of TB spondylitis, but during pregnancy, it is a symptom that's often overlooked and attributed to mechanical and positional overload. Due to the radiation risk, x-rays are often avoided for back pain investigation, and the paucity of MRI imaging facilities leads to delays in diagnosis. But chronic backache not resolved with analgesia should be evaluated adequately during pregnancy. Spinal TB in pregnancy causing neurological impairment is usually managed with urgent surgical decompression, despite the potential hazards to the fetus. The most suitable line of management should be decided following a multidisciplinary input on a case-by-case basis.

This is one of the few reported cases where a conservative approach was undertaken, with close observation and a positive outcome, until adequate fetal maturity is achieved. ATT is essential for management, even if surgery is performed. It poses a small hazard of inducing congenital anomalies, but the possibility of maternal drug toxicity should be considered.

Conclusion
Therefore, it is important to carefully select patients needing surgical interventions and those who would benefit better from a conservative approach. High suspicion, early diagnosis, prompt treatment initiation, and close monitoring are vital components in achieving the best outcome.

EP/O – 50
UNUSUAL PRESENTATION OF UTERINE RUPTURE BEFORE THE ONSET OF LABOUR

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Introduction
Uterine rupture is a rare complication of a previous cesarean section. It has a greater impact with maternal & fetal morbidity & mortality. The classical features like vaginal bleeding, and hemodynamic instability does not present in all cases and there may be an atypical presentation with abdominal discomfort, GI symptoms, and urinary symptoms.

Case presentation
A 32-year-old lady in her second pregnancy came at 34+3 weeks of gestation with continuous lower abdominal pain and back pain for 2 hours. She had a past caesarean section with an inverted T incision at 38 weeks 3 years before with early neonatal death. Her BMI was 42kgm-2 at the booking visit, and she was normotensive & normoglycemic throughout the current pregnancy.

On admission, she had lower abdominal pain, back pain, and dysuria, with satisfactory fetal movement Cardiorespiratory examination was normal without tachycardia or hypotension. The abdomen was soft and non-tender, and the fetus was in cephalic presentation with a heart rate of 140 beats per minute. Ultrasonography showed a single live fetus with an estimated fetal weight of 2.29kg and normal dopplers and anterior upper placenta without retroplacental clot. Her cervix was uneffaced without bleeding. The investigation was in favor of urinary tract infection with a hemoglobin 11.2g/dl and platelets $204*10^9$/dl.

A category 1 cesarean section was performed around 12hrs of admission due to pathological CTG. The uterine rupture & bladder injury was noted through a previous scar with well-organized blood clot covering it. The 2.2kg live fetus was delivered, and subtotal hysterectomy and bladder repair done. The post-operative period was uneventful, and both the baby and mother were discharged at post-operative day 10.

Discussion
Uterine rupture is rare before the onset of labor and can cause severe maternal morbidity and mortality. The risk of uterine rupture following a previous atypical uterine scar remains high compared to a typical uterine scar. Nonspecific signs and symptoms may mislead the diagnosis. Obesity is another difficulty for sonographic assessment. In this case, a cesarean section was performed based on the pathological CTG.

Conclusion
Nonspecific pain that occurs in the third trimester should be taken for special consideration as the symptoms may be misleading. Close follow-up of women with previous uterine scar is stressed in this case report.

EP/O – 51
A CASE OF PANCREATIC PSEUDOCYST IN PREGNANCY

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Introduction
Pancreatic pseudocyst in pregnancy is a rare (1 in 60000 deliveries) condition and has no standardized treatment. Natural history is similar to non-pregnant cases. It resolves spontaneously but can be complicated with infection, rupture, haemorrhage, and bowel and bile duct obstruction.

Case report
A 28-year-old primigravida at 21 weeks of gestation presented with severe epigastric pain radiating to the back and vomiting for 2 days. Which was not associated with fever, vaginal bleeding/ watery discharge. She didn't have a history of acute/chronic pancreatitis, abdominal trauma, or alcohol abuse. On examination, she was afebrile, hemodynamically stable, and found to have epigastric tenderness with a 20 weeks size gravid uterus. Her investigations revealed serum amylase 426U/L with normal liver function test, white cell count, and C-reactive proteins. Ultrasonography was found to have a 20-week size intrauterine live pregnancy with a thick wall cystic lesion 7*8 cm in size arising from the body of the pancreas with no calcification, duct dilatation, or peripancreatic fluid. The diagnosis of pancreatic pseudocyst was confirmed by an MRI scan. The obstetric and gastroenterology team managed her with supportive care, and she delivered a 2.8kg baby by caesarean section at 37 weeks. The size of the cyst was not reduced on postpartum ultrasonography, and she was discharged on post-op day 3 with a gastroenterology review in 6 weeks postpartum.

Discussion
Pancreatic pseudocyst is a complication of acute pancreatitis with an incidence of around 5%. Clinical presentation can vary from asymptomatic to epigastric pain, nausea/vomiting, and acute abdomen due to bleeding infection or rupture. The serum amylase & lipase levels can frequently be high, but possibly within the reference range. Ultrasound scan findings are very

useful in the diagnosis, but MRI is the investigation of choice in pregnancy. There is limited guidance on the management of pseudocysts in pregnancy but in non-gravid patients' pseudocysts <5cm resolve with time but >5cm enlarge /remain the same. In pregnancy, asymptomatic pseudocysts are managed conservatively till delivery, and caesarean or assisted vaginal delivery is preferred due to the risk of cyst rupture during vaginal delivery.

Conclusion
Majority of pancreatic pseudocyst has a recent history of pancreatitis or the presence of risk factors. Conservative management or percutaneous endoscopic drainage is more favourable during pregnancy than open surgeries. Preterm labour due to the consequences of cyst rupture remains the major concern in the management.

EP/O – 52
FIRST CASE REPORT OF AORTIC DISSECTION DURING 3RD TRIMESTER OF PREGNANCY IN AUSTRALIA

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Objectives
To emphasize the importance of epigastric pain in pregnancy which could be a catastrophic condition like aortic dissection (AD) in pregnancy, to emphasize the lack of evidence on how to manage AD in pregnancy because of its rarity and few cases were reported in medical literature and finally to emphasize the high maternal and fetal mortality of AD in pregnancy.

Case report
A 31-year-old, otherwise low-risk multigravida (gravida 5, para2) initially presented to our maternity unit with worsening epigastric pain at 37 weeks and 6 days of gestation. She was discharged after reassurance concluding this was a gastric reflux. Three days later, she represented to one of the emergency departments of Queensland Health (QH)complaining of worsening epigastric pain radiating to her back and flanks.

Her vitals were stable except for tachycardia. ECG was reported as sinus tachycardic. chest X-ray was normal. CTPA was performed and identified as type B (TBAD) aortic dissection. Then she was airlifted for further management to the most equipped tertiary care centre in the QH. She was seen by both the vascular surgical team and the obstetrics team. She underwent an emergency caesarean soon after retrieval to a tertiary centre and delivered a male foetus. Her AD was managed medically, and she had been in the intensive care unit for 15 days. Then she was discharged with a long term management plan liaise with the vascular team.

Discussion
Computed tomography angiography (CTA has nearly 100% of the sensitivity and 98- 99% of specificity for the diagnosis of AD. A Chinese group of vascular surgeons published a paper on "Aortic dissection in pregnancy: management strategy and outcomes" following 17 years of experience of managing 25 cases of AD in pregnancy.

According to them, the management decision should be based on the gestational age and the type of dissection. For TAAD occurring before 28 GWs, urgent surgical repair with aggressive foetal monitoring or abortion is preferred. When dissection occurs after 28 GWs, urgent caesarean section followed by aortic repair appears to offer the best chance for maternal and

foetal survival. For TBAD, medical therapy or thoracic endovascular aortic repair (TEVAR) is preferred unless open surgical repair is mandated by malperfusion or aortic rupture.

Conclusion
It is difficult to formulate guidelines or management plan for Adin pregnancy because of its rarity and limited experience. Moreover, to formulate guidelines or recommendations for managing AD in pregnancy need more studies.

EP/O – 53
AUDIT ON EPISIOTOMY INFECTION RATE FOLLOWING NORMAL VAGINAL DELIVERY AND POSSIBLE CAUSATION: A RETROSPECTIVE STUDY

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Introduction
Episiotomy is a common surgical procedure performed during normal vaginal deliveries to widen the birth canal. While it facilitates delivery, it can also increase the risk of infection in the perineal area. This audit aims to assess the infection rate associated with episiotomy and explore potential factors contributing to its occurrence.

Objectives
The primary objective of this study is to determine the infection rate following episiotomy during normal vaginal deliveries. Additionally, we aim to investigate potential risk factors associated with episiotomy infection. We hypothesize that certain factors, such as maternal age, duration of labor, and antibiotic prophylaxis, may influence the incidence of infection.

Design
This retrospective study analyzed data collected from April 2022 to November 2022 in Teaching Hospital Anuradhapura Unit A and B. We reviewed the bead head tickets (BHT) and readmission tickets of mothers who underwent normal vaginal deliveries with episiotomies. The rationale for this study design is to assess real-world outcomes and identify potential areas for improvement in clinical practice.

Method
Participants were selected based on documented cases of normal vaginal deliveries with episiotomies during the study period. Data collection involved recording demographic information, duration of labor, maternal age, gestational age, use of antibiotic prophylaxis, and the occurrence of episiotomy infections. Data were analyzed using appropriate statistical methods to identify trends and associations.

Results
Preliminary findings from the analysis revealed a total of 34 cases of episiotomy infection out of 1816 normal vaginal deliveries. The infection rate was calculated to be 1.87%(n=34). Qualitative analysis of a patient with infected episiotomy records identified themes related to unhygienic practices 47%(n=16), apply ayurvedic applications 67%(n=23), negligence of postpartum antibiotic 82%(n=28), Uncontrolled Diabetics 11%(n=4) and Episiotomy dehiscence 17%(n=6). The Normal World Health Organization accepted wound infection rate is less than 10%. We have successfully achieved it.

Conclusion
This audit highlights the significance of episiotomy infection following normal vaginal deliveries and provides insight into potential causative factors. Our findings suggest a need for improved adherence to hygiene practices, proper wound care, and optimized antibiotic prophylaxis protocols. Addressing these factors may help reduce the incidence of episiotomy infections, ultimately improving patient outcomes.

EP/O – 54
POST LSCS MASSIVE REFRACTORY RETROPERITONEAL HAEMORRHAGE SUCCESSFULLY MANAGED WITH SELECTIVE ARTERY EMBOLIZATION AND 200 BLOOD PRODUCTS TRANSFUSION-A RARE CASE REPORT

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Background
Massive transfusion and selective artery embolization are life-saving interventions in cases of severe refractory hemorrhage. It is not commonly employed in obstetrics settings, specifically after a lower segment cesarean section (LSCS). The purpose of this report is to highlight the challenges faced during the management of massive transfusion and selective artery embolization in the obstetric setting and emphasize the importance of prompt recognition and intervention in such cases.

Case report
34 years old G4P3C2 mother underwent CAT3 LSCS at 36 weeks POG as she had major degree anterior placenta praevia with a history of past two LSCS previously. Due to massive PPH from the lower segment hysterectomy was done. Massive blood transfusion done with 3 packed RBC,3-unit FFP. Same day reopening was done due to lateral wall massive retroperitoneal haematoma (2 L) .3 Compressive abdominal packs were inserted. Same day and night patient developed abdominal compartment syndrome.

The abdomen was kept open and a urine bag was attached to the rectus sheath. Urine bag perforation was done to release the increased abdominal pressure. Selective left-sided internal iliac artery embolization was done. Haematoma evacuation and 5L of serous fluid aspiration were done three days later. On a postop day 15 patient was extubated from the ventilator. During the ICU stay patient was transfused with 40 packed RBC,32 units of FFP, 43 units of platelets, and 85 units of cryoprecipitate (Altogether 200 blood products).

Discussion
Massive transfusion in the obstetric setting poses unique challenges, particularly in cases of post-LSCS hemorrhage. The etiology of bleeding in these cases can vary, including uterine atony, placental abnormalities, and surgical complications. Prompt recognition and intervention are crucial for preventing maternal morbidity and mortality. A multidisciplinary approach involving obstetricians, anesthesiologists, hematologists, and blood bank personnel is essential for successful management. Additionally, the use of hemostatic agents and adjunctive therapies should be considered in cases of refractory bleeding.

Conclusion
This case report highlights the successful management of a patient who required a massive transfusion following an LSCS due to uncontrolled postpartum hemorrhage. It underscores the

importance of early recognition, prompt intervention, and multidisciplinary collaboration in managing massive transfusions in obstetric emergencies. Further studies and research are needed to optimize transfusion protocols and identify strategies to prevent and manage postpartum hemorrhage effectively. Prompt recognition of refractory bleeding and a multidisciplinary approach involving obstetricians, interventional radiologists, and anesthesiologists are crucial for optimal patient outcomes.

EP/O – 55
SUCCESSFUL MANAGEMENT OF CHRONIC MYELOID LEUKEMIA DURING PREGNANCY WITH MULTIDISCIPLINARY TEAM INVOLVEMENT: A CASE REPORT

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Introduction
Chronic Myeloid Leukemia (CML) is a rare haematological disorder with the presence of the Philadelphia chromosome (Ph+). Tyrosine kinase inhibitors (TKIs) have greatly improved CML outcomes. However, managing CML during pregnancy is challenging and requires a multidisciplinary approach. This case report showcases successful management of CML during pregnancy with a multidisciplinary team.

Case report
A 37-year-old woman in her first pregnancy presented at 17 weeks of gestation with a history of CML. She had been on imatinib and later switched to nilotinib for several years. As she desired to conceive, TKI treatment was discontinued after achieving a BCR-ABL translocation ratio of 0.00%.

She was closely monitored throughout the pregnancy, the patient's BCR-ABL translocation ratio, full blood count, and blood picture were regularly monitored. A multidisciplinary team which included Obstetricians, hemato-oncologists, and neonatologists collaborated to ensure optimal care. Subcutaneous interferon-alpha therapy was initiated after an increase in BCR-ABL ratio to 0.42% at 14 weeks of gestation.

Regular ultrasound scans were performed to assess fetal growth and development, with all scans being unremarkable. Due to increasing BCR-ABL levels, nilotinib was reintroduced at 32 weeks of gestation. At 36+4 weeks of gestation, an elective cesarean section was performed to minimize fetal stress. A live, non-asphyxiated male baby was delivered, weighing 2.6 kg. The patient maintained a complete hematological response (CHR) throughout pregnancy. Postpartum period was uneventful, with the patient being followed up monthly by the Hemato-oncologist. Breastfeeding was withheld to resume nilotinib therapy immediately after delivery. BCR-ABL ratio remained at 0.00% at 4 weeks postpartum.

Discussion
Treating CML during pregnancy is difficult due to limited data on potential fetal harm. Balancing the mother's safety while treating cancer against the fetus's well-being is a major challenge. Women with CML should be informed of pregnancy-related risks upon diagnosis, and planned conceptions are recommended after achieving a stable complete cytogenic response. TKIs must be stopped before or immediately after conception, and BCR-ABL detection should be done monthly to monitor treatment response.

IFN-alpha therapy can be considered for women with suboptimal response when stopping TKI treatment. IFN therapy during pregnancy has similar outcomes to non-pregnant women and does not significantly increase the risk of major malformations, miscarriage, stillbirth, or preterm delivery.

Conclusion
The successful management of CML during pregnancy requires careful planning and a coordinated effort involving various medical specialties. This case demonstrates the importance of regular monitoring, individualized treatment approaches, and close collaboration between healthcare professionals to ensure favorable maternal and fetal outcomes.

EP/O – 56
IDIOPATHIC POST-PARTUM INTUSSUSCEPTION: A DIAGNOSTIC DILEMMA

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Introduction
Intussusception, a rarest cause of acute abdomen occurs in the postpartum period where one part of the bowel folds into another, and poses a critical threat by compromising mesenteric blood flow and causing strangulation obstruction. Consequently, urgent treatment becomes imperative.

Case report
A 23-year-old woman presented with a sudden onset of abdominal pain and vomiting following a postpartum ERPC (Evacuation of Retained Products of Conception) on the 18th day after a vaginal delivery. Her antenatal and intrapartum periods were uncomplicated. Upon admission, she experienced two episodes of vomiting, but there was no abdominal bloating. She had a mild fever and no significant past medical or surgical history. Physical examination revealed only right iliac fossa pain and tenderness. Initially, conservative management was pursued, involving intravenous administration of Ceftriaxone and Metronidazole, with a CRP (C-reactive protein) level of 11.

During her hospital stay, a contrast-enhanced computed tomography (CECT) scan was performed to rule out iatrogenic organ injury, which did not reveal any obvious organ damage but showed a bowel mass with thickened bowel wall. To gather further information, an MRI (magnetic resonance imaging) was conducted, but it did not provide additional insights. The following day, she experienced coffee-ground vomiting and low-grade fever. On the fifth day after the ERPC, her vomiting worsened, and did not respond to antiemetic treatment. Additionally, she had tarry stools.

An ultrasound examination revealed dilated bowel loops with some cystic appearance in the bowel wall. Her pain intensified, leading to an immediate laparotomy performed by the surgical team. The uterus, ovaries, and adnexa appeared normal, but an ileo-ileal intussusception was identified 30cm away from the ileocecal valve, with impending perforation. The affected ileal segment was resected, and a small bowel anastomosis was performed during the surgery. Postoperative bowel care was administered.

Discussion
Idiopathic intussusception commonly affects infants during the weaning process. Nonetheless, primary (idiopathic) intussusception in adults remains a rarity. Idiopathic post-partum intussusception, an infrequent cause of acute abdominal pain, puzzles medical professionals due to its unknown origins. Given the complexities involved in diagnosing the acute abdomen following childbirth, identifying idiopathic post-partum intussusception pre-operatively becomes an immensely challenging task without a high level of suspicion or the aid of appropriate imaging techniques. When post-ERPC abdominal pain is suspected, we must out rule the possibility of iatrogenic injury. In this particular case, the iatrogenic injury was ruled out, but arriving at an imaging diagnosis for intussusception proved to be challenging. The clinical presentation of subacute bowel obstruction necessitated immediate surgical intervention, playing a vital role in potentially saving the patient's life.

EP/O – 57
IDIOPATHIC ASCITES FOLLOWING CAESAREAN SECTION

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Introduction
Ascites is the accumulation of fluid within the peritoneal cavity due to benign and malignant etiologies such as liver failure, cirrhosis, malignancy, intraperitoneal infections, cardiac failure, or trauma. As the rate of caesarean delivery has been increasing in recent practice complications related to surgery also continuously increased.

Case report
She is 30 years old, in her second pregnancy, and delivered via lower segment caesarean section (LSCS) due to a previous C-section and general hospital. On the fourth day postpartum, she presented to us with abdominal distension and discomfort, as well as breathing difficulties that had been ongoing for one day. Her prenatal history was uncomplicated, with no diabetes or hypertensive disorders, and she did not have any pre-existing cardiac, liver, or renal diseases. She had a past history of inguinal hernia repair.

Initially, her postpartum period was uneventful until the third day when she noticed a rapid increase in abdominal size, making it difficult for her to wear clothes. She also experienced shortness of breath even with mild exertion, felt tired, lacked energy, and had a poor appetite, all of which affected her routine postpartum care for her newborn. However, her bowel habits and urine output remained normal. During the physical examination, she had difficulty lying down, and her abdomen appeared distended and tense. There was no evidence of abdominal tenderness or palpable masses. Her pulse rate was 140 with good volume, but her blood pressure was normal. Auscultation of the lungs revealed diminished breath sounds in the bilateral basal lung fields, while other vital signs were normal.

Laboratory investigations revealed normal hemoglobin, platelet, and leukocyte counts in the full blood count. The urine analysis and renal function tests were within normal limits, including urinal albumin creatinine levels. Serum electrolytes were also normal, but serum albumin levels were slightly decreased. An echocardiogram ruled out peripartum cardiomyopathy. Abdominal ultrasound showed significant ascites, involvement of the postpartum uterus, mild hydronephrosis, hydroureter, and Grade I fatty liver. Mild reactive pleural fluid was also noted. A contrast-enhanced computed tomography performed on the

same day revealed gross ascites, bilateral mild hydronephrosis, and hydroureter proximal to the pelvic brim, likely due to compression by the pelvic vessels. There was no evidence of contrast leakage from the bladder.

Since there is no specific management for idiopathic ascites, supportive measures and monitoring were provided. These included salt restriction, frequent small meals with adequate protein intake, leg elevation with TED stockings, and regular check-ups to assess ascites progression and treatment response.

Discussion

Post-operative ascites following a caesarean section during pregnancy is a relatively uncommon occurrence. Therefore, it is essential to investigate and rule out the possibility of iatrogenic injury to organs such as the urinary bladder, bowel, or blood vessels when suspecting ascites post caesarean section. In this particular case, multiple imaging modalities were employed, but none of the typical causes of ascites were detected, adding further complexity to the diagnostic challenge.

Conclusion

As there was no definitive cause to be identified by advanced imaging techniques, the most likely explanation is either an idiopathic, allergic, or inflammatory reaction of the peritoneum.

EP/O – 58
MENINGIOMA CAUSING RIGHT-SIDED LOWER LIMB WEAKNESS FOLLOWING CAESAREAN DELIVERY UNDER GENERAL ANESTHESIA, IN A PATIENT WITH LUMBAR SCOLIOSIS AND LEFT-SIDE LOWER LIMB WEAKNESS.

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Introduction

Meningioma is the most common primary brain tumor in adults approximately being 36% of all brain tumors. Even though it is common in the elderly it can be presented at any age. Estrogen, progesterone, HPL, and Prolactin play a role as risk factors for meningioma being more common among females, with increasing growth and recurrence during pregnancy along with exacerbation of symptoms. First-degree relatives with meningioma can increase the risk by four-fold. Ionizing radiation, and socio-demographic factors also may play a role as risk factors. General anesthesia has shown to play a role in inducing symptoms of silent meningioma. This slow-growing tumor has a good prognosis with approximate 5-year survival of 87-97%.

Case report

We present a 35-year-old patent that developed right-sided limb weakness following a brief period of jerky movements after recovery from general anesthesia for elective lower segment caesarean section. She was in her second pregnancy and had been diagnosed with lumbar scoliosis, bilateral sciatica, and left side foot drop for a few years duration. She was offered elective caesarean section at term under general anesthesia due to lumbar scoliosis and previous caesarean delivery. Following recovery from general anesthesia patient has had developed a right-sided lower limb weakness preceded by right lower limb jerky movements. Her neurological examination revealed reduced power with increased reflexes in bilateral lower

limbs but more prominent on the right side. Upper limbs were unaffected. MRI of the brain and spinal cord was done and left-sided meningioma without brain herniation was identified. There were no spinal cord or nerve root compressions identified. The patient was initially managed conservatively with physiotherapy and further management was arranged with the involvement of the neurosurgical team.

Discussion
Symptoms of meningioma in this patient may have been masked by her lumbar scoliosis. Exaggeration of symptoms with pregnancy and general anesthesia may have led to further investigations and to find out the real cause for her neurological deficit. Complex clinical scenarios like this provide insight to medical professionals, in enhancing their scope of clinical knowledge and in approaching patients with uncommon and complex presentations.

Conclusion
Neurological symptoms and signs in patients specially during pregnancy can be misleading and is almost always associated with significant clinical disorders. Hence, they must be thoroughly assessed and investigated by experts in the relevant fields to identify those problems and promptly manage as to minimize associated morbidity and mortality.

EP/O – 59
A CASE OF SELECTIVE FETAL GROWTH RESTRICTION (SFGR) IN DCDA TWIN

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Objectives
sFGR is seen less commonly in dichorionic (DC) than monochorionic (MC) twin pregnancies, with a reported prevalence of 10.5% compared to 19.7%, respectively.

Case report
37 years of old woman in her first pregnancy with DCDA twin. She was investigated for primary subfertility for 10 years and this is an Assisted pregnancy with IUI. A dating scan done at POA 7 weeks diagnosed DCDA twin and the date corrected. At POA 14 weeks detected high blood pressure and managed with methyldopa and nifedipine and underwent cervical cerclage. At POA of 22 weeks as ultrasound showed normal growth of both fetuses and no gross abnormalities detected.

At POA of 27 weeks she was admitted to the local hospital following detection of high blood pressure of 150 /90 mmHg with no PET symptoms. Her urine albumin was negative. She was detected to have selective fetal growth restriction_in T2. We decided to manage with daily Dopplers. Corticosteroid were given after 1-week. T2 IUD was detected at POA 31 weeks and 1 day. EM LSCS was done on the same day. T1 live Baby boy with a birthweight of 1190g and T2 fresh IUD weighed of 555grams. The baby and mother were discharged postpartum on day 30.

Discussion
In this case, she is a 37 years old, subfertile for 10 years with hypertension. Plan was to monitor fetal wellbeing with Doppler daily because the larger fetus is also not mature enough when she presented at POA 30 weeks. But after detecting the small fetus IUD and high blood pressure we had decided to deliver.

Conclusion
The recommended management for sFGR in DCDA twin pregnancies is the same as that of growth-restricted singletons.

EP/O – 60
"GRAY PLATELET SYNDROME" – A RARE CAUSE OF THROMBOCYTOPENIA IN PREGNANCY

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Objectives
Gray platelet syndrome is a rare inherited platelet disorder, characterized by moderate to severe thrombocytopenia. These are large and dysfunctional platelets with absent alpha granules giving the characteristic gray appearance on Wright-stained peripheral blood smear. Deficiency of alpha granules which otherwise contain essential proteins for platelet aggregation and haemostasis, results in easy bruising, epistaxis, and heavy bleeding during dental procedures which are out of proportion to the severity of thrombocytopenia. Although 6% - 15% of women experience moderate thrombocytopenia during pregnancy towards term, gestational thrombocytopenia being the commonest cause, the outcome of pregnancy complicated with gray platelet syndrome is not widely known. Therefore, we thought of presenting this case explaining how to manage a case of gray platelet syndrome complicating pregnancy during the antepartum period and delivery.

Case Report
A 26-year-old primi gravida born to consanguineous parents was booked in the antenatal clinic in first trimester, with a background history of gray platelet syndrome which was diagnosed at the age of 12. She was extensively investigated at 12 years of age due to easy bruising and gum bleeding, and the blood picture showed a persistent thrombocytopenia along with normal other cell lines. Further analysis revealed reduced aggregation response of platelets while clotting factor levels were normal. The whole blood lumi-aggregometry revealed a secretory defect of the platelets which was confirmed as gray platelet syndrome after characteristic staining of platelets on Wright-stain.

She was followed-up in the haematology clinic and in her last ultrasonography there was mild hepatospleenomegaly which is a common and expected complication of the disease. Adding further to her disease burden, trephine biopsy done in 2016 revealed myelofibrosis, although all three cell lines were seen in equal proportions. In this background after explaining all possible complications during pre-pregnancy counseling, patient and her husband opted to have a baby as risk of transmission of the disease to their offspring is found to be minimal. She was closely followed-up by consultant Obstetrician, haematologist, consultant anaesthetist and neonatologist throughout her pregnancy in a multidisciplinary setup and despite having a low platelet count, pregnancy was uncomplicated with no episodes of bleeding from any site.

Obstetric scan at 36 weeks revealed an assymetrical foetal growth restriction with abdominal circumference falling between 3rd to 10th percentiles when plotted on a customized chart with a normal amount of liquor. As umbilical artery doppler studies were slightly high, every 3rd day doppler assessment was performed aiming delivery at 37 weeks. As at 36 weeks and six days her platelet count was 26x 10^3/ µL she was transfused three units of platelets. At 37 weeks

her platelet count was 34x 10^3/ µL. With a minimal risk for normal vaginal delivery in the background of a platelet count of 34x 10^3/ µL, foley catheter was inserted for cervical ripening as the cervix was unfavourable for induction of labour. Next day as the cervix was favorable induced with artificial rupture of membrane and syntocinon infusion. Unfortunately, an emergency cesarean section had to be performed due to lack of progress in first stage of labour after 8 hours of induction.

Pre-operatively four units of platelets transfused along with intravenous tranexamic acid 1g and keeping 6 units of group specific platelets and three units of cross-matched blood, she was taken to the operating theater. Under general anaesthesia a lower segment cesarean section was performed, and all the measures were taken to do a non-traumatic delivery, giving birth to a baby boy with a birthweight of 2.3 kg. Intra-operatively she was managed with intravenous syntocinon infusion, intravenous ergometrine and five units of platelets as there was mild oozing from incision over skin, rectus sheath and uterus. Complete haemostasis achieved and patient was managed in the intensive care unit post-operatively. On post-operative day 2 she was transferred to the postnatal ward and her platelet count was 50x 10^3/ µL postoperatively with no bleeding vaginally or from surgical site. Baby's platelet count done on day one was normal and blood picture revealed normal looking platelets. Intravenous tranexamic acid continued for three days and she was discharged home five days after cesarean section.

Discussion

Being a very rare disorder, the management and follow-up of patients with gray platelet syndrome is not well described, thus multidisciplinary approach made the management of this patient easy. Issues confronted in this case are the risk of a fatal hemorrhage during delivery and the possibility of foetal hemorrhage secondary to thrombocytopenia. Our patient received platelet transfusions along with tranexamic acid prophylactically before surgery which ultimately produced a good outcome.

Conclusion

Patients with gray platelet syndrome can have a safe pregnancy and delivery, with multidisciplinary team approach, especially the involvement of the consultant haematologist. Blood and blood products should be used whenever necessary during pregnancy and delivery and close monitoring is of utmost importance.

EP/O – 61
AUDIT ON EARLY ONSET NEONATAL SEPSIS (EOS) IN A BASE HOSPITAL, SRILANKA

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Introduction

Neonatal sepsis can be classified as early (<72 hours) or late onset. In Sri Lanka, 11% of neonatal mortality is attributed to infections, with 75% of deaths occurring during the first week due to early onset neonatal sepsis (EOS). Preventive strategies to reduce EOS include minimizing invasive interventions and promoting hygienic practices.

Objectives
To conduct an audit and implement measures to reduce early onset neonatal infections.

Method
We conducted a retrospective cross-sectional study of all deliveries over two consecutive months at the maternity unit of Base Hospital Udugama, Sri Lanka. A pretested checklist was used, and the results were compared against the national guideline for newborn care (Ministry of Health; 2020).

Results
A total of 105 deliveries were studied during January and February 2023. The median maternal age was 30 years, while the median gestational age of neonates was 37 weeks + 5 days. The early onset neonatal infection (EOS) rate was found to be 3.8% (N=4) in this population. Risk factors for EOS included preterm labor (<37 weeks) in 36.1% (N=38) of cases, newborns of mothers with diabetes in 9.5% (N=10) of cases, instrumental/difficult delivery in 4.7% (N=5) of cases, >3 vaginal examinations in 25.7% (N=27) of cases, PROM >18 hours in 0.9% (N=1) of cases, low birth weight <10th Centile in 6.6% (N=7) of cases, and low APGAR at 5 min in 1.9% (N=2) of cases.

Conclusion
According to the Sri Lankan national guideline for newborn care, risk factors for EOS include maternal pyrexia, PPROM/Prolonged rupture of membranes >18 hours, preterm delivery, low birth weight, low APGAR, difficult delivery/instrumentation, ≥3 vaginal examinations, or unclean delivery. However, in this population, the only factor associated with EOS was newborns of mothers with diabetes.

To mitigate early onset neonatal infection, we have implemented quality improvement measures, including limiting the number of vaginal examinations, ensuring strict asepsis during vaginal examinations, introducing a visitor pass system to limit the number of visitors, regular sterilization practices, changing linen, and providing individual allocated linen for each baby. Proper diabetic control has been achieved through home blood sugar monitoring. Follow-up audits are currently being carried out to assess the effectiveness of these new hygienic practices.

EP/O – 62
PREGNANCY COMPLICATED WITH TYPE 2 VON WILLEBRAND DISEASE (VWD)

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Objectives
Von Willebrand disease (VWD) is a common bleeding disorder that can leads to significant post-partum haemorrhage (PPH). Especially type 2 VWD variants need to be monitored closely because of the qualitative variation in subtypes.

Case report
A 22-year-old primigravida, diagnosed patient with type 2 VWD was admitted to the antenatal ward for further assessment at POA of 37 weeks. USS revealed late-onset FGR with normal Doppler studies and antenatal CTG was normal. Haematology opinion was taken and labour was induced with prostaglandin.

The patient was started on oral tranexamic acid and factor correction is planned with VWF and FVIII at the beginning of 2nd stage and 12 hours postpartum. Neuraxial anaesthesia, IM injections, and traumatic delivery were to be avoided and active 3rd stage management was planned.

Unfortunately, the patient developed fetal distress which led to EM/LSCS under general anaesthesia. After delivery, IV Oxytocin bolus plus infusion, IV tranexamic acid, and IV ergometrine were given. Modified B-lynch sutures were applied. Oral tranexamic acid was continued until postoperative day 5 and factor correction was done. No bleeding manifestation was noted and the overall post-partum period was uneventful.

Discussion
VWD is caused by defects of the VWF which mediates the adhesion of platelets to clotting factor VIII (FVIII). VWD is classified into 3 types. Type 1 and type 3 are caused by a quantitative reduction of a normal VWF. Type 2 is caused by qualitative abnormalities of VWF and is divided into 4 subtypes. In pregnancy, coagulation factors (VII, VIII, X), fibrinogen, PAI1 increase, and fibrinolytic activity with anticoagulant factors (protein S) decreases. VWF and FVIII increase reaching the highest in the third trimester with levels > 100 U/dL at delivery. But in type 2 the qualitative defects don't improve during pregnancy.

There can be an increase of FVIII and VWF with variations in the amount according to subtype. Immediately after delivery FVIII and VWF fall to baseline levels and thus oral tranexamic acid should be considered to prevent delayed PPH due to heavy lochia. Also, patients usually require treatment with FVIII/VWF concentrates. Post-operative thrombo-prophylactic treatment with LMWH should be considered in such patients treated with replacement treatment anticipating high FVIII levels.

Conclusion
VWD type 2 variants need to be monitored vigorously according to the unique peculiar pathophysiology of each variant subtype. The presence of VWD is not a reason to prefer caesarean section. Antifibrinolytics and factor replacement have utmost importance during late post-partum period to prevent PPH.

EP/O – 63
USE OF ROBSON CLASSIFICATION TO ASSESS CAESAREAN SECTION RATE

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Introduction
There is an increasing trend in the Caesarean section (CS) rate worldwide; the CS rate has increased threefold between 1998 and 2016 in Sri Lanka. The World Health Organization (WHO) has advised that CS rates should not be more than 15%. Robson's 10-group classification (RTGC) is based on parameters such as parity, number of fetuses, fetal presentation, previous CS, the onset of labour, and gestational age but, It does not include the indication for CS. WHO has recommended RTGC to assess care at delivery and to optimize the CS rate.

Objective
Aim to analyze CS rate by using RTGC

Method
A retrospective analysis was done on all women in this cohort who gave birth during 6 months starting from September 2018.

Results
344 deliveries out of 1199, were delivered by CS. According to the RTGC, both group 2 and group 1 are the most represented groups respectively 22.3% and 21.9%, in this cohort. The CS rate of Wards 9 &10 is 28.7% and the major contributors to the CS rate are Group 5 (32.8%) and Group 2 (29.1%).

Conclusion
The CS rate for group 3 is within the expected range which indicating the management of multiparas in spontaneous labour at term is adequate. In contrast, the CS rate for group 5 is very high. The size of 5.1 is higher than 5.2 which indicates group 5.1 has undergone reasonable trials of labour. Similarly, the CS rate for group 10 is also high because most pre-term women have undergone prelabour CS due to complications.

Although this tertiary centre is receiving high-risk patients, the CS rate of Ward 9&10 is 28.7 %. While the national level of CS rate is 36%. This reduced CS rate is achieved due to practicing less induction and allowing a reasonable number of trials of labour after CS. Robson's classification help to identify and analyze the groups which are contributing the most to the overall CS rate and it is ultimately helping us to modify strategies and interventions to optimize the CS rate. Further, this classification also helps us to focus on certain groups to reduce the CS rate.

E-POSTERS – GYNAECOLOGY

EP/G – 01
A CASE REPORT ON HYSTEROSCOPIC MYOMECTOMY IN A VIRGO INTACTA

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Background & Objectives
The vaginal approach remains one of the easiest, safest and most convenient ways for surgical procedures in many gynaecological pathologies, including polyps, cervical fibroids or pedunculated sub-mucosal fibroids. But classical procedures are hindered by the disruption of the integrity of the hymen, an issue which remains controversial if not unfavourable in certain conservative geographical areas and societies. We report a case where an alternative novel approach is applied for hysteroscopic myomectomy in Virgo intacta.

Case report
A 39-year-old lady with an intact hymen presented with recurrent episodes of abnormal uterine bleeding with intermenstrual bleeding. Trans-rectal sonography revealed a 4*4cm solid mass presenting as a pedunculated cervicovaginal fibroid. A hysteroscopic resection was considered the optimum treatment method. Trans-hymenal 3.5 mm rigid hysteroscopy was performed, and the diagnosis was confirmed as a pedunculated fibroid with a stalk attached to the endocervix.

Insertion of a 5.5 mm hysteroscope and resectoscope with operating fluid pressure can traumatise an intact hymen. And Fluid leaks through the introitus will reduce hysteroscopic vision during surgery and a greater risk of hymenal injury when specimen retrieval is performed after the procedure. To overcome these challenges, a wound protector port was used, which is a flexible, elastic membrane with malleable internal and external rings that causes minimal interference to tissue planes through which the insertion is performed. This creates adequate space to insert and operate while providing a sealing effect for fluids. The need for surgical assistance was also less. Following completion of the procedure, retrieval of the internal ring is crucial as it can lead to hymenal tears. But making an incision to divide the internal ring, make eases this step without injuring the hymen.

Conclusion
This is an alternative to open or laparoscopic colpotomy in which hymenal conservation is considered the prime need of the patient.

EP/G – 02
AN AUDIT ON KNOWLEDGE, PRACTICE, AND ATTITUDES OF POSTGRADUATE TRAINEES TOWARDS CONSENTING PRIOR TO OBSTETRICS AND GYNECOLOGICAL SURGICAL PROCEDURES.

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Introduction

Informed consent is a fundamental process establishing an agreement between patient and surgeon to conduct clearly outlined intervention. It is not a casual formality or casually signed document. Instead, this comprehensive process involves a competent patient, a clearly communicating medical officer, and the delivery of focused information about the planned surgical procedure. This shared understanding and decision-making opportunity improves patient care and minimises medico-legal issues. At present, many studies and clinical audits have been performed to assess the strengths and deficiencies of the surgical consenting process. This audit aims to detect knowledge, attitudes, and practice of obtaining surgical consent among obstetrics and gynaecology postgraduate trainees to improve the quality of care.

Method

The audit was conducted over two weeks commencing 20-08-2022 and had 30 participants (postgraduate trainees in obstetrics and gynaecology). Data was gathered using a self-administered questionnaire which was completed anonymously. The questionnaire covers fundamental aspects of knowledge, attitude, and practice of consenting before surgical interventions.

Results

100%(n=30) of participants were confirmed that they directly involved in surgical procedures, and out of them, 67% involved in obtaining consent prior to the intended procedure by themselves. All participants (100%) believed consenting should essentially be in document format to become valid. Only 10% of participants have used photos, videos, or animations occasionally to obtain valid consent, and the main reason for such a low percentage was the unavailability of such pre-designed pictorial or video/animation formats.

Conclusion

It is mandatory to explain the nature of the condition, its prognosis, and consequences of not receiving treatment / undergoing surgical interventions, available treatment options as medical or surgical options, and how it affects the disease condition. There are many strengths in this audit on obtaining valid consent prior to surgery, as about 2/3rd participants are actively involved in the surgical consenting process. Apart from that, 100% of participants explain the nature of the condition to patients, and over 2/3rd cover sequelae of not getting treatment and preoperative preparation.

EP/G – 03

A CASE REPORT ON CYSTIC ADENOMYOSIS: A RARE VARIANT OF UTERINE ADENOMYOSIS

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Background

Cystic adenomyosis is a rare variant of adenomyosis that can easily be misdiagnosed due to the non-specific nature of symptoms. USS & MRI are essential in making a diagnosis which is later confirmed through histopathological evaluation. Surgical interventions are favoured over medical management, as complete resection reduces the risk of recurrences and alleviates the chances of malignant transformation.

Case report
A 37-year-old multipara presented with chronic abdominal pain, exacerbated by menstruation, lasting most days of the month for over one year. Clinical evaluation revealed a tender, less mobile pelvic mass mimicking an intramural fibroid on USS. Considering the long-standing symptoms and lack of fertility wishes, she underwent a laparotomy. During surgery, an unexpected finding of chocolate-coloured exudate with a thick epithelium-lined myometrial cystic lesion was noted. Histo-pathology evaluation revealed endometrial glands and stroma distributed throughout the myometrium, with the endometrium lining the epithelium of the mass, thus leading to the diagnosis of cystic adenomyosis.

Discussion & Conclusion
Cystic adenomyosis is considered to arise due to persisting Mullerian epithelial cells stimulated by estrogen leading to periodic bleeding into the myometrium. Surgery of the myometrium can also introduce endometrial tissue to the myometrium. To preserve the quality of life and reduce the risk of recurrence, minimal access surgery should be carried out. Even though rare, a young woman presenting with chronic pelvic pain and not responding to analgesics should raise the possibility of cystic adenomyosis, which should warrant further investigation and treatment.

EP/G – 04
A CASE SERIES OF HERLYN-WERNER-WUNDERLICH SYNDROME (HWSS) -A RARE TYPE OF MULLERIAN ABNORMALITY

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Introduction
Herlyn-Werner-Wunderlich syndrome is a rare type of Mullerian abnormality characterised by Uterus Didelphys, Obstructed Hemivagina due to transverse septum and unilateral renal agenesis. The usual presentation is with cyclical abdominal pain a few months to a year after menarche. Early diagnosis and treatment are necessary to prevent long-term complications.

Case series
Our first case is a 15-year-old girl presented after one year of menarche with cyclical bleeding with severe dysmenorrhoea. Initial cyclical pain later progressed to continuous pain even without menstruation. On examination, she had a palpable 14-week size uterus with an open vaginal canal. Further imaging with Ultrasound Scan and MRI diagnosed HWSS with a uterine didelphys, right-sided hematocolpus and hematometra and absence of right kidney. Diagnostic Laparoscopy and hysteroscopy were performed and confirmed a patent left cavity with obstructed right uterine cavity and an upper vagina with a transverse vaginal septum. The transverse vaginal septum was incised, and the hematocolpus was drained. A vaginal dilator inserted postoperatively to prevent stenosis. Her symptoms resolved after surgery. On follow-up, a well-healed surgical site was noted without stenosis.

Our second patient is a 16-year-old girl who presented with a similar presentation one year later. Examination and imaging confirmed HWSS with Right-sided transverse septum and absent right kidney. Diagnostic laparoscopy and hysteroscopy were done to demonstrate that cervices were connected to their respective uterus and uterus has a patent ostium and normal fallopian tubes, indicating the possibility of conception in the future. The transverse vaginal septum was excised as in the previous case, and vaginal dilators were inserted for a transient

period. Patient completely recovered without stenosis or pain. Both patients were referred to a nephrologist for advice regarding a single kidney.

Discussion
Gynaecologists should have a high suspicion of different Mullerian anomalies when a patient presents with cyclical abdominal pain with or without vaginal bleeding. It can be easily confused with Imperforate hymen. Further imaging, like an MRI pelvis is warranted to confirm the diagnosis, as proper surgery is necessary to prevent an impact on fertility in the future. Multidisciplinary team involvement including a radiologist, will help estimate the distance of the transverse vaginal septum from the introitus, which is useful when planning the surgery.

Conclusion
Early correct diagnosis, Proper imaging and planned surgery are important in HWSS to prevent irreversible complications such as infertility.

EP/G – 05
A CASE SERIES OF SMOOTH MUSCLE TUMOR OF UNCERTAIN MALIGNANT POTENTIAL (STUMP): A RARE ENTITY

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Introduction
Smooth Muscle Tumour of Uncertain Malignant Potential (STUMP)is a group of uterine neoplasms which cannot be definitely classified as benign or malignant according to histology criteria. The incidence of STUMP is reported as0.01%in the literature. However, due to rarity and dilemma in diagnosis, the real incidence of this tumour is unknown. This is thought to be a transition between leiomyoma and leiomyosarcoma or possibly undiagnosed low-grade leiomyosarcoma. We present two case reports of STUMP.

Case series
Our first patient is a 49-Year old multiparous woman who presented with a history of regular heavy menstrual bleeding for two years, affecting her quality of life. On examination, the patient was pale, and found to have an 18-week size anteverted uterus. An ultrasound scan revealed a multiple fibroid uterus; her haemoglobin was 93 g/dL. She underwent a Total Abdominal Hysterectomy and Bilateral salpingectomy and recovered without complications. Histology revealed multiple intramural leiomyomas, with one of them being STUMP. The patient was counselled, referred to the gynaecology team and planned to follow-up6 months for recurrence or distant metastasis.

The second patient is a 40yearl old multiparous woman presented with incidental finding of a large cervical polyp during a routine pap smear. Her only symptom was discomfort during sexual intercourse. USS pelvis showed a normal uterus and ovaries. She had a cervical polypectomy, and histology confirmed a 40x35x20mm lesion with features of STUMP. The patient was further counselled on the condition and decided to go ahead with a hysterectomy as no further fertility wishes. She underwent a total abdominal hysterectomy and bilateral salpingectomy. A further plan was made with the gynae-oncology team to follow her up6monthly for recurrence and metastasis.

Discussion
STUMP presents with symptoms similar to leiomyoma. The mean age of presentation is reported as 43 years. Due to the rarity of the disease, demographic data and data on risk factors are limited. All these make the pre-operative diagnosis impossible, and most of the time, it's diagnosed post-hysterectomy, myomectomy or polypectomy. STUMP has a combination of mitosis, cellular atypia and areas of coagulative tumour cell necrosis without fulfilling the diagnosis of leiomyosarcoma. STUMP has been shown to recur, metastasise and transform into leiomyosarcoma. However, they are slow growing and metastasise later when compared to leiomyosarcoma. Studies reported a recurrence rate of 11% with a duration of 51 months (ranging from 15 months to 9 years). Therefore, follow-up is recommended at least six monthly for five years and annually for five years after the hysterectomy.

Conclusion
STUMP is a rare uterine neoplasm with a paucity of literature available to plan follow-up and definitive treatment plan, especially in young women who desire fertility.

EP/G – 06
CASE REPORT OF ENDOMETRIAL STROMAL NODULE: A RARE UTERINE TUMOUR

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Objectives
Endometrial Stromal tumours (ESTs) are very rare neoplasms of the uterine corpus with an incidence of 2 per million women. WHO classification divides ESTs into four groups: Endometrial stromal nodule (ESN), Low-grade endometrial stromal sarcoma, High-grade endometrial stromal sarcoma and undifferentiated uterine sarcoma. In this case study, we describe a patient who has undergone a subtotal hysterectomy and bilateral salpingectomy for a suspected degenerating fibroid and was subsequently diagnosed with an endometrial stromal nodule.

Case report
Forty-one years old women presented with worsening right-sided abdominal pain for1week duration with a background history of heavy menstrual bleeding for1year duration. Abdomino-pelvic examination revealed a 24 weeks size enlarged uterus. Ultrasonography showed an anteverted uterus with a posterior wall degenerating fibroid of 8×10 x11cm size with cavity distortion. Her Haemoglobin level was 92mg/dl. She underwent a laparotomy and subtotal hysterectomy with bilateral salpingectomy due to multiple omental and bowel adhesions noted to the lower uterus with a previous normal cervical smear test. She recovered well from surgery without any short- or long-term complications. Histology revealed a benign endometrial stromal nodule without any invasion to the adjacent myometrium.

Discussion
Benign endometrial stromal nodule is a rare subtype that accounts for about one fourth of the endometrial stromal tumours. Patients may present with abnormal vaginal bleeding, enough to produce anaemia with lower abdomen or pelvic pain. However, they can sometimes be asymptomatic. Pre-operative diagnosis is not possible, and there is a need to obtain complete specimen to correctly classify the tumour. Both of these make the hysterectomy the gold standard treatment of ESN, despite being benign in nature. Recurrence is uncommon and follow-up is rarely necessary.

Conclusion
Essential stromal tumours are rare and benign entities with difficulty in preoperative diagnosis. This should be differentiated from invasive malignant stromal tumours as ESN carries a good prognosis.

EP/G – 07
TORSTION OF PARA-OVARIAN CYST IN THIRD TRIMESTER OF PREGNANCY- A CASE REPORT

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Introduction
The incidence of ovarian torsion during pregnancy is 1-3%, with the risk of torsion less with increasing gestational age, unusual after 20 weeks (5, 6, 7). The diagnosis is challenging, and surgery is associated with perinatal morbidity, including preterm birth (8).

Case report
31-year-old in her second pregnancy, with a history of past section, at 31 weeks of gestation, presented to us with continuous right side lower abdominal pain for one day. On examination, she was hemodynamically stable and had tenderness over the right-side lower abdomen. Her sonography showed live fetus with normal liquor, doppler and R/S echogenic ovarian cyst measuring 6cm in diameter with normal vascularity. Thus, a cyst accident was suspected due to continuous pain and she was prepared for laparotomy.

During surgery, there was a twisted right side para ovarian cyst. Right-side salpingectomy was done as there was bleeding from the fallopian tube. Blood supply to the ovary was established and confirmed it by turning the colour to bright red in the ovarian pedicle. Post-operative recovery is uneventful. She delivered her second baby at 38 weeks by elective caesarean delivery. Histology awaits.

Discussion
Torsion of the ovary or ovarian cyst is less common in the third trimester, as the gravid uterus restricts the mobility of the ovarian pedicle. Diagnosis of the twisted ovarian cysts remains challenging as the differential diagnosis for lower abdominal pain could be preterm labour, placental abruption, urinary tract infection, gastroenteritis etc., which direct the management and patient will end up losing the ovary or emergency caesarean delivery of a baby who is preterm. Conservative management has been proposed during pregnancy, which has the threat of losing the ovary; thus, surgical management is the treatment of choice. Sonographic follow-up and documentation of adnexal cysts from the first trimester, if there is one, is important to suspect torsion later in pregnancy if they present with lower abdominal pain.

Conclusion
Prompt suspicion of torsion and early intervention would allow to save the ovary and fallopian tube as well as to prevent unnecessary surgical interventions such as caesarean delivery and laparotomy.

EP/G – 08

HYSTEROSALPINGOGRAPHY (HSG) FINDINGS AMONG INFERTILE WOMEN: A SRI LANKAN DESCRIPTIVE STUDY

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Background
In a period where infertility is increasing worldwide, despite the introduction of sophisticated techniques, the relatively simple, less costly and readily available HSGs play a prominent part in Sri Lankan reproductive healthcare. HSGs are important in detecting tubal pathologies and identifying uterine and cervical filling defects, and they may also have a therapeutic effect on tubal blockages.

Method
This study was conducted as a descriptive cross-sectional study at the Department of Radiology- Colombo South Teaching Hospital. 327 Patients with infertility referred for HSGs were included in the study. HSGs were performed according to standard criteria and interpreted by Consultant Radiologists.

Results
The population's mean age was 33.28±5.3 years, ranging from 21 – 47 years. The mean age of primary infertile women was higher compared to the secondary infertile group. The mean period of infertility was 2.61±0.05 years at the time of undergoing the HSG. A majority (86.2%) of HSGs were normal, more in primary infertile patients (87.8%) in comparison to secondary infertile (84.2%). Tubal pathologies (10.7%) constituted the largest proportion of abnormal HSGs, whereas right-sided tubal blockage (6.7%) was the commonest finding.

The proportion of uterine pathologies was higher among primary infertile (2.1% vs 0.6%), and the percentage of congenital uterine abnormalities was low compared to other studies. Cervical and combined abnormalities were not seen in our population. No statistically significant associations were discovered between the bio-demographic parameters and the type of infertility ($p \geq 0.05$). Compared to other studies, our population had a higher proportion of normal HSGs.

Conclusion
The place of HSG in suspected tubal factor infertility in a limited-resource context is still valid due to its capacity to identify tubal abnormalities and its potential to act as a foundation for subsequent, advanced evaluation.

EP/G – 09

DECISION TO OVARIAN CONSERVATION VS OOPHORECTOMY AT THE TIME OF HYSTERECTOMY

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Abstract
Residual ovarian syndrome (ROS) is a clinical syndrome that presents after a hysterectomy in which one or both ovaries have been preserved. Clinically present as fullness and heaviness in the abdomen and Discomfort, chronic pelvic pain, pressure symptoms on adjacent organs, dyspareunia or an asymptomatic pelvic mass.

Introduction

Concomitant bilateral salphingo-oophorectomy with hysterectomy reduces the potential risk of ovarian cancer. The overall lifetime risk for developing ovarian cancer is 1.4% in the general population, but after excluding the high-risk group, the risk for low-risk women is less than 1%. Other benefits are the prevention of subsequent benign Ovarian Cyst Formation and reduction in future adnexal surgery.

Early oophorectomy carries a number of potential risks, which include increases in the risks of cardiovascular disease, osteoporosis, hip fractures, neurologic and psychiatric disorders, colorectal and lung cancers and overall quality of life. Most ovarian cysts are asymptomatic and disappear spontaneously in 3-4 months, but if persist, they became enlarge and may become symptomatic.

Case report

A 47-year-old woman presented to the Gynaecology clinic with a history of Chronic Pelvic Pain for eight months and recent onset Increased frequency of Urination; her CA 125 value was normal, and Ultrasound revealed a left side 8cm * 10cm adnexal cyst with benign Ultrasound features, which made a diagnosis of ROS.

She underwent total abdominal hysterectomy and B/L Salpingectomy (TAH & BS) for AUB, Dysmenorrhea and Dyspareunia 3 years back. Histology confirmed a clinical diagnosis of Adenomyosis. She had three past caesarean sections and two laparotomies, one for appendicectomy and other for past TAH & BS. With the consideration of the risk and benefit of ovarian preservation or oophorectomy and risk with future surgery, with patient request and consent, laparotomy and B/L Oophorectomy with drainage of the cyst was performed. Histology was remarkable, without any malignant features, and she recovered well with the improvement of her symptoms.

Discussion

Nurses' Health Study showed a more than 10% increase in all-cause mortality and composite morbidity following bilateral oophorectomy between the ages of 50 and 54 years old for benign disease, and findings and benefit on cardiovascular disease, protection against osteoporotic fracture, age-related decline of cognitive function and risk of parkinsonism and effect on sexual pleasure. Concurrent Oophorectomy would be a safer option for a patient with a complex surgical history, severe intra-abdominal adhesions or advanced endometriosis at the time of benign hysterectomy.

EP/G – 10

A RARE PRESENTATION OF UTERINE LEIOMYOSARCOMA WITH PYREXIA OF UNKNOWN ORIGIN: A DIAGNOSTIC CHALLENGE

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Abstract

Uterine leiomyosarcoma (LMS) is a rare and aggressive malignancy arising from the smooth muscle cells of the uterus. We present a case report of a 49-year-old female who presented with pyrexia of unknown origin (PUO) as the initial presenting complaint. The diagnostic challenges encountered in identifying the underlying malignancy are discussed, emphasizing the importance of considering uterine LMS in the differential diagnosis of PUO.

Case report

A 49-year-old female presented with a two-month history of recurrent fever, fatigue, and generalized malaise. Extensive investigations, including blood cultures, imaging studies, and autoimmune workup, yielded no specific etiology for the fever. During the pelvic ultrasound assessment large uterine mass was identified. A subsequent surgical intervention (TAH +BS) and histology confirmed the diagnosis of uterine LMS.

The initial presentation of uterine LMS with PUO posed a significant diagnostic challenge. Infectious causes were thoroughly investigated, ruling out common infections. Autoimmune and rheumatological disorders were also considered and excluded through extensive laboratory testing. However, the persistence of symptoms and the absence of an alternative diagnosis prompted surgical intervention of the uterine mass, leading to the identification of the uterine LMS.

The patient underwent a total abdominal hysterectomy with bilateral salpingectomy, removing the uterine mass. Histopathological examination confirmed the diagnosis of uterine LMS. Postoperatively, the patient was referred to the oncologist for further evaluation and management.

Discussion

The association between uterine LMS and PUO is extremely rare, and the exact mechanism by which the tumor causes fever remains unclear. It is postulated that tumor necrosis, cytokine release, and immune-mediated responses may contribute to the febrile presentation. Therefore, it is crucial for clinicians to maintain a high index of suspicion for rare malignancies, including uterine LMS when confronted with persistent unexplained fever.

Conclusion

Uterine leiomyosarcoma presenting with pyrexia of unknown origin poses a diagnostic challenge. Physicians should consider this rare malignancy in the differential diagnosis of PUO, especially in the presence of other clinical manifestations such as uterine enlargement or abnormal bleeding. A comprehensive evaluation, including pelvic imaging and targeted biopsies, is essential to identify uterine LMS as the underlying cause. Early recognition and appropriate management of uterine LMS can potentially impact patient outcomes, although the prognosis remains generally poor for this aggressive malignancy. Further research is warranted to elucidate the mechanisms of fever in uterine LMS and develop strategies for early detection and effective treatment.

EP/G – 11
SUCCESSFUL PREGNANCY OUTCOME WHILE ON CHEMOTHERAPY FOR BREAST CANCER

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Abstract
Breast cancer is the most common cancer in women and most common malignancy associated with pregnancy. it's more common in older women, but 1 in 7 cases are diagnosed in women aged less than 45 years.

Introduction
Chemotherapy is the mainstay of treatment for invasive and high-grade lesions. Pregnancy-associated breast cancers are usually associated with, invasive and high-grade lesions, making chemotherapy necessary for treatment. Chemotherapy reduces the recurrence of breast cancer by 37% and deaths by 27%. Chemotherapy during 1st trimester is associated with a 17% risk of fetal malformation and spontaneous abortion and is considered contraindicated during the first trimester.

Chemotherapy is considered as safe during the second and third trimesters of pregnancy but still can affect the eyes, genitals, haematopoietic system and central nervous system. Cyclophosphamide, doxorubicin and fluorouracil, are the recommended combination of drugs used in chemotherapeutic regimens.

Case report
Thirty years old, who was diagnosed with Nottingham Grade II, invasive breast carcinoma with positive ER, PR and her 2 receptors, while she breasts fed for five-month-old kid. With the suppression of lactation, she was stated on cyclophosphamide and Doxorubicin. This was her 2nd pregnancy, which was unplanned, unexpected, conceived while on chemotherapy detected at 24 weeks. Anomaly Scan reassured the fetus without any gross anomalies. She developed Gestational Hypertension was on labetalol and Nifedipine dose titrated according to Blood pressure. Her urine albumin was negative, and her blood sugar, haemoglobin, and platelet count remained stable through pregnancy.

Multidisciplinary management continued; she was started on Paclitaxel weekly. A serial growth scan revealed an IUGR Fetus with a reduced amniotic fluid index but normal Doppler studies. Considering all the factors caesarean delivery was performed at 34 weeks, delivering a 1.1kg baby without any gross anomalies. Cu IUCD was inserted at the time of the caesarean section. Lactation was suppressed, and chemotherapy was continued. Trastuzumab was started once paclitaxel was over. The baby was discharged after six days of NICU care with a satisfied weight gain of up to 1.4kg.

Discussion
The current case, as its unplanned pregnancy since 1st trimester, with the fetus exposed to cytotoxic chemotherapy. Even though it's complicated with gestational hypertension, IUGR and reduced amniotic fluid, there were no structural anomalies. Throughout pregnancy, all her investigations were normal. She received a positive pregnancy outcome discharge with the baby on the 6th day.

EP/G – 12

SMALL INTESTINE TUMOR PRESENTING AS AN ADNEXAL AREA MASS: A UNIQUE CASE REPORT

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Objective

This case report aims to highlight a unique presentation of a small intestine tumour as a solid mass in the adnexal area during the gynaecological examination, emphasising the importance of considering extragenital pathologies in patients with gynaecological complaints.

Case report

A 40-year-old woman with a history of chronic pelvic pain presented with iron deficiency anaemia. Gynaecological ultrasound revealed a solid mass in the right adnexal area, initially suspected to be a fallopian tube tumor. However, a subsequent CT scan revealed a solid intraperitoneal mass in the right flank, suggesting an extraluminal lesion of the small intestine or mesentery.

Exploratory laparoscopy confirmed a multifocal tumour of the small intestine, leading to a 15cm resection. The histological analysis identified the tumour as a gastrointestinal stromal tumour (GIST), multifocal in nature, with a low mitotic rate.

Discussion

This case highlights the importance of considering non-gynaecological causes when evaluating patients with gynaecological complaints. Gynaecological ultrasound, while primarily used for evaluating the uterus and adnexa, can provide valuable insights into the entire pelvic region. In this case, the incidental finding of a solid mass in the adnexal area prompted further investigation, leading to the diagnosis of a small intestine GIST.

The implications of this case on practice emphasise the need for clinicians to maintain a broad differential diagnosis when encountering pelvic masses. Gynaecological ultrasound, as a readily available imaging modality, can aid in the identification of extragenital pathologies, potentially guiding appropriate management strategies. Collaboration among specialists, such as gynaecologists and general surgeons, is crucial in such cases to ensure timely and accurate diagnoses.

Conclusion

This unique case report underscores the significance of considering extragenital pathologies in the evaluation of pelvic masses. Gynaecological ultrasound serves as an important tool for identifying incidental findings beyond the reproductive organs. Clinicians should maintain a high index of suspicion for extragenital tumours, such as GISTs, particularly in patients with atypical clinical presentations or risk factors. Further research and collaboration among specialities are warranted to develop standardised protocols for the evaluation and management of such cases.

EP/G – 13

A CASE OF CONGENITALLY CORRECTED TRANSPOSITION OF GREAT ARTERIES WITH EBSTEIN ANOMALY IN PREGNANCY: A UNIQUE SCENARIO

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Objectives

This case report aims to present a unique case of a 27-year-old patient in her third pregnancy, with congenitally corrected transposition of great arteries (CCTGA), mild Ebstein anomaly of the tricuspid valve, and associated cardiac anomalies. The objective is to highlight the special considerations and management strategies for such patients during pregnancy.

Case report

The patient, who had previously experienced a first-trimester miscarriage, was incidentally found to have a murmur during her second pregnancy. A 2D echocardiogram revealed situs solitus, dextrocardia, CCTGA, mild Ebstein anomaly of the tricuspid valve, hypertrophied smallish right ventricle (RV), and a dilated main pulmonary artery (MPA). Despite these complex cardiac anomalies, intervention or surgery was not deemed necessary at present. The patient was followed up in the routine antenatal clinic with plans for normal vaginal delivery.

Discussion

The implications of this case on practice are significant. The coexistence of CCTGA and Ebstein anomaly poses unique challenges in managing the patient during pregnancy. Close monitoring of cardiac function, including echocardiographic assessments, is crucial to ensure optimal maternal and fetal outcomes. A multidisciplinary approach involving obstetricians, cardiologists, and neonatologists is necessary to provide comprehensive care.

Pregnancy in patients with CCTGA and Ebstein anomaly carries an increased risk of complications, including heart failure, arrhythmias, and preterm labour. The physiological changes during pregnancy, such as increased blood volume and heart rate, can further strain the compromised cardiac system. Careful evaluation of maternal symptoms, fetal well-being, and cardiac function throughout pregnancy is essential in management.

Conclusion

This case highlights the successful management of a pregnant patient with CCTGA and Ebstein anomaly without the need for intervention or surgery. It emphasises the importance of regular antenatal follow-up and close monitoring of cardiac function. Future research should focus on expanding our understanding of the long-term outcomes of pregnancy in patients with complex congenital heart diseases and developing evidence-based guidelines for their management.

EP/G – 14

ROKITANSKY SYNDROME: A CASE REPORT OF PRIMARY AMENORRHEA WITH RUDIMENTARY UTERUS AND BILATERAL OVARIAN STREAKS

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Objectives

This case report aims to present a rare and interesting case of Rokitansky syndrome, also known as Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome, characterised by primary amenorrhea, hypoplastic uterus, absence of ovaries, and a rudimentary cervix opening into the vagina. The objective is to emphasise the importance of multidisciplinary management and psychological support in such cases, along with the potential need for neo-vaginal formation.

Case report

We report a case of a 20-year-old unmarried woman with primary amenorrhea and a history of hypogonadotrophic hypogonadism. She defaulted to follow-up at the endocrinology clinic. Fasting blood sugar and thyroid function were normal. FSH 117.8 IU/L, LH 25.07 IU/L, Anti-TPO 4.1Iu/ml. Magnetic Resonance Imaging (MRI) scan revealed a rudimentary uterus and the absence of visible ovaries. Karyotyping confirmed a 46XX chromosomal pattern.

The patient underwent diagnostic laparoscopy, which revealed a hypoplastic uterus and bilateral streaky ovaries. The diagnosis of Rokitansky syndrome was established. No renal tract malformations were detected.

Discussion

Rokitansky syndrome is a rare congenital disorder characterised by Mullerian duct anomalies, resulting in an underdeveloped or absent uterus and variable degrees of vaginal agenesis. The diagnosis often presents challenges due to the absence of visible ovaries and the need for comprehensive evaluation. In this case, the patient's clinical presentation, hormonal profile, imaging findings, and laparoscopic evaluation confirmed the diagnosis.

The management of Rokitansky syndrome requires a multidisciplinary approach involving gynaecologists, endocrinologists, and psychologists, to address both the physical and psychological aspects of the condition. Neo-vaginal formation is often considered for patients with absent or rudimentary vaginas.

Conclusion

This case report highlights the importance of early recognition and appropriate management of Rokitansky syndrome. A multidisciplinary team approach, encompassing medical, surgical, and psychological interventions, is crucial for comprehensive care. Future research should focus on refining diagnostic techniques, exploring genetic predispositions, and improving long-term outcomes, including fertility preservation options and the impact of neo-vaginal formation on patient satisfaction and quality of life.

EP/G – 15

"GAS ACCUMULATION WITH SUBSEQUENT LABIAL SWELLING IN A CASE OF RIGHT-SIDED TUBAL ECTOPIC PREGNANCY AND INFERIOR EPIGASTRIC ARTERY DAMAGE BY LATERAL PORT''

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Objective

This case report aims to highlight a rare complication of laparoscopy involving gas accumulation and subsequent labial swelling and inferior epigastric artery damage in a patient undergoing surgical management for a right-sided tubal ectopic pregnancy. The report emphasises the significance of recognizing and managing this unusual complication.

Case report

A 36-year-old mother of two presented in her third pregnancy with early pregnancy bleeding, abdominal pain, and tenderness at 8+6 weeks of gestation. A right-sided suspected mass with organised clots was identified by an initial ultrasound scan. Haemoglobin levels were low (7.8 g/dl), necessitating an emergency diagnostic laparoscopy. During the procedure, a right-sided tubal ectopic pregnancy was confirmed, and a salpingectomy was performed. Bleeding from a lateral port was noted, leading to the introduction of a Foley catheter with an inflated bulb and traction placement. Despite these interventions, the bleeding did not subside, necessitating extracorporeal suturing. Postoperatively, the patient's haemoglobin levels increased to 7.3 g/dl. Notably, the patient developed swollen labia majora due to subcutaneous gas accumulation.

Discussion

This case highlights a rare complication associated with laparoscopy, accidental inferior epigastric artery damage and labial swelling caused by subcutaneous gas accumulation. The mechanism leading to this complication remains unclear, but it may be related to the introduction of gas during insufflation or the subsequent leakage and migration of gas into the surrounding tissues. Prompt recognition and appropriate management are crucial to prevent potential discomfort and distress to the patient. After identifying lateral port bleeding, the use of a Foley catheter with an inflated bulb and traction placement was attempted; however, it failed to resolve the bleeding. Consequently, extracorporeal suturing was performed to control the bleeding.

Conclusion

This case emphasises the importance of recognising and managing uncommon complications associated with laparoscopy. Prompt interventions, such as the use of Bipoler and cauterise or extracorporeal suturing, may be necessary when conservative measures fail. Increased awareness and further research are necessary to improve patient outcomes and prevent similar complications in the future.

EP/G – 16
LAPAROSCOPIC DYE TEST-RELATED UTERUS FUNDUS INJURY: A CASE REPORT

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Objective
This case report aims to document and highlight a incident of laparoscopic dye test-related fundal injury. The objective is to raise awareness about this potential complication, discuss its implications on clinical practice, and emphasise the need for further research and guidelines in similar cases.

Case report
A 28-year-old female who is body mass index (BMI) 20, with a history of primary subfertility underwent a laparoscopic dye test due to failed ovulation induction cycles. During the procedure, a veress needle injury to the fundus of the uterus was observed, resulting in active bleeding. Prompt intervention, including cauterisation of the bleeding point, achieved hemostasis. Macroscopic examination revealed normal bilateral tubes, ovaries, and uterus. Dye spillage was observed from the fundal injury site, while no spillage occurred from the fimbrial ends. The patient remained stable postoperatively.

Discussion
This case raises important considerations regarding laparoscopic procedures. A fundal injury was noted just after entering the camera, and we suspected a possible veress needle injury. it emphasises the need for careful surgical techniques and highlights the potential risk of complications in such patients. The implications of this case on practice include the importance of preoperative evaluation and identification of high-risk individuals, as well as the need for vigilant intraoperative monitoring to promptly address any unforeseen events.

Conclusion
This case report underscores the significance of recognising and managing complications associated with laparoscopic procedures in patients with low BMI. Clinicians should exercise caution during these interventions, ensuring thorough preoperative assessments and close intraoperative monitoring. Further research is warranted to establish guidelines and optimise safety measures in this specific patient population. Future studies may explore preventive strategies, refine surgical techniques, and evaluate the long-term outcomes of patients with undergoing similar procedures.

EP/G – 17
HYSTERECTOMY IN FEMALE-TO-MALE TRANSGENDER PATIENTS: A CASE REPORT

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Objectives
This case report highlights the unique experience of a female-to-male transgender patient who underwent a hysterectomy as part of their gender transition. The objectives of this report are to discuss the case, explore the implications of this procedure on clinical practice, and draw conclusions regarding future research, practice, policy, and theory.

Case report
A 30-year-old transgender man presented to our clinic seeking gender-affirming procedures. After thorough evaluation and counselling, the patient expressed a strong desire for a hysterectomy to alleviate gender dysphoria and enhance congruence with his male identity. The surgical team performed a laparoscopic total hysterectomy, including removal of the uterus and cervix. The patient had an uneventful postoperative course, experienced significant improvement in psychological well-being, and reported increased satisfaction with his physical appearance. The patient continued to have male hormones.

Discussion
This case report emphasises the importance of a comprehensive approach to transgender healthcare. Providing appropriate gender-affirming surgeries, such as hysterectomy for female-to-male transgender individuals, is crucial in aligning their physical characteristics with their gender identity. Hysterectomy can alleviate gender dysphoria, reduce the risk of reproductive health issues, and improve the overall quality of life for transgender men.

Furthermore, this case highlights the need for healthcare professionals to be knowledgeable about transgender healthcare and competent in providing gender-affirming care. It emphasises the importance of interdisciplinary collaboration involving surgeons, mental health professionals, and endocrinologists to ensure optimal outcomes for transgender individuals seeking gender-affirming procedures.

Conclusion
This case report demonstrates the positive impact of hysterectomy on a female-to-male transgender patient's well-being and gender congruence. It underscores the importance of providing access to gender-affirming surgeries and comprehensive healthcare for transgender individuals. Future research should focus on long-term outcomes, quality of life assessments, and surgical techniques to improve patient care. Additionally, healthcare policies should be developed to support transgender individuals and ensure equitable access to gender-affirming procedures.

EP/G – 18
"A RARE CASE OF DOUBLE VAGINA IN A PATIENT INVESTIGATED FOR PRIMARY SUBFERTILITY"

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Objective
This case report aims to highlight the unique presentation of a double vagina in a patient with primary subfertility and discuss its implications on clinical practice.

Case report
We present the case of a 28-year-old female patient who presented to our infertility clinic with a history of primary subfertility. Initial investigations revealed normal ovarian function, regular menstrual cycles, and normal hormone levels. However, further evaluation using transvaginal ultrasound and hysterosalpingography revealed the presence of a double vagina, a rare congenital anomaly. The patient had two separate vaginal canals, each with its cervix and uterine cavity. Upon further examination, both vaginas appeared to be normal in terms of anatomy and function. The patient reported no previous symptoms or complications associated

with her condition. After thorough counselling, the patient opted for surgical intervention to correct the anatomical anomaly and subsequent intrauterine insemination was performed.

Discussion
The presence of a double vagina in a patient with primary subfertility is an uncommon finding. This anatomical abnormality can lead to difficulties in conception due to the partitioning of the uterine cavity and the presence of two separate cervixes. It is essential for clinicians to be aware of such anomalies to ensure accurate diagnosis and appropriate management. Surgical correction can be considered in selected cases, especially if other fertility factors are within normal limits. Additionally, appropriate counselling and support should be provided to the patient to address any psychological or emotional concerns related to their condition.

Conclusion
This case highlights the importance of considering anatomical abnormalities, such as a double vagina, in the evaluation of patients with primary subfertility. Early identification and appropriate management can improve the chances of successful conception. Further research is needed to explore the prevalence, underlying causes, and optimal management strategies for patients with double vagina and subfertility.

EP/G – 19
A CASE REPORT ON COMPLETE HYDATIDIFORM MOLE COEXISTING WITH A DIPLOID TWIN FETUS LEADING TO GESTATIONAL TROPHOBLASTIC NEOPLASM

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Objective
A complete mole coexisting with a twin fetus (CMCF) is an exceedingly uncommon condition that poses diagnostic & therapeutic challenges. Ultrasound is vital in making an early diagnosis, and the continuation of pregnancy is a multidisciplinary decision based on many factors, as there's an increased risk of maternal & fetal morbidity involved.

Case report
An elderly primigravida was incidentally diagnosed with CMCF at eight weeks of gestation. She later presented with severe vaginal bleeding at 14 weeks, which led to suction-evacuation of the uterus. Routine postnatal monitoring revealed a drop followed by a rise of serum β-hCG at eight weeks which led to the diagnosis of gestational trophoblastic neoplasm with pulmonary metastases, for which she was treated with single-agent chemotherapy with a satisfactory response.

Discussion
Two mechanisms of dizygotic twins with molar pregnancy are possible. A normal diploid fetus can coexist with either a complete mole (all paternal in origin) or a partial mole (PM) (triploid, maternal or paternal in origin). Our patient had the former, a CMCF. This occurs when an empty egg is fertilised by a sperm, which leads to isolated duplication of paternal genetic material. Diagnosis is primarily based on ultrasound. A normal-looking fetus of appropriate dimensions for gestation, together with an aberrant cystic mass, is likely to be CMCF. The PM

will be either empty or contain unorganised, small fetuses with anatomical anomalies. Unusual elevation of β-hCG and suggestive clinical features, including vaginal bleeding, the passage of vesicles, rapid abdominal enlargement, elevated blood pressure, preeclampsia, hyperemesis, and hyperthyroidism, are common presentations.

Proper guidelines are not yet established due to rarity & management remains controversial. The initial step is to differentiate CMCF from PM. If CMCF, continuation of pregnancy should be decided after counselling the couple on all possible maternal & fetal complications. Maternal complications occur in about 50%, including elevated BP, preeclampsia, hyperthyroidism, hyperemesis, and vaginal bleeding, which may end up in a hysterectomy & the probability of gestational trophoblastic neoplasm (GTN). Fetal complications include fetal growth restriction, miscarriages, intrauterine fetal demise, preterm labour & associated complications. There's approximately a 25–50% chance of live birth if pregnancy is permitted to continue until a reasonable level of maturity is reached. Cesarean section is reserved only for obstetric reasons. Post-partum β-hCG monitoring is important to diagnose the emergence of GTN.

Conclusion
Early prenatal diagnosis, appropriate counselling, meticulous antepartum surveillance, and adequate postnatal follow-up can achieve satisfactory fetal and maternal outcomes in CMCF.

EP/G – 20
ADULT GRANULOSA CELL TUMOUR OF THE OVARY WITH ATYPICAL ENDOMETRIAL HYPERPLASIA

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Objective
Adult granulosa cell tumours (AGCT) of the ovary are rare malignancies with good prognosis and a tendency for late recurrences. Manifestations of unopposed oestrogen are common with various degrees of endometrial hyperplasia. Surgery remains the mainstay of treatment, and prolonged surveillance is mandatory as recurrences occur years following initial surgery.

Case report
51-year-old multipara presented with irregular heavy menstrual bleeding for four months. On gynaecological examination, the uterus was normal in size with age-appropriate cervix and normal adnexa. The transvaginal scan revealed a thick endometrium of 15mm, with ultrasonically normal-looking ovaries on both sides with no evidence of free fluid.

The patient underwent hysteroscopy, which showed polyps in the endometrial cavity and was subjected to dilatation & curettage. Histology revealed atypical endometrial hyperplasia. As the patient had completed her family, a total abdominal hysterectomy and bilateral salpingo-oophorectomy were carried out. Histology of the specimen revealed atypical endometrial hyperplasia & AGCT of the ovary. These findings were quite unexpected as ultrasound and gross morphology did not reveal evidence of an ovarian neoplasm, and she did not have apparent risk factors either. Further management included specialised oncological input, completion of omentectomy and contrast CT of the abdomen-pelvis.

Discussion
AGCT originates from proliferating normal preovulatory granulosa cells and retains the ability to produce oestrogen, thus giving rise to menstrual abnormalities. This leads to early diagnosis, most at Stage-I, thus leading to favourable outcomes. Due to long-term exposure to endogenous oestrogen endometrial hyperplasia is common, and around 2% develop endometrial cancer. Given the perimenopausal age and menstrual symptoms and menstrual abnormalities, the clinician is driven to exclude endometrial pathologies, but as in AGCT the primary cause could be an ovarian pathology.

The serum level of CA-125, oestradiol, inhibin, and anti-Müllerian hormone is used in different capacities, but none has been correlated with tumour progression in large studies. The somatic missense mutations in the transcription factor FOXL2 is pathognomonic for AGCT.
Evidence-based management of AGCT is limited, considering its rarity. Surgery remains the mainstay of treatment. There's controversy surrounding the extent of the surgery and fertility preservation in young women. Adjuvant radiotherapy, chemotherapy & hormone therapy may have a place in recurrent or extensive disease. In comparison to epithelial ovarian cancers, AGCT has a good prognosis (5-year survival-91.3%).

Conclusion
AGCT of the ovary is an uncommon neoplasm with a favourable prognosis and late recurrences. Surgery remains the mainstay of management.

EP/G – 21
PRIMARY PERITONEAL SARCOIDOSIS – A RARE AND CHALLENGING DIAGNOSIS

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Introduction
Sarcoidosis is a rare multisystemic inflammatory disorder which has a predilection towards lungs and lymph nodes. Diagnosis is challenging and is dependent on demonstrating non-caseating epithelioid granulomas with the exclusion of common granulomatous diseases.

Case presentation
A 57-year-old postmenopausal female, while being evaluated for a cystocele was found to have ascites on USS along with elevated CA-125 levels. CECT didn't demonstrate adnexal masses or enlarged lymph nodes. Although Mantoux was positive, HRCT-chest didn't demonstrate evidence of TB or other lung pathology, thus leaving us in a diagnostic dilemma.

An exploratory laparotomy was undertaken where multiple white tubercle-like lesions that were consistent with peritoneal tuberculosis and marked adhesions were found. Pathological evaluation revealed multiple epithelioid cell granulomata, leaving us with the possibility of tuberculosis or sarcoidosis and excluding the diagnosis of peritoneal carcinomatosis.

Given that TB is common, the patient was started on anti-TB regimen for peritoneal tuberculosis. However, ESR and CA-125 continued to rise after weeks of therapy, and a diagnosis of peritoneal sarcoidosis was made. The patient is currently on corticosteroids, improving with treatment.

Discussion and Conclusion
Extrapulmonary involvement in sarcoidosis is considered rare, and primary peritoneal sarcoidosis is extremely uncommon, with only a handful of reported cases. Given that TB is widely prevalent, the initial diagnosis of TB-peritonitis or widespread carcinomatosis as suggested by elevated CA-125 and ascites is justifiable, but sarcoidosis is a disease entity that should not be overlooked. In conclusion, peritoneal sarcoidosis should be considered as a possible differential diagnosis when noncaseating epithelioid granulomas are demonstrated.

EP/G – 22
AUDIT ON KNOWLEDGE AND PRACTICE OF ACCURATE BLOOD PRESSURE MONITORING TECHNIQUE IN MEDICAL OFFICERS OF BASE HOSPITAL MAHAOYA

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Introduction
Hypertensive disorders are one of the leading causes of maternal morbidity & mortality, which can be mitigated with early and accurate diagnosis and timely interventions. Accurate blood pressure (BP) measurement is the most vital step in diagnosing and monitoring treatment. BP measurements depend heavily on the technique utilized and on a multitude of performance factors. If the measurements are not obtained accurately, it can result in erroneous readings that can lead to under or over-treatment. Given the physiological changes of pregnancy, BP measurement becomes even more challenging. Given the fact that it is a routine procedure done on a daily basis multiple times by healthcare workers, the importance of the correct technique is taken for granted.

Method
This audit was conducted at the Mahaoya Base Hospital, Ampara District, among the 24 medical officers directly responsible for maternal care using a Google form questionnaire.

Results
All medical officers except one (95.8%, n=23) had been taught at some point in their career how to monitor blood pressure in a pregnant mother. Only half of the doctors (58.3%, n=14) agreed that the best position to measure BP was seated position. The majority preferred a mercury sphygmomanometer (n=18, n=75%). Only 20.8% (n=5) had an accurate understanding of the ideal cuff size to be used. 52.4% (n=13) were under the impression that the bladder size should be 60% of the arm size. When asked on how to position the patient during BP measurement, all doctors (n=24, 100%) agreed that the arm should be rested at the heart level for accurate readings. Only (n=6, 25%) agreed that the right arm is better than the left. The cohort was divided (n=12, 50%) between Korotkoff sounds IV & V to use when obtaining the diastolic BP. When obtaining the reading (n=10, 41.7%), doctors agreed that the record should be taken to the nearest even number, while other (n=10, 41.7%) doctors were under the impression that the value should be taken as it is shown on the device. Four (16.7%) doctors have stated that the values should be rounded up to the closest zero values (terminal digit preference).

Discussion & Conclusion
The knowledge and practices of BP measurement techniques seem inconsistent among the medical officers involved in the study. A hands-on training programme to improve the knowledge and skills of medical officers of base hospitals is needed.

EP/G – 23

ASSOCIATION BETWEEN BODY MASS INDEX OF MEN WITH THEIR SEMINAL PARAMETERS: A SYSTEMATIC REVIEW

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Introduction
Male obesity, as well as male infertility, have become serious health issues in modern society. The impact of obesity or being overweight on male reproductive health has gained significant attention recently, especially the impact on seminal parameters. However, studies show a controversial relationship between male obesity and their seminal parameters.

Objectives
This study aimed to systematically review the published literature on the association between body mass index (BMI) of men with their seminal parameters.

Design
This study was a descriptive systematic literature review.

Method
A systematic search of PubMed and SCOPUS databases was conducted to identify related studies published in the English language from January 2010 to April 2023. The search strategy included terms such as anthropometric measurements, BMI, seminal parameters, sperm, volume, concentration, count, motility, morphology, seminal fluid analysis, and male infertility. In accordance with the PRISMA statement for systematic review, ten studies were identified, including 10,665 men. The systematic review was carried out by two independent researchers, and selected papers were critically appraised. Data on seminal parameters such as semen volume, sperm concentration, sperm count, sperm motility, and sperm morphology were methodically extracted to pre-designed data extraction forms. Statistical software SPSS version 25.0 was used to analyse data.

Results
Out of the selected ten studies with a total of 10,665 participants, 04 studies with 2391 participants reported that there was no significant association between the BMI of men with their seminal parameters, while the other 06 studies with 8274 participants showed a significant association between BMI of men with their seminal parameters. The latter 06 studies found that there was a statistically significant inverse association between BMI with sperm concentration, sperm count as well as sperm motility ($p = 0.01$, $p = 0.017$, $p = 0.01$, respectively). However, there was no significant association between BMI with semen volume and sperm morphology ($p = 0.46$, $p = 0.17$, respectively).

Conclusion
BMI has a significant impact on sperm concentration, sperm count, and sperm motility. However, BMI shows no significant impact on semen volume and sperm morphology.

EP/G – 24

COEXISTING UNICORNUATE UTERUS AND PELVIC ECTOPIC KIDNEY: A CASE REPORT

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Objectives

Studying the association between the unicornuate uterus and urinary tract anomalies. Fusion of the müllerian ducts occurs between the 6th and 11th weeks of gestation, forming the uterus, fallopian tubes, cervix, and proximal two-thirds of the vagina. But, failure of fusion or normal development or incomplete medial wall resorption of the müllerian ducts can result in a complex spectrum of congenital abnormalities termed müllerian duct anomalies (MDA)[1]. MDAs are also commonly associated with renal anomalies, with a reported prevalence of 30%–50%, including renal agenesis, ectopic kidneys and fusion. Therefore, the diagnosis of MDAs is clinically important in preventing urinary tract injuries in pelvic surgeries.

Case report

A 49-year-old woman, para two, who had a history of low cavity forceps delivery, presented with a lump at the introitus for four years duration. She had no urinary voiding or storage symptoms. However, the condition affects her quality of life significantly. On examination, she had a first-degree uterine descent with moderate cystocoele and rectocoele. An ultrasound scan revealed a unicornuate uterus with a pelvic kidney on the left adnexae. Surgery is performed while taking extra precautions to prevent ureteric injuries. The patient was discharged the following day without any complications.

Discussion

Of ureteral injuries from gynecologic surgery, roughly less than 5 percent result from vaginal hysterectomies. Ureters can be injured during any anterior vaginal wall surgery that extends to the bladder neck. The majority of ureteral injuries here are during vaginal vault reconstruction or vaginal cuff closure. In vaginal hysterectomy, the primary risk point is the clamping and ligation of the cardinal ligaments.[2] As the cervix is pulled down through the vaginal opening, the bladder and ureters follow. Therefore, if the incision is high on the cervix, the bladder/ureters can be incorporated into the incision. Abnormalities of the ureter and/or surrounding tissues can alter the ureter pelvic anatomy and displace the ureter into an abnormal location, and substantially increase the risk for ureteral injury. Congenital abnormalities such as pelvic kidney make injury during surgery more likely.

Conclusion

Suspect a urinary tract anomaly, particularly of the kidney, in all women with a unicornuate uterus detected in pre-operative ultrasound scan in order to prevent ureteral injuries during surgery.

EP/G – 25
MANAGEMENT OF URETHRAL INJURIES DURING VAGINAL HYSTERECTOMY: A CASE REPORT

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Objectives
To evaluate incidence, characteristics and consequences of urethral injuries during vaginal hysterectomy for benign conditions. Urethral injuries are rare type of a complication compared to other visceral injuries during vaginal hysterectomy. Early identification and management is paramount in minimizing surgery related morbidity in these patients.

Case report
58 years aged mother of two children presented with a lump at the introitus for two years' duration, which had affected her quality of life. She had no urinary storage or voiding symptoms. No significant past surgeries. On examination, she had a second-degree uterine descent with moderate cystocoele and a urethrocoele. An ultrasound scan revealed a uterus with fundal intramural 6*8 cm fibroid. A vaginal hysterectomy with anterior colporrhaphy was offered to her as the method of management.

A hysterectomy was performed, and the fibroid was delivered piecemeal. During the surgical procedure, a urethral injury (0.5cm in length) was identified following bladder dissection. An urgent urology opinion was taken, and the injury was repaired with intermittent 3O polyglactin sutures, following which the surgery was completed. The patient was discharged with the indwelling silicon catheter in situ for a duration of one month in addition to oral antibiotic prophylaxis. A cystoscopy was arranged on urosurgical review and found no urethral strictures or associated complications. The patient had no lower urinary tract symptoms following catheter removal.

Discussion
Urethral injuries during vaginal hysterectomies are a rare complication. Early identification and prompt intervention with expertise will minimise the possible stricture formation and associated complications. In the index case, to achieve a good repair process of the cysto-urethrocoele, an extensive bladder dissection has been carried out at the Fothergill's point just below the urethra. The injury was identified and confirmed with a metal catheter insertion to the bladder, which is a good practice point.

Conclusion
Urethral injuries are uncommon compared to bladder and ureteral injuries. Surgeons should be very careful during the bladder dissection process to minimise these complications. The index case shows the importance of being cautious during urethrocoele repair at the Forthergill's point under the urethral orifice. However, early identification with metal catheter insertion if urethral injury is suspected and repair with multi-disciplinary team involvement is the cornerstone of management in minimising disastrous complications.

EP/G – 26

MANAGEMENT OF EXTERNAL ILLIAC ARTERY INJURY IN LAPAROSCOPIC ADHESIOLYSIS IN PELVIC ENDOMETRIOSIS: A CASE REPORT

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Objectives

Laparoscopy is one of the most commonly performed procedures worldwide. Injury to a major retroperitoneal vessel occurs in 0.3% to 1.0% of procedures. Fatal outcome occurs due to exsanguination. The recommended treatment of major vessel injury with massive haemorrhage consists of urgent laparotomy and control haemorrhage until a surgeon experienced in vascular procedures arrives. It is difficult to accurately determine the frequency of injury to each of the major retroperitoneal vessels because major vessel injuries are relatively uncommon, injuries are not always reported, and injuries with fatal outcome might be more likely to be reported. Thus, reporting a major arterial injury, especially an external iliac injury, is imperative in the perspective of patient care.

Case report

Thirty-one years aged subfertile lady presented with chronic pelvic pain for 1-year duration. She had associated dysmenorrhoea and dyspareunia. On examination, anteverted, fixed uterus with left adnexal tenderness noted in addition to uterosacral thickening. A transvaginal ultrasound scan revealed left-sided endometrioma adhered to the uterus. Laparoscopic adhesiolysis and chromotubation were planned.

During the procedure, the uterus was found to be adhered to the left side lateral pelvic wall along with the endometrioma and sigmoid colon. During the adhesiolysis process, partial laceration of the external iliac artery was identified where the massive haemorrhage was stopped by diathermization. Immediately femoral pulse was checked on suspicion and found to be weaker including low saturation. A Doppler ultrasound scan was arranged, which demonstrated a low arterial velocity of the limb. The patient was immediately transferred to vascular surgical unit, where the occluded part was resected and grafted. Following surgery, the patient recovered, and the postoperative period was unremarkable.

Discussion

External iliac arterial injuries are rarely reported. Early identification and prompt management is the cornerstone of management in order to minimise complication. A delay in diagnosis may result in unsalvageable limbs. In the index case life-threatening haemorrhage was controlled at the time the injury was identified, and the repair process was implemented without a delay which led to an unremarkable outcome.

Conclusion

Laparoscopists must be aware of this rare, serious, and potentially lethal complication. Once recognized, immediate conversion to an open procedure and application of appropriate vascular surgical techniques are required to reestablish arterial and venous continuity and minimise morbidity and mortality.

EP/G – 27
OVARIAN FIBROMA IN A POSTMENOPAUSAL WOMAN: A CASE REPORT

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Objectives
Ovarian fibromas are uncommon. They represent 1% of ovarian neoplasms and are generally benign. These lesions often appear in elderly postmenopausal patients. Preoperative diagnosis is challanging; surgery with histological study is used to establish the diagnosis. It is imperative to report these tumours to increase the awareness of such rare tumours among gynaecologists.

Case report
A 60-year-old nulliparous menopausal woman, presented with lower abdominal pain and nonspecific symptoms of abdominal bloating, fullness and increased urinary frequency. On examination, 12cm x 16 cm size abdominal mass was detected which was mobile. Ultrasonography revealed a multiple fibroid uterus with a separate mass which is mobile with a sonographic appearance similar to a fibroid. Right side ovary was normal. However, left side ovary could not be visualized. There was no free fluid. Patient was offered a surgery which detected a large 12cm x 15cm left ovarian fibroma with coexisting multiple fibroid uterus. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Patient was discharged on day 2 following surgery without any complications.

Discussion
These tumors may be asymptomatic or may manifest with lower abdominal pain associated with nonspecific symptoms as in our case. The definitive diagnosis of these lesions is difficult prior to surgical removal. Because there are no pathognomonic symptoms or characteristic imaging findings. In the index case during the sonography separately mobile mass, with features consistent with fibroid lead us to the diagnosis of pedunculated fibroid along with the presence of multiple fibroid uterus. However, with the inability to visualize one ovary led us to the differential diagnosis of an ovarian fibroma, which was confirmed during surgery.

Conclusion
This rare tumor of the ovary should be considered in the differential diagnosis of solid ovarian masses. Uterine myoma or leiomyoma is a benign tumor of the smooth muscle tissue of the uterus. The extrauterine localization is rare and pathophysiology is poorly understood. Cystic degeneration and hemorrhage are common, but calcification in ovarian fibromas is rare.

Radiological exploration is often insufficient to give a precise diagnosis. Ultrasound is inconclusive, and a magnetic resonance imaging (MRI) examination may be proposed. The correct diagnosis of an ovarian fibroid requires identification of the smooth muscle nature of the tumor. The recommended treatment is surgical. Salpingo-oophorectomy can be considered in perimenopausal or postmenopausal women. The correct diagnosis of an ovarian leiomyoma is confirmed immunohistochemically.

EP/G – 28

MEDICAL MANAGEMENT OF 1ST TRIMESTER MISCARRIAGE IN THE BACKGROUND OF ANTICOAGULATION

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Objectives

With the advancement of cardiac surgeries and anticoagulation, the rate of pregnancies among women who undergo valve replacement has increased. With a diagnosed miscarriage, maintaining an adequate INR level for a metal cardiac valve while achieving hemostasis fallowing miscarriage management is challenging.

Case report

A 33-year-old woman who was diagnosed patient with rheumatic valvular heart disease with mechanical valve replacement 16 years back and was on warfarin since, presented with an unexpected pregnancy. While on warfarin she has had 3 first trimester miscarriages. An initial USS showed a single live fetus. After MDT discussion, decided to continue the pregnancy under LMWH and warfarin was omitted. The Target INR value was 2.5-3.5. At POA of 16 weeks, the patient was readmitted for bridging therapy of LMWH to warfarin. Target INR was achieved with warfarin 8mg daily dose, but at the discharge, unfortunately, USS showed evidence of missed miscarriage (CRL-11+5). The patient was asymptomatic, and no bleeding manifestations were noted.

It was decided to proceed with medical management. LMWH was started at the therapeutic dose, and warfarin was omitted. After achieving an INR of 1.5, unfractionated heparin (UFH) infusion was started in 18 units/kg per hour dose. The target was to maintain APTT more than twice the normal value. Per vaginal misoprostol 800µg was inserted, and the patient was kept under strict observation. With early evidence of expulsion of products of conception, UFH infusion was stopped, and products of conception passed after 4 hours. TVS showed a bulky uterus with an empty cavity (ET- 6mm). Subsequently, LMWH was restarted at the therapeutic dose. Following bridging therapy patient was discharged with warfarin 9.5mg daily dose. A levonorgestrel-releasing implant was inserted for contraception.

Discussion

Rheumatic heart disease is a huge burden to countries with emerging economies and the age-standardized prevalence is high in women of childbearing age. With the advancement of cardiac surgeries and anticoagulation, the rate of pregnancies among women who undergo valve replacement has increased. Because of the teratogenic nature of warfarin, the risk of early pregnancy loss is high and, in such instances, UFH is a good alternative because of the easy reversal of action and monitoring by using APTT.

Conclusion

Preconception counselling and changing into LMWH from warfarin in women with mechanical heart valves is essential. With a background history of bleeding tendency, medical evacuation is reasonable for miscarriage management under UFH cover. For contraception, Levonorgestrel-releasing implant is a preferred option.

EP/G – 29
RARE MASSIVE LYMPHEDEMA OF LOWER LIMBS FOLLOWING TREATMENT OF ENDOMETRIAL MALIGNANCY WITH A STRONG IMPACT ON QUALITY OF LIFE

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Objective
Lymphedema is a common complication following treatment of endometrial cancer. Though massive lymphedema hindering patient's quality of life significantly is rarely seen.

Case report
A 40year old lady who underwent Total abdominal hysterectomy, B/L oophorectomy, pelvic lymph node dissection and omentectomy at 34years of age, with histology of adenocarcinoma of uterus with more than 50% of myometrial invasion (FIGO Stage 1B) she was offered with adjuvant chemoradiotherapy. She had developed B/L lower limb oedema within one-year post treatment which gradually worsened with time. She has undergone liporeduction surgery by means of excision and liposuction under the care of plastic surgeons. Though some improvement was seen condition had worsened with her struggle to get hold of appropriately sized compression garments added to of loss of follow-up during covid 19 pandemic.

Discussion
Massive lymphedema is a devastating complication following endometrial cancer treatment, with every domain of quality of life (QoL) being reduced. In addition to the lack of survival benefits, it adds up to higher cost of care and morbidity. Risk factors include anatomy of regional lymphatic's, presence of alternate pathways of lymphatic drainage, surgical aggressiveness, number of nodes removed, adjuvant radiotherapy and patient characteristics (age, comorbidities, BMI).

Conclusion
Lymphadenectomy remains the principal cause of lymphedema of lower limbs. The true prevalence of the condition is unknown. It strongly impacts QoL with poor response to treatment efforts. Evidence-based selection of patients that could benefit from lymphadenectomy is strongly advocated. Prior patient education of the complication and special attention once diagnosed must be paid in order to minimise its impact.

EP/G – 30
MOSAIC TURNER SYNDROME: A RARE CASE REPORT

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Introduction
Mosaicism refers to the presence of two or more different cell lines within an individual. In the context of Turner syndrome, Turner's mosaicism means that not all cells in the body have the same chromosomal makeup. While the most common form of Turner syndrome involves a complete or partial absence of one X chromosome in all cells (45, X), individuals with Turner's mosaicism have a mixture of cells with 45, X and some cells with a normal chromosomal complement (46, XX or 46, XY).

The extent and distribution of the mosaic cell lines can vary among individuals with Turner's mosaicism. Some individuals may have a high percentage of 45 X cells with only a small proportion of normal cells, while others may have a more balanced mixture of the two cell lines.

Case report

An 18-year-old girl presented with secondary amenorrhoea for three years duration. She attained menarche at 13 years and had irregular cycles for one year. She was 142 cm in height, 33 kg in weight, with a BMI of 16 kg/m2. Breast and pubic hair growth was at tanner stage 4. She did not have features of neck webbing, wide-spaced nipples, cubitus valgus or radius undergrowth. On TAS, she had bilateral streaky ovaries with normal size uterus. FISH karyotyping was done. It revealed two cell lines; the first cell line in 21 cells showed monosomy 21. The second cell line showed deletion of the second chromosome's p and q arm. Her cardiac 2D echo was normal. TSH, DEXA scan, LFT, Lipid profile and FBS were normal.

Preliminary investigations revealed unconjugated hyperbilirubinaemia, hypocalcaemia, Vitamin D insufficiency and high cortisol levels. AMH was 0.848ng/ml (lower normal range). She was started on low-dose COCP, including calcium and Vitamin D supplements, and was referred to an Endocrinologist. Since she has a normal uterus, she was counselled that should she have future fertility; she can undergo IVF with donor eggs (ICSI, IVM Natural pregnancy) with ovary preservation success being very low. Aortic dissection during a future pregnancy is a serious complication which needs to be taken into consideration.

Conclusion

Diagnosis of Turner's mosaicism typically involves chromosomal analysis through methods such as karyotyping or fluorescence in situ hybridization (FISH) to detect the presence of different cell lines.

Genetic counselling and further medical evaluations are often recommended to assess the specific implications of the mosaic cell lines and to guide appropriate management and treatment options. Factors to consider regarding fertility are adoption/surrogacy/IVF with donor eggs/oocyte preservation/Embryo preservation/ovarian tissue preservation/ovary preservation.

EP/G – 31
ENDOMETRIOSIS IN DISGUISE: PRESENTING WITH SEVERE ASCITES AND BILATERAL PLEURAL EFFUSION

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Introduction

In 1954 Brews published a unique case of ascites with endometriosis. Since then literature has recorded 63 cases, the majority African, and only 2 of Asian origin. No cases reported yet, in Sri Lanka. Peculiarly, the occurrence of endometriosis with both pleural effusion *and* ascites is even rarer with only 15 cases described. Furthermore, 82% were nulliparous women of reproductive age.

Case report
A 46-year-old nulliparous lady presented with dysmenorrhoea, progressive abdominal distension, anorexia, and weight loss for 1 year. She could only lie propped up, and was cachexic, with reduced breath sounds, and a fluid thrill on abdominal examination. Of note, a diagnostic laparoscopy done abroad, 9 months prior, identified hemorrhagic ascites (HA) and necrotic tissue deposits. Samples were histologically congruent with endometriosis. Preliminary investigations showed a hemoglobin of 5.9g/dl, normal renal and liver functions. Ultrasound scan revealed massive ascites, bilateral pleural effusions, normal liver, and renal parenchyma, with no evidence of endometriosis. CT-abdomen was inconclusive. Further, her CA-125 was 38.9U/ml, TB-PCR was negative, and paracentesis revealed a transudative fluid.

A total abdominal hysterectomy and bilateral salpingo-oophorectomy was collectively decided. Intraoperatively, an astounding 3.5L of dark, chocolate-coloured, tenacious fluid was drained. Dense pelvic adhesions were noted with yellowish necrotic tissue on pelvic organs, peritoneum, and omentum. No endometriomas noted. Histology revealed ovarian and serosal endometriosis. Regular post-operative assessment showed improvement in her weight and demeanour, no recurrence of ascites, and complete resolution of pleural effusion.

Discussion
Despite presenting with recognized symptoms, HA due to endometriosis is a rare presentation and can be easily misdiagnosed. CA-125 concentrations vary greatly, thus an unreliable marker. Ascitic fluid cytology has limited diagnostic accuracy. Interestingly, effusions were preferentially right-sided (90%), very rarely bilateral as in the index case. Reports show, most patients have undergone thoracentesis and pleurodesis, yet this case showed complete resolution after surgery. The main treatment modalities were GnRH analogs, (recurrence occurred upon halting treatment), and surgery.

Conclusion
Massive HA is highly suggestive of hepatic tumours, carcinomatous peritonitis, or cirrhosis of the liver. Once liver pathology is excluded, the clinician is in a dire predicament as it mimics ovarian neoplasms. Thus, a diagnosis of endometriosis is obscured prior to surgical exploration.

This is an extremely rare entity that leaves clinicians in a quandary, essentially due to a lack of guidelines or consensus. Its presentation ‘in-disguise’ avails a diagnostic dilemma for gynaecologists and drives a potential delay in management.

EP/G – 32
CASE REPORT OF PYOMETRON IN POSTMENOPAUSAL WOMEN WITH UNREMOVED IUCD

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Abstract
Pyometron, is defined as the accumulation of pus within the uterine cavity. It is a serious and uncommon condition with an incidence of less than 1 %. Which occurs mostly in post-menopausal women, which may associate with underlying malignancy.
Here we report a case of a 68-year-old female who presented with excessive vaginal discharge and lower abdominal pain for 1-month duration.

Introduction

Pyometron is a rare condition that can be seen as a collection of purulent material in the uterine cavity The causes can be malignant and benign, which includes cervical or uterine malignancy in post-menopausal women, and other benign causes like structural abnormalities, cervical stenosis, endometrial polyps, endometritis and pelvic inflammatory disease. Patients classically present with vaginal discharge, pelvic and abdominal pain, fever, and per vaginal bleeding. Pyometra may rupture spontaneously, but it's a very rare complication and very difficult preoperatively to diagnose, symptoms usually similar to that of GI perforation and peritonitis, uterine fundus is the most common site for perforation. TVS plays a major role in the diagnosis of pyometra, as well perforation of pyometra. Post-menopausal hormonal replacement therapy and post-operative cervical occlusions are the most common precipitative causes. in post-menopausal women with clinically suspected pyometron need to exclude associated malignancy.

Case report

68-year-old women presents with a history of excessive vaginal discharge and lower abdominal pain. Her Clinical and all Biochemical parameters including Full blood count and C reactive protein and Blood Sugar values were normal. Speculum examination only demonstrate scanty, Purulent smelly discharge, negative for any growth, or ulceration, and couldn't visualize any Intra Uterine Contraceptive Device (IUCD) Thread. Ultrasound scan demonstrated heterogeneous fluid collection within the endometrial cavity with Cu IUCD in situ, which is suggestive of pyometron. History recalls state that IUCD was inserted 38 years back and thought it was fallen. The hysteroscopic assessment revealed pyometron, Cu IUCD removed, Pus drained, and sent for culture. Intra Venous antibiotics followed by oral Antibiotics were implemented according to the microbiologist's plan. Histology of endometrial curating results in atrophic endometrium without evidence of malignancy.

Discussion

Pyometra is a rare and mostly occurring in post-menopausal elderly women, usually secondary to cervical stenosis. post-menopausal women with vaginal discharge should evaluate to exclude endometrial collection and pyometron without symptomatic treatment as it can be associated with endometrial carcinoma. Current case drainage of uterine collection and histological evaluation of endometrial tissue reassured and exclude malignancy and prompt intravenous and oral antibiotics improved her quality of life.

EP/G – 33
EFFECT OF COVID PANDEMIC AND ECONOMIC CRISIS IN MATERNITY CARE: A DESCRIPTIVE EPIDEMIOLOGICAL STUDY

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Abstract

originate of coronavirus SARS-CoV-2 in China, within a few months spread globally and WHO declared COVID-19 as a global health emergency and then as a pandemic. COVID-19 increases adverse maternal and perinatal outcomes which include increased risk of preeclampsia, maternal death, disseminated intravascular coagulopathy, intrauterine fetal demise, intrauterine growth restriction, preterm delivery, spontaneous abortion, preterm birth, and stillbirth. Since the beginning of covid in 2020, Sri Lanka has practice strike lockdown and

mobility restrictions along with, the health sector, police & tri forces. The pandemic itself and mobility restrictions affect to health care in several ways.

Since the past as country Sri Lanka faced many economic challenges which were the civil war, the tsunami, and the recent Easter Sunday attack. In 2022 it reaches to peak in crisis with a lot of economic restrictions. The unavailability of fuel, electricity, and gas makes all Sri Lankan into a state of uncertainty about future. Even though a shortage of drugs migration of health staff affects to quality of care, still health sector was able to deliver adequate quality care with minimum facilities.

Method
Epidemiological descriptive study, data collect Retrospectively by using hospital recorded data of 6 years from 2017 to 2022 in De Soysa Maternity Hospital, Colombo. There was a drop in the total hospital admissions in 2021 and 2022 by approximately 3000 to 5000. Total number of clinic visits also dropped by almost 50% in 2020 to 2022. The total number of deliveries dropped slightly in 2020 to 2022 whereas the maternal mortality rates more than doubled from 2020 to 2022. Neonatal, perinatal mortality and still birth rates didn't change much.

Discussion
Before the Covid pandemic in 2017,2018,2019 there were relatively stable hospital admission, clinic attendance, and deliveries. But since 2020 all the above numbers were coming down, with relatively stable neonatal mortality, perinatal mortality, and still births, but increased maternal mortality. stable neonatal mortality, perinatal mortality, and still births reassured adequate quality of care even with less numbers of hospital admission and less numbers of clinic attendance. Direct covid deaths may also contribute to Increased maternal death. Because of that need to evaluate individual maternal deaths to assess the cause and identify any lags.

EP/G – 34
A CASE REPORT OF OVARIAN CARCINOSARCOMA IN POSTMENOPAUSAL WOMEN

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Introduction
Ovarian carcinosarcoma is a rare tumor. It accounts for 1-4% of ovarian malignancies. ovarian carcinosarcoma is also known as a malignant mixed mesodermal tumor or malignant mixed Mullerian tumor. This tumor consists of both epithelial and stromal components. They are further sub- classified as “heterologous” or “homologous” depending on the sarcoma component. If it is homologous, the sarcoma component derives from the stromal component of the primary tumour site (fibrosarcoma and leiomyosarcoma) and if it is heterologous, the sarcoma component does not derive from the primary site of the stromal component (osteosarcoma, rhabdomyosarcoma, liposarcoma or chondrosarcoma). Usual presentation average age is between 60-70 years. Most patients are diagnosed in the advanced stage. Most of the patients presented with high CA 125 (>75IU/L). It is a poor prognostic and aggressive tumour. The primary treatment has traditionally been cytoreduction, followed by chemotherapy or chemotherapy and radiotherapy.

Case report
This 67-year-old postmenopausal lady, initially presented with right side lower abdominal pain for 2 weeks duration. History and examination suggestive of pelvic inflammatory disease which was confirmed by ultrasound scan (It showed compatible with right side tubo-ovarian abscess 6.2*4.8cm). CA- 125 was 21IU/L. The routine hematological (WBC- 14500) and biochemical investigations (CRP-160 mg/l) were deranged. Managed with Intravenous antibiotics for 14 days. The size of the tubo-ovarian abscess was reassessed, and it reduced (2.5*3 cm).

After 1 month she presented with the right-side lower abdominal pain and an ultrasound scan revealed that the right side enlarged adnexal mass suggestive of a tubo-ovarian abscess. She underwent optimal debulking surgery (total abdominal hysterectomy, bilateral salpingo-oophorectomy and omental biopsy) after Intravenous antibiotics administration for 48 hours. Histology revealed carcinosarcoma of the right side tubo-ovary. Peritoneal fluid cytology is negative. She failed to turn up at the clinic to take a histology report.

After 6 weeks postoperatively, she presented with abdominal distension compatible with 20 weeks size gravid uterus with the pressure symptoms. CECT chest and abdomen and pelvis revealed – Large mass involving pelvis and abdomen with pressure effect on bowel loops, B/L ureteric and pelvic vessels. The approximate size of the lesion is 24*12*30 cm.? Tumour recurrence. Haematological (WBC-12700) and biochemical investigations (CRP-37mg/l) were deranged. She underwent optimal debulking surgery for tumour recurrence and planned for chemotherapy. post-operative ICU care given. Tumour recurrence histology revealed features compatible with known carcinosarcoma with heterologous differentiation and predominant rhabdomyosarcoma component.

Discussion
Ovarian carcinosarcoma with a predominant rhabdomyosarcoma component is a rare presentation. Preoperative diagnosis of the disease cannot be reliably made by core biopsy or FNA. Carcinosarcoma can only be diagnosed with final histology. The optimal surgical removal of tumour mass &, when possible, macroscopically disease-free post-operative peritoneal cavity seems to have an important role in improving the survival of these patients. In our patient, because of her poor follow-up, she presented with recurrence.

Conclusion
Ovarian carcinosarcoma is a rare tumour which has no specific clinical and imaging features. To gain optimal management for this rare entity needs further studies. Because tumours are aggressive in nature and have a poor prognosis, need careful follow-up.

EP/G – 35
VON WILLEBRAND TYPE 2B DISEASE PRESENTED AS HEMOPERITONEUM: A CASE REPORT

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Introduction
Von Willebrand disease (VWD) is the most common inherited genetically and clinically heterogeneous bleeding disorder caused by deficiency or dysfunction of the protein termed von Willebrand factor (VWF). There are 3 types of VWD, types 1,2,3. Type 1 is the most common

one (60-80%) and type 2 represents 20%. Types 1 and 3 are caused by quantitative defects. Type 2 results from a qualitative defect of VWF and inherited as autosomal dominant manner. VWD type 2 is further divided into 4 variants based on characteristics of dysfunction VWF, 2A, 2B, 2M, 2N.

Case report

A 22-year-old female is a diagnosed patient withVWD type 2B. Her diagnosis was made by thorough investigation including vWD factor antigen Assay, Ristocetin Co Factor Assay, Platelet Rich Plasma Lumi-Aggregometry, Platelet aggregation Study, and other basic investigations. Genetic testing was not done. This time she presented with severe pelvic abdominal pain in the right iliac fossa, which is not associated with vaginal bleeding, discharge, or fever.

On admission, she was hemodynamically unstable with BP - 87/45mmHg and PR 120 bpm. She had diffuse abdominal tenderness with a normal gynecological examination. Her hemoglobin was 9.2 g/l, WBC 9800 /mm3, platelets 39 000 /mm3 with normal clotting profile. Urine-HCG was negative. Abdominal ultrasound showed a right latero-uterine echogenic cystic image with a moderate amount of free fluid. The exploratory laparotomy revealed a ruptured ovarian cyst with active bleeding and a large hemoperitoneum. A cystectomy was performed with the aspiration of hemoperitoneum, supported with transfusion of blood and cryoprecipitate and IV tranexamic acid. Post-operative ICU care was given with a transfusion of one unit of vWD factor. She was discharged with combined oral contraceptive pills and levonorgestrel intrauterine devices.

Discussion

The estimated prevalence of VWD is 1: 100 to 1: 10,000. VWD. VWF is needed for platelet aggregation, adhesion and stabilize factor 8. VWD typically presents with mucosal bleeding epistaxis, easy bruising, and menorrhagia. All type 2A VWD patients lack the HMW multimers and therefore have reduced VWF activity, which results in bleeding.

Type 2B VWD results from gain-of-function mutations that increase the ability of VWF to bind platelets. This leads to increased clearance of both VWF and platelets from circulation and results in the loss of HMW multimers and decreased VWF activity. Therefore, type 2B VWD is diagnosed either by direct measurement of the increased platelet binding or by an increased response to low-dose ristocetin on platelet aggregation testing. Thrombocytopenia is not always present and may be more prominent during times of stress such as surgery or pregnancy. Desmopressin is relatively contraindicated in type 2B VWD, as it may accelerate VWF-platelet binding and clearance.

Type 2M VWD includes those patients with decreased VWF activity but normal (or near normal) multimer distribution. This is generally caused by a defect in the ability of VWF to bind platelet GPIb.Type 2N VWD is characterized by a defect in the ability of VWF to bind FVIII. Plasma VWF concentrates are effective in all types of disease. Apart from situations where there is a high risk of bleeding, in most cases, correction of VWF deficiency is not necessary. However, it is important to follow simple preventive measures. A massive transfusion may be necessary with a transfusion of packed red blood cells (RBC), platelets and fresh frozen plasma, and IV tranexamic acid.

Conclusion

VWD type 2B is a rare type of bleeding disorder that needed multidisciplinary team approach. In any hemorrhagic shock, clotting profile abnormalities should always be looked into. Desmopressin is a relatively contraindicated treatment in VWD 2B. A crucial step in therapeutic therapy is surgical hemostasis to halt the bleeding with the support of blood products and IV tranexamic acid. As in any state of hemorrhagic shock, massive transfusion may be required in some extreme situations.

EP/G – 36
MANAGEMENT DECISIONS IN CRITICAL CASES, CASE REPORT OF RUPTURED TUBAL ECTOPIC PREGNANCY IN DIAGNOSED DENGUE PATIENT.

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Abstract

Dengue itself carries a high mortality, doing surgery in a critical phase, at the stage of leaking further increased mortality. Ruptured ectopic also carries high mortality, and surgical management is the only remaining option if already ruptured. We present the case of 26years old lady who was diagnosed with dengue, with a ruptured ectopic pregnancy.

Introduction

Dengue is a mosquito-borne viral infection "flavivirus", caused by the mosquito *Aedes aegypti*, which is endemic in Southeast Asia. Serologic diagnosis depends on the presence of IgG and IgM antibody and management of Dengue includes close observation and monitoring of vital signs, platelet, WBC, and hematocrit and meticulous fluid management. Pregnancy occurring outside the normal uterine cavity is termed ectopic pregnancy. Its estimated incidence in the general population is 1%–2%. Ruptured ectopic pregnancy is a potentially life-threatening condition and continues to be a major cause of maternal morbidity, and mortality.

Case report

A diagnosed Dengue patient with Day 5 of Fever, was admitted with the features of acute abdomen with positive Urine HCG. Ultrasound demonstrated Left side adnexal mass with a moderate amount of Free Fluid which makes the diagnosis of ruptured tubal ectopic pregnancy. Her Dengue Ig M was positive and her IgG was negative, and her Full blood count revealed Hemoglobin 9.6g/dl, WBC 2300, Platelet 88000, and Hematocrit (HCT) 33.1. Her clotting profile, Liver Function, and renal function tests were normal. Following the MDT approach decision was to avoid Laparotomy and to do Laparoscopic surgery, amount of blood to be replaced with blood and post-operative ICU care.

Laparoscopy detected ruptured tubal ectopic pregnancy with 1200ml of hemoperitoneum. Intra operative transfusion of blood, Salpingectomy followed by meticulous hemostasis and postoperative ICU care. As we all wish next FBC was reassured, platelet started risen to 106000, 109000 and then to 156000. Her WBC and HCT became normalized, and 4th postoperative day patient was discharged.

Discussion

Management decisions were crucial here. Patients are presented with free fluid it masks leaking stage of dengue. At the time of transfer from the medical ward, patients' natural history and

investigations were towards the leaking stage. Laparoscopy rather than laparotomy was decided to minimize the cutting area and to minimize intraoperative and postoperative bleeding. Blood replaced by blood and avoiding fluid overloading improved quick recovery. Timely and correct decisions save maternal life and improved the quality of care.

EP/G – 37
EXTRAPULMONARY TUBERCULOSIS IN THE YOUNG FEMALE-TWO CASE REPORTS AND CLINICAL LESSONS

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Introduction
Extrapulmonary tuberculosis caused by Mycobacterium tuberculosis (rarely atypical mycobacteria) is usually rare in the young healthy population. Pelvic infection typically occurs secondary to pulmonary infection reaching the pelvis through haematogenous, lymphatic, or direct spread.

Case report 1
Asymptomatic 27 years old female being investigated for primary subfertility for 2 years was admitted for laparoscopy as previous Hysterosalpingography revealed bilateral tubal block. She had bilateral hydrosalpinges with external adhesions distorting both fimbrial ends. The sigmoid colon was adhered to the left ovary and tube. Additionally, perihepatic adhesions and omental adhesions to the anterior abdominal wall was noted. Laparoscopy confirmed that both tubes were not patent. Pelvic tuberculosis was suspected and confirmed by further investigations, and she was started on category 1 therapy.

Case report 2
A 21-year-old female was investigated for 3 months history of lower abdominal pain, with menorrhagia and dysmenorrhoea with palpable solid abdominal mass, advanced imaging revealed bilateral solid ovarian masses with few internal iliac, para aortic lymph nodes, thickened omentum. Her mediastinal and hilar lymph nodes are enlarged on CECT –CAP and the Risk of malignancy index was 858 and referred to Gynaeoncosurgeon. She underwent midline laparotomy which revealed matted bowel loops, surface deposits on the liver, bowel and thickened omental, and ovarian deposits. Surgery was abandoned after taking a biopsy and urgent histology revealed granulomatous inflammation with caseous necrosis suggestive of tuberculosis. She immediately started on category 1 treatment for disseminated tuberculosis.

Conclusion
Pelvic tuberculosis is rare and often difficult to diagnose which can present in various scenarios. For the diagnosis great degree of suspicion is essential. Diagnostic laparoscopy is currently the principal modality of diagnosis of genital tuberculosis. Most common macroscopic findings are pelvic adhesions followed by tubal pathology or occlusion, peritoneal, fallopian, ovarian tubercles, perihepatic adhesions, Tubo ovarian masses, ascites, and caseous or granulomatous nodules. Its worth suspecting pelvic tuberculosis in patients with subfertility secondary to tubal pathology.

EP/G – 38
UTERINE LIPOLEIOMYOMA: AN UNCOMMON VARIANT OF THE LEIOMYOMA

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Objectives
Uterine lipoleiomyoma is a rare variation of the common benign leiomyoma. The incidence of lipoleiomyoma was reported between 0.03% and 0.2%. They were characterized by composed of varying degree of adipose tissue, fibrous tissue, and smooth muscle cells. Some women may present with menorrhagia but most of the time this is an incidental finding. Imaging produces significant help in diagnosing and confirming the location of the lesion. Histopathological examination is required for definitive diagnosis. Here we report a case of a postmenopausal female with an incidental finding of lipoleiomyoma who underwent total abdominal hysterectomy.

Case report
A 58-year-old post-menopausal lady presented with a history of abdominal discomfort and bloating for one-week duration without a history of post-menopausal bleeding. Abdominal examination revealed a firm non tender abdominal mass arising from the pelvis extended above the umbilicus. Ultrasound abdomen revealed a hyperechoic mass without significant vascularity seen within the mass on the Doppler study. The contrast-enhanced computed tomography (CECT) scan shows the body of the uterus grossly enlarged with a heterogeneously dense mass with few specks of calcifications and fatty tissues without pelvic lymphadenopathy or ascites. Total abdominal hysterectomy and bilateral salphigoopherectomy done for her and histopathological examination confirms the diagnosis of lipoleiomyoma.

Discussion
Lipoleiomyomas are lipomatous variant of the commonest benign tumor of the uterus leiomyoma. The underlying pathogenesis is multifactorial, either simultaneously differentiating during the differentiation of leiomyoma or there may be lipomatous metamorphosis of a preexisting leiomyoma. Even though intramural is the commonest location, they can be seen in the cervix, ovary, or broad ligament. The postmenopausal age group is the most vulnerable age group with a mean age of 55.5 years. Most of the patients were asymptomatic but can experience pressure symptoms due to the size of the tumor mass or associated with vaginal bleeding. Imaging produces significant help in diagnosing and confirming the location of the lesion. Ultrasound scanning is the first-line imaging modality used to locate the tumor and assess the gross size of the tumour. CECT and MRI scanning aid in diagnosing. Histopathological examination is necessary for confirmation of diagnosis. Surgical management is the treatment of choice and lesions should differentiate from mature ovarian teratoma or malignant transformation of leiomyoma.

Conclusion
Lipoleiomyomas of the uterus are extremely rare entity of common leiomyomas with similar clinical presentation, but characteristic radiological and histological features. Surgical management is curative with an excellent prognosis.

EP/G – 39
A RARE CASE OF BROAD LIGAMENT LIPOLEIOMYOMA.

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Introduction
Lipoleiomyoma (LL) is a rare benign variant of leiomyoma with an incidence ranging between 0.03% and 0.2%. Lipomatous tumors of the uterus are rare neoplasms that can be divided into three broad groups – pure, mixed, and exceedingly rare malignant liposarcoma. Benign lipomatous uterine tumors are uncommon and rare. The histogenesis of these benign tumors is still unknown, though, there are several theories supported by immunohistochemical staining. These tumors can contain a variable amounts of smooth muscle, fat cells, and fibrous tissue.

Case report
A 52-year-old perimenopausal, mother of two, presented to a local hospital with abdominal discomfort, distension, and irregular menstrual bleeding for a one-year duration. Abdominal examination revealed a pelvic mass corresponding to a 20 weeks size gravid uterus which was firm and non-tender. Ultrasonography revealed an enlarged uterus with posterior wall fibroid. Contrast Enhanced Computed tomography (CECT) showed, heterogeneously enhancing solid well-defined mass (17x18x14cm) originating from the left adnexa. Serum CA 125 was within normal range.

She underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy. On gross examination of the specimen, it showed an entirely solid mass measuring 17x15x9cm and the cut surface appeared yellowish. It was soft in consistency. The immune profile was strongly positive for Smooth Muscle Actin (SMA) and negative for Human Melanoma Black (HMB 45). Based on these findings, the tumor was diagnosed as a lipoleiomyoma with myxoid changes.

Discussion
Lipoleiomyoma can occur anywhere in the uterine corpus and cervix. The common differential diagnosis of pelvic fatty tumors includes benign cystic ovarian teratoma, uterine fatty tumors, pelvic fibromatosis, well-differentiated liposarcoma, carcinosarcoma with heterologous liposarcomatous differentiation, and degeneration of leiomyomas. Usually, they are asymptomatic. Patients usually experience symptoms similar to those seen in leiomyomas such as abnormal uterine bleeding, pelvic discomfort, palpable mass, urinary frequency, and incontinence. Uterine artery embolization or surgical excision can be performed through myomectomy or hysterectomy as indicated.

Histological examinations of lipoleiomyomas show a mixture of bland, spindle-shaped smooth muscle cells without nuclear atypia in a whorled pattern with admixed mature adipocytes. IHC studies have played an integral role in understanding its complex histogenesis. Reported immunoreactivity of fat cells with vimentin, desmin, and SMA supports the hypothesis of a direct transformation of smooth muscle cells into fat cells.

EP/G – 40
A CASE OF UTERINE SCAR ECTOPIC PRESENTED WITH UTERINE RUPTURE

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Introduction
Ectopic pregnancies in cesarean section scars (CSPs) are extremely rare, representing 0.4% of all pregnancies and constituting 6% of all ectopic pregnancies in patients with a history of a previous cesarean section. They constitute a continuous pathology that ranges from gestation with implantation on a properly healed scar (superficial CSP) to those implanted in a dehiscent scar ("niche") (deep CSP) which have a worse prognosis than those that are inserted on the scar.

Case report
A 37-year-old woman (gravida 3, para 2), who had undergone two previous caesarean sections, and second of which had been complicated with placenta accreta spectrum disorder (placenta accreta) presented to the gynaecology clinic at 8 weeks of period of amenorrhoea for her booking visit. However, she did not have abdominal pain nor did she have vaginal bleeding. On examination, her vital signs were stable and did not have abdominal tenderness.

Transvaginal sonography (TVS) revealed an antevert uterus with a GS in the anterior myometrium of the lower part of the uterus in the region of the isthmus. A live embryo of crown-rump length (CRL) 26.2 mm corresponding to nine weeks three days was seen. No adnexal abnormality was identified. These sonographic findings with a history of previous Caesarean sections were considered highly suspicious for Caesarean scar ectopic pregnancy. Therefore, she was referred to a specialized centre for further management after explaining the possible risk and the management options to the patient.

She was admitted one month after the initial scan with acute onset abdominal pain and vaginal bleeding. She was found to be pale with tachycardia, hypotension, and generalized abdominal tenderness with evidence of hypovolaemic shock. The transvaginal scan revealed a live fetus in the lower part of the uterus close to the previous scar and a very thin myometrial wall with a massive amount of free fluid in the hepato-renal pouch. Immediate fluid resuscitation and blood transfusion was carried out and the woman was taken into the theater for an emergency laparotomy under general anesthesia.

More than 1.5 liters of blood were noted in the peritoneal cavity with evidence of ruptured scar ectopic pregnancy through the myometrium. The decision was made to proceed with a hysterectomy, followed by bilateral ligation of internal iliac arteries, and managed to do so successfully. The woman was taken to the Intensive care unit for observation and immediate postoperative care. She was discharged on the third day of the postoperative period with a haemoglobin of 10.2g/dl after a transfusion of altogether 4 units of red cell concentrates.

Discussion
Scar pregnancies with minimal or absent overlying myometrium should be diagnosed in the first trimester and carry an increased risk of hemorrhage and uterine rupture.
TVS remains the imaging modality of choice for diagnosis of CSP in the first trimester, but MRI is used as an adjunct to ultrasound evaluation. MRI is specifically indicated in cases with

inconclusive or equivocal USG findings and in patients where placenta accreta cannot be excluded on the ultrasound. CSP can be managed conservatively by medical treatments or surgically, but there is no standardized approach for its treatment. Management decisions are dictated by gestational age and size, severity of implantation abnormality, clinical stability, and patient's desire for future fertility.

Conclusion
Early recognition by imaging and prompt diagnosis of CSP is critical to prevent maternal morbidity and mortality.

EP/G – 41
HERLYN-WERNER-WUNDERLICH SYNDROME – A RARE CASE OF HAEMATOCOLPOS

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Objective
Herlyn-Werner-Wunderlich (HWW) syndrome is a rare congenital anomaly characterized by the triad of uterine didelphys, obstructed hemi-vagina, and ipsilateral renal agenesis. It usually presents with cyclical pelvic pain and abdominal mass. As this is a rare disease it is easily misdiagnosed leading to varied complications, future subfertility, and delayed treatment.

Case report
A 10-year-old girl presented with cyclical pelvic pain since menarche for a 6-month duration without any associated bladder or bowel symptoms. She was afebrile and was not pale. Her abdomen was nontender and non-distended without any palpable masses or free fluid. The rest of the examination was unremarkable. Baseline investigations were normal while the ultrasound of the pelvis and abdomen revealed uterine didelphys, right-sided hemi-vagina with haematocolpos, absent right kidney, and a normal left kidney. The same findings were evident in the MRI of the abdomen and pelvis confirming the diagnosis of HWW syndrome type 1. Management included Combined oral contraceptive pills (COCP) to suppress menstruation followed by Laparoscopy guided right hemi-vaginal septal resection and haematocolpos drainage under general anaesthesia.

Discussion
HWW syndrome, belonging to class 3 of the American Fertility Society Classification of Female Genital Anomalies, is a result of lateral nonunion of the Mullerian ducts. Its occurrence is reported to be 1/2000 to 1/28000. The associated anomalies are usually found on the right side. It is further classified into two types according to the morphology of the vagina. Type 1 is when the hemi vagina communicates with the ipsilateral cornua while type 2 is when cervical atresia is noted in the side of the hemi vagina giving rise only to haematometra.

As the usual clinical presentation is with acute or chronic pelvic pain, it could be easily misdiagnosed as primary dysmenorrhea leading to treatment with non-steroidal anti-inflammatory drugs or COCP delaying the diagnosis further. Delay in treatment could be detrimental as it can give rise to endometriosis due to retrograde flow, pelvic adhesions, pyometron, pyocolpos, or infertility. Though Contrast tomography and Ultrasound scan are widely used, Magnetic Resonance Imaging is the gold standard imaging modality. The

recommended treatment of choice would be vaginal septal removal for type 1 disease and surgical removal of the affected cornua for type 2 disease.

Conclusion
Though rare, HWW imposes significant patient morbidity. Thus, prompt diagnosis with a high index of suspicion and initiation of early effective treatment is crucial.

EP/G – 42
A RARE CASE OF ROUND LIGAMENT LEIOMYOMA PRESENTING AS AN INGUINAL LUMP

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Introduction
Leiomyoma of the uterus is a common benign gynecological tumor affecting 20-40% of women during their lifetime. But round ligament leiomyomas are very rare and usually present as an inguinal lump mimicking an inguinal hernia. We report a case of a 48-year-old female presented with a painful inguinal lump, which was thought to be an irreducible indirect inguinal hernia. Intraoperative mass was found to be attached to the round ligament and the diagnosis of leiomyoma was confirmed histopathologically.

Case report
A 48-year-old mother of 3 admitted with a history of a left-sided inguinal lump for a 6-month duration with slow progression of the size and acute onset pain at the site. It was a firm, irreducible mass with tenderness on deep palpation. So, working diagnosis of incarcerated hernia was made and elective surgical repair was planned under general anesthesia. During the surgery round well, circumscribed mass was identified near the round ligament, and excision was done. Mesh repair was done for the inguinal canal and the patient recovered post-surgically. Histopathological examination of the specimen shows interlacing fascicles of spindle cells with interspersed collagen revealed the inguinal mass as a leiomyoma.

Discussion
The round ligament (RL) is the fibro muscular connective tissue connecting the cornu of the uterus through the inguinal canal to labia majora. Even though uterine leiomyoma is the commonest gynecological tumor, they arise from extra uterine sites such as RL being rare. Clinically they manifest as slow progressive inguinal lump mimicking incarcerated inguinal hernia or inguinal lymphadenopathy. The right side is the commonest. Diagnosis of this kind of parasitic leiomyoma is challenging. On imaging, it is usually seen as a hypoechoic, solid, well-circumscribed mass. Doppler ultrasound shows vascular connections of the mass with the uterus. Being extra peritoneal site of the round ligament is the commonest location open surgical excision is the treatment choice. For intra peritoneal location, laparoscopic excision can be considered.

Conclusion
Even though a rare condition, round ligament leiomyoma can be taken as a differential diagnosis for inguinal lumps in middle-aged women. USS, Doppler studies, and CT scan aids in diagnosis. Surgical exploration provides symptomatic relief for the patient and provides histological diagnosis.

EP/G – 43
A CASE OF BARTHOLIN GLAND ENDOMETRIOSIS (VULVAR ENDOMETRIOSIS)

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Introduction
Endometriosis is defined as endometrial glands and stroma outside the uterus, and it is a common disease, affecting 6–10% of women of childbearing age. Endometriosis in the lung, pleura, skin, muscles, and abdominal wall has been reported. However, Vulvar involvement of endometriosis is very rare.

Case report
A 40-year-old nulliparous lady with a history of primary sub-fertility of five years duration presented with a recurrent vulvar lump in the right labia with a history of cyclical exacerbation of pain during menstruation. Furthermore, she has secondary dysmenorrhoea and deep dyspareunia for the last 10 years duration. She had undergone marsupialization and incision and drainage of the right bartholin gland four times during the last five years. Histology was obtained during the fourth time which revealed chronic bartholian abscess.

On Examination, she had a firm lump in the mucocutaneous junction with tenderness and swelling over it. With clinical suspicion, wide local excision of the bartholin gland was carried out under spinal anaesthesia. The histopathologic examination confirmed the presence of endometrial tissue with glands appearing throughout the fibro-fatty tissue presenting irregular arrangement with stroma. Two months after the excision the patient was symptom-free with no cyclical pain in the vulvar region.

Discussion
Endometriosis is an oestrogen-dependent chronic inflammatory process and is defined as the presence of endometrial glands and stroma-like tissue outside the uterine cavity. The history of this lady is suggestive of pelvic endometriosis, however, Bartholin gland endometriosis is an extremely rare occurrence. Endometriosis in the Bartholin gland may present itself with cyclic pain and swelling during menstruation. It presents as a dark red, brown, or blue cystic swelling at the posterior half of the vulva.

The three most common hypotheses of endometriosis are retrograde menstruation, metaplasia theory, and lymphatic or hematogenous spreading. New theories of endometriosis pathogenesis are multifactorial including theories regarding estrogens, genetics, direct transplantation, immune system, environment, and congenital factors.

Conclusion
Endometriosis in the gland of Bartholin may or may not be an isolated finding. However, perineal endometriosis in the gland of Bartholin should be considered when there is cyclic pain and swelling of the Bartholin gland.

EP/G – 44
A CASE OF GESTATIONAL CHORIOCARCINOMA WITH DISTANT METASTASIS IN A PERIMENOPAUSAL WOMAN

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Introduction
Gestational choriocarcinoma is a rare malignant condition with distinct immunogenicity with highly sensitive to chemotherapy. It occurs following a pregnancy or miscarriage, from the trophoblastic cells derived from previous pregnancy. The incidence is about one in 50000 pregnancies and occurs during the fertile period, especially at extremes of reproductive life such as perimenopause.

Case report
A 49-year-old unmarried woman admitted to the hospital with abnormal uterine bleeding of one and half months duration with symptoms of anaemia and generalized abdominal pain of five days duration. On examination, there was a pelvic mass of 22 weeks size. Ultrasound scan revealed an enlarged uterine mass containing echogenic cystic areas compatible with a hydatidiform mole. Serum beta hCG level was 1329738mIU/mL. Suction evacuation was planned and misoprostol inserted for prior preparation of cervix, which ended up in a anterior uterine wall rupture with massive bleeding.

Emergency laparotomy was done and total abdominal hysterectomy and bi lateral salpingo-ophorectomy was performed. Histological appearance was compatible with gestational trophoblastic disease with features of invasive hydatidiform mole. Her beta HCG was coming down following surgery and after 3 weeks of surgery when beta HCG level had fallen down to 40000mIU/mL. Three months later she got re-admitted to with vaginal bleeding and a history of fall following a fainting attack. She was anaemic with a hemoglobin of 7.4g/dl. An exophytic growth in the vaginal vault was detected on speculum examination. Ultrasound revealed free fluid in the peritoneal cavity. Chest X-ray shows cannon ball lesions in bilateral lungs with bi lateral pleural effusion. Serum beta hCG level was 200000mIU/mL.

Two units of red cell concentrate was transfused pre-operatively and vaginal vault biopsy was performed under general anesthesia. There was massive uncontrollable bleeding from the vaginal vault which did not settle with hemostatic sutures and diathermy. Estimated blood loss was approximately three liters, and the patient went in to a cardiac arrest with decompensated shock. Histology of the lung and the brain following the post-mortem revealed features of choriocarcinoma.

Discussion
GTD should be considered as a cause for abnormal uterine bleeding in peri-menopausal bleeding. Urine HCG should be done if there is high clinical suspicion. If urine HCG is negative serum beta HCG should be done since very high HCG values will not be detected during urine HCG testing. The classic features of molar pregnancy/GTN are irregular vaginal bleeding, hyperemesis, excessive uterine enlargement. Ultrasound examination is helpful in making a pre-evacuation diagnosis, but the definitive diagnosis is made by histological examination of the products of conception. Treatment used is based on the FIGO 2000 scoring system for GTN following assessment at the treatment center.

Conclusion
As a reflective practice, this woman should have been referred for chemotherapy(multi-agent) once the recurrence is suspected with features of metastasis without attempting for biopsy of the vaginal lesion as advised by the NICE guidance.

EP/G – 45
ABNORMAL UTERINE BLEEDING IN BLEEDING PHENOTYPE OF DYSFIBROGENAEMIA: A CHALLENGING PATIENT CASE

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Objectives
Dysfibrinogenemia is a coagulation disorder caused by structural abnormalities in the fibrinogen molecule that alters its action. It can be congenital or acquired which can affect the quantity (hypofibrinogenaemia and afibrinogenaemia) or the quality (dysfibrinogenaemia) of circulating fibrinogen. It is inherited in autosomal dominant pattern. Dysfibrinogenaemia is associated with increased risk of bleeding, thrombosis or both. Most patients are asymptomatic and are usually discovered by the findings of prolongation of routine parameters of coagulation, such as prothrombin time (PT), activated partial thromboplastin time (APTT) and thrombin time (TT). Its exact prevalence is not known.

Case report
A 21-year-old lady presented with prolonged heavy menstrual bleeding (HMB) associated with palpitations and episodes of syncope. On admission she was severely pale with a haemoglobin of 3.8 g/dl and she was transfused with 4 .0 packed red cells (PRC) along with fibrinogen replacement therapy (FRT). She is a diagnosed patient with bleeding phenotype of dysfibrinogenaemia (BPD) which was diagnosed following prolonged umbilical stump bleeding at birth. During childhood she has developed spontaneous bruising, haemorrhage following minor trauma, tooth extraction and denied bleeding into joints. She attained menarche at the age of 14 years and had regular cycles with light to moderate flow lasting for eight to ten days. She had PRC transfusions & FRT in two occasions following prolonged HMB until now. She had undergone evacuation of a chronic subdural haematoma five years ago, since then she was on regular FRT.

Discussion
Currently, there is no evidence-based recommendations for the management of BPD. To increase the fibrinogen levels, fresh frozen plasma, cryoprecipitate or plasma-derived fibrinogen concentrate (PDFC) can be administered depending on the availability. PDFC has the most favourable safety and efficacy profile. Though it's debatable, a threshold fibrinogen activity level of 1 to 1.5 g/L is used for fibrinogen supplementation. In this case we added tranexamic acid and mefenamic acid to limit bleeding alongside combined oral contraceptives.

Conclusion
Management of abnormal uterine bleeding (AUB) in BPD is complex and requires multidisciplinary collaboration with specialists in haematology, gynecology and transfusion medicine. Careful assessment of clinical and laboratory factors is of utmost importance to guide the treatment. This case adds to the sparse literature on the management of AUB in fibrinogen disorders and highlights the importance of contraception and periconceptional advice.

EP/G – 46
SURGICAL MANAGEMENT OF ECTOPIC PREGNANCY: A FOUR-YEAR EXPERIENCE FROM A SRI LANKAN TERTIARY CARE CENTER

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Background
Ectopic pregnancies have a rising incidence worldwide. Despite advances, early diagnosis and timely interventions remains a challenge. Surgery is the mainstay of management and laparoscopy offers significant advantages over laparotomy. The decision of tube preservation needs to be decided based on a multitude of factors.

Method
A prospective cross-sectional study to evaluate the clinical presentation, prevalance of risk factors, surgical techniques, patient's preference in type of surgery and post procedure fertility among patients who underwent surgery for ectopic pregnancies at Colombo South Teaching Hospital university unit from 2018 March – 2022 March.

Results
Mean age of mothers was 30 years & 11 months which was higher compared to regional studies. Subfertility & treatment (29.8%), miscarriages (22.8%), use of IUCD (22.8%), pelvic surgeries (14%) & pelvic inflammatory disease (5.7%) were identified as common risk factors. The classical triad of symptoms; abdominal pain, per vaginal bleeding & amenorrhoea was seen among the majority (45.6%). Most of the ectopics were right side tubal (42.1%) and laparoscopic salphingectomy was the surgical technique utilized (59.6%) for most. 66.7% of mothers who had further fertility wishes became pregnant within six months of the ectopic pregnancy.

Conclusion
Early diagnosis and timely interventions lead to favourable outcomes even in patients with a ruptured tube. Tube preservation needs to be decided on an individual basis.

EP/G – 47
A GIANT NABOTHIAN CYST IN AN ADVANCED AGE, IS IT A SIGN OF CERVICAL CANCER? A RARE CASE REPORT

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Introduction
This case report follows a 72 year-old menopause lady undergoing routine investigation for Chronic backache. Incidentally, the patient was found to have a cystic pelvic mass on initial imaging via ultrasound scan including transvaginal. Subsequent imaging with MRI confirmed

findings of giant Nabothian cysts. This case outlines the rare, asymptomatic nature of giant Nabothian cysts in elderly women and emphasizes the efficacy of MRI as a tool for diagnosis of pelvic masses and may hide the cervical neoplasm.

Nabothian cysts are benign cervical cysts that are frequently seen in women of reproductive age. They are usually associated with chronic cervicitis andtypically small and do not present with clinical symptoms. The cysts frequently resolve on their own with no need for medical intervention. Very rarely, they can grow into large cysts that may cause compression of surrounding viscera and produce symptoms related to mass effect. The following case reports the findings of giant nabothian cysts in asymptomatic patient undergoing screening for chronic backache. More importantly this case report is about advanced age where nabothian cyst are rare.

Case report

A 72 year old menopause for 24 yers with multiple medical cormobidities including recent PCI for coranaray heart disease being investigatetdfor long standing backache.she had a lengthy married life which given a 6 child birth .all were vaginal birth and birth space maintain with natural methods only. However her reprodutive period not complicated with menstrual irregularties or post coital bleedingor vaginal dischrge which are the common presntatin of cervicakl pathology.she never had a pap smeare. After MRI pelvis and abdomen she has preparied for the TAH +BSO.during surgery ureterilysis done to prevent accidental l;igatiobn.post operative period was unremarkable and comfotable as she is got rid of the trouble some backache. Interestly her histolgy report confirm the nabothian cyst but surprisingly there was a glandular type cervical carcinoma with tumor free resection margin.

Conclusion

Nabothiyan cyst at advanced age is rare.so need other experties invovement for tghwe better out come. MRI abdomen and pelvis is the investigation of the choice.may associate with the cervical neoplasia.

EP/G - 48
THINK TWICE BEFORE PRESCRIBE THE COCP IN YOUNG GIRL (OCP INDUCED SUPERIOR SAGITTAL SINUS THROMBOSIS IN YOUNG GIRL): CASE REPORT

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Introduction

In Sri Lanka various hormonal preparation are overuse in context of treating menstrual irregularities among the adolescent and young girls. Combined hormonal methods contain both oestrogen and a progestogen and are available as oral, transdermal (patch) and vaginal preparations (vaginal ring). The risk of VTE associated with different COC pills was influenced by type of progestogen, with levonorgestrel, norethisterone and norgestimate having the lowest risk (5–7 per 10,000 women) and those containing third generation (desogestrel, gestodene) or fourth- generation (drospirenone) progestogens having the highest risk (9–12 per 10,000 women), compared with 2 per 10,000 women amongst nonusers.

Case report
A 20-year-old healthy young girl was admitted to the neurology ward with persistent severe headache and left side upper limb weakness following commencement of COCP. Which has been given for oligomenhorrea with clinical evidence of PCOS two weeks ago. It has treated with the enoxaparin and warfarin. MRV Brain confirmed the diagnosis of the superior sagittal sinus thrombosis. Fortunately, she responded well.

Conclusion
Hormonal treatment for adolescent and young girl needs careful evaluation. prioritization of other modality of management (non-hormonal, life style modification). Proper counselling and education at the time of start will help to reduce the morbidity.

EP/G – 49
A CASE OF AN EARLY ABDOMINAL ECTOPIC PREGNANCY

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Introduction
Abdominal ectopic pregnancy is a rare form of ectopic pregnancy that accounts for almost 1% of all ectopic pregnancies. Immediate termination of pregnancy is indicated for early abdominal ectopic pregnancy to prevent major intra-abdominal bleeding.

Case report
A 32-year lady in her 3rd pregnancy with 2 children by vaginal delivery presented with epigastric pain for 2 weeks duration. Her urine pregnancy test was positive with unknown dates. She denied lower abdominal pain, vaginal bleeding, or urinary symptoms. An ultrasound scan found an empty uterus with 14 weeks of live pregnancy in the right adnexa without free fluids. The termination of pregnancy was decided, and laparotomy was performed. The ruptured abdominal ectopic pregnancy was noted during laparotomy and the placenta was adhered to the right adnexa. The ectopic pregnancy was removed with right-side salpingo-oophorectomy and 2 units of blood were transfused for 1800 ml of blood loss. The postoperative period was uneventful, and the patient was discharged on day 3 with family planning counselling. Histology was found to have the product of conception with ovary and fallopian tube and ectopic pregnancy.

Discussion
Abdominal ectopic pregnancies are classified according to the site of the implantation and gestational age at diagnosis. Early abdominal ectopic pregnancy includes gestation of less than 20 weeks and the rest are advanced abdominal ectopics. In a primary abdominal ectopic pregnancy, implantation occurs directly in the abdominal cavity, and in a secondary one, the conception is pushed out of the primary site and implanted in the abdominal cavity. MRI is the imaging modality of choice for diagnosing abdominal ectopic pregnancies, but ultrasound features help the diagnosis with the presence of an enlarged "empty" uterus, visualization of the fetus and placenta outside the uterus, and absent uterine myometrium around the fetus. Termination of pregnancy is indicated for early abdominal ectopic pregnancy by immediate active surgical intervention. The fetus should be removed without disturbing the placenta. The placental site can be managed surgically, expectantly with methotrexate and an embolization procedure.

Conclusion
Early abdominal ectopic pregnancy usually presents with abdominal pain with or without vaginal bleeding. First-trimester ultrasonography involves routine confirmation of the location of the gestational sac in relation to the cervix, endometrial cavity, and uterus to diagnose an abdominal ectopic pregnancy. Undiagnosed cases can present with acute abdomen and hypovolemic shock due to intra-abdominal bleeding.

EP/G – 50
CASE REPORT OF A PATIENT WITH MASSIVE DEEP VEIN THROMBOSIS OF LEFT POPLITEAL TO ILIAC VEIN COMPLICATING A LARGE UTERINE LEIOMYOMA

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Objective
The association between the uterine leiomyoma and venous thrombo embolism arises due to compression of the veins with large fibroids, leading to venous stasis in the pelvis and lower extremities. The incidence was very low till couple of years back. But, recently within the last few months we have encountered few cases of thrombosis associated with uterine fibroids including 2 deaths due to thrombo embolic events including a case with arterial thrombo embolism at Teaching Hospital Mahamodara, Galle. So, we need to find out the causative or contributory factors which can give rise to the above scenario which were not there till recent years.

Case report
A 53-year-old nulliparous woman who reached menopause 2 years ago, presented to the Gynaecology clinic, with left sided lower abdominal pain and abdominal distention for 2 years duration. Her symptoms got worse rapidly during the past 6 months. She denied any vaginal bleeding but had urinary symptoms but no bowel symptoms. She didn't have any significant past medical history and did not have any risk factors related to deep vein thrombosis (DVT). She was vaccinated against COVID-19 infection with 3 vaccines.

On general examination, she was average build was not pale but in distress due to abdominal pain. She had left sided ankle oedema without calf tenderness. Her abdomen was distended with a mass equivalent to a 28 weeks size gravid uterus, deviated to the left side of the abdomen, with restricted mobility. Ultrasound scan showed a large Intramural uterine leiomyoma which was rotated to the left side with degenerative changes. The patient underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Intra operatively there was a large leiomyoma 18x15 cm size and was attached to the omentum on left side. Samples were sent for histopathology. On post operative day 3, patient complained of left sided lower limb pain and swelling from groin to foot. Investigations revealed the diagnosis of left sided extensive DVT. She was started on enoxaparin, warfarin and DVT stockings were arranged.

Discussion
Though the association between the uterine leiomyoma and venous thrombo embolism is due to compression of the veins by large fibroids Other potential risk factors like polycythaemia and reactive thrombocytosis secondary to menorrhagia also contribute.
As the incidence of thrombo embolism complicating uterine leiomyoma had gone up during the recent past, we need to emphasis on whether there is any association which we have missed to find out during the recent years.

Conclusion
So, more research will be required to find out the causation or association with potential causes such as Covid 19 infection and vaccination, as they also found to be associated with thrombotic events.

EP/G – 51
MANAGEMENT OF LARGE UTERINE LEIOMYOMA COMPLICATED WITH ILIOFEMORAL VEIN THROMBOSIS – A MULTIDISCIPLINARY APPROACH: A RARE CASE REPORT

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Introduction
The coexistence of deep vein thrombosis (DVT) with a degenerated fibroid compressing the iliac vein and the inferior vena cava (IVC) is a rare entity. Here, we present a rare case of mechanical compression of fibroid leading to left iliofemoral DVT, which was successfully managed with multidisciplinary approach for anticoagulation and hysterectomy.

Case report
A 34-year-old unmarried woman who presented with painful left lower limb swelling and fever. Her past medical history was unremarkable, she had an edematous left lower limb up to the mid-thigh level with calf tenderness. Abdominal examination revealed a 36-week gravid uterus-sized firm and non-tender abdomino-pelvic mass. Investigations showed a hemoglobin level of 3.8 g/dL, normal clotting profile, and elevated D-dimer levels. Left iliofemoral DVT was confirmed by duplex scan, and further evaluation with CECT revealed a fibroid mass possibly with degeneration or sarcomatous changes, compressing the common iliac vein and IVC. CTPA and 2D-echo ruled out pulmonary embolism.

The patient received five units of red cell concentrate for anemia and was started on medical thrombolytic therapy using heparin, followed by LMWH. During hospitalization, she developed AV nodal re-entrant tachycardia, requiring successful radiofrequency ablation. A multidisciplinary team discussed the management plan, including gynecologist, interventional radiologist, hematologist, anesthetist, and cardiac electrophysiologist. IVC filter insertion was performed, and myomectomy was planned after one month of anticoagulation.

During myomectomy, a degenerative fibroid was found. However, the patient experienced profuse bleeding, leading to a decision for hysterectomy. Both reactive enlarged ovaries were preserved, and the postoperative period was uneventful. The patient was advised to continue therapeutic LMWH and the IVC filter was scheduled for removal after 3 months. The histology report confirmed a benign leiomyoma with degeneration.

Discussion
Benign uterine fibroids can lead to venous stasis and deep vein thrombosis (DVT) by compressing the iliac veins, similar to May-Thurner phenomenon. During hysterectomy, iatrogenic manipulation of iliac veins may dislodge thrombi, increasing the risk of pulmonary embolism. To mitigate this risk, inserting an IVC filter and initiating therapeutic anticoagulation before surgery is advisable. Management options range from conservative to medical, interventional radiology, and surgical approaches, with the primary goal being patient stabilization and prevention of life-threatening complications.

Conclusion

It is important to pay attention to the rare complications of uterine fibroids and implement appropriate treatment based on the clinical conditions and available facilities. Timely multidisciplinary involvement is crucial for optimal patient management.

EP/G – 52

CASE REPORT OF HYPER ANDROGENISM IN POSTMENOPAUSAL WOMEN- AN OVARIAN HYPERTHECOSIS

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Abstract

Menopause is a relative hyperandrogenic state, but development of hirsutism accompanied by virilizing features like male type alopecia, acne, voice deepening and clitoromegaly is rare.
We present 63 years women who presented with features of hyperandrogenism for 14 months duration with Histologically confirmed leydig cell to tumor of the Left ovary.

Introduction

Ovarian hyperthecosis is a functional disorder in which ovarian cells differentiate into clusters of luteinized thecal cells within the hyperplastic ovarian stroma, which produce excessive amounts of testosterone. This condition commonly presents in postmenopausal women with symptoms of hyperandrogenism. Secondary to high testosterone, commonly present as androgenetic alopecia, progressive hirsutism, and Acne but can result in metabolic abnormalities such as insulin resistance which lead to hyperinsulinemia which can result in an increased risk for type 2 diabetes mellitus and cardiovascular disease.

Case report

63-year-old woman present to the clinic with the features of progressive hyperandrogenism. Her initial investigations revealed high testosterone (17.47nmol/l), elevated De Hydro Epi Androsterone Sulphate (DHEAS) (173.00 Micro g/dl), normal TSH (1.69 mIU/ml), and Normal prolactin (5.13ng/ml). Her ultrasound couldn't visualize any Ovarian or adrenal masses and a CT scan confirmed by Ultrasound diagnosis. Repeat Serum Testosterone (20.80 nmol/l) level was further elevated by confirming diagnosis of hyper androgenism. Combined Adrenal & Ovarian venous sampling results was inconclusive as only the Left Adrenal vein is successfully catheterized. With clinical suspicion of Ovarian Hyperthecosis, Laparotomy was performed and histology confirmed Leydig cell tumour of the Left ovary**.**

Discussion

Postmenopausal patients presenting with symptoms of hyperandrogenism, it is important to exclude malignant androgen-producing ovarian or adrenal tumors and evaluate for late-onset congenital adrenal hyperplasia, and Cushing's disease. As testosterone levels in this patient were markedly elevated, the clinical picture was suggestive of ovarian hyperthecosis. After reviewing the patient history, physical exam findings, imaging, and laboratory results, even though Combined Adrenal & Ovarian venous sampling results were inconclusive the diagnosis of hyperthecosis was at the top of the differentials. Post oophorectomy, patients showed remarkable improvement in serum testosterone levels. Histology came as Leydig cell tumour of the Left ovary, which was confirmed clinical diagnosis.

EP/G – 53

PRIMARY MALIGNANT MELANOMA OF THE UTERINE CERVIX: A CASE REPORT

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Introduction

Malignant melanomas do develop within the female genital tract, and account for 3–7% of cases. The vast majority of these occur in the vulva and vagina. The cervix is a rare site for melanomas to develop as the primary site. They usually present at an advanced stage, and the diagnosis is confirmed histologically using special staining and by immunohistochemical study. Radical hysterectomy with regional lymphadenectomy is generally advocated. Due to delayed diagnosis and a lack of standardized treatment, primary malignant melanoma of the cervix has a poor prognosis.

Case report

A 63-year-old, multiparous woman presented with postmenopausal bleeding for 2 weeks. An elongated, 3 cm long, black to brown colored mass was noted on the posterior lip of the cervix. Involvement of the vagina with multiple brown color satellite lesions in the entire length of the vagina. Parametrium was not involved. The clinical diagnosis was stage 3a cervical carcinoma, and an excision biopsy was taken. The abdominopelvic computed tomography revealed cervical cancer with vaginal involvement and without parametrial invasion or lymph node enlargement. The histology showed malignant melanoma. The immunohistochemical staining for HMB-45, vimentin, and melan A antibodies were positive, but negative for S100, chromogranin, synaptophysin, and leukocyte common antigen. Ki67 was high.

The patient was thoroughly examined for a melanotic lesion in the skin, but we could not find any. We discussed the optimal treatment for this patient with the oncologist and concluded that we would do the surgery because primary melanomas of the cervix were poor responders to radiation. We performed a radical hysterectomy with colpectomy and pelvic lymphadenectomy. The final pathologic report confirmed malignant melanoma of the cervix with tumor involvement in the vagina up to the resection margin. With negative parametrial, external iliac, and common iliac lymph nodal involvement. She was referred for adjuvant chemotherapy.

Discussion

Primary melanoma of the cervix is very rare. Patients with cervical melanoma have ranged in age from 19 to 83 years, although most have been between 60 and 70 years. Vaginal bleeding or discharge is the usual presenting complaint. Some patients have been asymptomatic. Clinical examination has usually revealed an exophytic polypoidal pigmented cervical mass with variable sizes. In about half of the cases, brown to blue-black pigmentation of the tumors has been noted. Cervical melanoma is seldom diagnosed by Pap smear in the absence of typical pigmented polypoid growth. The diagnosis is usually based on pelvic examination and histopathology.

Diagnosis should always be confirmed by immunohistochemical staining. A combination of S100 protein (more sensitive) or HMB-45 (more specific) is the best combination for an

accurate diagnosis and is useful in distinguishing melanoma from anaplastic carcinoma, high-grade lymphoma, and sarcoma. Norris and Taylor have suggested the diagnostic criteria for primary malignant melanoma: the presence of melanin in the normal cervical epithelium, the absence of melanoma elsewhere in the body, the demonstration of the junctional change in the cervix, and the metastases according to the pattern of cervical carcinoma.

There is no consensus on the optimal management of primary malignant melanoma, because of the rarity of the lesion. Radical hysterectomy with pelvic and paraaortic lymphadenectomy is usually the most common procedure. There is a lack of evidence on the efficacy of postoperative radiation or chemotherapy. Radiotherapy can be used for palliation. A combination of chemotherapy with cisplatin, vinblastin, and bleomycin may produce a better response than a single agent dacarbazine.

The prognosis is generally poor because of late diagnosis and the tumor is highly aggressive. The 5-year survival rate after radical hysterectomy is not exceed 40% in stage 1 and reaches only 14% in stage 2. The reported survival time ranges from 6 months to 14 years, 90% of the reported patients with follow-up data have died of their diseases, within 2-3 years of presentation.

In the differential diagnosis of cervical cancers, primary malignant melanoma of the cervix needs to be taken into account. Using specific stains and immunohistochemistry, the diagnosis should be confirmed. This is crucial since cervical melanoma needs to be discovered early on in order to be treated successfully.

EP/G – 54
DISSEMINATED PERITONEAL LEIOMYOMAS – A CASE REPORT

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Abstract
Uterine leiomyomas are common benign neoplasms that develop from uterine smooth muscle, with an estimated incidence of 20%–40% in women of reproductive age. During myomectomy, if all fragments are not removed, they may find another blood supply and develop into abdominal masses. We present a case of disseminated peritoneal leiomyomatosis in a patient following laparoscopic myomectomy.

Introduction
Uterine myomas are common benign tumors found in 20%–40% of women of reproductive age, and they are subclassified by location. Disseminated peritoneal leiomyomatosis (DPL) is rare and can occur in patients following myomectomy or hysterectomy for myomas.
We report a rare case of DPL in a patient with a history of laparoscopic myomectomy.

Case report
A 40-year-old woman presented with persistent lower abdominal pain for 3 months duration. She had an ultrasound scan of the abdomen which showed multiple masses in the pelvis and

upper abdomen. She underwent CECT of the abdomen pelvis which showed multiple contrast-enhancing solid tumours in the pelvis and peritoneum suspecting ovarian or primary peritoneal carcinoma. Blood tests including a cancer antigen 125 (CA125) were normal.
She had a past history of laparoscopic myomectomy with a power morcellator 3 years back for an intramural posterior wall fibroid due to menorrhagia. A 5-cm intramural fibroid was excised and the myoma was removed using a morcellator.

Due to the suspicion of ovarian malignancy, she underwent a midline staging laparotomy in this presentation. During the operation, multiple well-defined tumours ranging in size from 2 to 5 cm were found in the abdominal wall, peritoneum, and omentum. Her bilateral tubes and ovaries were normal. There were no deposits in the liver, or diaphragmatic surfaces, and no ascites. She underwent excision of all the visible deposits in the abdomen without hysterectomy or oophorectomy. Histology revealed disseminated leiomyoma. Subsequently, the patient has been followed regularly as an outpatient.

Discussion
Myomectomies are commonly performed in gynecologic practice, but peritoneal leiomyomatosis occurs rarely and the aetiology and risk factors remain unclear. They originate from uterine leiomyomas and are estrogen/progesterone-receptor positive. Current hypotheses for DPL include detachment and revascularization of fibroids at distant sites as one cause. With the introduction of power morcellation, the number of cases of DPL increased. Therefore, intraperitoneal seeding during surgery is a possible cause.

The iatrogenic spread of leiomyomas in the peritoneal cavity is of particular interest in light of recent concerns related to power morcellation in laparoscopic surgery. In the literature review of laparoscopic myomectomy surgeries, peritoneal myomas occurred in around 0.1 to 1% of myomectomies using power morcellation. Our patient also had the morcellator used during the initial laparoscopic myomectomy. We hypothesize that the relapse was likely from myoma tissues left behind after the surgery.

There is no recognized DPL management protocol. The therapeutic strategy depends on the patient's age, symptoms, size location, and desire for conception. Asymptomatic DLP can be managed conservatively, Surgical excision is recommended if the patient is symptomatic with a persistent or recurring lesion that is not responding to hormone treatment or if the patient refuses surgical menopause.

EP/G – 55
BENIGN METASTASIZING LEIOMYOMA – A CASE REPORT

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Introduction
Benign metastasizing leiomyoma (BML) is a rare extrauterine benign smooth muscle. The commonest site of metastasis is the lungs. We present the case of a woman who had numerous benign pulmonary metastasizing leiomyoma.

Case report

A 39-year-old woman was found to have multiple lung shadows in a chest x-ray during screening. Her past surgical history was notable for a myomectomy for menorrhagia at the age of 27. The patient denied any respiratory symptoms, weight loss, smoking, or recent travel. Physical examinations including respiratory examinations were normal. She was investigated by a pulmonologist with negative sputum for AFB, restrictive pattern in lung function test. She underwent HRCT chest which showed innumerous, well-defined soft tissue densities in both lungs in all three zones.

Then she had a thoracoscopy & wedge biopsy of left lung lobes which showed metastasizing leiomyomata. She was followed up with regular lung function tests and during follow-up, she develops progressive exertional dyspnea which was managed with inhalers and breathing exercises for 6 months. Due to the deterioration of lung function tests and she had multiple deposits in both lungs involving all the lobes, she underwent TAH & BSO.

Discussion

BML is a rare disorder. They present with multiple extrauterine nodules of benign smooth muscle origin. usually localizes primarily in the lungs (80%), with rare reports of localization in extrapulmonary sites. The hypotheses of BML include mechanical dissemination or intravascular spread of smooth muscle cells from the uterus to distant locations. Furthermore, nearly all known cases reported involve women with a history of uterine surgery, suggesting that surgery may predispose them to BML by means of facilitating the dissemination of the primary tumor.

Chest X-ray findings include single or multiple nodular opacities in the lungs. On CT, these pulmonary lesions often present as well-defined soft tissue densities. Definitive diagnosis of BML made histopathological by demonstrating the proliferation of smooth muscle cells identical to leiomyomas at other sites. The IHC profile will show positive for actin, desmin, and smooth muscle actin and a low Ki-67 expression (<5%) with positive estrogen and progesterone receptors.

There is no standardized treatment for BML. Several strategies include surgical resection, progesterone therapy, oophorectomy, and medical management using aromatase inhibitors and GnRH agonists. The aim of the surgery is that will allow for complete en bloc removal of lesions with minimal dissemination and seeding of tumors. Our patient had multiple lung fibroids that were not amenable to complete resection so managed with bilateral oophorectomy through an open approach.

Conclusion

BML is a rare entity. The final diagnosis requires histopathological examination to exclude primary or metastatic malignancy. There is no standardized treatment for BML, with the choice of therapy ultimately depending on tumor size, location, receptor positivity, and progression over time.

EP/G – 56
CONTRACEPTIVE COUNSELLING: A SINGLE CENTER EXPERIENCE IN SRILANKA

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Introduction
Postpartum contraception is crucial for improving maternal and child health by spacing pregnancies and family planning.

Objectives
To review postpartum contraception usage in a single center following contraception councelling.

Method
A retrospective cross-sectional study was conducted using an interviewer-administered questionnaire among postpartum mothers who delivered at Base Hospital Udugama between December 2022 and February 2023.

Results
Out of 132 deliveries, 71 (53.8%) mothers participated. Mean age at delivery was 29.9 years (median 30), and the mean time expected for the next pregnancy was 4 months (median 5.1). The majority of mothers (97%) were legally married, with a median of 2 living children. Before the current pregnancy, the most common contraception methods were none and fertility awareness (23.5%), followed by condoms (2.3%), COCP (6.8%), implants (6.1%), IUCD (6.8%), and DMPA (8.3%). Reasons for not using previous contraception included partner's absence (66%) and fear of side effects (33%). After the last delivery, there was a change in contraceptive usage, with some relying on fertility awareness or using no method (2.3%), condoms (2.4%), implants (20.5%), IUCD (26.5%), and DMPA (2.3%).

Awareness of the natural postpartum contraception period (6 weeks) was low (28.2%), while 81.7% were aware of the recommended 18 to 24-week gap between pregnancies. 93% of mothers were aware of the risks of not using postpartum contraception, with 95% receiving contraceptive advice immediately postpartum or during antenatal care. 87% agreed to use contraception, while 13% declined due to various reasons. The most common postpartum contraceptive methods used following advice were IUCD (54.4%) and implants (38.2%). Most mothers initiated the method immediately postpartum (72.7%), while 27.3% started it later. Factors considered when choosing contraception were side effects (53%), non-hormonal options (19.7%), and long-term fertility preservation (15.2%).

IUCD-related problems included pain (3.8%), inability to feel the threads (6.1%), lost IUCD (2.3%), heavy and irregular bleeding (0.8%), and sexual discomfort (2.3%). Implants caused amenorrhea (2.3%), local infection, and bruising (1.5%). DMPA caused weight gain (0.8%), heavy bleeding (1.5%), and irregular bleeding (0.8%). The study found high satisfaction (95.7%) with the current contraceptive method, and 92.8% of mothers would recommend it to others. 81.2% considered their current method for future contraception, with fear of side effects being the main reason for change (69.2%). Laparoscopic tubal ligation (LRT) was the most

preferred future method (69.2%) due to reliability (50%) and hormone-free nature (40%), 33% were aware of the laparoscopic route of LRT.

Conclusion
This study highlights a good uptake (87%) of postpartum contraception, primarily using PPIUCD. Proper antenatal and postpartum counseling can further improve the uptake rate. The study recommends promoting Antenatal contraception counselling aiming LARCs, such as IUCD and implants, for their high user satisfaction and preference rates.

EP/G – 57
IMPLEMENTATION OF SAFETY ALERT MEASURES: QUALITY IMPROVEMENT PROJECT

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Introduction
Loss of swabs after surgery is considered a serious patient safety event and poses significant risks to postoperative health. To prevent such incidents, it is essential to implement a robust documentation system that clearly identifies foreign bodies left inside patients' body cavities.

Objectives
This quality improvement project aims to address this issue by introducing safety measures and documentation procedures for the removal of foreign bodies, such as catheters, packs, and drains, to enhance patient safety and adherence to modern concepts of enhanced recovery.

Method
The following safety measures have been implemented to ensure patient safety: Safety Sticker: A pink safety sticker is placed on the first page of the patient's bed head ticket, clearly stating the dates of insertion and expected dates of removal for all foreign bodies. Healthcare providers are required to sign the relevant box after each removal. Wrist Band: A pink band is worn around the patient's wrist at the insertion of any foreign body, which is cut upon removal. Documentation: Insertion and removal of all foreign bodies are clearly documented using red ink in theaters, labor wards, procedure rooms, and during ward rounds. Counting Book and Notice Board: A counting book and notice board are maintained in theaters to ensure proper counting and accountability.

All staff members received training to familiarize them with the new protocol. A written protocol was developed to guide staff in adhering to the new safety measures. The incident reporting system was strengthened to ensure proper adherence to the protocol.

Results
The implementation of the safety measures and documentation procedures has resulted in several benefits: Increased Satisfaction: Both healthcare providers and patients are more satisfied as they are now aware of when to expect the removal of foreign bodies. Patients feel empowered to remind healthcare staff of the timely removal of foreign bodies. Enhanced Recovery: The project has strengthened the concept of enhanced recovery by promoting early mobilization, early discharge, and reduced infection rates. Cost-Effectiveness: The project was implemented at a low cost (sticker printing and ribbons) while delivering a high cost-benefit

ratio. Cost savings are primarily attributed to reduced hospital stays and decreased use of antibiotics and analgesics. Additionally, there are intangible benefits, such as improved patient satisfaction and enhanced institutional image.

Conclussion
A follow-up audit is planned in two months to assess the effectiveness of the implemented protocols and ensure continued adherence to the safety measures.

EP/G – 58
AUDIT ON KNOWLEDGE AND PRACTICE OF HYSTEROSCOPIC SURGERIES AMONG SRI LANKAN OBSTETRICS & GYNECOLOGY POSTGRADUATE TRAINEES

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Introduction
Hysteroscopy is a minimally invasive surgical procedure of visualizing and performing procedures in the endometrial cavity from a trans-cervical approach and is a valuable tool, especially in low-resource settings. Knowledge to confidently perform such procedures and negate complications comes through hands-on teaching and practice.

Method
A pre & post-workshop questionnaire was given to all post-graduate trainees who attended a workshop on basic hysteroscopy organized by the menopause society of Sri Lanka.

Results
49 participated in the programme ranging from first-year registrars to post-MD senior registrars, while most were first-year trainees (n=23, 46.9%). Only 57.1% (n=28) of the trainees were at stations that had hysteroscopy facilities. Of them, 25 (89.3%) had rigid hysteroscopies, and only 3 had flexible hysteroscopies. Nevertheless, 81.6% (n=40) had seen hysteroscopy performed at some point during their career, and a considerable proportion of them (n=37, 92.5%) were rigid hysteroscopies. Half of the trainees (n=26, 53.1%) who attended the programme had performed hysteroscopies to some capacity during their training period, out of which 51% (n=25) had been rigid hysteroscopies while only one trainee had performed both (2%).

When inquired about the knowledge of equipment used for hysteroscopy, 57.1% (n=28) provided satisfactory answers on the parts of the hysteroscope. 46.9 % (n=23) and 42.9% (n=21) had adequate knowledge of how to assemble & disassemble the equipment, respectively. With regards to the usage of hysteroscopy for various purposes, 65.3% were aware of the distention media, 49% were aware of the use of electro-surgery in hysteroscopic interventions, 40.8% had adequate knowledge of the safety fluid level, 30.6% were aware of the steps that need to be taken to minimize the fluid overload, 22.8% were aware on fluid overload management, 51% knew maneuvers to overcome difficult negotiation, 73.5% were aware of complications that may ensue during the process but only 39.2% claimed that they were capable of managing these.

The post-workshop questionnaire revealed that there had been a significant improvement in knowledge. Confidence to perform hysteroscopy on their own had increased from 48.2% to 70.6%. A striking two-fold rise in confidence in managing complications was noted. However, most trainees (82.4%) claimed that further practice is needed for them to be confident in performing procedures and managing complications. A majority recommended having annual workshops to improve and update their knowledge.

Conclusion
Comprehensive hands-on sessions are needed to improve the skills of postgraduate trainees given the inconsistencies in facilities at training centres.

EP/G – 59
LEFORTE COLPOCLEISIS WITH A FOLEY CATHETER GUIDE: A SURGICAL CASE REPORT

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Introduction and Objectives
Leforte colpocleisis is a surgical procedure rarely performed to treat pelvic organ prolapse in women, particularly in those who are frail and have completed their childbearing not requiring their sexual function. Leforte colpocleisis aims to restore pelvic organs and alleviate the symptoms.

Case report
We describe a 76-year-old female, who had to undergo colpocleisis for uterine procidentia with an ulcer following failed treatment with vaginal ring pessary.

Steps of Leforte Colpocleisis: Before the procedure, a thorough preoperative evaluation including medical history, physical examination, and ultrasound scan was done. Betadine pack was used to heal the decubitus ulcer. The patient is placed under combined spinal epidural aneasthesia to ensure comfort and minimize pain during the procedure.

This procedure is amenable under local aneasthesia in frail patients. A surgical incision is made in the anterior vaginal wall, rectangular pattern. The vaginal mucosa is carefully dissected anteriorly and posteriorly and repositioned to create a solid closure. The vaginal walls are sutured together (keeping a foley catheter in between walls as a guide) reinforcing the support structures and narrowing the vaginal opening. This closure restores the anatomical position of the pelvic organs and reduces the risk of recurrent prolapse.

Finally, the guiding foley catheter is removed leaving two tunnels on either side. After the procedure, the patient is monitored, Pain management and antibiotics are prescribed. Patients are advised to avoid strenuous activities and heavy lifting during the recovery period. Postoperatively: Vulval estrogen cream application was done. The patient had an uneventful recovery; Quality of life was markedly improved.

Discussion and Conclusion
Leforte colpocleisis offers a minimally invasive and effective solution for women seeking relief from pelvic organ prolapse, improving their quality of life and restoring pelvic support.

 Video found at https://www.youtube.com/watch?v=wT6p9eXCqOE

EP/G – 60
CASE REPORT IN FIBROID COMPLICATING PREGNANCY IN POSTPARTUM PERIOD

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Background
Degenerative changes in a large uterine fibroid during the postpartum period can lead to troublesome complications.

Case report
A 28-year-old primipara had a large anterior wall lower segment fibroid of diameter 13cm. That was diagnosed in the first-trimester scan and pregnancy was well followed up and progressed up to 38 weeks without any antenatal complications. The baby was delivered by elective cesarean section and the mother developed major postpartum hemorrhage and underwent bilateral internal iliac artery ligation. During the postpartum period, the mother had unexplained high-grade fever which was not responding to broad-spectrum antibiotics for fourteen days. Then she was hemodynamically unstable and underwent laparotomy and total abdominal hysterectomy. So, she recovered after three days of ICU care and histology came as red degeneration of the fibroid.

Conclusion
to the best of my knowledge, fibroids can undergo a variety of changes during their course. But, during pregnancy and puerperium, it can show red degeneration and might end up with troublesome complications.

EP/G – 61
CASE REPORT IN RELATED TO ECTOPIC PREGNANCY IN INTESTINAL MESENTERY

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Introduction
Ectopic pregnancy is a pregnancy in which the fetus develops outside the normal endometrial cavity. Implantation of the fetus in intestinal mesentery is a rare occurrence and difficult to diagnose. It is a potentially life-threatening form of ectopic pregnancy.

Case report
A 23-year-old woman, married for six months and POA of 6 weeks, was admitted to our gynecology ward with abdominal pain for 5 days duration. She had tachycardia and her blood pressure was 95/50mmHg. Her urine pregnancy test was positive and inward USS showed significant free fluid in the peritoneal cavity. Her Hb was 7.9g/dl. So, an emergency laparotomy

was done with the diagnosis of ectopic pregnancy. During the laparotomy, a haemoperitoneum of 1.5 liters of blood with clots was evident and the uterus was about 6-8 weeks, bilateral tubes and ovaries were healthy. No obvious ectopic was identified. But she had continuous bleeding from the paracolic gutters. Then, with the help of the surgical team, she underwent midline laparotomy and bowel exploration. So, there was a bleeding ectopic pregnancy which was implanted in the mesentery of the ileum. Then the ectopic pregnancy was removed, and bleeding sites were sutured. During the surgery, she was resuscitated with a transfusion of 4 units of blood.

Conclusion

Ectopic pregnancies can develop in many places outside the endometrial cavity. More than 95% of them occur within the fallopian tubes. Abdominal ectopics are a much rarer occurrence with an incidence of 1% of all ectopic pregnancies and their diagnosis is very difficult. During its course of development placenta can implant any organ in the abdominal cavity. Separation of the site of the implantation at any time of the pregnancy can lead to massive hemorrhagic shock as in this case.

PROF SIR SABARATNAM ARULKUMARAN YOUNG GYNAECOLOGIST AWARD – 2023

YGA 01
THE WOMEN'S PERSPECTIVE: OBSTETRIC VIOLENCE IN THE LABOUR ROOM IN A TERTIARY CARE HOSPITAL IN SRI LANKA

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Objective
The obstetric outcome indices of Sri Lanka are the highest among the South-Asian countries and current aim is to improve the quality of care. However, this has led to more medicalization of childbirth with unpleasant experience for the women. Our study is the first quantitative study conducted in a hospital setting in Sri Lanka to understand about the mistreatment during childbirth in the country.

Method
A descriptive cross-sectional study conducted in a tertiary care Hospital in Sri Lanka. A self-administered questionnaire was used to collect data after vaginal delivery.

Results
From the total 350 participants, 96.8% stated that they are happy with the overall care during childbirth. However, not all the women felt that every aspect of care was satisfactory. Obstetric violence perceived by women in the labour room in our setting are verbal, discrimination, failure to meet professional standards, poor rapport and due to suboptimal healthcare facilities. The most common obstetric violence was denial of their preferred birth positions (16.3%). Further, denial of food, fluid and mobility accounts for one fourth of the mistreatment.

Painful vaginal examination contributed to 15.4% of perceived obstetric violence. Though labour partner is not allowed in any labor wards, 10.6% recognized is a mistreatment. Few patients also raised their concern on refusal of pain relief (2.6%), poor communication (5.4%) and lack of privacy(1.1%). 4.6% of the women felt that they were treated as passive participants during labour. However, our study did not demonstrate any significant association between different age group, ethnicity, educational status, Parity and any form of the mistreatment.

Conclusion
Although there was overall satisfaction shown by most of the women during childbirth in our setting, in depth analysis shows that there is a need for improvement of quality of care in different aspects of care in labour. There should be an integrated approach needed to improve the professional standards of the care providers as well as to address the deficiency of the health care system and facility.

YGA 02
CONTRACEPTIVE PREFERENCES AND PRACTICES AMONG PERI-MENOPAUSAL FEMALES IN A RURAL AREA OF SRI LANKA

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Introduction
Perimenopause marks the transition phase from normal ovulation to anovulation and, ultimately to permanent loss of follicle maturation and ovulation causing menopausal changes in females. Fertility and probability of conception decline by half as early as the mid-forties; however, women during perimenopause still need effective contraception. Many studies and multiple reports worldwide have shown perimenopausal contraception to be an important but rather neglected issue.

Method
An audit was conducted among the medical clinic attendees at the rural base hospital of Mahaoya. Knowledge of contraception, usage patterns, basic sociodemographic details and medical conditions were evaluated.

Results
The study cohort had a mean age of 46.9 years with poor education levels and low-income backgrounds. Approximately half of the women (45.9%) have had an unexpected pregnancy. Even though a considerable proportion of women were sexually active (82.4%), the usage of contraception was only seen among (54.1%) of the participants. Permanent sterilization with LRT (30%) was the most common method employed, followed by DMPA (25%), IUCD (22%), Jadell (13%), COCP (5%) and condom (5%) usage. The knowledge of contraception (knowledge, attitudes, side effects, emergency contraception etc.) was adequate only among a minority (28.4%) and only 14.8% had adequate knowledge on when to stop contraceptive usage. The main source of knowledge had been through well-women clinics.

Discussion & Conclusion
Comprehension of the importance, appropriate time of stoppage and usage of contraception is quite low in this cohort of women selected from a rural population of Sri Lanka. Some women have given up on usage based on side effects, but the majority have a clear deficiency of knowledge, thus resulting in a higher incidence of unexpected pregnancies.

Suggestions
A series of educational programs are essential to uplift the knowledge among these women. A re-audit done later can assess the improvement in practices.

YGA 03

DEPRESSION AND QUALITY OF LIFE IN WOMEN FOLLOWING ELECTIVE HYSTERECTOMY IN A TERTIARY CARE HOSPITAL IN SRI LANKA

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Objectives
To study the rate of depression and quality of life and its correlates in women following elective hysterectomy.

Methods
A longitudinal observational study was conducted at Gynecology outpatient and in-patient settings at Colombo North Teaching Hospital (CNTH), Ragama, Sri Lanka. Patients scheduled for hysterectomy for a benign condition at 18 – 65 years were consecutively recruited from August 2020 to April 2021. Data collection was done on a patient at three-time points; two weeks before the surgery, three months, and six months after the surgery. Beck Depression Inventory-II (BDI-II) and World Health Organization Quality of Life-BREF (WHOQoL-BREF) Questionnaire were used to assess depression and quality of life, respectively.

Results
The study population consisted of 66 participants who completed both questionnaires (BDI-II and WHOQoL-BREF) at least at two time points, including the baseline and at either three months or six months. Of which, 60 women completed at all three-time points. At the baseline, 28.8% of patients had clinical depression (a score of more than 16), while the corresponding figure at 3 months and six months follow-up was 27.3%. Of the participant, 87.9% of patients had a good quality of life (a total WHOQoL-BREF score ≥ 60%), while at three months and six months, a decreasing trend of the quality of life was seen as 80.3% and 75.8%, respectively. The repeated measures ANOVA test showed that total BDI-II and BREF scores didn't significantly affect three different time points (baseline, three months, and six months), meaning that time assessment has no impact on the overall quality of life and 2 depression in the present study population. Spearman rank analysis showed significant negative correlations between WHOQoL-BREF and BDI-II scores at each time point. Multinomial regression analysis showed no socio-demographic, clinical, surgical, or social factors significantly associated with total BDI-II or WHOQoL-BREF scores.

Conclusion
The study found nearly one-third of women had depression at the baseline before undergoing hysterectomy. This rate of depression did not change significantly following hysterectomy. Although statistically not significant, quality of life of women was observed to be declining following hysterectomy. Depression correlated with poor quality of life at all three-time points. We highlight the importance of preoperative evaluations to identify patients with an increased risk of developing depression to give them a better quality of life by treating depression in addition to gynecological treatment. We also encourage immediate postoperative psychological monitoring in addition to routine care.

YGA 04
AN AUDIT ON WELL-WOMEN CLINIC ATTENDANCE AND CERVICAL SCREENING IN THE RURAL AREA OF THE EASTERN PROVINCE

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Introduction
Cervical cancer can be successfully treated if identified early, considering its long pre-malignant phase. Sri Lanka has the lowest incidence of cervical cancer in South Asia owing to strong public health screening programmes and universal vaccination. Despite that, the participation in the screening of susceptible women is only around 50 –70%, which is lesser in rural areas and the majority (70%) of Sri Lankan cervical cancer is identified at advanced stages. Pap smear is offered to all women between 35 & 45 years at multiple delivery points, free of charge.

Method
This audit was conducted in the Mahaoya MOH area, a rural farming community, with poor socio-economic & educational background. MOH data suggest that women in Mahaoya are exposed to sexual activities in their teen years and remain sexually active until the sixth decade. Data were extracted from an audit conducted by the same team on perimenopausal contraceptive practice among women attending the Mahaoya Base hospital, who were above 45 years.

Results
Majority (n=51, 77.3%) of the women attending the gynaecology clinic were active recipients of the services provided by the well-woman clinic (WWC). A considerable amount of perimenopausal women (n=24, 34.6%) had never undergone a Pap smear, despite being freely offered at 35 & 45 years at WWC and at gynaecology clinics in government hospitals. Only a minority (n=9, 13.6%) of the women who had regularly attended WWC but had never undergone a Pap smear. This was attributed to a poor understanding of the importance of the screening test and the fear of undergoing an invasive procedure.

Discussion & Conclusion
Despite pap smears being offered freely and widely in the Sri Lankan public health system, the utilization of cervical screening seems to be at a low rate. Certain gaps in knowledge on cervical cancer need to be filled and an effective method of knowledge transfer on Pap smear procedure is in need in the rural areas of the country.

Suggestions
Implementing opportunistic screening programmes, educating and motivating women at all possible occasions on the need for cervical screening, training health care staff to counsel and perform cervical screening, provision of infrastructure and necessary equipment for WWC and conducting mobile screening clinics more frequently can enhance the cervical screening in the community.

YGA 05

PREVALENCE AND ASSOCIATED FACTORS OF POST-TRAUMATIC STRESS DISORDER (PTSD) AMONG A COHORT OF POST-PARTUM MOTHERS IN HORANA MEDICAL OFFICER OF HEALTH AREA: A CROSS SECTIONAL STUDY

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Introduction

Post Traumatic Stress Disorder (PTSD) is a response to a catastrophic event. Child birth is an intense stressful and emotional event which is severe enough to cause PTSD in some postpartum mothers. Severe form of postpartum PTSD can lead to maternal morbidity and mortality.

Objectives

To describe the prevalence and associated factors of PTSD among postpartum mothers in Horana Medical Officer of Health (MOH) area

Method

A cross sectional study was conducted at the field clinic settings in Horana MOH area, over a period of eighteen months from November 2016. Study participants were selected with a two staged sampling technique by randomly selecting 4 polyclinics out of all 9 polyclinics in first stage and final study units were taken from all the post partum mothers attended to those polyclinics till collected the required sample size of 225. A pre-tested interviewer administered questionnaire was used to collect socio-demographic data and factors related to pre-pregnancy, antepartum, intrapartum and post-partum periods. Self-administered, validated Sinhalese versions of Edinburgh Postnatal Depression Scale (EPDS) and PTSD Symptom Scale-Self Report (PSS-SR) were used to assess the presence of Post-Partum Depression (PPD) and PTSD, respectively. Scores of PPD >9 and PSS-SR >13 were taken as screening positive for two conditions respectively. Each participant was assessed at one month, two months and six months after the delivery for PTSD and PPD. The data gathered were tabulated, and SPSS statistical package version 18 was used to analyze the data. Qualitative and quantitative data were calculated with standard summary measures and effect measures. Significance of associations was determined by Fishers' exact test with 5% significant level. 3

Results

Data was gathered from 225 post-partum mothers who were at 1-month postpartum period for the initial study. The response rate at follow-up postpartum visits at second and sixth months were 95% (n=214) and 94% (n=211). Point prevalence of postpartum PTSD was recorded as 2.7% (n=6), 0.9% (n=2) and 0.5% (n=1) at postpartum first, second and sixth months respectively. Period prevalence was 3.6% during the postpartum six months period. Verbal abuse during labour (p=0.04) and presence of postpartum depression ($P \leq 0.001$) were significantly associated with postpartum PTSD. Anticipation of pain during labour was approaching significance level (p=0.054). There were no significant associations between PTSD and education level of mothers, gestational age at delivery, inter-pregnancy interval, whether pregnancy is planned or unplanned, history of subfertility, history of psychiatric disorders, partner violence, number of antenatal hospital visits, received antenatal counseling, hospital of delivery, delivery at non-state hospital, type and mode of delivery, labour duration, verbal or physical abuse during labour, presence of labour companion, mental trauma, post-

partum hemorrhage, manual removal of placenta, negative birth experience , low APGAR score of the baby at delivery, received neonatal and maternal intensive care, birth defects, breast feeding problems and opportunity to discuss problems with a health care worker. Of the mothers detected to have postpartum PTSD during the study no adverse outcomes were encountered during the study.

Discussion and Conclusion

Prevalence of postpartum PTSD in this semi-urban community during the study period was 3.6%; which is in par with overall global prevalence. It is significantly associated with verbal abuse during labour and postpartum depression.

Recommendations

Labour preparedness during antenatal period, respectful care in labour, and prompt recognition followed by timely referral of postpartum PTSD mothers are recommended in minimizing the associated adverse outcomes to postpartum mothers.