Sri Lanka College of Obstetricians & Gynaecologists

SUPPLEMENT ISSUE

SLJOG

The Sri Lanka Journal of Obstetrics and Gynaecology

57th ANNUAL ACADEMIC CONGRESS 2024

30th August to 1st September 2024

"Quality Healthcare Through Standards in Training and Service Delivery"- A right of all women.

Abstracts

Published by Sri Lanka College of Obstetricians and Gynaecologists

SLCOG
The Sri Lanka Journal of Obstetrics and Gynaecology

57th Annual Academic Congress 2024

SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

The Sri Lanka Journal of Obstetrics and Gynaecology

30th August to 1st September 2024

"Quality Healthcare Through Standards in Training and Service Delivery"- A right of all women.

Abstracts

SLCOG
The Sri Lanka Journal of Obstetrics and Gynaecology

57th Annual Academic Congress 2024

Sri Lanka College of Obstetricians & Gynaecologists

30th August to 1st September 2024
at Galadari Hotel, Colombo, Sri Lanka

The Sri Lanka Journal of Obstetrics and Gynaecology

"Quality Healthcare Through Standards in Training and Service Delivery"- A right of all women.

Printed by Lakcom Print, Nugegoda. Tel 075 9 555 558, 011 2 825 666 E-mail: pushpakumara@gmail.com Web: lakcom.lk

SLCOG
The Sri Lanka Journal of Obstetrics and Gynaecology

Editorial Process

Abstracts were reviewed by the Scientific Congress Committee rather than as part of the SLJOG peer review process.

Disclaimer

This supplement has been produced using author-supplied copy. Editing has been restricted to some corrections of spelling and style where appropriate. No responsibility is assumed for any claims, instruction, methods or drug dosages contained in the abstracts: it is recommended that these should be verified independently.

SLCOG
The Sri Lanka Journal of Obstetrics and Gynaecology

CONTENTS

ORAL PRESENTATIONS – OBSTETRICS

OP/O - 01
FETAL OCCIPUT–SPINAL ANGLE AT FIRST STAGE OF LABOUR IN PREDICTING LABOUR OUTCOME

Senevirathne, JTN[1], Shafraz, SM[1], Watthuhewa, DY[1], Thushara, SVPN[1], Kumara, NAKSR[2], Mathota, C[1], Silva, R[1], de Silva, PHP[1].
[1]Colombo North Teaching Hospital Ragama, Sri Lanka.
[2]Department of Medical Education Unit, Faculty of Medicine, University of Kelaniya, Sri Lanka

Introduction
Fetal head deflexion plays an important role during the labour process and in predicting the outcome of labour. Though traditionally it was assessed via digital examination, recent advancements have shown that ultrasonographic parameters might be useful to measure of head flexion via fetal occiput-spine angle (OSA).

Objective
Evaluate the role of fetal OSA measured at the early active phase of the first stage of labour in predicting labour outcome.

Design
Cross-sectional longitudinal study conducted at Colombo North Teaching Hospital Ragama.

Method
292 uncomplicated singleton pregnant mothers without occiput posterior positions were recruited via convenient sampling from August to December 2023. At the early active phase of labour (OS= 4 – 6cm), the angle between two tangential lines to the occipital bone and the vertebral body of the first cervical vertebra was measured as OSA. Labour progression and mode of delivery were monitored. Demographic and labour progress data were analysed.

Results
The mean OSA value was 133.88 $\pm$ 7.39°. The OSA measurement showed good inter-observer agreement ($r = 0.99$; $p<0.001$). The mean OSA was significantly less for the group of patients who had to undergo operative delivery (instrumental and caesarean) due to labour dystocia (n=37) as compared to women who had vaginal delivery (n=251), (128 $\pm$ 7.28° vs 134.83 $\pm$ 6.97°, $P<0.001$). The mean OSA was significantly greater for the group of patients who had a normal labour progression (n=32) as compared to women who had an abnormal progression (n=260), (134.67 $\pm$ 7.06° vs 127.47 $\pm$ 6.99°, $P<0.001$). Sonographic assessment of deflexion using OSA was found to be an independent predictor of labour outcome according to multivariate regression analysis. OSA value less than 127.8° (obtained via ROC curve) was associated with abnormal labour progression and operative delivery with a good sensitivity of 86.5% & 85% respectively. However negative predictive value for operative delivery being 6.8%, suggests that multiple clinical parameters should be considered when the decision of caesarean section is made. This is the only study with more than 200 participants reported in the literature so far. Including both nulliparous and multiparous mothers, and having analysed the association of OSA with regard to mode of delivery and as well as to labour progression are the strengths of our study.

Conclusion
Sonographic assessment of fetal head deflexion during the early active phase can be used as a reproducible, feasible screening parameter to predict labour progression and mode of delivery. Decisions for operative delivery should be made using multiple clinical assessments.

OP/O - 02
LABOUR COMPANIONSHIP: PERSPECTIVES OF ATTENDEES OF SELECTED ANTENATAL CLINICS IN COLOMBO

Wijewardena, SM[1], Wimaladharma, T[1], Ziyard, MS[1], Yathushan, R[1], Jayawardane, DBIA[2]
[1]Faculty of Medicine, University of Colombo.
[2]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo.

Introduction
A labour companion is recommended to improve maternal and perinatal outcomes. The Sri Lankan Maternal and Newborn Health National Strategic Plan aims to increase the proportion of women with a companion of choice during labour and delivery to 100% by 2025. Locally, the perspectives of antenatal women on labour companionship were previously unassessed.

Objectives
To assess the knowledge and attitudes of antenatal women regarding the provision of a labour companion.

Design
Observational descriptive cross-sectional study with an analytical component.

Method
The study systematically sampled 125 adult pregnant women over 28 weeks gestation attending antenatal clinics at De Soysa Hospital for Women (DSHW), Colombo. Women planning for a cesarean section and women with documented major psychiatric illnesses were excluded. Trained interviewers administered a pretested questionnaire on knowledge (11 items), attitudes, sociodemographic, and pregnancy-related factors. Data was subjected to bivariate analysis using chi-squared tests (SPSS 27). Ethical clearance was granted by the Ethics Review Committee of the Faculty of Medicine, University of Colombo.

Results
Of the 125 women sampled, 98 (78.4%) had previously heard about having a lay companion during birth, 12 (9.6%) knew about national recommendations for labour companionship, and 12 (9.6%) knew about World Health Organization (WHO) recommendations. Of the sample, 112 (89.6%) desired a labour companion of which 83 (74.1%) selected their spouse as their most preferred labor companion. The most desired support actions were “providing encouragement and motivation” (82.46%) and “comforting” (72.8%). The highest-ranked type of support was emotional support (68.42%). A good knowledge level (>50th percentile) was significantly associated with residence in Colombo compared to those residing outside Colombo (65.9% vs. 27.0%, $p < 0.001$), absence compared to the presence of pregnancy-related medical conditions (58.5% vs. 31.6%, $p = 0.03$) and planned pregnancies compared to unplanned pregnancies (66.7% vs. 40.7%, $p = 0.004$).

Conclusion
Most participants were aware of the concept of having a labour companion although knowledge of its benefits and awareness of national initiatives or WHO recommendations were limited. A majority expressed a desire for a labor companion, with most participants preferring their spouse. Uniform introduction of optional labor companionship in consultations, addressing logistical barriers for spousal companions (presently not permitted at DSHW), and targeted awareness programs for populations with lower knowledge levels, particularly outside Colombo, are recommended.

OP/O - 03
OBSTETRICS OUTCOME OF WOMEN WITH VERY ADVANCED MATERNAL AGE FOLLOWING ASSISTED REPRODUCTIVE TECHNOLOGY.

Raguraman, S[1], Abirame, S[1], Sajeeba V[1]
[1] Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Jaffna

Introduction
Advanced maternal age (AMA), defined as 35 years or older, impacts obstetric and neonatal outcomes. Further investigation into AMA subgroups, particularly between women aged 45 and older than 45 defined as Very Advanced Maternal Age (VAMA), warrants high-risk pregnancies in terms of maternal and neonatal outcomes. The rising prevalence of pregnancies in older women, attributed to advancements in Assisted Reproductive Technology (ART), underscores the importance of understanding outcomes in these age groups.

Methods
This retrospective cohort study analysed women aged 45 years and above who underwent in vitro fertilization (IVF) at McLeod Hospital, Jaffna, and received obstetric care at the Teaching Hospital professorial obstetric unit between August 2020 and January 2024. Patients were categorized into two age groups: <45 years and >45 years. Obstetric and neonatal outcomes were compared using SPSS-21, including Chi-square or Fisher's exact tests.

Results
Among 110 women, ages ranged from 45-55 years, with mean age (of 47.0 ±2.268 years). All are fit into the older than 45 years of age group with overweight/obese (61.8%). All of them opted for third-party-assisted reproductive treatment; 78.8% were donor eggs with partner sperm, and 21.2% were donor embryos. The spontaneous abortion rate ($p = 0.048$) was significantly associated with their age. However, pregnancy-induced hypertension ($p = 0.908$), gestational diabetes ($p = 0.517$), caesarean section type ($p = 0.048$), early neonatal death ($p=0.423$), neonatal birth weight ($p = 0.665$), or postpartum ICU admission rate ($p = 0.441$) were not significantly associated with age.

Conclusion
This study found no significant disparities in obstetric and neonatal outcomes between women over 45 undergoing ART procedures. However, spontaneous abortion following the treatment is significant with age. More extensive studies are needed to confirm these findings and explore additional factors influencing outcomes in advanced maternal-age populations.

OP/O – 04

MACROSCOPIC PLACENTAL PARAMETERS OF HEALTHY, TERM NEWBORNS DELIVERED TO HEALTHY MOTHERS IN A TERTIARY CARE CENTRE IN SRI LANKA

Ranaweera, GG[1], Ranaweera, AKP[2], Marious, WDS[2], Abhayasundara, D[2],
Priyani, AAH[1]
[1] Department of Pathology, Faculty of Medicine, University of Colombo, Sri Lanka
[2] Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo, Sri Lanka

Introduction
Examination of the placenta provides many insights into the nature of the in-utero journey of a fetus. Placental weight (PW) is one of the main parameters assessed in the pathological examination of placentae. The PW in each case is compared with standard weight charts for the stated gestation. The charts currently used for this purpose are developed based on data obtained from European countries. No weight charts are available for South Asian countries.

Objective
To describe the PW and other macroscopic parameters of normal placentae at term and to determine whether PWs are comparable to those given in European weight charts.

Design
A prospective descriptive cross-sectional study was conducted in the Professorial Obstetric Unit of De Soysa Hospital for Women, involving the examination of 67 placentae.

Methods
We examined the macroscopic parameters of 67 placentae (30/67 male) of healthy mothers who delivered healthy newborns via normal vaginal delivery at term. Fresh PW were compared with existing weight charts. Fetal to placental weight ratio was calculated.

Results
The POA of the placentae ranged from 37+3 – 41 weeks. Mean placental weight (fresh) for male and female fetuses were 379.96g and 440.53g and ranged from 230–525g and 251-633g respectively. PW was within the normal range for the gestational age in 60% and less than the normal range in 40%. Umbilical cords had a mean diameter of 12.39 mm. All had three vessels. Hypo/hyper/normal coiling was seen in 3.0%, 26.9%, and 43.5% respectively. The mean birth weight was 3.02 kg (Range: 2.54 – 3.68 kg). Fetal to placental weight ratio was less than normal/normal/more than normal in 11.67%, 55%, and 33.34% of cases suggesting reduced, normal, and increased placental efficiency respectively.

Conclusion
Close to half of the otherwise healthy newborns in this population showed placental abnormalities when compared with European standards. A larger scale study is required to determine whether these changes are due to factors inherent to populations in our parts of the world and to develop our very own placental charts.

Keywords
placental weight, fetal /placental ratio, healthy newborns

OP/O – 05

ASSESSING THE ASSOCIATION BETWEEN THE MODE OF DELIVERY AND THE RISK OF POSTPARTUM DEPRESSION

Shakoor, MZ[1] , Shahana, MMF[1], Rupasinghe, IDJW[2]
[1]Teaching Hospital Anuradhapura, Sri Lanka.
[2]Castle street Hospital for women, Colombo, Sri Lanka.

Introduction
Psychiatric disorders during the postpartum period are common and often serious. Postpartum depression (PPD) is defined as a depressive episode occurring within four weeks of childbirth, according to the Diagnostic and Statistical Manual of Mental Disorders. Despite the availability of valid screening tools, PPD is frequently underdiagnosed, especially in developing countries, leading to negative outcomes for both mothers and infants. Screening for PPD using the Edinburgh Postnatal Depression Scale (EPDS) within the first 2-3 days postpartum has been shown to accurately predict scores at 4-6 weeks. Early detection and intervention can significantly reduce the disease burden on the mother, infant, and family.

Objective
To assess the association between mode of delivery and the risk of postpartum depression.

Design
This case-control study design was chosen for its efficiency, particularly for conditions with low prevalence like PPD (around 10%).

Methods
Mothers of any age with uncomplicated antenatal histories were selected from the postnatal wards of Castle Street Hospital for Women and Colombo South Teaching Hospital. The sample size was calculated using the Z Test. These mothers were screened using the EPDS on the 2nd or 3rd day postpartum. Women with a total EPDS score of ≥13 were considered cases until the desired sample size was reached. Controls were randomly selected using a random number table, maintaining a 1:2 case-to-control ratio, with a total sample size of 360. Mothers with suicidal ideations were referred to the psychiatry team. Odds ratios (OR) and 95% confidence intervals (CI) for different delivery modes and PPD risk were calculated using the "Select-statistics.co.uk" online tool.

Results
Compared with uncomplicated vaginal delivery (VD), emergency/low-segment cesarean section (EM/LSCS) and vacuum delivery were associated with a higher risk of PPD, with OR 1.27 (95% CI: 0.77, 2.11) and OR 1.78 (95% CI: 0.55, 5.81), respectively. The risk of PPD was higher with VD compared to elective/low-segment cesarean section (EL/LSCS), with OR 3.07 (95% CI: 1.53, 6.16). Among the 120 cases, 36 had suicidal ideations.

Conclusions
Women who undergo emergency cesarean section or vacuum-assisted delivery are at increased risk of developing postpartum depression. These groups should be prioritized for close monitoring and early intervention to mitigate the impact of PPD on both the mother and her family.

OP/O – 06

PREGNANCIES COMPLICATED WITH MECONIUM-STAINED LIQUOR AT TEACHING HOSPITAL PERADENIYA – CROSS-SECTIONAL STUDY

MMH Dissanayake[1], IC Kandauda[2], SSN Chandrasiri[1], WMRD Weerakoon[3]
[1]De Soyza Hospital for Women, Colombo, Sri Lanka.
[2]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya.
[3]Professorial Unit of Paediatrics, Teaching Hospital Peradeniya

Introduction

Meconium is a dark green substance passed by the foetus which contains mucus, bile and epithelial cells. Passage of meconium occurs due to foetal distress and post-maturity. It can lead to increased perinatal morbidity and mortality due to meconium aspiration syndrome. Though this is a very common complication in pregnancy, very few number of studies have been conducted in worldwide, to assess the causative factors and epidemiological variations.

Objectives

Aim of this study is to assess the prevalence of pregnancies complicated with the passage of meconium and to analyse it according to parity, age, period of gestation, mode of delivery, duration of abdominal pain prior to the induction of labour or caesarean section, consistency of meconium, maternal comorbidities, pregnancy complications and previous history of meconium complicating pregnancies among mothers delivered at Professorial Unit of Obstetrics and Gynaecology, Teaching Hospital Peradeniya.

Method

This is a descriptive cross-sectional study conducted at the Professorial Unit of Obstetrics and Gynaecology, Teaching Hospital Peradeniya from 1st of May to 31st of August in 2019 over 4 months duration. All mothers complicated with the passage of meconium during the intrapartum period were included. Data collection was done using study proforma and analysed using SPSS statistical software.

Results

During this 4-months period, 1479 mothers were delivered and 163(11.02%) pregnancies were complicated with meconium, out of which 19(10.4%), 93(9.6%) and 51(15.4%) were delivered by mothers less than 20years, between 20–35 years and more than 35years of age respectively. 71(14.7%) were delivered by primi mothers. 120(73.6%) pregnancies were complicated with thin meconium and 43(26.4%) were complicated with moderate, thick & old meconium. 83(24.2%) were emergency caesarean sections, 16(3.3%) were elective caesarean sections, 53(8.4%) were vaginal deliveries and 11(30.5%) were instrumental deliveries. 77(17.4%) delivered at 40- 42 weeks, 69(7.8%) delivered at 37-40 weeks, 14(11.2%) delivered at 34-37 weeks and 3(8.1%) delivered at less than 34 weeks of gestation. 71(43.5%), 35(21.4%) and 21(12.8%) mothers had abdominal pain more than 48hours, 24-48hours and less than 24hours prior to delivery respectively. 36(22.0%) mothers had no pain prior to delivery. 134(82.2%) mothers had medical comorbidities and pregnancy complications. 25(27.1%) out of 92 multipara mothers had previous pregnancies complicated with the passage of meconium.

Conclusion

The risk of passage of meconium during the intrapartum period is increased with advanced maternal age, primi and grand multiparity, continuation beyond 40 weeks of gestation,

increased duration of pain prior to delivery, previous pregnancies complicated with meconium, maternal comorbidities and pregnancy complications.

OP/O - 07
THE DUAL JOURNEY: FETOMATERNAL OUTCOMES AMID NON-COMMUNICABLE DISEASES

Matthias AT [1] , R Prathapan [2] , P Ranaweera [3] , Madura Jayawardane [1] , Rasika Herath [4] , Hiruni Abeysinghe [1] , Rukshan Fernandopulle [1] , Ajith Fernando [1] , Dhamikke Silva [1] , Shameera Dilhan 2 , Shamini Prathapan [1]
[1] Faculty of Medical Sciences, University of Sri Jayewardenepura
[2] Ministry of Health
[3] University of Colombo
[4] University of Kelaniya

Introduction
Adults with Non-Communicable Diseases (NCDs) specially in low-middle-income countries are increasing. NCDs are by no means confined to the older age groups and those in reproductive age groups are increasingly affected, including women, during pregnancy.

Objectives
To find out the fetal outcomes of pregnant women with NCDs in the country.

Design
The study was a hospital based descriptive study carried out at four tertiary care hospitals in Sri Lanka in which 1200 anonymous data were collected from discharged bed head tickets from the postnatal obstetric wards.

Methods
NCDs and outcomes were confirmed with a written diagnosis and loss of more than 20% of data was considered as incomplete and were excluded. Proportions with chi-square tests and trends was used to calculate the statistical significance of qualitative data. The significance level was set at 0.05.

Results
Among the 1200 pregnant women, 727 (60.6%) had one or more NCDs. Among the 1200 deliveries, 168 (14%) were pre-term deliveries, of which 8 (4.7) were extreme preterm, 98 (58.7%) were late preterm. There were 13 (1.1%) neonatal or stillbirths and 191 (15.9%) infants needed respiratory support. Neonatal hyperbilirubinemia, hypoglycemia, and sepsis were found in 112 (9.3%), 20 (1.7%), and 122 (10.2%) respectively. Among all the adverse fetal outcomes, there was a statistically significant difference between having at least one NCD and having a preterm delivery (p=0.04), providing respiratory support (p=0.002), Neonatal hyperbilirubinemia (p=0.025), and hypoglycemia (p=0.007). There is a significant trend indicating that as the number of NCDs increases from 1 to 5, preterm deliveries (p=0.016), type of preterm (p=0.001), and Neonatal hyperbilirubinemia (p=0.001) also increase

Conclusion
Non-communicable diseases in pregnancy are becoming increasingly important in contributing to death and poor health. At all stages of a life course approach, a more systematic process for identifying and overcoming barriers to prevent NCDs and thus adverse fetal outcomes.

OP/O – 08
SILENT STRUGGLE: A FOLLOW UP OF PREGNANT WOMEN WITH HYPERGLYCEMIA IN SRI LANKA

Matthias AT [1], R Prathapan [2], P Ranaweera [3] , Madura Jayawardane [1] , Rasika Herath [4] , Hiruni Abeysinghe [1], Rukshan Fernandopulle [1] , Ajith Fernando [1] , Dhamikke Silva [1] , Shameera Dilhan [2] , Shamini Prathapan [1]
[1] Faculty of Medical Sciences, University of Sri Jayewardenepura
[2] Ministry of Health
[3] University of Colombo
[4] University of Kelaniya

Introduction
Adults with Non-Communicable Diseases (NCDs) specially in low-middle-income countries are increasing. Hyperglycemia in pregnancy is a significant cause of morbidity among pregnant women.

Objectives
To find out the progression and impact of hyperglycemia in pregnancy.

Design
The study was a hospital-based descriptive study carried out at four tertiary care hospitals in Sri Lanka in which 1200 anonymous data were collected from discharged bed head tickets from the postnatal obstetric wards.

Methods
The study was a retrospective hospital-based descriptive study carried out at four tertiary care hospitals in Sri Lanka in which 1200 pregnant women were collected from discharged bedhead tickets from the postnatal obstetric wards. Hyperglycaemia in pregnancy and outcomes were confirmed with a written diagnosis and the loss of more than 20% of data was considered incomplete and was excluded. Odds ratios with 95% confidence intervals were used to assess the risk.

Results
Among all pregnant women, 204 (17%) were diagnosed with hyperglycemia in the current pregnancy. Pregnant women with hyperglycemia when compared to those without hyperglycemia were at a significantly higher risk with the following maternal morbidities and fetal outcomes; obesity (OR= 2.2; 95%CI = 1.5-3.1), hypertension (OR= 2.9; 95%CI = 1.9 – 4.4) and hypothyroidism (OR= 2.2; 95%CI = 1.1- 4.3) and the need of respiratory support (OR= 1.6; 95%CI = 1.1-2.4), neonatal hyperbilirubinemia (OR=2.1; 95%CI = 1.4-3.3) and neonatal hypoglycemia (OR= 3.3; 95%CI = 1.3 – 8.3). A family history of diabetes (OR= 4.2; 95%CI = 3.0-5.8) was also a statistically significant risk factor for hyperglycemia during pregnancy. Data from 691 (incomplete data 0.2%) women were retrospectively looked at for past pregnancies. Among the 63 (9.1%) women who were diagnosed with GDM in the previous pregnancy, 57% (36) had GDM in the subsequent pregnancy, whereas 6.3% (4) of the women, transformed into Type 2 DM. However among those women who were not diagnosed with either type 2 or GDM in the previous pregnancy, 65 (10.6%) developed GDM, and 9 (1.5) developed Type 2 DM.

The risk of developing GDM in a subsequent pregnancy was 12.9 (95%CI = 7.2-23.2) higher when compared to a woman who had GDM in the pregnancy before.

Conclusions
Diabetes in pregnancy is becoming increasingly important in contributing to morbidity and poor outcomes. The results show that we need new perspectives and ways of dealing with these challenges for the future. Diabetes during pregnancy in low and middle-income countries such as Sri Lanka presents some paradigms relevant to public health and health system needs of the future.

OP/O – 09
AUDIT ON POSTNATAL CARE AND FOLLOW-UP AFTER PREGNANCY IN WOMEN WITH PRE-PREGNANCY OBESITY

WAK Senanayake[1], Liyanagama PD[2]
[1]Post Graduate Institute of Medicine, University of Colombo, [2]Castle Street Hospital for Women, Colombo, Sri Lanka

Introduction
The prevalence of pre-pregnancy overweight and obesity in Sri Lanka has risen from 16.2% to 23.7% between 2012 and 2016. Pre-pregnancy obesity carries adverse effects related to pregnancy, including maternal, fetal, and neonatal outcomes, as well as a negative impact on the general female population. There is a spectrum of care for screening, monitoring, and managing obese women during the antenatal and pregnancy period in the primary care setting, with shared care at secondary and tertiary levels in Sri Lanka. However, the arrangement of follow-up plans for obese women after delivery is not well established yet.

Objectives
This clinical audit aimed to assess the postnatal care and follow-up after pregnancy in women with pre-pregnancy obesity at Castle Street Hospital for Women (CSHW).

Design
A retrospective, cross-sectional study was conducted involving 63 pregnant mothers who were admitted for confinement in ward 10, CSHW.

Methods
Data was collected from Bed Head Tickets and Antenatal Cards from June 03, 2024, to June 16, 2024. All pregnant mothers who delivered within this period were included, excluding individuals with twin pregnancies. The audit standards were based on the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines on the care of women with obesity in pregnancy, 2018.

Results
Among the 63 pregnant mothers, 29% were overweight, and 19% were obese. Of the obese and overweight mothers, 33.33% and 22.22% respectively had excess weight gain during the pregnancy period. Out of 12 obese and 18 overweight mothers, 2 and 5 mothers had Gestational Diabetes Mellitus, respectively. None of the obese mothers were offered nutritional advice following childbirth from an appropriately trained professional, with a view to weight

reduction. Furthermore, none of the obese women were supported to lose weight postpartum or offered referral to the medical nutrition unit at CSHW for weight management.

Conclusion
This audit reveals significant shortcomings in the follow-up and postnatal treatment provided by CSHW to women who were obese prior to becoming pregnant. None of the obese mothers received recommendations for weight control or nutritional counselling, even though it was acknowledged that postpartum weight management was necessary. This suggests that in order to help these women lose weight and improve their general health, structured postnatal care programs and follow-up plans must be established.

OP/O – 10
PREVALANCE OF LOW BIRTH WEIGHT AND ITS ASSOCIATIONS IN A RURAL AREA.

Kaumudu, PWIV[1], Wickramasinghe, WMRPTB[1]
[1] District Base Hospital Rikillagaskada

Introduction
Birth weight has been one of the main indicators of child mortality and morbidity. World Health Organization (WHO) has defined Low Birth Weight (LBW) as live-born infants with a birth weight of less than 2,500 grams (5.5 lb.). The chronic nature and rising trend of LBW is a major public health issue in the Nuwara-Eliya district, Sri Lanka. Identifying factors associated with LBW in the community is essential for further reducing the magnitude and burden of perinatal health issues in low- and middle-income settings.

Objectives
To assess the prevalence of Low birth weight and its associated Maternal and Socioeconomic Risk Factors in District Base Hospital Rikillagaskada (DBHR).

Design
This was an institutional-based Descriptive Cross-sectional study.

Methods
An institutional-based Descriptive Cross-sectional study was carried out in District Base Hospital Rikillagaskada among 192 postnatal mothers. The data was collected using a pretested interviewer-administered questionnaire adopted from a different literature and for further information, antenatal cards and clinic records were used. The data was entered into Epi-Data® version 3.1 and exported to RStudio® version 2023.06. for analysis. Bi-variable and multivariable binary logistic regression was implemented. Finally, the odds ratio with a 95% CI and p-value of <0.05 were used to identify factors associated with low birth weight.

Results
The prevalence of low birth weight was 29.9%. Maternal height (AOR 0.701, 95% CI 0.529, 0.928) maternal weight gain during pregnancy (AOR 1.405, 95% CI 1.123, 1.758), pregnancy-induced hypertension (AOR 0.171, 95% CI 0.056, 0.523), exposure to tobacco smoking (AOR 1.125, 95% CI 0.969, 1.306), poor family support (AOR 0.611, 95%CI 0.244, 1.527), number of antenatal clinic visits (AOR 0.77, 95%CI 0.378,1.566) and birth order (AOR 1.71, 95% CI 0.374, 7.813) has shown a statistically significant association with low birthweight.

Conclusion
In this study, the prevalence of low birth weight was higher than the data recorded in the RDHS Nuwaraeliya. Collaborative attention and actions of healthcare professionals will be essential in early identification and modification of factors associated with low birth weight.

OP/O – 11
USAGE OF TRADITIONAL REMEDIES AS GALACTAGOGUES AMONG LACTATING MOTHERS IN GALLE DISTRICT, SRI LANKA

Wijesingha, WAWU[1], Napagoda, MT[2], Sisira Kumara, PK[3]
[1]Department of Nursing, Faculty of Allied Health Sciences, University of Ruhuna, Sri Lanka
[2]Department of Biochemistry, Faculty of Medicine, University of Ruhuna, Sri Lanka
[3]Base Hospital-Wathupitiwala, Wathupitiwala, Sri Lanka

Introduction
Breastfeeding is considered the best way to provide infants with essential nutrients and promote their overall health and development. However, many mothers face challenges with lactation, where lactation failure being a common concern. Thus, mothers often turn to traditional remedies without fully comprehending the potential advantages and adverse effects. Although several studies have been undertaken to evaluate the knowledge and usage trends of traditional galactagogues among breastfeeding mothers in different countries, to the best of our knowledge, such a study has not been conducted in Sri Lanka yet.

Objectives
This study aimed at assessing awareness and usage patterns of traditional remedies for lactation failure among lactating mothers in selected areas of Galle District.

Method
A pre-validated, self-administered questionnaire was provided to 412 randomly selected lactating mothers residing in three MOH areas in the Galle district. The data were analyzed by SPSS statistical package version-26. The chi-squared test was used to determine the statistical association between socio-demographic data and the utility of traditional remedies.

Results
The findings of this study indicated that the majority of the respondents (358, 87%) were knowledgeable about traditional galactagogues while 316 (77%) reported the usage. Almost 45% of the study population (187 individuals) have encountered breastmilk production issues out of which 91% (171) opted for the conventional treatments. Interestingly, a statistically significant association was observed between breast milk production problems and the usage of traditional galactagogues (p=0.000). Moreover, religion (p=0.024) and family type (p=0.006) were significantly associated with the utilization of traditional remedies, thus reflecting deep-rooted cultural and social influences. *Artocarpus heterophyllus* (baby jackfruit), *Vincetoxicum bracteatum* (green milkweed), *Momordica charantia* (bitter gourd), and *Moringa oleifera* (moringa) were the most frequently used food, which was typically integrated into daily meals instead of being prepared separately. Notably, parents were the most influential source of information for 76.4% of the respondents while the role of the internet and social media cannot be understated. Particularly, the high reliance on parental advice underscores the strong influence of familial and cultural traditions in shaping health behaviors.

Conclusion
This study revealed that traditional remedies were a common approach among mothers seeking to address lactation failure. This highlights the necessity for further research to investigate the safety and efficacy and scientifically validate the lactogenic properties of traditional remedies. This could bridge the gap between traditional wisdom and contemporary healthcare practices, providing evidence-based support for these dietary practices.

Keywords
Galactagogues, Lactation failure, Sri Lanka, Traditional remedies

OP/O – 12
A PATIENT WITH CAESARIAN SCAR ECTOPIC PARTIAL MOLAR PREGNANCY – CASE REPORT

Mohamed, FR[1], Jayasinghe, KL[2], Madugalle, MEMYDB[2], Marleen, FS[1], Akmeemana, SP[1]
1. Sri Jayawardenapura General Hospital, Thalapthpitiya, Sri Lanka
2. Teaching Hospital Mahamodara

Objectives
Cesarean scar pregnancy (CSP) is a rare and potentially life-threatening variant of ectopic pregnancy, resulting from embryo implantation into the myometrial site of a cesarean section scar. The incidence is increasing due to the increasing rates of cesarean sections and the use of high-resolution ultrasound scans. CSP accounts for 6% of all ectopic pregnancies in women with at least one previous lower uterine segment scar. Molar pregnancy, a type of gestational trophoblastic disease (GTD), occurs with an incidence of 0.6-8 per 1000 pregnancies. The simultaneous occurrence of CSP and molar pregnancy is infrequent and we will describe the surgical management of this rare case scenario.

Case report
A 36-year-old Sri Lankan woman presented with abdominal pain, vaginal bleeding, and cramping six years after her last childbirth. She had two previous Caesarian sections and one heterotopic pregnancy, which was medically managed. She was diagnosed with epilepsy at age 14 and was treated with Sodium Valproate 200mg daily. Upon examination, she was afebrile, had mild pallor, stable vital signs, and a soft abdomen. Transvaginal scans revealed an empty uterine cavity and fundus, no fetal pole, and an irregular sac within the caesarian scar. Both ovaries appeared normal and no free fluid. Serum Beta-HCG was 31665.

Ultrasound-guided suction and evacuation were performed through the cervical canal, with laparoscopic visualization of the scar site and resection of both tubes. Serum Beta-HCG 48 hours following the procedure was 33375. A transabdominal scan revealed a multi-septate cystic lesion in the LSCS scar with peripheral vascularity, likely of scar molar pregnancy. We proceeded for Hysterectomy and histology revealed a Caesarian scar partial molar pregnancy. Her Beta HCG values dropped drastically following surgery and normalized in six weeks.

Discussion
The exact pathophysiology behind CSP is not fully understood. A possible mechanism is that damage to the myometrium caused by the cesarean incision creates microscopic tracts through which an implanting blastocyst pathologically invades. CSP is estimated to complicate 1/1800–1/2500 cesarean deliveries. The implantation of abnormal trophoblasts characterises GTD. CSP

and GTD are rare, but they can be diagnosed using ultrasound correlating with serum beta HCG, and successfully surgically managed.

Conclusion
Physicians should be alert to the possibility of an ectopic molar pregnancy implanted on a cesarian scar, regardless of risk factors for Hydatidiform mole. Further research is needed to establish a more comprehensive approach to diagnosing and managing these rare cases.

OP/O – 13
AUDIT ON BIRTH-COMPANIONSHIP OF LABOURING WOMEN IN A TERTIARY CARE HOSPITAL

Wijesiriwardhana, YS[1] Jayasekara, RMMSB[1] Mohamed, ALS[1] Eshwarage, KS[1] Karunasingha,JI[1]
[1]Castle Street Hospital for Women

Background
In the year 2020, the WHO highlighted the importance of a "Companion of choice during labour and childbirth". They further enhanced the importance of respectful maternity care in improving maternal and foetal outcomes. A prospective comparative study in Delhi, India revealed increased spontaneous vaginal birth, shorter duration of labour, good 5min APGAR score, and higher satisfaction rates with labour companionship. This is a novel concept in Sri Lanka and many institutions do not possess adequate facilities to accommodate a male labour companion (LC)

Objectives
The main objective was to find perceptions of companionship in laboring women. Furthermore, to assess the percentage who had a birth companion, to find the preferred companion during labour and to assess reasons for not having an LC.

Method
Sixty-four mothers were allowed for spontaneous or induction of labour in the months of March and April 2024 at a Tertiary care hospital and data were analyzed. Frequently mothers were made aware of the facility for female labour companionship during parental craft meetings and antenatal clinic visits

Results
All the participants in the pre-audit were married with a mean age of 28.8 years. Period of gestation varied from 34+1 days to 41 completed weeks and 38 (59.3%) of them were primi - gravida. Out of the total 20.4% were induced labours. 14 (21.8%) underwent emergency cesarean deliveries and the commonest indication was a lack of labour progress. The mean birth weight of babies in this population was 2927.2g Although the facility for female labour companion was available, only a very few (3%) utilized it. All of them expressed that they would like to have a labour companion and 61(95.3%) expected their partner to be the labour companion. The main reasons for not having a labour companion were either the selected companion couldn't make it to the hospital during labour (54.6%) or there was no suitable female companion to attend during labour. (39%)

Conclusion
Companion of choice during labour is a right of all women which should not be overlooked. Outcomes of the audit reveal all women preferred to have a labour companion and 95% preferred to have their partner in labour room. The commonest reasons for not having a companion were either preferred person couldn't attend at the time the woman went into labour or there was no suitable female companion. Following the partitioning of the labour room male labour companions were allowed. Educational sessions during parental craft meetings and antenatal clinics were carried out. Thirty-one mothers have been allowed so far to keep a male birth companion in the labour room since 01st June 2024. Only four emergency cesarean sections were done which accounts for a 13.3% cesarean section rate and half of them were done due to pathological cardiotocographs. All the participants in the post-audit gave positive feedback about their labour experience.

OP/O – 14
CAPACITY ENHANCEMENT OF MIDWIVES AND NURSING STAFF IN MEDICAL MANAGEMENT OF POSTPARTUM HAEMORRHAGE

Pathak, A, Kumar, P

Introduction
Postpartum Hemorrhage (PPH) remains a leading cause of maternal morbidity and mortality globally, particularly in low-resource settings. Effective management of PPH requires skilled healthcare providers who can implement life-saving interventions promptly and accurately. This study focused on the capacity building of midwives and nursing staff in Sri Lanka through targeted training to improve the medical management of PPH.

Objective
The objective of training midwives and nursing staff is to assess practice gaps and provide a tailored approach to capacity building in the medical management of PPH within the existing framework of the healthcare system in Sri Lanka.

Design
The study employed a pre-post intervention design to evaluate the effectiveness of a targeted training program for midwives and nursing staff on the medical management of Postpartum Hemorrhage (PPH).

Procedure
The training was conducted by The Safe Motherhood Committee, Federation of Obstetrics and Gynaecological Societies of India (FOGSI) and was supported by The Sri Lanka Society of Obstetrics and Gynaecology in Colombo, Sri Lanka. 202 midwives and nursing staff from public facilities were enrolled for training. A questionnaire-based survey was conducted among healthcare providers. The survey content included questions that recognised the skills and understanding of Medical Management of PPH on:

1. 1st Response Bundle
2. Dose of Misoprostol in Management of PPH
3. Fluid Bolus in PPH Management
4. Tranexamic Acid
5. Supportive Measures of 1st Response
6. Foley's Catheterisation in PPH

7. Compression Manoeuvres
8. Use of Non-pneumatic Anti-Shock Garment (NASG)
9. NASG Segment
10. Monitoring while removing NASG
11. Debrief
12. Use of Uterine Balloon Tamponade (UBT)

The knowledge and practice gaps in the enrolled subjects were identified. Training on the PPH Response Bundle was tailored considering the identified gaps. The impact of the training was assessed through various simulations. The data was collected & analysed in frequency and percentage by trainers of Sri Lanka Obstetrics and Gynaecology Society.

Results

The project identified and highlighted the knowledge gaps in first response bundle, specifically in the use of:

• Tranexamic acid
• Standardised Use of Uterotonics
• Every Second Matters Uterine Balloon Tamponade/Other UBTs

There was also a significant gap in the Application Removal and Storage of NASG. The most correct responses were recorded for debriefing. Focused Training Sessions helped bridge these insufficiencies with hands-on training provided the midwives and nursing staff to get much needed experience in handling such situations. Non-clinical components, such as obstetrics rapid response team, communication skills, and referral protocols were also up skilled in the trainees.

Conclusion

The study emphasizes the variability in practices among obstetric healthcare providers in Sri Lanka regarding the management of postpartum hemorrhage (PPH). Targeted training efforts can address these knowledge gaps and rectify the current practices. The implementation of standardized protocols has the potential to substantially enhance maternal care in the management of PPH.

OP/O – 15
INDUCTION OF LABOR WITH FOLEY CATHETER – STUDY: CERVICAL AND LABOR OUTCOME

Wickramarahchi W.G.B[1], Jayasundara, DMCS[1,2] Jayawardena, IA[1,]
[1]De Soysa Hospital for Women, Colombo, Sri Lanka
[2]Department of obstetrics and gynaecology, Faculty of Medicine, University of Colombo, Sri Lanka

Introduction

Induction of labor is the initiation of labor 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 and 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 labor outcomes following induction of labor 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 labor and delivery.

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

Results
We analyzed a total of 188 women who underwent Foley insertions. We matched with 88 in the spontaneous onset of labor (SOL)group. For Foley inductions, median gestation was 38 weeks, and for the SOL group 39 weeks ended up with successful vaginal delivery. 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. From Foley catheter-induced labor, only 44% delivered vaginally. The median time for cervical preparation with Foley was 10 hours. There were no statistically significant differences between induction outcomes and indications for IOL. At 48 hours, 69.4 %(39) ended in LSCS for failed induction, and 7.4% had PGE2 insertions (progression of bishops score more than 2 by Foley). For the PGE2 group outcome of EM/LSCS was 60% (10/17). 20% of spontaneous onset labor ended up with EM/LSCS. Mother's BMI at term, estimated fetal weight, and parity were statistically not significant with the outcome with Foley-induced mothers

Conclusion
Compared with spontaneous onset of labor, induction of labor in women at term with a single fetus in cephalic presentation is associated with a clinically increased risk of cesarean delivery, predominantly related to an unfavorable Bishop score. Further studies should be conducted to analyze the other associated factors affecting the changes in the cervix around term and during labor.

OP/O – 16
SCREENING FOR GESTATIONAL DIABETES MELLITUS: REALITY BITES

Nivedita Datta

Objectives
Gestational Diabetes Mellitus (GDM) accounts for 10-14% of pregnancies in India and is associated with adverse Maternal & Neonatal outcomes. Govt of India, FOGSI & DIPSI (Diabetes in Pregnancy Study group India) recommend "Universal screening of all pregnant women by non-fasting oral glucose tolerance test with75 grams anhydrous glucose at first visit, with a cut-off at >=140mg/dl. If normal, to be repeated at 24-28 weeks." In spite of the ease of screening, GDM remains underdiagnosed, with non-adherence to guidelines.

Vistrit, a collaborative pilot project of Safe Motherhood Committee FOGSI, USAID and IPE Global aimed at:
1. Identifying gaps in GDM screening by recommended guideline
2. Preparing innovative and replicable training modalities for capacity building of providers & infra-structure strengthening to bridge the gaps

Method
34 private sector hospitals (227 Health Care Workers and 34 Doctors) from 7 aspirational districts of Jharkhand were enrolled for 6 months, with informed consent after ethical clearance.

Knowledge Assessment Questionnaire based on "When to test, how to test, whom to test, cut off value" was used to assess gaps. Online training followed by mentoring with standardized modules based on GOI & FOGSI guidelines and provision of IEC materials (posters and booklets) was done to bridge gaps. Logbook entry of 5 cases of GDM by each provider about the method of training and Medical Nutrition Therapy. GDM data is maintained in the Record Book to note the prevalence of GDM and follow-up. Post-training improvement was analyzed by comparison with pretraining 'Assessment Questionnaire' and 'Practice evaluation'.

Results
Improvement in record maintenance (48%), DIPSI Screening (80%), the time lag in testing (100% reduction), IEC material in OPD (63%), provider shift, from medics to paramedics, in testing (100%) & counseling (77%). Detection rate: 33% of Pregnant women in semi-urban population of Jharkhand

Conclusion
Adherence to DIPSI guidelines enhanced GDM detection. Vistrit initiative helped identify & bridge gaps in the detection of GDM, enhancing skill and knowledge, initiating "provider shift" & creating innovative and replicable training modalities, and optimizing Obstetric outcomes.

OP/O – 17
IMPROVEMENT IN KNOWLEDGE OF HEALTHCARE WORKERS IN ACTIVE MANAGEMENT THIRD STAGE LABOUR
Shukla, BS Kumar, PK

Objective
Jeevandhara was a project undertaken by FOGSI and the Safe Motherhood Committee to train healthcare workers. The aim of this study was to evaluate the change in knowledge of Healthcare workers after the training-(in managing the third stage of labour and first response bundle of PPH management)

Design
It was a hybrid study in districts of Uttar Pradesh. Focused mentoring, improved knowledge of healthcare workers.

Method
Healthcare professionals from 3 District Combined Hospitals and four Community Health Centres were enrolled in the project and given online training and on-ground revision and support. They were given a pre-training questionnaire to assess their knowledge about the active management of the third stage of labour and the first response bundle approach. A post-

training questionnaire was filled by the participants at the end of the training, and the difference was evaluated.

Result
The post-training questionnaire results of doctors showed a 33.3% increase, while a 53% increase was seen in the result of nurses involved in conducting deliveries at these centers.

Conclusion
Jeevandhara training resulted in improvement in knowledge of doctors and nurses when managing the third stage of labour and PPH. Focused training and repeated mentoring opened the pathway to good clinical practice and improved results in patient outcomes.

Keywords
PPH, AMTSL, Focused training, Knowledge-based survey.

OP/O – 18
PHYSICAL ACTIVITY DURING FIRST TRIMESTER AMONG PRIMIGRAVIDA MOTHERS

Chathurika, SN [1], Rathnayake, RMCJ [2], Nanayakkara, SDI [3], Thennakoon, SUB [4]
[1] Department of Clinical Nursing, Faculty of Nursing, University of Colombo, Sri Lanka.
[2] Department of Obstetrics & Gynecology, Faculty of Medicine, University of Peradeniya, Sri Lanka.
[3] Department of Physiology, Faculty of Medicine, University of Peradeniya, Sri Lanka.
[4] Department of Community Medicine, Faculty of Medicine, University of Peradeniya, Sri Lanka.

Introduction
Pregnancy is considered a state which associated with low levels of Physical activity (PA). Once become pregnant, performing PA is usually altered due to several factors. It is more apparent in early pregnancy and identified as a barrier to maintaining healthy pregnancy.

Objectives
This study was aimed to assess the level of PA & to explore views on PA among primiparous mothers in their first trimester.

Design
A descriptive cross-sectional study was conducted in the ante-natal clinic, Teaching Hospital, Peradeniya from September'2019 to March'2020 with 181 healthy primigravida mothers in the first trimester.

Methods
Data collection was done through a validated, self-administered pregnancy PA Questionnaire (PPAQ). Energy expenditure, duration for PA, and intensity were estimated using scoring criteria of PPAQ. The chi-square test & t-test were adopted to analyze data using SPSS version 25.0. Afterward, a qualitative survey was done through in-depth interviews (n=6) to explore expectant mothers' views on PA during pregnancy. Pre-designed semi-structured interview guide was used to collect qualitative data and they were subjected to thematic analysis using inductive approach.

Results
Mean age of participants was 25.56 ± 3.24 years and their response rate was 98.3%. It is found that 19.3% (35) mothers did not follow at least minimum required amount of PA (150 minutes / week of moderate intensity PA) & considered as inactive. Significant associations were found between active group and the nuclear family type (χ^2=19.31, p=0.001, df =1), sub-urban area (χ^2=6.96, p=0.03, df =2), normal BMI category (χ^2=8.22, p=0.016, df =2) by chi-square test. Employed mothers expended significantly higher energy for total PA (p=.0.001, t=5.27, d=58.74) rather than unemployed mothers. Even though most mothers recognized that PA is advantageous for both mother and fetus to sustain their heath, inadequate knowledge & numerous misconceptions were detected. They stressed that insufficient guidance from health care professionals and sickness during this early period prevent them from engage in PA. Walking was the only identified suitable activity among them in first trimester and anyone didn't explore on recommended other PA types.

Conclusion
Approximately, one fifth of primigravida mothers didn't meet at least minimum required PA during their first trimester. Inadequate health education provision, and lack of focus on PA during ante-natal period were recognized as main problems which lead to inactivity among pregnant mothers. So, structured, individualized PA programs are recommended for them since first notification of pregnancy while improving their awareness, readiness and self-motivation to engage in PA.

OP/O – 19
AUDIT ON MANAGEMENT OF SECOND STAGE AND INSTRUMENTAL DELIVERY

Wijesinghe, D[1], Zammit, M[2], Mubusher, K[3], Gunaratne PM[2]
[1]Registrar in Obstetrics and Gynaecology, Buckinghamshire Healthcare NHS Trust, UK
[2]Consultant in Obstetrics and Gynaecology, Buckinghamshire Healthcare NHS Trust, UK
[3] Specialist General Practitioner Trainee, Buckinghamshire Healthcare NHS Trust, UK

Introduction
National UK statistics for 2023 reveal an average instrumental delivery rate of 10%, with normal vaginal deliveries at 50% and Caesarean sections at 40%. In contrast, our trust (Buckinghamshire Healthcare NHS Trust) reports a higher instrumental delivery rate of 15% and a lower NVD rate of 45%.

Objectives
This audit aims to evaluate the indications, techniques, and outcomes of instrumental deliveries. The goal is to ensure compliance with clinical guidelines and to explore potential areas for reducing the rate of instrumental deliveries, thereby enhancing both maternal and neonatal outcomes.

Design
Audit study

Method
A retrospective analysis was conducted on 30 randomly selected case notes of instrumental deliveries performed at the Stoke Mandeville Hospital maternity unit from January 1, 2023, to July 31, 2023. Key variables assessed included maternal age, parity, ethnicity, gestational age,

the onset of labour, induction methods, duration of the second stage, fetal head station, instrumental techniques used, and Apgar scores at 5 minutes.

Results
The analysis revealed that the average maternal age was 28 years, with deliveries predominantly occurring at around 39 weeks of gestation. Common indications for instrumental delivery included prolonged second stage of labour and fetal distress. Instrumental deliveries were predominantly conducted in the labour ward (53%). A mix of non-rotational (77%) and rotational techniques (23%) was used. Out of 30 deliveries, 22 were performed using Neville Barnes forceps, and 7 utilized the Kiwi device, with one case involving the use of sequential instruments. Notably, 63% of the deliveries were performed by junior registrars, 40% of whom lacked senior supervision. Regional anaesthesia was administered in 26 out of 30 cases. The mean duration of the active second stage was 55 minutes for fetal distress cases and 140 minutes for prolonged second stage cases. The majority (80%) had mid cavity instrument deliveries. Postpartum haemorrhage (PPH) exceeding 1000 ml was observed in 34% of cases, with half of these cases experiencing PPH greater than 1500 ml. Despite these complications, 98% of the newborns had Apgar score at 5 minutes greater than 7, while 2% had scores between 5 and 7.

Conclusion
The audit highlights that instrumental deliveries are generally effective for managing prolonged second stages of labour and fetal distress in the second stage, with favourable outcomes for most newborns. However, the audit also underscores the need for improved supervision and training, particularly in rotational techniques and PPH management. Addressing these areas can further enhance the safety and effectiveness of instrumental deliveries, leading to better maternal and neonatal outcomes.

OP/O – 20
ASSESSING INFORMED CONSENT EFFECTIVENESS FOR LOWER SEGMENT CAESAREAN SECTIONS: GAPS AND IMPROVEMENTS

Fernando, LGN[1], Roshan, BE[2], Kanchana, JLS[1], Bandara, WWMMK[1]
[1]Colombo North Teaching Hospital[2]Teaching hospital Kandy

Introduction
In Sri Lanka, house officers are primarily responsible for obtaining consent for lower segment caesarian sections (LSCS). Significant lapses in this process have been observed, impacting patient autonomy and medico-legal aspects. Proper consent is essential to address these emerging issues.

Objectives
Evaluate the Current Effectiveness: Assess how effectively house officers handle the informed consent process, identifying gaps in patient awareness and comprehension. Identify Key Deficiencies: Determine where patients lack information about the LSCS procedure, including common and serious complications, alternatives, and risks related to future pregnancies and neonatal outcomes. Enhance Consent Practices: Implement a targeted educational intervention for house officers to improve the informed consent process and evaluate the impact on patient understanding and consent quality. Monitor and Measure Improvement: Conduct a follow-up audit to measure improvements in consent process post-intervention and ensure ongoing compliance with best practices and legal standards.

Design
A complete audit cycle was conducted over 6 months involving 120 postpartum mothers admitted to Ward 17 at Colombo North Teaching Hospital.

Method
Postpartum mothers who underwent LSCS were given a printed questionnaire with 18 questions based on RCOG Consent Advice No. 14, August 2022. A teaching session on proper LSCS consent was conducted for house officers, followed by a re-audit to assess improvements over 3 months.

Results
The initial audit revealed that while most mothers understood the urgency and indication for surgery, only 28.3% were aware of the procedure itself. Only 5% were offered alternatives to LSCS, especially in cases of previous cesarean sections. Awareness of common complications such as wound infection and prolonged hospital stay was low, with only 25% and 31.6% acknowledging these, respectively. However, awareness of serious complications such as bladder and bowel injuries was high at 90%. Risk communication regarding blood transfusions and the need for future LSCS was less effective, with fewer than 30% of patients informed. Awareness of neonatal injuries and respiratory distress was particularly poor at 5%.

Conclusions
The audit revealed significant deficiencies in the LSCS consent process before the educational intervention, with patients initially poorly informed about the procedure, common complications, and neonatal risks. Post-intervention, the teaching session notably improved consent comprehensiveness and patient awareness. However, ongoing reinforcement and evaluation are essential to ensure full patient information on LSCS aspects, including maternal complications and neonatal outcomes. Continuous training and periodic audits are crucial for maintaining high standards of patient autonomy and medico-legal compliance.

OP/O - 21
AUDIT ON MAINTENANCE OF MODIFIED OBSTETRIC EARLY WARNING SCORE (MOEWS) AND ITS USE IN POSTPARTUM MOTHERS AT NATIONAL HOSPITAL KANDY, SRI LANKA

Dahal P[1],Muthumali YGRMA[1], Mahdoom BWMA[2], De Silva DYK[2]
[1] Medical Student, Faculty of Medicine, University of Peradeniya.
[2] National Hospital, Kandy.

Introduction
The Modified Obstetric Early Warning Score (MOEWS) system is designed to reduce the maternal morbidity and mortality based on the abnormal physiological parameters triggering the coded color system which promotes the medical staff to manage the deteriorating mothers early.

Objective
To assess the proper and timely maintenance of MOEWS charts in postpartum mothers.

Method
A retrospective analysis was conducted over two weeks in May 2024 among 30 postpartum mothers in Ward 6 of the National Hospital Kandy, using their MOEWS charts. The maintenance of parameter recordings at the 1st, 2nd, and 3rd hours (immediately) postpartum was assessed.

Results
All patients' demographic and identification details were comprehensively recorded. Post-delivery documentation was thorough, with complete records of respiratory rate, systolic and diastolic blood pressure, bleeding, uterine condition (firm or soft), and fundal height. Pulse rate was documented in 96% of cases, urine output in 93%, temperature in 86%, and neurological status in 83% of the forms.

Conclusions
Although the maintenance of the MOEWS chart is generally proper, with most vital parameters recorded, there is a need to continue and improve the thoroughness of chart maintenance. It is crucial to ensure that no details are missed. A lecture highlighting the importance of maintaining the MOEWS chart, and its role as a bedside and cost-effective tool, should be delivered to all nurses, midwives, and house officers working in the ward. Assessing their knowledge regarding the MOEWS chart before and after the lecture can help measure the effectiveness and improvement in their understanding. Additionally, re-auditing the maintenance of MOEWS charts can be conducted to assess improvements.

OP/O – 22
DISCREPANCIES BETWEEN IDENTIFIED RISK FACTORS IN SMALL FOR GESTATIONAL AGE (SGA) BABIES

Mahdoom BWMA[1], Rakshana MNF[1], Meegoda VJ[2], De Silva DYK[1],
[1]National Hospital – Kandy
[2]Teaching Hospital, Kaluthara

Objectives
Small for gestational age (SGA) infants have a birth weight below the 10th percentile for their gestational age. They represent a significant concern in obstetrics due to the implications of long-term outcomes. While mothers with known risk factors are subject to thorough evaluation, others may not receive the same level of attention. This discrepancy underscores the need for consistent monitoring and assessment of all pregnancies to ensure early identification and intervention for SGA infants, regardless of risk factors.

Design & Methodology
This study was conducted as a retrospective cohort analysis, including all SGA infants born at the obstetrics unit of Kandy General Hospital over three months.

Results
39 mothers were selected for this study, aged 23-40 years. When evaluating the RCOG major risk factors for SGA infants, only 5.1% of the participants had a history of a previous SGA baby, and none exhibited other major risk factors during the current pregnancy despite delivering an SGA infant. Regarding minor RCOG risk factors, 15.4% of the mothers were over 35, 7.7% had a body mass index (BMI) of less than 20 kg/m², and 7 mothers (17.9%) were nulliparous. SGA was detected between 32 and 38 weeks of gestation, and the majority (84.6%)

maintained a symphyseal-fundal height (SFH) chart. Serial ultrasounds were performed on 76.9% of the women; the remainder did not attend the recommended follow-up appointments for scans. All mothers underwent a routine third-trimester ultrasound along with a Doppler study at least once.

The period of gestation at the time of delivery ranged from 35 to 39 weeks. Some admissions were planned for confinement, while others occurred due to labour or other complaints. Most deliveries were elective cesarean sections (35%), attributed to fetal growth restriction, oligohydramnios, past section, or low-lying placenta. Another 35% of mothers had normal vaginal deliveries, while 30% underwent emergency cesarean sections due to fetal distress or an unfavorable cervix, among other indications. Birth weights ranged from 1.5 to 2.45 kg, with three infants requiring admission to the neonatal intensive care unit. None of the infants required mechanical ventilation; however, three (7.6%) received supplemental oxygen.

Conclusion
This study indicates that a significant number of SGA infants do not exhibit the typical major or minor risk factors. Therefore, it is crucial to closely monitor all expectant mothers to identify SGA babies and conduct regular follow-ups to prevent potential complications.

OP/O – 23
PREDICTING GESTATIONAL DIABETES: SIGNIFICANCE OF EARLY ORAL GLUCOSE TOLERANCE TEST VALUES

Thilakarathna, KMCH[1], Kandauda, C[2], Manathunga, SS[2]
[1] Colombo North Teaching Hospital, Ragama, Sri Lanka
[2] Faculty of Medicine, University of Peradeniya, Peradeniya, Sri Lanka

Introduction
Gestational Diabetes Mellitus (GDM) is defined by the American Diabetes Association as glucose intolerance first recognized during the second or third trimester of pregnancy, which is not overt diabetes. GDM is a significant health concern because it is associated with various maternal and fetal complications. Additionally, it poses long-term metabolic risks for both the mother and her offspring, including the development of type 2 diabetes and obesity.

Objective
The primary objective of this study was to determine whether there was a significant difference in the oral glucose tolerance test (OGTT) values at the booking visit between mothers who later developed GDM and those who did not. Identifying such differences early in pregnancy could facilitate earlier interventions and potentially mitigate the adverse outcomes.

Design
This observational study was conducted in antenatal clinics within the Kandy district. After obtaining written informed consent, pregnant women with no other comorbidities were recruited. Participants underwent a 75g OGTT at booking visits between 12-14 weeks of gestation and 24-28 weeks. The diagnosis of GDM at 28 weeks was made according to the cutoffs established by the Hyperglycemia and Adverse Pregnancy Outcomes (HAPO) study.

Method
The study sample comprised 75 pregnant women who met the inclusion and exclusion criteria. Data were collected through structured interviews and recorded in an Excel spreadsheet for analysis. The R statistical package was utilized for data analysis.

Among the 75 participants, 15 were diagnosed with GDM at 28 weeks based on their OGTT results. The OGTT readings from the booking visit for these GDM mothers were compared with those of the non-GDM mothers. A t-test assessed whether the two groups' booking visit OGTT values significantly differed.

Results
The analysis revealed that mothers diagnosed with GDM at 28 weeks had higher blood glucose values at the booking visit across fasting, one-hour, and two-hour measurements compared to mothers who did not develop GDM. Specifically, the fasting and one-hour blood glucose levels were significantly higher in the GDM group, with p-values of 0.014 and 0.028, respectively. The difference in the two-hour glucose levels was not statistically significant, with a p-value of 0.28.

Conclusion
The study found that fasting and one-hour OGTT levels at the booking visit can predict the development of GDM later in pregnancy. Early identification through these measures allows for timely intervention, reducing the risk of complications. Further research with a larger sample size is needed to establish precise cutoff values for predicting GDM.

OP/O – 24
PREVALENCE AND ASSOCIATED FACTORS OF DOMESTIC VIOLENCE AMONG PREGNANT WOMEN ATTENDING A TERTIARY CARE HOSPITAL ANTENATAL CARE SERVICES.

Mohamed, ALS [1], Wijesiriwardana, Y.S[1], Eshwarage,K.S. [1],Jayasekera, RMMSB [1], Wijesinghe,WAND[1], Karunasingha,J [1]
[1]Castle Street Hospital for women.

Introduction
Domestic violence is defined as controlling, coercive, or threatening behavior, violence, or abuse between intimate partners or family members aged 16 or over. Globally, one in three women experience domestic violence. MBRRACE-UK estimates that 30% of domestic violence cases start or escalate during pregnancy leading to complications like low birth weight, preterm birth, and developmental delay. In Sri Lanka, 20.4% of women have faced physical or sexual violence from intimate partners. Sri Lanka's maternal and child health statistics are exemplary, but domestic violence among pregnant women remains under-researched.

Objectives
This study aims to understand the prevalence, types, and socio-demographic factors of domestic violence and, assess the awareness of hospital-based GBV care centers among pregnant women in Sri Lanka.

Design
This is a descriptive cross-sectional study conducted at the antenatal clinic of Ward 6 in Castle Street Hospital for Women in the months of June and July of 2024. The sample size is calculated based on an expected domestic violence prevalence of 20%, requiring a minimum of 135 participants. Systematic random sampling is employed to collect data. Data was collected using interviewer-administered questionnaires which contained demographic and obstetric information. Abuse Assessment Screen and Ongoing Abuse Screen were used to analyze the prevalence of domestic violence in pregnancy. Analysis was performed using SPSS Version 21, using descriptive statistics and chi-square tests to identify significant predictors.

Results
The study, with a sample size of 134 antenatal women, revealed that 55.2% had completed Grade 6-O/Level, and most resided in Colombo Municipal Council (CMC) (46.3%). Housewives comprised 47.8%, and monthly incomes ranged from 43.3% earning 20,001-50,000 LKR. Ethnicity was predominantly Sinhalese (49.3%). Medical co-morbidities were present in 40.3%. Psychiatric illnesses were noted in 7.5%. Domestic violence was reported by 41.8% emotionally, 10.4% physically,3% sexually. Violence during pregnancy is present in 7.5%. Present emotional abuse was 10.4%, with 21.4% seeking help, mostly from mothers (66.6%). Only 23.9% of participants were aware of Mithuru piyasa. Significant associations of emotional violence were found in residents of CMC (P=.001), housewives(p=.001), patients with psychiatric illnesses (p = .001), younger partners (p =.001), partner's low education level (p =.038), and partner's recreational drug use(p=.021).

Conclusions
This study finds important variables linked to emotional abuse in Sri Lankan pregnant women. Urban living, staying at home, mental health conditions, younger spouses, and lower partner educational level are important risk factors. These findings underscore the need for targeted interventions, such as urban support services, economic empowerment for housewives, and integrated mental health and violence prevention screens in antenatal care. It is important to raise awareness and make support services like the Mithuru Piyasa GBV centers more accessible. To create efficient, customized preventative and intervention plans for antenatal set up more researches are required.

OP/O – 25
KNOWLEDGE ATTITUDE AND PRACTICES: POSTPARTUM HAEMORRHAGE SCENARIO IN SRI LANKA

Singh, A[1]
[1]Gurukripa Hospital, Ramgarh, Jharkhand, India

Introduction
Postpartum Haemorrhage still remains one of the major maternal killers in Sri Lanka, a country with fair health indices.

Objective
To identify the gaps existing in knowledge, attitude and practices in the prevention and diagnosis of Postpartum haemorrhage (PPH) amongst nurses and midwives in Sri Lanka. Role of focused training and capacity building to bridge the gaps by International Federation of Gynaecology and Obstetrics (FIGO) recommended module of Postpartum Haemorrhage Emergency Care Using a Bundle Approach (PPH EmC)

Design
A random sample of nurses and midwives from in and around Colombo was selected for the survey, to get a generalised overview of PPH related awareness. The sample size was 202.

Methods
Safe Motherhood Committee, Federation of Obstetrics and Gynaecological Society of India (FOGSI) in collaboration with Sri Lanka College of Obstetrics and Gynaecology (SLCOG) and South Asian Federation of Obstetrics and Gynaecology (SAFOG) conducted a survey on a sample of 202 nurses and midwives in Colombo on Postpartum Haemorrhage. The survey was done by pre-training printed questionnaire, which was followed by the training based on FIGO recommended standardised training module of PPH Emergency Care Using a Bundle Approach (PPH EmC), along with hands-on capacity building. Information Education and Communication (IEC) materials were distributed for better understanding. Survey concluded with post-training oral questionnaire. Language barrier was overcome by faculty from Sri Lanka. The data obtained from training was collected and analysed.

Results
The collected data when extrapolated, revealed significant gaps at both preventive and diagnostic level. A gap of 88% was found at the most important preventive level, Active Management of Third Stage of Labour (AMTSL). 52% gap was detected in the early diagnosis and management of PPH. Majority of the participants practiced visual estimation of blood loss. 32% gap was found in the diagnosis of shock using Shock Index and Rule of 30. Post-training oral questionnaire revealed remarkable improvement in their knowledge.

Conclusions
Significant knowledge enhancement was observed in the prevention and diagnosis of PPH after a single dedicated training. Hence, sustainable capacity building of the obstetric care providers by focused periodic training and mentoring with hands-on, could help in bridging the gaps in knowledge and implementation and adherence to the standard labour room practices, thereby making considerable value addition to the already robust healthcare delivery system of Sri Lanka.

OP/O – 26
BERNARD SOULIER SYNDROME IN PREGNANCY

Withana, KH[1], Dassanayake, L[1], Madushanka AHLD[1], Jayasekara, GL[1],
[1]German Sri Lanka Friendship Hospital for Women, Galle, Sri Lanka

Objectives
The Bernard Soulier syndrome is a rare autosomal recessive disorder caused by a defect in membrane glycoprotein (GP) Ib-IX complex, a platelet von Willebrand factor adhesion receptor. The risk of bleeding during pregnancy in affected women is low but there is an increased risk of post-partum hemorrhage (PPH)

Case report
A 34 - year old mother of 2 children with past vaginal delivery & EM – LSCS presented to the antenatal ward at POG of 37+3 with pain. She is a diagnosed patient with Bernard Soulier syndrome and is under Hematology clinic follow-up. Her pregnancy is complicated with Acute Kidney Injury (AKI) & Hospital-acquired pneumonia with sepsis following “PRINSO”

poisoning (A detergent used as washing powder containing Potassium Permanganate with calcium oxalate) at POG of 30 weeks. She underwent hemodialysis, was intubated and ventilated & ICU care was given. Following recovery, a psychiatric referral was done & treatment started for moderate depression. On admission vaginal examination cervical OS 5cm dilated & fully effaced. FBC revealed Hb – 9.8g/dl and a platelet count of 5000. The patient was transfused with group-specific platelets as there is no time for HLA-matched platelet transfusion and delivery is covered with IV Tranexamic acid. Live non-asphyxiated baby delivered by Vaginal Birth after Caesarian section (VBAC). Bakri balloon catheter was inserted due to atonic PPH & 1 unit of RCC transfusion was done. Both mother & baby were discharged in healthy condition

Discussion

Prevalence of Bernard–Soulier syndrome in pregnancy is very rare and literature shows it as 1 in 1 million but it may be much higher due to underrecognition or misdiagnosis. Active management of the third stage of labor with prompt admission of oxytocic drugs immediately following delivery is essential to reduce PPH.

Conclusion

The pregnancy course of the affected individual is variable and unpredictable. Strict monitoring of platelet count is advised. Mode of delivery is according to obstetric indications and management of pregnancy requires a multidisciplinary team and individualized medical decisions.

OP/O – 27
A CASE OF RESISTANT IMMUNE THROMBOCYTOPENIA IN PREGNANCY

Sanjeewani DMD[1], Sandya PH[1], Isanka DWAS[2], Senadheera SPSS[3]
[1]Castle Street Hospital for Women, Colombo, Sri Lanka
[2]Anuradhapura Teaching Hospital, Sri Lanka
[3]Base Hospital- Puttalam, Sri Lanka

Introduction

Immune thrombocytopenic purpura(ITP)is an acquired platelet disorder that accounts for 3.4% of all cases of thrombocytopenia in pregnancy.It is a rare auto immune disorder caused by abnormal T cell function,which results in the production of antiplatelet antibodies.These antibodies facilitate platelet destruction and concomittent impairment of megakaryocyte maturation.we will report a case of resistant ITP diagnosed during pregnancy and successfully managed untill delivery.

Case report

A 30 years old multigravida in her forth pregnancy was found to have a platelet count of < 20,000 during her booking visit at 14 weeks.A diagnosis of ITP was made following blood picture.Her previous pregnancies were uncomplicated and past medical history was insignificant.At the first encounter, she was started on oral prednisolone.Due to poor response, she was given IV immunoglobulin three times during pregnancy and platelet transfusion twice.At 17 weeks of gestation,a bone marrow biopsy confirms the diagnosis of ITP. She was transfusion dependent despite high doses of oral and IV steroids as well as IV immunoglobulin, hence the diagnosis of resistant ITP was made.She underwent elective caesarean delivery with a low platelet count,requiring 12 units of platelet transfusion prior to delivery.The baby was closely observed following delivery.Baby diagnosed with neonatal alloimmune

thrombocytopaenia(NAIT),treated with IV immunoglobulin.The mother was started on eltrombopag and breast milk suppression was done.The baby was started on formula feeding.

Discussion

ITP complicates 1-3 in 10,000 pregnancies and can occur during any trimester or may be diagnosed preconceptionally.Patients can be asymptomatic or present with symptoms such as bruising,epistaxis or gingival bleeding.Management is extremely challenging in pregnancy, due to the potential side effects of the drugs.The target platelet count in pregnancy 50,000/µl.Glucocorticoids are the first line of treatment and intravenous immunoglobulin is considered safe during pregnancy.For refractory cases, thrombopoietin mimetic drugs such as eltrombopag have been used successfully in non pregnant individuals,though studies on their effect on pregnancy are still limited.Breastfeeding should be discontinued if eltrombopag is used during the postpartum period as it is secreated in breast milk. The most important neonatal complication is NAIT,which carries a 15% risk due to transplacental transfer of antibodies.The baby should be observed for intracranial haemorrages.

Conclusion

The management of resistant cases of ITP in pregnancy is based on clinical expertise.The involvement of a multidiciplinary care team is important.Patients who fail to respond to steroids or immunoglobulin may need recurrent platelet transfusions and eltrombopag is an option.

OP/O - 28
AUDIT ON EPISIOTOMY ANGLE IN PROFESSORIAL OBSTETRIC UNIT TEACHING HOSPITAL PERADENIYA

Wanniarachchi, WADP[1] Kandauda, KIC[2] Ratnayake, C[2] Liyanagae, LNM[1] Devapriya,YS[1] Lakshika, AAA[1]
[1]Professorial Obstetrics & Gynaecology unit, Teaching Hospital Peradeniya
[2] Department of Obstetrics & Gynaecology, Faculty of Medicine University of Peradeniya

Introduction

Episiotomy is a one of the most commonly performed surgical procedure(1) It is useful in minimizing perineal tears and shortening of the second stage of labour. Appropriate angle, depth and length of episiotomy minimize the risk for anal sphincter injury(1) Incision angle of 60° resulting in a low incidence of perineal pain, anal sphincter tearing (OASI) and anal incontinence(2). It would yield post-delivery angle of forty-three degrees(3) (4)

Objectives

To assess the episiotomy angles in the unit.
To compare it with gold standard references.
To find out deficient areas & strengthen them with intervention.
To upgrade the intrapartum care and minimize the risk of OASI.

Design

A prospective clinical audit was performed in a Professorial unit post-natal ward of Teaching Hospital Peradeniya. OASI Care Bundle developed by the RCOG, was used as the gold standard reference. Acceptable range of post delivery angle was taken as range of 30-50 degrees

Method
All women with episiotomy were included until target of hundred patients. Instrumental deliveries were excluded. 'Angle after repair' was defined as the angle formed by the suture line and the midline. It was measured using reusable plastic protractor with single use clear cover on post-delivery day one.

Results
100 episiotomy angles were measured. 45% was within the acceptable range (30-50 degrees). 49% was less than 30 degrees. 6% was above 50 degrees.

Conclusions
Almost half of the cases (49%) were less than expected angle & more towards the Anal sphincter. Practice correct incision angle for episiotomy needs attention and proper training using the available resources. Re-audit will be carried out after implementation of education programs.

OP/O – 29
ASEPTIC CAVERNOUS SINUS THROMBOSIS IN PREGNANCY- A CASE REPORT

Chandrapala, HMDP[1] , Wickramasinghe, NH[1] , Ayeshmantha, DD [1] , Shakoor MZ[1]
[1]Teaching Hospital Anuradhapura

Introduction
Aseptic cavernous sinus thrombosis (CST) is a rare life-threatening complication in which a blood clot forms in the cavernous sinus without infection. Hypercoagulable state and immunosuppression during pregnancy can lead to aseptic CST in pregnancy. Here we present a rare case of aseptic CST in 1st trimester

Case report
A 29-year-old lady, 8 weeks of gestation came with severe left-sided frontal-orbital headache advancing to the right side, associated with photophobia, diplopia, nausea and vomiting which progressively worsened over 2 weeks. She also had bilateral numbness over the ophthalmic and maxillary areas. Neurological examination revealed bilateral papilledema and trigeminal nerve palsy with Right sided abducens nerve palsy. Past medical history is unremarkable. Blood investigations including WBC, ESR and CRP showed no evidence of infection. left-sided CST and early right-side CST were diagnosed with the help of Magnetic Resonance Venography (MRV) and the condition was treated with low molecular weight heparin (LMWH) and Mannitol. LMWH was continued throughout the antenatal period, and she delivered a baby boy at 37 weeks of gestation without intrapartum and post-partum complications. The patient was later discharged with oral warfarin for 6 months targeting INR 2-3. A diluted Russell's viper venom test (DRVVT) was arranged for thrombophilia screening.

Discussion
Due to the physiological immunosuppression and hypercoagulability during pregnancy, the risk of thrombosis increases by 3-4 times. Aseptic CST presents with neurological deficit, seizures and more commonly, headache making the diagnosis and treatment challenging due to varied and overlapping symptoms with many other similar conditions such as Cerebrovascular accidents, meningitis, sinusitis and eclampsia. To help with the diagnosis, a widely available

CT venogram may be utilised instead of MR-V. Prompt treatment with LMWH or unfractionated heparin following warfarin for 6-12 months along with a postpartum DRVVT is recommended.

Conclusion
This case highlights the importance of adding CST as a differential diagnosis in a pregnant lady presenting with headache and neurological deficit. Early diagnosis using MRV and timely intervention with LMWH, following warfarin for 6-12 months will greatly improve perinatal mortality and morbidity.

OP/O – 30
SEXTUPLET PREGNANCY: MANAGEMENT OF HIGHER ORDER PREGNANCY IN A LOW RESOURCE SETTING

Rathigashini R[1], Dias TD[1]
[1]University Obstetrics & Gynecology Unit, North Colombo Teaching Hospital, Ragama, Sri Lanka

Objectives
Since 1968, only 18 sextuplet pregnancies have been notified. Higher order pregnancy (3 or more foetuses) rate is rising due to more availability and accessibility to ovulation induction methods and Assisted reproductive techniques. However, there are regulating authorities in developed countries and there is availability of Multifetal reduction therapy to prevent higher-order pregnancy as it carries increased maternal and fetal morbidity.

Case Report
A 30-year-old woman in her second pregnancy with one first-trimester miscarriage, conceived after Ovulation induction for primary subfertility secondary to PCOD. Her viability ultrasound scan confirmed six foetuses with six placentas and sacs. Both parents counselled on possible complications and offered multifetal reduction therapy (MFTR). As the facility for MFRT is not available in the country, the patient was planned to be sent to Singapore. However, due to COVID-19 travel restrictions, MFRT could not be done. She had a dating USS at 12 weeks which confirmed six viable foetuses and a short cervix. She underwent cervical cerclage at 12 weeks and was started on high-dose progesterone (IM progesterone 500mg twice weekly and Oral progesterone 10mg bd) throughout pregnancy to prevent pre-term labour. High-dose calcium is given to prevent pre-eclampsia. Detailed anomaly USS done by fetal medicine specialist and excluded any anomalies. She was diagnosed with Gestational Hypertension at 28 weeks and managed with Nifedipine 20mg bd and methyldopa 250mg tds. Regular blood pressure monitoring was carried out and needed to adjust methyldopa up to 750mg tds. Serial two weekly ultrasound scans are done to ensure fetal growth and well-being. Antenatal corticosteroids are provided at 28 weeks and thromboprophylaxis is provided from 28 weeks. MDT team has planned to deliver in 32 weeks. However, she ended up with a caesarean section at 31 weeks due to worsening symptoms of overdistension. The multidisciplinary team involved in delivery include obstetricians, two neonatologists and six separate midwives. The birth weights varied from 800 to 1600g. Apgar scores were greater than 9 at five minutes. Respiratory support varied from intermittent positive pressure ventilation to oxygen via the head box. The mother and babies were discharged on day 26. All the babies were followed up and did well up to six months.

Discussion
Higher-order pregnancy carries increased risks such as pre-term labour, Pre-eclampsia, Gestational Diabetes mellitus, Fetal growth restriction, Postpartum haemorrhage and prematurity and its complications. In our patient, additional measures are taken to monitor and prevent these complications, which lead to good maternal and neonatal outcomes.

Conclusion
Higher-order pregnancies carry tremendous strain on limited health services and social and economic resources of the country, in addition to great stress to the concerned family. Therefore, every effort should be taken to prevent higher-order pregnancies.

OP/O – 31
BEYOND THE BLEED: CARBETOCIN VS OXYTOCIN IN THE POSTPARTUM HEMORRHAGE ARENA

Agrawal, M[1], Bag, S[2]
[1,2] King George's Medical University, Lucknow ,India

Introduction
Postpartum hemorrhage (PPH)remains a big challenge in maternal health . Global estimates indicate that there were 287 000 maternal deaths in 2020. 87% deaths occurred in sub-Saharan African and South Asian countries. 27 % maternal mortality worldwide occurs dure to obstetric hemorrhage .Most of these deaths are due to PPH. In India 38 % of maternal deaths are attributed to PPH.

Objectives
To assess, efficacy and safety of carbetocin versus oxytocin in prevention of PPH in high risk women.

Study design
Single centre, prospective ,open labelled randomised controlled trial comparing oxytocin vs carbetocin in the prevention of PPH. The rationale for conducting this study lies in the importance of effectively managing PPH. High-risk conditions like a scarred uterus, eclampsia, twins and fibroids etc predisposing women to PPH , require special attention .While oxytocin is commonly used for PPH prevention, carbetocin presents a promising alternative due to its longer duration of action and potential efficacy in reducing blood loss.

Method
Using a computer generated randomisation sequence, 120 eligible women were randomly divided into two groups (60 in each group) with at least one risk factor
Group A- Oxytocin group 10 IU IM immediately after delivery.
Group B- Carbetocin group 100 mcg IV bolus over 1minute immediately delivery.
Maternal hemodynamic status,hematocrit and hemoglobin values were measured immediately before and 24 hours after delivery. Maternal blood loss was estimated by caliberated V drapes Adverse effects of both drugs were noted. Primary (mean blood loss and adverse reactions) and secondary outcomes (use of additional uterotonics) were analysed.

Results
There was no significant difference in sociodemographic characteristics between 2 groups. Mean blood loss in the oxytocin group (498.17±442.99) was significantly $P<0.001$ higher than

the carbetocin group (295.61±278.69). In the Oxytocin group, 6.7% required PRBC, 8.3% needed second line uterotonics and 5 % Balloon tamponade. None of the patients in the carbetocin group required PRBC or additional uterotonic. This difference in both groups was statistically significant. Both the groups were similar in terms of adverse outcomes

Conclusion
Usage of single injection, heat-stable carbetocin offers a practical solution to overcome challenges associated with the storage and transportation of oxytocin, particularly in low and middle-income countries. Healthcare institutions should ensure the availability of carbetocin at minimum cost and enforce it as a part of AMTSL which will eventually contribute towards reducing maternal morbidity and mortality.

Key words
Postpartum hemorrhage, maternal mortality, oxytocin, carbetocin

OP/O – 32
MODIFIED LOTUS BIRTH OVER DELAYED CORD CLAMPING; A RANDOMIZED CONTROL TRIAL

Rubasinghe, AJ[1], Jayawardane, MAMM [2], Perera, R[3], Perera, KR[2], De silva, NM[2], Rathnapriya D[2]

1. De Soysa Hospital for Women, Colombo
2. Department of Obstetrics & Gynaecology, Faculty of Medical Sciences, University of Sri Jayewardenepura
3. Department of Paediatrics, Faculty of Medical Sciences, University of Sri Jayewardenepura

Introduction
In obstetric practice, multiple measures are implemented to minimize anaemia in infancy and the neonatal period. Delayed Cord Clamping (DCC) is the current international recommendation to increase neonatal haemoglobin levels (Hb) and reduce the risk of infant anemia. Modified Lotus Birth (MLB) is a refined version of the Lotus birth technique which is an alternative birth strategy to improve placental transfusion during delivery and to hamper the drawbacks of DCC. Although MLB has potential benefits, studies on this area are scarce.

Objectives
To evaluate the effects of MLB and DCC on iron stores in newborns and to compare maternal and neonatal outcomes of babies delivered by elective Lower Segment C-Section (LSCS) at a tertiary care hospital in Sri Lanka.

Design
A randomized control trial

Methods
80 pregnant women who underwent elective LSCS at 37-42 weeks of gestation at the Professorial Obstetric Ward of Colombo South Teaching Hospital from 2020 to 2023 were included in the study. Elective LSCS were performed according to NICE standards. In the intervention group (MLB), the placenta remained attached for at least 15 minutes before separation while the control group (DCC) had cord clamping after 2 minutes or when pulsations ceased.

Postoperative neonatal red cell indices were measured at 24 h and 8 weeks of delivery. Maternal and neonatal outcomes were assessed and the development assessment of newborns was done using the validated Ages and Stages Questionnaire (ASQ-3) at eight months. Statistical analysis was performed using SPSS version 27.0.

Results
An equal number of participants underwent MLB(n=40) and DCC(n=40). Maternal sociodemographic and pre-operative hematological parameters were comparable between the groups. MLB resulted in a significantly lower operating time and estimated blood loss during delivery ($p<0.05$). Neonates born via MLB had a statistically significant higher mean packed cell volume on Day 1($p<0.01$). Although not statistically significant, the mean Hb level, MCHC, MCV, umbilical cord ferritin and serum ferritin levels in the neonate were higher in the MLB group. Maternal postpartum pyrexia and the need for phototherapy in the neonates were higher in the MLB group ($p<0.05$) and a lower rate of hospital admissions was reported during the first year of life ($p<0.05$). Developmental outcomes assessed at 3 months showed no significant differences between the groups.

Conclusions
Modified Lotus Birth is a safer alternative to DCC, necessitating further evaluation using larger clinical trials.

Keywords
Umbilical Cord Non Severance, lotus birth, anaemia

ORAL PRESENTATIONS – GYNAECOLOGY

OP/G – 01
MISOPROSTOL USE FOR MANAGEMENT OF MISSED MISCARRIAGES: A CLINICAL AUDIT

Madugalle TMSSB[1], Maddumaarachchi M[2], De Silva D[3]
[1] Senior registrar in Obstetrics and Gynaecology, National Hospital Kandy, Sri Lanka,
[2] Registrar in Obstetrics and Gynaecology, Teaching Hospital Ragama,
[3] Consultant Obstetrician and Gynaecologist, National Hospital Kandy

Background
Medical management of missed miscarriage prevents surgical risks, has similar infection risks, and has slightly lower success rates than surgical evacuation. It has better success rates compared to conservative management. To ensure that women receive these benefits high clinical standards must be maintained.

Objective
Auditing the compliance with SLCOG guidelines in misoprostol use for managing missed miscarriage.

Methods
A retrospective audit looked at all the missed miscarriages <13 weeks of gestation (NICE diagnostic criteria) from March to August 2023 in our unit at National Hospital Kandy. All missed miscarriages had been managed as in-patients, with transvaginal ultrasound follow-up in 24 hours with signs of expulsion, and a repeat dose if retained products were demonstrated ultrasonically as per unit protocol. Audit standards were set according to SLCOG guidance on Misoprostol (January 2020). Statistical analysis was performed using SPSS 26.
Audit Standards: 100% compliance on the following,

1. Administering Misoprostol according to standards
2. Leaving for 2 weeks unless infection or heavy bleeding

Results
61 missed miscarriages were identified. 33 (54.1%) had received Misoprostol according to guidelines. With signs of expulsion, transvaginal endometrial thickness (ET) was measured in 24 hours. 19 (57.57%) had responded (<15mm ET). 14 (42.43%) had not responded as expected. Out of non-responders 8 (57.1%) women had undergone a 2nd cycle of Misoprostol, 6 (42.9%) had undergone surgical evacuation. 6 out of 8 (75%) had responded after the 2nd cycle and 2 had undergone surgical evacuation with >15mm ET in 24 hours. None had been left for 2 weeks after Misoprostol administration.

Conclusion and discussion
Moderate compliance in misoprostol use in managing missed miscarriages <13 weeks of gestation was noted, and a refresher discussion has been conducted in the unit. During this discussion, reasons for total non-compliance with the second criteria were identified, namely difficulties in, monitoring women in the field, engaging women in 2 weeks, and risks associated with women finding it difficult to reach specialist care in an emergency due to infrastructure deficiencies. A unit protocol was developed to guide management considering the identified difficulties. A post-analysis is currently being conducted.

OP/G – 02

FEASIBILITY OF COMMUNITY HEALTHCARE WORKERS FACILITATED FERTILITY CARE IN NORTHERN SRI LANKA.

Raguraman S [1], Balagobi B [1], Kumaran S [1], Kiruththiga T [2], Shanmuganathan Y [1], Kanesamoorthy S [1], Arulkumaran S[3]
[1] Faculty of Medicine, University of Jaffna
[2] Independent Gender and Communication Consultant, University of Jaffna
[3] Emeritus Professor, St. George's University Hospital

Introduction

Subfertility poses a significant global reproductive health challenge, impacting couples' mental, social, and economic well-being. In low- and middle-income countries, subfertility affects approximately 16.5% of the population. Studies in Sri Lanka, especially in Colombo and recently in Jaffna (22% - under review), indicate higher rates of subfertility.
Social stigma, lack of knowledge among young couples, inadequate primary healthcare resources, and the high workload of Public Health Midwives (PHMs) hinder effective subfertility care. Thus, we propose a model that integrates Community Health Workers (CHWs) into the healthcare system to address these challenges.

Objective

To assess the acceptability and feasibility of the Community Health Workers Facilitated Fertility Care (CHWFFC) model in the Nallur Medical Officer of Health (MOH) area in Jaffna, Sri Lanka.

Design

This qualitative research method used focus group discussions, in-depth interviews, and thematic analysis to identify the model's acceptability and feasibility.

Methodology

CHWFFC model was implemented from June to November 2023 in six randomly selected PHM areas within the Nallur MOH in the Jaffna district. CHWs were recruited from Mother's support groups, and training was given according to the standard module based on the FIGO fertility toolbox. CHWs were assigned to selected PHM areas and provided on-the-job training to identify and interact with sub-fertile couples, provide health education, and facilitate clinical work. Focus Group Discussions and in-depth Interviews were conducted with PHMs, Primary Care Doctors and MOHs. Discussions were recorded, transcribed to Tamil, then translated to English, and thematic analysis was conducted.

Results

The main themes identified are the significant reduction in PHMs' workload, the acceptance of community, concerns about the position of CHWs in the hierarchy, and CHWs' proactive nature in learning subfertility care activities.

Acceptability:
Qualitative measures indicated positive feedback and promised administrative support from stakeholders. Public health midwives showed increasing acceptability of CHWs over the period. CHWs showed a proactive nature in learning new tasks, and PHMs requested an increase in the frequency of clinic visits.

Feasibility:
In this intervention, 47 health awareness programs were conducted to identify and refer 61 subfertile couples to primary health care. Subsequent consultations with specialist family physicians and referrals to tertiary care centres further facilitated subfertility management. The involvement of CHWs proved instrumental in guiding couples through the healthcare system at all levels.

Conclusion
In conclusion, the Community Health Workers Facilitated Fertility Care (CHWFFC) model has shown promising outcomes in addressing subfertility issues within the Nallur MOH area, Jaffna, Sri Lanka. The study highlights this model's acceptability and feasibility. Continued monitoring and refinement of the model are essential to optimise its effectiveness.

OP/G – 03
A COMPLETE AUDIT CYCLE ON SURGICAL NOTE DOCUMENTATION IN MAJOR GYNAE-ONCOLOGICAL SURGERIES

Dissanayake, DMC[1], Wijeratne, YMTY[2], Hapuachchige, C[2]
[1]Medical officer, National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.
[2]Senior Registrar in Gynaecological Oncology, National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.
[2]Consultant Gynae-oncological Surgeon, National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Introduction
Operative notes of the patient's clinical records are crucial for patient management as well as for legal grounds. Poor documentation has been observed in all surgical specialties worldwide. Proper documentation in gynae-oncological procedures is important as they almost always require long-term follow-up which mainly relies on the operative notes. Royal College of surgeons (RCS) England has published the guidelines for good practice points in surgical documentation. This audit aimed to improve the quality of operative note documentation.

Methods
Eighteen criteria (date, time, elective/emergency procedure, names of the operating surgeon and assistant, anesthetist, operative procedure, incision, operative diagnosis, operative findings, complications, any extra procedure, details of tissue removed, added, or altered, use of any implants/ prosthesis, blood loss, closure technique, antibiotic and DVT prophylaxis, postoperative care instructions, signature) from RCS as stated in ‘Good Surgical Practice’ and seven additional criteria (patient position, indication for operation, mode of anaesthesia, surgical stage, completeness of the surgical cytoreduction, state of hemostasis and the insertion of drains) that were relevant to operation notes were assessed retrospectively over the 3 months. Scores 0, 1, and 2 were given for zero, incomplete, and complete documentation respectively. Pre-intervention data were collected between January and March 2022 and presented in the audit meeting in March 2022 and SLCOG sessions in 2022. Printed proforma was introduced and attached to all patient tickets as a guide for surgeons/ assistants. Re-audit was carried out in March-July 2024.

Results
For pre-and post-intervention data, 64 and 70 operative notes of laparotomies were randomly selected respectively. Date, procedure, name of the surgeon and assistant, incision, indication, extra procedures, and surgical complications were mentioned completely in more than 80% of cases. Time, elective/ emergency nature, and use of prosthesis were not mentioned in any operative note.The date, name of the surgeons, incision, indication, and mode of anesthesia were 100% in post-intervention. Operative findings, diagnosis, estimated blood loss, position, stage, details of tissue removed and cytoreduction have improved significantly. Problems encountered, the requirement for extra procedures, and the use of implants were not mentioned accurately.

Conclusions
Although most components were already documented in operative notes, there had been lapses in some legally and oncologically important criteria including the state of cytoreduction/ surgical stage which have significantly improved following the intervention. Frequent auditing is vital to maintaining the quality of operative notes.

OP/G – 04
KNOWLEDGE REGARDING SUBFERTILITY AMONG SUBFERTILE WOMEN: A SINGLE CENTRE EXPERIENCE

Raguraman, S[1], U. Powsiga[2] KAUC Dayananda[1] HMPB Thilakarathne[1], R Hemapala[1], S. Thevapriyan[1].
[1] Professorial Obstetrics and Gynaecology Unit, Teaching Hospital Jaffna and Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Jaffna
[2] Faculty of Medicine, University of Jaffna.

Background
Subfertility is one of the significant public health issues that affect a growing number of individuals globally, including low-middle-income countries (LMICs) like Sri Lanka. One out of six individuals of reproductive age worldwide encounter subfertility during their lifetime. WHO revealed that subfertility is not only a medical problem, but it impacts the psychosocial aspect of couples. Understanding the level of knowledge regarding natural fertility, subfertility and treatment modalities among affected women is crucial for effective patient education, management, and outcome.

Objective
This study aims to assess the knowledge of subfertility among subfertile women attending the subfertility clinic at Teaching Hospital Jaffna.

Methodology
A cross-sectional study was conducted with 90 subfertile women attending the Professorial unit subfertility clinic at Teaching Hospital Jaffna. Data were collected using a structured questionnaire, which included sections on demographic factors, type of subfertility, knowledge of subfertility, subfertility causes, and treatment options. SPSS V 26 was used to analyse the data. Less than 50 was considered a low level of knowledge, 50-74.99 was moderate, and 75 and above was considered a high level of knowledge.

Results
In total, 90 women were included in the analysis; the mean (SD) age was 33.8(5.4) years, less than two-thirds were housewives (57.8%), the majority were Sri Lankan Tamil (97.8%), less than two-fifths attained advanced level of education or above (37.8%). Two-thirds were primary subfertility (62.2%), and the rest encountered secondary subfertility (37.8%). Among the women, nearly 57.8% are undergoing treatment, 13.3% are awaiting treatment, whereas more than one-fourth, 27.8%, are not undergoing any treatment for subfertility. Less than two-thirds, 64.4%, were aware of fertility. Regarding the subfertility level of knowledge, 12.2% have a low level of knowledge, 43.3% have a moderate level, and 44.3% have a high level of knowledge.

Conclusion
The study highlights the need for targeted educational interventions to improve knowledge about subfertility. Enhancing patient education can lead to better management and outcomes for subfertile women attending the Teaching Hospital Jaffna.

OP/G – 05
IMPACT OF SUBFERTILITY ON SUBFERTILE WOMEN: PSYCHOLOGICAL EVALUATION USING DASS 21

Raguraman, S[1], U. Powsiga[2] KAUC Dayananda[1] HMPB Thilakarathne[1], R Hemapala[1], S. Thevapriyan[1].
[1] Professorial Obstetrics and Gynaecology Unit, Teaching Hospital Jaffna and Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Jaffna
[2] Faculty of Medicine, University of Jaffna.

Introduction
Subfertility is not only a medical-related public health problem, but it is also impacting the psychological well-being of women due to several factors, such as social stigma, poor self-esteem and anxiety related to the treatment and its success. Identifying this impact helps understand the issue clearly, which is a basis for an appropriate preventive strategy and provides comprehensive care for the woman and her family. The Depression, Anxiety, and Stress Scale-21 (DASS-21) is a widely used instrument for assessing emotional states.

Objective
This study aims to evaluate the levels of depression, anxiety, and stress in subfertility women attending a subfertility clinic in a tertiary care centre in Northern Province, Sri Lanka.

Methodology
A cross-sectional study involved 98 subfertile women attending a subfertility clinic at Teaching Hospital Jaffna. Data collection was conducted in the clinic days after the participant's concern. Data were collected using a questionnaire that captured general information about the participants and a DASS-21 questionnaire. DASS-21 is a 21-item self-report questionnaire designed to measure the severity of depression, anxiety, and stress. Data were analysed to identify the prevalence and severity of psychological distress among the participants using SPSS V26.

Results
In total, 82 women were included in the analysis; the mean (SD) age was 33.8(5.4) years. Two-thirds of them were housewives (61.0%, n=50), the majority were Sri Lankan Tamil (97.6%,

n=80), and less than two-fifths attained an advanced level of education or above (37.8%, n=31). Two-thirds were primary subfertility (63.4%, n=52), and the rest encountered secondary subfertility (36.6%, n=30). Among the women, nearly 61% (n=50) were undergoing treatment, 14.6% (n=12) were waiting for the treatment, whereas less than one-fourth (23.2%, n=19) were not undergoing any treatment for subfertility. Severe and extremely severe depression, anxiety and stress were found in 34.1%, 47.5% and 24.4%, respectively.

Conclusion
The findings underscore the high prevalence of psychological distress among subfertile women, with anxiety being the most prominent issue. These results highlight the need for comprehensive psychological assessment and support as part of the routine care for subfertile women

OP/G – 06
AUDIT ON KNOWLEDGE ABOUT MENOPAUSE AMONG PERIMENOPAUSAL WOMEN AT DE SOYSA HOSPITAL FOR WOMEN

Rathnapriya, DY[1], Dissanayake, CN[1], Tissera, WGM[1]
[1]De Soysa Hospital for Women, Colombo, Sri Lanka

Introduction
Menopause is the depletion of ovarian function followed by cessation of menstruation and is usually diagnosed when a woman does not have a menstrual period for 12 consecutive months. With the advancement of modern medicine, the longevity of the human life span comes hand in hand. Therefore, the life expectancy of women after menopause is also on the rise. Menopause is a period of transition that has many physiological, psychological, and social components associated with it. As it is a natural transition in any woman's life, women must have a good understanding of what it entails.

Objectives
To audit the knowledge about menopause among perimenopausal women attending the gynaecology clinic at De Soysa Hospital for Women

Methods
Data was collected from perimenopausal women attending the gynaecology clinic at De Soysa Hospital for Women via a self-administered questionnaire. Socio-demographic factors as well as data regarding their knowledge and understanding of menopause were systematically collected.

Results
Data was collected from 75 women aged 40 – 66 years. Ninety-two percent of women were married, with the majority educated up to O/Ls (48.8%). Fifty-six percent had undergone menopause.

Discussion
While they were aware that menopause is the cessation of monthly cycles, only 43% knew that menopause is due to a decrease in female hormones. Only 65% were aware that a woman cannot conceive after menopause. Hot flashes (48%), body aches (36%) and mood changes (34%) were the most well-known menopausal symptoms. The majority of the women knew that the risk of osteoporosis (58%) and depression (58%) increased with menopause but were

unaware that cardiovascular risk (41%) increased as well. Sixty-six percent of women agreed that hormone replacement therapy is a good solution to alleviate the symptoms of menopause, however, more than 70% believed that it was associated with multiple side effects. Therefore, it is evident that we need to educate perimenopausal women on menopause and what it entails along with the modalities of treatment available.

Conclusion
The majority of the women had a very poor understanding of menopause and its associated sequelae. While background knowledge about hormone replacement therapy as a treatment modality existed, many women considered the complications and side effects outweighed the potential benefits. This knowledge gap needs to be addressed to empower women to achieve their full potential even after menopause.

OP/G – 07
AUDIT ON KNOWLEDGE ABOUT CONTRACEPTION AMONG PERIMENOPAUSAL WOMEN AT DE SOYSA HOSPITAL FOR WOMEN

Rathnapriya, DY[1], Dissanayake, CN[1], Tissera, WGM[1]
[1]De Soysa Hospital for Women, Colombo, Sri Lanka

Introduction
Contraception is a modality of healthcare that should be accessible to women of all ages and socio-economic backgrounds. While the absolute risk of pregnancy decreases with increasing age and approaching perimenopause, it has been observed that unplanned pregnancies occur in this age group at ratios similar to those of younger women.
Therefore, all perimenopuasal women must have a strong understanding of the modalities of contraception methods available to them.

Objectives
To audit the knowledge about contraception among perimenopausal women attending the gynaecology clinic at De Soysa Hospital for Women

Methods
Data was collected from perimenopausal women attending the gynaecology clinic at De Soysa Hospital for Women via a self-administered questionnaire. Socio-demographic factors as well as data regarding their knowledge and understanding of contraception were systematically collected.

Results
Data was collected from 75 women aged 40 – 66 years. Ninety-two percent of women were married, with the majority educated up to O/Ls (48.8%). Sixty percent of the women did not use a contraceptive method (60%).

Discussion
Even though most women were educated up to at least O/Ls, most of them did not use a contraceptive method. The majority of the women were aware of the availability of different contraceptive methods but knowledge about male sterilization was minimal. The commonest methods of contraception used were male condoms (31%) and sub-dermal implants (31%) while male sterilization was not used at all. The knowledge of contraception was acquired via healthcare workers (58%) or through family members and friends (31%). The majority of the

women were aware that male condoms prevented sexually transmitted diseases (87%). Many women considered weight gain a major side effect of oral contraceptive pills (60%) and their use as a contraceptive method was not very popular. The commonest reason for not using a method of contraception was cited as the concern about potential side effects (50%). These findings highlight the unmet need of contraception among perimenopausal women. It is important that we, as healthcare workers take steps to address this unmet need and support them in proper family planning.

Conclusion
It is important to properly educate perimenopausal women about the advantages and disadvantages of contraceptive modalities and empower them to use a method most suitable for their needs.

OP/G – 08
AUDIT ON QUALITY OF DOCUMENTATION OF GYNECOLOGICAL SURGERIES IN TEACHING HOSPITAL RATHNAPURA

Wickramarachchi. WGB[1], Lasanga, TDR[1], Liyanage, AS[1]
[1] Teaching Hospital Rathnapura, Sri Lanka

Introduction
Clear, accurate documentation of surgical operation notes is a cornerstone of good medical practice. There are various formats for writing operative notes, and the one given by the Royal College of Surgeons of England is well accepted. Evidence from several audits across all specialties indicates the overall standard of reporting and documentation in medicine is poor.

Objective
Compare and adhere of surgical notes with the guidelines published in Good Surgical Practice by the RCS Eng, Educate staff regarding proper documentation

Method
A Retrospective Audit was carried out in Gynecology unit of Teaching Hospital Rathnapura with all the laparotomy operation notes done from July to October 2023 and compared with the guideline

Results
112 notes were analyzed in initial audit and 64 were analyzed in re-audit. All the operation notes were handwritten. The initial audit was evident of mentioning date and time, elective or emergency procedure, and name of the theater anesthetist respectively, 49(44%), 40(36%), and 73(65%). Out of 112, 65 (58%) have mentioned the operative findings completely but only 30 (27%) had noted the complications and the problems that occurred during the surgery. Both anticipated blood loss and DVT prophylaxis were noted at 9(8%). None of the operation notes contained the signature of the person who wrote. After educating the staff with 6 sessions and providing a checklist and a template re-audit was done to achieve target of 85% of each domain. In re-audit mentioning of date and time, elective or emergency procedure, and name of the theater anesthetist were upgraded respectively to 60 (94%), 55 (86%), and 64 (100%). Mentioning the operative findings completely was improved up to 55 (86%) while noting complications and the problems occurred during the surgery was 57 (89%). Noting anticipated blood loss, DVT prophylaxis and signature were improved up to 51(80%), 32 (50%), and 51 (80%).

Discussion
Hand-written surgical notes are often produced as evidence in medico-legal malpractice cases. If the surgeon/assistant writing the operation note is not aware of all the information required, a substandard document will be the likely result. Overall completeness of the record was substandard and trend of documentation of the surgical procedures and findings was poor in initial assessment. The results correlate with other research in the area suggesting similar areas of sub-optimal

Conclusion
The quality of the operative notes can be improved by adding aide-memory attached to operative note sheets or by introducing computerized operative notes.

OP/G – 09
AN AUDIT ON DOCUMENTATION OF GYNAECOLOGICAL OPERATION NOTES

Rajayohan, T[1], Rishard, MRM[1], Dissanayake, CN[1]
[1] De Soysa Hospital for Women, Colombo, Sri Lanka

Introduction
An operative note is a medicolegal document that maintains the continuity of care between the operating team and other healthcare providers. It should be completed immediately after the surgery by a member of the surgical team and should include all the essential information to enable continuity of care by any doctor who is not involved in the surgery.
According to the guideline published by the Royal College of Surgeons (RCS) of England, the following details should be included in any standard operative note; Date and time of the procedure, operative procedure and anaesthesia, indication, name of the surgeon, assistant and anaesthetist, skin incision, operative diagnosis, operative findings, complications Additional procedure performed with reason, tissues removed, prosthesis used, closure technique, estimated blood loss (EBL), antibiotic prophylaxis, deep vein thrombosis (DVT) prophylaxis, post-operative instructions, and name and signature.

Objectives
The audit aims to assess the completeness and accuracy of the gynaecological operative notes according to the RCS recommendations and improve the practice.

Design
Clinical audit

Methods
103 random bedhead tickets of patients who underwent gynaecological surgery between June 2023 to September 2023 in the professorial unit at the National Hospital of Sri Lanka were collected from the record room. Information on operative notes was collected retrospectively and compared with the RCS recommendations. The data was analyzed, and an operative note format was designed in accordance with RCS guidelines. A meeting was arranged for the doctors of the professorial gynaecological unit. The results of the audit were discussed, and the operative note format was introduced. We further discussed the importance of documentation, the reason for incomplete operative notes, the difficulties they have, and their suggestions. Following a few modifications the operative note format was implemented into practice. After

3 months we collected 105 filled operative note formats and compared them with the pre-intervention audit date.

Results
None of the operative notes was complete. Documentation of time and place (25.24%), indication (26.21%), name of the anaesthetist (17.48%), EBL (17.89%), prophylactic antibiotic, DVT prophylaxis (1.85%), catheter removal (10.94%), mobilization (23.3%) and diagram (5.13%) were very low. Following the implementation of the printed format documentation rate of all information was more than 50% with the majority at more than 80% except for the diagram (22.86%).

Conclusions
It is important to maintain an accurate and complete operative note to provide optimal health care and printed operative note formats help to achieve this.

OP/G – 10
CLINICAL AUDIT ON THROMBOPROPHYLAXIS IN GYNAECOLOGICAL SURGERY

Colombage, CN[1], Karunarathne, SMG[1], Kapilesan, K[1], Jeevethan, J[1]
[1] Sri Jayawardenepura General Hospital, Sri Lanka

Introduction
Venous thromboembolism is one of the known preventable post-surgical complications. Incidence of deep vein thrombosis following a major abdominopelvic surgery is ranging from 17 – 40%. This incidence can be significantly reduced by adhering to the internationally recommended thrombophylactic practices. National Institute for Health and Care Excellence (NICE) has published a guideline on measures to reduce the risk of hospital-associated venous thromboembolism. Also, an important account on the current available evidence is given on the article published in The Obstetrician and Gynaecologist on 2023, under the heading Thromboprophylaxis in Gynaecology. They were taken as the standards to audit the current practice in the subjected gynaecology unit in the tertiary care hospital.

Objectives
Evaluate and audit the deviations from international thromboprophylaxis protocols in a gynaecological unit in a tertiary care hospital.

Method
A complete audit cycle was conducted in the gynaecology unit, Sri Jayawardanapura General Hospital over the month of June and July 2024. Data collection was done prospectively using observer checklists. 25 patients who have undergone major gynaecological surgeries were evaluated with the above-mentioned method. Standards to compare was established using the guidance given in NICE. Baseline audit data were analyzed using simple statistical data analysis using Numbers software. Action plan was developed following identifying the unmet need of thromboprophylaxis, knowledge gaps and existing and potential barriers to adhere to guidelines. An interactive session was carried out with the doctors and the nursing staff involved in the patients care. Assigning a thrombotic risk score for patients admitting to routine surgeries was initiated and that risk score is modified post-surgically accordingly. After the implemented changes, re-audit was carried out over the next month and 25 cases analyzed prospectively.

Results
Baseline audit revealed 76% of unmet need of thromboprophylaxis. And 24% out of them fell into highrisk category. Re-audit following the action plan revealed 98% adherence to the guideline. There were no reports of adverse events such as pulmonary embolism during the audit period.

Conclusion
Unmet need of the thromboprophylaxis in the pre-intervention period was overcome after the implementation of pre-operative and post-operative risk score. Adherence to the guideline has an utmost importance in this context given the high mortality rate in venous thromboembolism. This audit has successfully identified and addressed the issues as evident by the high rates of adherence to the policy after the action plan was implemented.

OP/G – 11
MENSTRUAL DISORDERS AND ASSOCIATED FACTORS AMONG WOMEN IN GAMPAHA, SRI LANKA

Abayawickrama, ASMVG[1], Abeykoon, AMBAH[1], Abijukthan, B[1], Alagiyawanna, AMT[1], Weerasinghe, MC[2]
[1]Faculty of Medicine, University of Colombo
[2]Department of Community Medicine, Faculty of Medicine, University of Colombo

Introduction
Menstrual disorders occur when the menstrual cycle deviates from its natural course. As most menstrual disorders are associated with treatable underlying pathologies, practicing effective health-seeking behaviors and early identification of menstrual disorders are of utmost importance.

Objectives
The study was undertaken to assess the prevalence of menstrual disorders, patterns, and factors affecting the health-seeking behavior for menstrual disorders, among the reproductive-aged women in the Gampaha MOH area, Sri Lanka. The posed research question was “Is there an association between the prevalence of menstrual disorders and socio-demographic factors and psychosocial parameters, and how do these factors influence health-seeking behavior?”

Design
To assess the point prevalence of menstrual disorders, characteristics of health-seeking behavior, and its associated factors, we conducted a descriptive cross-sectional study with an analytical component to provide valuable insights for public health administrators

Methodology
One-hundred twenty females aged between 15-49 years, in the Gampaha MOH area were selected using multistage cluster sampling. A pre-tested, interviewer-administered questionnaire was used to obtain data. SAMANTA questionnaire, WaLIDD score, and Premenstrual Symptoms Screening Tool were used to identify menstrual disorders. The study period extended from June 2022 to February 2023.

Results
The majority of participants were in the age group of 22-30 years (39.1%) with a mean age of 28.5 years. The majority were unmarried (72.5%) and nulliparous (75.8%). In the sample, 54.2% experienced heavy menstrual bleeding, and 46.6% reported moderate or severe dysmenorrhea. Symptoms suggesting of pre-menstrual syndrome were observed in 20.8%, of which 5% were diagnosed with pre-menstrual dysphoric disorder. A majority of 34.2% had never visited any health service for menstrual issues. General practitioner (GP) was the most (20.8%) sought after health service provider for reproductive health issues, but on the contrary majority of 68.3% had an unsatisfactory procurement with a GP. Most participants (88.3%) demonstrated a satisfactory knowledge regarding menstruation. Similarly, 58.3% of respondents reported receiving satisfactory family support. Prevalence of heavy menstrual bleeding showed significant associations with being unmarried (p=0.016), nulliparous (p=0.044), being employed (p=0.001), and with education below grade 11 (p=0.001). No associations were observed between the prevalence of menstrual disorders and knowledge regarding menstruation or family support.

Conclusion
Approximately half of the women in the study were suffering from a menstrual disorder due to reluctance to reach health services for prompt diagnosis and treatment. The overall health-seeking behavior of the study population was unsatisfactory, despite having good family support, knowledge, and awareness of the physiology of menstruation.

OP/G – 12
MENSTRUAL HYGIENE PRACTICES AND ASSOCIATED FACTORS AMONG FEMALES IN WALALLAWITA, SRI LANKA

Amarasinghe, SH[1], Alawala, MI[1], Aloka, DMS[1], Weerasinghe, MC[2]
[1]Faculty of Medicine, University of Colombo
[2]Department of Community Medicine, Faculty of Medicine, University of Colombo

Introduction
Period poverty remains a pressing issue in Sri Lanka, where access to menstrual hygiene products and sanitation facilities is limited. Since poor menstrual hygiene can result in negative physical and psychosocial consequences, proper menstrual hygiene management is imperative for overall health and quality of life.

Objectives
This study was planned to assess practices on menstrual hygiene management and their association with sociodemographic factors and knowledge of menstrual hygiene among females of 18-30 years, in Walallawita MOH area, Sri Lanka. The posed research question was "Do the sociodemographic factors and knowledge of menstrual hygiene affect the quality of menstrual hygiene practices?"

Design
Since we focused to assess prevalence of having good menstrual practices, describing along with frequencies, and to determine the causal relationship of menstrual hygiene practices with sociodemographic factors and knowledge, descriptive cross-sectional study with an analytical component was chosen.

Method
140 females aged 18 – 30 years, in Walallawita MOH area were selected by multistage cluster sampling. The study period extended from June 2022 to February 2023. Data was collected using a pretested interviewer-administered questionnaire. The chi-square test was used to determine the association of practices on menstrual hygiene management with sociodemographic factors and knowledge of menstrual hygiene. Results obtained were expressed as associations ($p < 0.05$).

Results
The majority of females used sanitary pads (n=113,80.7%) while the minority used self-prepared clothes/towels (n=27,19.3%). The majority washed their hands before (n=84, 60%) as well as after (n=125,89.3%) changing sanitary materials, maintaining genital hygiene (n=128,91.4%), and using soap to wash genitals(n=100,71.4%). Most females who use sanitary pads changed sanitary pads less than 4 times per day(n=59,52.2%), discarded their used sanitary pads by burning (n=67,59.3 %) and wrapping them before discarding them (n=81, 83.5%). The most of females who use self-prepared menstrual clothes/towels changed their clothes/towels 3 times per day (n=11,40.7%), washed before reuse (n=27,100%), checked dryness before reuse (n=23, 85.2%) but never boiled before reuse (n=15,55.6%). Approximately equal proportions of females had good (n=71,50.7%) and a poor menstrual hygiene management (n=69,49.3%). Current marital status (p-value = 0.026), type of family (p-value = 0.004), and knowledge of menstrual hygiene(p=0.018) had a statistically significant association with practices of menstrual hygiene management.

Conclusions
Only around 50% of participants reported good menstrual hygiene practices. As knowledge of menstrual hygiene has a significant association on practices, improving awareness in the community is recommended.

OP/G – 13
OPPURTUNISTIC SCREENING FOR NON-COMMUNICABLE DISEASES IN WOMEN ATTENDING GYNAECOLOGY CLINICS

Dissanayake, AD[1], Madanayake, YR[2], Kapuge, UH[2]
[1]Consultant Obstetrician and Gynaecologist, Senior Lecturer, Kothelawala Defence University, Sri Lanka
[2] Senior house officer, Obstetrics and Gynaecology Department, Kothelawala Defence University Hospital, Sri Lanka

Introduction
Noncommunicable diseases (NCDs) are diseases not transmissible to each other. NCDs account for 77% of deaths globally. With increasing life expectancy, women may spend more than one-third of their lives after menopause increasing the morbidity and mortality caused by NCDs. Commonest NCDs amongst Sri Lankan females include cardiovascular disease, hypertension, diabetes mellitus, carcinomas, obesity, osteoporosis, and mental disorders. Sustainable developmental goal 3.4 aims to reduce premature mortality by NCDs by one-third.

Objective
The study was conducted to assess the prevalence of NCDs through opportunistic screening at gynaecology clinics and assess its feasibility.

Design
A descriptive cross-sectional study was conducted at Kothelawala Defence University Hospital involving women above 40 years attending routine gynaecology clinics. A pre-tested interviewer administered questionnaire was used to assess demography details, reproductive factors, and medical and surgical co-morbidities. Height, weight, waist circumference and mid-calf circumference were measured. Screening was performed for cardiovascular disease by WHO epidemiological charts, for osteoporosis by self-assessment tool for osteoporosis in Asians (OSTA) and fracture risk assessment (FRAX) scores, for sarcopenia by SARC-F and SARC-CalF scores and for cognitive impairment by functional assessment questionnaire (FAQ). Cut-offs were based on the World Health Organization (WHO) package of essential NCDs prevention (WHO PEN) intervention tools.

Results
Of the 84 participants mean age was 53.83(±SD10.53). The majority of 52 (61.9%) were menopausal. The 10-year risk of cardiovascular disease was <10% for 83.3%, 10-20% for 14.28%, 20-30% for 1.19%, 30-40% for 1.19%, and >40% for 0%. Diabetes and obesity prevalence was 8(11.4%) and 16(19.04%). Only 38 (45%) had done a Papanicolaou smear. OSTA scores were low risk at 79.9%, moderate risk at 23.09%, and high risk at 7.14%. FRAX score without bone mineral density revealed a hip fracture risk of 8.3% and a major osteoporotic fracture risk in 0%. Using SARC-F score of 1.19% and SARC-CalF score of 4.76% were predicted to have sarcopenia. All were negative for dementia using FAQ score < 9.

Conclusion
WHO PEN is a pragmatic and feasible tool that could be readily adopted for NCD screening during gynaecology service provision.

OP/G - 14
MEN AGE AND SEMEN QUALITY: DATA FROM A SRI LANKAN CENTRE

Nasmil UHM[1], Logenthiran PV[2], Hunukumbure RMCB[3], Fernando TAN[3], Fernandopulle RC[3], Fernando DMS[2]
[1]Department of Nursing and Midwifery, Faculty of Allied Health Sciences, University of Sri Jayewardenepura, Nugegoda, Sri Lanka
[2]Department of Physiology, Faculty of Medical Sciences, University of Sri Jayewardenepura, Nugegoda, Sri Lanka
[3]Department of Obstetrics and Gynaecology, Faculty of Medical Sciences, University of Sri Jayewardenepura, Nugegoda, Sri Lanka

Introduction
Infertility affects 48.5 million couples globally, with male factors contributing to 20-30% of them (account for 50% of the cases, 30% solely, and 20% in combination with female factors). Seminal fluid analysis (SFA) is a non-invasive, less expensive test to assess male fertility. In a routine SFA semen volume, sperm concentration, motility, morphology, and viability are evaluated and they provide insights into semen quality and the capacity to fertilize the oocyte.

Objectives
The present study investigated the relationship between age and semen parameters (volume, sperm concentration, and progressive motility) in men.

Design
A retrospective descriptive study was conducted at the Andrology Laboratory, Colombo South Teaching Hospital (CSTH), Sri Lanka.

Methods
Anonymized sperm parameters were extracted from existing SFA reports between June 2017 and December 2018 archived at the andrology laboratory, CSTH. Semen parameters were interpreted based on the 2021 World Health Organization (WHO) reference criteria. Data were analyzed using descriptive and inferential statistics in SPSS software, v.26. Statistical significance was set at $p<0.05$. The study was exempted from review by the Research Ethics Committee, Faculty of Medical Sciences, University of Sri Jayewardenepura.

Result
We analyzed data from 824 men. Their mean age (SD) was 35.3 years (± 5.6), the range being 20 to 61 years. Utilizing the 2021WHO criteria, normal semen volume (≥1.4mL) was observed in 77.9% (n=642), normal sperm concentration (≥16 million/mL) in 88.8% (n=732), and 86.9% (n=716) had normal progressive motility. There were no statistically significant associations between age and any of the evaluated sperm parameters (Spearman coefficient < 0.19). However, there was a significant difference in the mean age between men with normal and abnormal semen volume ($p<0.001$). Specifically, individuals with low semen volume were older (36.6 years) compared to those with normal volume (34.9 years). No other significant age-related differences were observed between subgroups categorized by other abnormal sperm parameters.

Conclusion
The semen volume tends to decrease with age. There was no significant association between age and other semen parameters assessed including sperm concentration and progressive motility. The age of the male partner could have a significant impact on the total number of progressively motile sperm per ejaculate, thus having an impact on fecundity. Studies with larger cohorts to explore the potential age-related effects on semen parameters among Sri Lankan men investigated for infertility are recommended.

OP/G – 15
OVARIAN FOLLICLE DENSITY MODEL IN CHILD ADOLESCENT AND YOUNG ADULT CANCER COHORT

Jayasingam, M[1,5], Assis, M[1,5,6], Gook, D [1,2,5], Kelsey, T[3], Anderson, Ra[4,] Jayasinghe, Y[1,2,5,6]
[1] Department of Obstetrics, Gynaecology and Newborn Health, University of Melbourne, Parkville, Victoria, Australia
[2] Reproductive Services, Royal Women's Hospital, Parkville, Victoria, Australia
[3] School of Computer Science, University of St Andrews, St Andrews, UK
[4] Centre for Reproductive Health, Institute for Regeneration and Repair, University of Edinburgh. Edinburgh, UK
[5] Gynaecology, The Royal Children's Hospital, Parkville, Victoria, Australia
[6] Murdoch Children's Research Institute, Parkville, Victoria, Australia

Introduction
Since the 1980s, the incidence of childhood cancer has been steadily increasing. However, advancements in cancer treatment have significantly improved the survival rates of paediatrics

with cancer (exceeding 80%). Despite these advancements, cancer treatments often cause infertility, making fertility preservation a critical consideration in the care of these patients. Nongrowing follicles (NGF), constitute the ovarian reserve, are finite and established before birth. Understanding the dynamics of follicle density (FD) is crucial, especially in paediatric populations who undergo ovarian tissue cryopreservation (OTCP) for fertility preservation. Previous models focused primarily on the relationship between follicle number and age, with limited data on paediatric populations and minimal methodological detail.

Objective

This study aims to develop a comprehensive model of follicle density in a substantial paediatric adolescent and young adult (CAYA) cancer cohort who have not received prior chemotherapy. Comprehensive models of FD across age groups are essential for improving fertility preservation decision-making, understanding ovarian reserve, and improving the quality of life for cancer survivors.

Design

This Cross-sectional study included chemo-naïve patients 0-25 years, who underwent OTCP.

Method

A small ovarian biopsy tissue sample was fixed, and processed, and haematoxylin and eosin-stained sections were scanned and cortical follicle numbers both nucleated and non-nucleated follicles were counted and classified according to the new NICHD proposed nomenclature system. Logarithmic linear regression models of FD according to age were generated for each follicle category.

Results

The 174 patients were evenly distributed across the age range [0-5=26(14.9%), 5.1-10=37(21.2%), 10.1-15=38(21.8%), 15.1-20=43(24.7%),20.1-25=30(17.2%)]. Data was the best fit with the logarithmic linear regression model of FD in patients across all follicle categories. The model revealed at birth mean follicle density for NGF was $35mm^{-2}$ and FD of NGF is halved every 6.3 years(P=<0.001), exhibiting a higher density and faster decline with age compared to growing follicles (Primary to advanced follicles), which displayed a longer half-life of >10years (P=<0.001). Abnormal follicles constituted 1.78% of follicles and showed a more rapid rate of decline than other follicle categories (Half-life-5.5yr, P=<0.001).

Conclusion

Our study provides a detailed model for a large population of CAYA chemo-naïve patients filling a gap in existing literature. We report half-life declines in FD across all types of follicles, including abnormal follicles, which showed the steepest decline. This model enhances the understanding of the ovarian reserve and aids clinical decision-making for fertility preservation, ultimately improving the quality of life of the survivors.

OP/G – 16
PRESENTATION OF ABNORMAL UTERINE BLEEDING ASSOCIATED WITH INVASIVE MOLE - CASE REPORT

Eshwarage KS[1],Wijesiriwardeha YS[1],Mohomed ALS [1],Karunasinghe J[1],Jayasekara RMMSB[1]
[1]castle street hospital for women

Introduction
Gestational trophoblastic disease (GTD) encompasses a spectrum of pregnancy-related trophoblastic disorders, ranging from the benign hydatidiform mole to the highly malignant choriocarcinoma. Among these, invasive moles represent a rare unique and intriguing pathologic entity, offering both diagnostic and therapeutic challenges. Invasive moles, also known as chorioadenomas destruens, are characterized by the aggressive invasion of molar tissue into the myometrium, with potential for vascular invasion and distant metastases.
The incidence of invasive mole following a hydatidiform mole ranges between 10-15% in complete moles and is significantly less common in partial moles. Despite this, invasive moles deserve particular attention due to their potential for severe morbidity and, in rare cases, mortality if not promptly diagnosed and adequately managed

Case report
A 42-year-old woman, with three prior vaginal deliveries, ceased DMPA contraception in 2019. had regular menstrual periods from 2019 up to March 2024. She initially presented in July 2023 with heavy menstrual bleeding, diagnosed with a 14-week size adenomyotic uterus with probable adenomyoma. Treatment with tranexamic acid and mefenamic acid was effective. From March to June 2024, she suffered from spotting and abdominal discomfort. Physical examination revealed a palpable uterus consistent with 20 weeks gestation. Urine hCG was positive, and ultrasound indicated a mixed echogenic lesion with cystic areas, suggestive of a hydatidiform mole; other findings were normal. Serum beta hCG was elevated at a level of 121,963 IU. Chest X-ray normal. She underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy since she was not having fertility wishes.Histology came as an invasive mole. initial serum beta hCG follow up 4312 IU/L and second beta hCG value 129 IU/L

Discussion
Gestational trophoblastic neoplasia (GTN), including persistent or invasive moles, is managed similarly to choriocarcinoma with single-agent chemotherapy, such as methotrexate or dactinomycin. Treatment response is monitored via β-hCG levels, with remission defined by normalization and stability for three weeks. If resistant, second-line therapies or more intensive treatments are considered. Given the patient's lack of fertility desires, the decision to perform a total abdominal hysterectomy with bilateral salpingo-oophorectomy was appropriate. This approach not only addressed the invasive mole but also eliminated the risk of future trophoblastic disease in a patient with completed childbearing.

Conclusion
This case emphasizes the importance of considering gestational trophoblastic disease in differential diagnoses for abnormal uterine bleeding and elevated hCG levels. The patient's outcome was favorable with appropriate surgical intervention, and ongoing monitoring will be essential for ensuring complete resolution and preventing recurrence

OP/G – 17

CLINICAL AUDIT: DOCTOR'S KNOWLEDGE, ATTITUDE, AND PRACTICE OF OBTAINING CONSENT FOR GYNAECOLOGICAL PROCEDURES

Fonseka, NA[1], Herath, R[2], Edirisinghe, EKMP[1], Kajeepan, V[1], Thilakaratne, KMH[1]
[1]Colombo North Teaching Hospital, Sri Lanka
[2]Faculty of Medicine, University of Kelaniya, Sri Lanka

Introduction

Obtaining consent is part of informed decision-making and a cornerstone in medical ethics. While consent-taking is practiced as a routine, there can be lapses compared to standard practice, which can adversely affect the quality of care, including lower patient satisfaction, legal issues, and breaches of medical ethics.

Objective

To assess and empower doctors' knowledge, attitude, and practice of obtaining informed consent for gynaecological procedures to improve the quality of care.

Method and Design

This cross-sectional study was conducted on all categories of doctors in the professorial Obstetrics and Gynaecology unit at Colombo North Teaching Hospital, Ragama. Consent-taking recommendations given in RCOG and FIGO guidelines are considered as the standard. Doctors' knowledge, attitude, and practice of the four main elements of consent-taking, including assessment of capacity, disclosure, understanding, voluntariness, and consent-taking for medical education, were evaluated. A digital questionnaire was given, and the chief author collected data. Lectures and demonstrations were arranged to cover deficiencies, and re-auditing was done in the same manner.

Results

The total number of participants was 26, with 38.4% (10) interns, 15.4% (4) relief house officers, 11.5% (3) senior house officers, 19.2% (5) postgraduate trainees, and 11.5% (5) consultants. Among them, 53.8% (14) did not have formal teaching sessions on consent-taking. The majority learned about consent-taking through observing others and self-learning. 38.4% (10) were aware of all four elements of informed consent. 46.2% (12) received support from non-medical personnel to overcome language barriers. Almost all participants always discussed the diagnosis, intended procedure, and complications before the procedure. However, 57.6% (15) did not discuss the mode of anesthesia. The practice of giving alternative treatment options, discussing additional procedures, assessing the patient's understanding, and taking voluntary consent was seen in 92.3% (24), 76.9% (20), 69.2% (18), and 69.2% (18) of participants, respectively. However, less than 14% of participants had taken consent for taking photographs during the procedure, using them for academic teaching, and examining anesthetized patients for trainees/medical students. After analyzing the data, formal lectures and demonstrations on consent-taking for gynecological procedures were conducted. Re-auditing was done one month later, and participants reported practicing the discussed components in consent-taking more than 75% of the time.

Conclusions

Frequent discussions and teaching sessions are important to update the knowledge, attitude, and practice of consent-taking in gynecological procedures among doctors.

OP/G – 18
MANAGEMENT OF FIRST TRIMESTER MISCARRIAGES: WHERE DO WE STAND; CLINICAL AUDIT

Rathnayaka, RMAN[1], Wanniarachchi, WADP[1], Sarathchandra, DNS[1], Dissanayaka, MMHV[1], Ratnayake, C[1]
[1]Teaching Hospital Peradeniya, Sri Lanka

Objective

First trimester miscarriage is one of the commonest presentations to the gynecology units in Sri Lanka. Although there are various options of management, there is a wide discrepancy in management of these patients in various settings, depending on available facilities and patient preferences.

Design

A clinical audit was performed for the cost analysis for the management of first trimester miscarriage in a tertiary care setting in Sri Lanka to identify the cost effectiveness and the impact on the health care economics.

Method

A retrospective audit was performed in Teaching hospital Peradeniya, Sri Lanka over a period of two months. All the patients who presented with first trimester bleeding were included in the study. All the bed head tickets were traced and cost analysis was performed on the provided facilities and management strategies.

Results

There was a total of 42 patients with first trimester miscarriages admitted to the gynaecology unit. Among them 47% were due to missed miscarriages, 28% were following threatened miscarriages, 14% and 11% of them were complete miscarriages and incomplete miscarriages respectively. All patients were provided inpatient care except for one patient who was discharged on the same day after diagnosing a complete miscarriage. with an average cost of 70$ to manage a complete miscarriage. The 12 patients with threatened miscarriages were provided micronized progesterone orally after an ultrasound scan where the average cost for one patient was 100$. Among 20 patients with missed miscarriages two patients were given expectant management and others were managed with misoprostol with FIGO guidance. Surgical evacuation products of conception are offered for 4 patients after failing medical management which gives an average cost of 248$ for the management of missed miscarriage. Incomplete miscarriages were managed medically with misoprostol and one patient directly offered surgical evacuation due to heavy bleeding which gives an average cost of 256$ to manage an incomplete miscarriage. The audit revealed an average cost of 177$ for the management of first-trimester miscarriage in a tertiary care setting in Sri Lanka.

Conclusion

Management of early pregnancy bleeding is a challenging clinical entity due to patient preferences and social and cultural issues. However, with the current economic crisis, it is necessary to look forward on cost effective ways in managing first trimester bleeding which makes a huge impact on health care costs.

OP/G – 19
AN AUDIT ON THE SURGICAL CONSENT PROCEDURE FOR GYNAECOLOGICAL SURGERIES

Dissanayake, CN[1], Tissera, WGM[1], Rathnapriya, DY[1], Jayawardane, IA[1,2]
[1] De Soysa Hospital for Women, Colombo 08
[2]Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo

Introduction
Consent is an important reflection of the doctor-patient relationship. Valid informed written consent is required before any surgical procedure. It is an essential part of the patient care pathway. Consent plays a major role in the medico-legal aspect as well. Junior doctors are usually assigned the task of obtaining consent.
International Federation of Gynaecology and Obstetrics (FIGO) Education Communication and Advocacy Consortium (ECAC) has realized that the quality of consent varies considerably across the world and has developed simple guidelines regarding consent and procedure-specific checklists for the most common obstetric and gynaecological procedures.

Objectives
To assess and improve our institutional practice for better patient care by developing an institutional checklist and appropriate consent forms.

Method
A total of fifty-bed head tickets (BHT) of patients who underwent gynaecological surgeries between May 2024 and June 2024 in the professorial gynaecological unit at the National Hospital of Sri Lanka were collected. Information on consent forms was collected retrospectively and compared with the FIGO recommendations. Data was analyzed by Microsoft Excel. A meeting was arranged for the doctors of the professorial gynaecology unit to discuss the results to improve the quality of obtaining consent and to complete the audit cycle in intervals of three months.

Results
None of the consent forms were complete. Documentation of name of the procedure (100%), date of consent (76%), name of the patient (96%), and associated risks (88%) were the highest. Documentation of indication and intended benefits were 34% and 28% respectively. Additional procedures were mentioned in 6% while none of the alternatives to surgery were mentioned. Documentation of the type of anaesthesia (4%) and procedures not to be carried out without further discussion (8%) were deficient. Details of the clinician obtaining the consent were unavailable in any of the forms. Though a copy of the consent form was not given to any of the patients undergoing surgery, all the BHTs had them attached while only 82% were legible.

Conclusions
An accurate consent reflects upon the doctor-patient relationship. Developing an institutional checklist and appropriate consent forms to improve patient care is important. This audit warrants further studies after creating such a tool to obtain consent.

OP/G – 20
PITUITARY TUMOR MASQUERADING AS SECONDARY AMENORRHEA: A CRITICAL DIAGNOSTIC CHALLENGE

Hewawitharana KG[1] Meegoda VJ[2], Raiyees RA[3], Mallawarachchi J[4]
[1]Whipps Cross University Hospital, Leytonstone, East London, United Kingdom
[2]Base Hospital – Tangalle, Southern Province, Sri Lanka
[3]District General Hospital-Ampara, Eastern Province, Sri Lanka
[4] Base Hospital-Mahaoya, Eastern Province, Sri Lanka

Objectives
Secondary amenorrhea, defined as the absence of menstruation for three or more consecutive cycles with previously normal menstrual cycles, is a common clinical presentation with a broad differential diagnosis. Pituitary tumors are rare but a significant cause, which may often be overlooked as a diagnosis.

Case report
A 35-year-old woman, who had undergone a cesarean section and received Depo-Provera injections for two years, presented with secondary amenorrhea upon attempting to conceive her second child. She presented to our team five years after the onset of amenorrhea, which had previously been investigated without a definitive diagnosis. Her clinical history lacked common risk factors for secondary amenorrhea, including major postpartum hemorrhage, curettage, or family history of premature ovarian failure. Notably, she did not report symptoms like headaches, diplopia, breast discharge, or significant climacteric symptoms. On physical examination, notable findings included hyperpigmentation of the skin, particularly in the skin creases, prognathism, enlargement of hands, feet, supra-orbital ridges, nose, chin & enlarged tongue. Patient claims that she had noted a change in her facial appearance and had to change her shoes annually over the last 3 years due to the enlarging size. These features raised suspicion of acromegaly, caused by a pituitary tumor. CECT of the brain identified a pituitary macroadenoma (2.2 x 1.1 x 1.3cm) with compression of the pituitary stalk. An MRI was not performed due to metallic elements in scalp from a bomb blast. Hormonal assays indicated elevated growth hormone, markedly increased prolactin levels (7093 mIU/L), and reduced levels of FSH, LH, and thyroxine. These findings confirmed the diagnosis of a mammosomatotroph cell adenoma, a rare pituitary tumor that secretes both growth hormone and prolactin. A multidisciplinary team was assembled, and the patient was initially treated with Cabergoline. Subsequently, she underwent successful transsphenoidal resection of the tumor with an uneventful recovery. Despite this, the delay in diagnosis and treatment adversely affected her plans for a second pregnancy.

Discussion
Pituitary tumors can disrupt the hypothalamic-pituitary-ovarian axis and lead to menstrual irregularities. Due to their ability to present with symptoms that overlap with more common gynecological conditions, these tumors can be easily overlooked. Misdiagnosis or delayed diagnosis of pituitary tumors can result in prolonged patient suffering and unnecessary treatments

Conclusions
This case underscores the importance of considering pituitary pathology in the differential diagnosis of secondary amenorrhea and highlights the need for timely diagnosis to prevent long-term impacts on patient quality of life.

OP/G – 21

ASSESSMENT OF KNOWLEDGE, UNDERSTANDING, AND AWARENESS OF CLINICAL STAFF AT NATIONAL HOSPITAL KANDY TOWARDS MENOP AUSE HORMONE THERAPY: A SURVEY

Mahdoom, BWMA[1], Namgay,D[2], De Silva, DYK[1], Wijewardhana, HMCG[2]
[1] National Hospital, Kandy
[2]Medical Student, Faculty of Medicine, University of Peradeniya

Background
Sri Lanka today faces the challenge of a rapidly ageing population with women outnumbering men. According to statistics, about 25 million women experience menopause every year and it is predicted that number of postmenopausal women will reach 1.2 billion by 2030. Menopausal Hormone Therapy (MHT) is recommended for women experiencing climacteric peri and postmenopausal symptoms. The use however is very low compared to the countries in the west. Health care providers especially nurses and midwives play a major role in educating women in society about the availability and access to menopause hormonal therapy.

Objective
There are no studies published in Sri Lanka that assess the knowledge and understanding of healthcare providers on MHT. Therefore, this study was conducted to assess the knowledge and understanding of MHT among clinical nurses and midwives at the National Hospital Kandy.

Method
Data from 96 clinical staff (63 nurses and 33 midwives) were collected using self-administered questionnaires. The data was later fetched into Excel Sheet and analyzed using JAMOVI, an open-source analytical software.

Results
According to the results generated, 68% of the participants thought that menopausal hormonal therapy is necessary for women in the climacteric period. Also, 74 participants (77%) believed that MHT can relieve vasomotor symptoms. The major concerns about MHT were the risk of malignancies and about 80 (84%) and 74 (77%) were apprehensive that MHT could increase the risk of breast and endometrial cancer.

Conclusion
The survey demonstrated that Sri Lankan medical professionals had a very good understanding of menopause hormonal therapy. This knowledge should be actively practiced in educating the women attending clinics throughout the country to immobilize understanding and knowledge among the general population.

OP/G – 22

EFFECT OF COARSE GRANULATION ON OOCYTE MATURATION, FERTILIZATION, EMBRYONIC DEVELOPMENT AND PREGNANCY RATES

Daniel, CR[1], Wijeratne, S[1], Jayasingam, M[1], Rathmal D, Batcha M[1], Kaluarachchi A[1], Seneviratne HR[1]
[1]Vindana Hospital for IVF and Fertility Care, Colombo, Sri Lanka

Introduction

Oocyte morphology plays a crucial role in fertilization, embryo development, blastocyst formation, implantation, and pregnancy rates. Coarse granulation in the perivitelline space (PVS) of oocytes is occasionally observed after denuding the oocytes for intracytoplasmic sperm injection (ICSI). These granules are believed to be remnants of cellular metabolism as a result of various factors including hormonal changes, genetic predisposition and epigenetic factors.

Objective

The objective of this study was to investigate the effect of coarse granules in the perivitelline space of oocytes on the rate of maturation, fertilization, embryonic development and the pregnancy rate.

Design

This is a comparative retrospective study design consisting of a study group with the presence of only coarse granules as an oocyte abnormality and an age matched controlled group without coarse granulation.

Method

A study group and a control group of 50 patients each, treated from 2020 to 2024 June were studied. In the study group, more than 50% of the oocytes retrieved per cycle contained coarse granules in the PVS, and the age matched control group with almost similar number of oocytes retrieved had no coarse granulation. Data analysis was performed using unpaired t-test and chi-square analysis. The SPSS software was used for this statistical data analysis.

Results

The mean age of the patients from the study group was 35±4. From the study group, a total of 678 oocytes were retrieved, of which 489 were mature and subjected to ICSI, resulting in 384 eggs with two pronuclei. No significant difference was detected between the study group and the control group with regard to oocyte retrieval and fertilization rates. However, the control group showed a significantly higher maturation rate and blastocyst formation rate (79.2% and 47.3% respectively) resulting in a pregnancy rate of 81%. Maturation and blastocyst formation rates in the study group were 70.6% and 29.9% respectively, resulting in a comparatively lower pregnancy rate of 62%. The study group also depicted a higher cycle cancellation rate of 26% compared to the control group which was 12%.

Conclusion

In this study, the presence of coarse granules in the PVS correlates with low maturation, blastocyst formation, pregnancy rates and higher cycle cancellation rates. While the exact origins and functions of these granules require further investigation, their presence and characteristics can provide valuable insights into the physiological state of oocytes. Continued research in this area can help in optimizing fertility treatments for increased positive outcomes.

OP/G – 23
IMPACT OF MATERNAL AGE ON IMPLANTATION FOLLOWING EUPLOID EMBRYO TRANSFER

Herath, M[1], Rathmal, D[1], Wijeratne, S[1], Batcha, M[1], Kaluarachchi, A[1], Seneviratne, H[1]
[1]Vindana Hospital for IVF and Fertility Care, Colombo, Sri Lanka

Introduction
Chromosomal abnormalities which increase with the advancement of maternal age, have limited the pregnancy success in older women. Pre-implantation genetic testing for aneuploidy (PGT-A) is now widely used to screen embryos for chromosomal anomalies enabling the selection of embryos with higher fertility potential, thereby increasing the chance of implantation following frozen embryo replacement.

Objective
To study the association between maternal age and implantation ability following euploid embryo transfer.

Design
A retrospective analysis was conducted using data from PGT-A reports of 536 embryos from 119 women, biopsied on D5, D6 & D7. A comparative analysis was performed using data retrieved from patients' clinical records.

Method
Analysis of clinical data of 119 women aged 29-49 who underwent *in vitro* fertilization (IVF) followed by PGT-A, at Vindana Hospital for IVF and fertility care, from 2019 to date was carried out. Ploidy rates were determined from biopsy reports. Results of 47 double embryo transfers (DETs), with two euploid embryos (D5 or D6/7) were included. Human Chorionic Gonadotropin (β-HCG) values measured after 14 and 16 days of DETs were used to confirm implantation of embryos. Implantation was considered positive if the second β-HCG value was twice the first or more. The participants were divided into two groups based on maternal age; Group A (age<= 35 years; n= 29) and Group B (age> 35 years n=90) for analysis. The aneuploidy rates and implantation outcomes were compared between two groups using SPSS with a significance set at 0.05.

Results
No significant difference was observed in aneuploidy rates of D5 (n=382) and D6/7 (n=154) embryos (49.2% vs 55.8% respectively, p=0.379) in the total population. This insignificance persisted when Groups A (D5= 99, D6/7=47, 41.4% vs 51.1%, p=0.494) and B (D5= 283, D6/7=107, 51.9% VS 57.9%, p=0.344) were analyzed separately. Aneuploidy rates of D5 embryos were significantly higher in Group B than in Group A (51.9% vs 41.4%, p=0.016). However, no significant difference in the proportion of positive cases was observed between Group A and Group B following DET (68.4% vs 85.7%, p= 0.276).

Conclusion
Although maternal age significantly influences the aneuploidy of an embryo, this analysis shows that implantation success following euploid embryo transfer is independent of maternal age.

OP/G - 24
GROSS ASCITES DUE TO ENDOMETRIOSIS – A RARE PRESENTATION

Mahdoom, BWMA[1], De Silva, DYK[1], Sumithraarachchi, LD, Fernando, MUM, Wijethunga W.M.K.M [1].
[1] National Hospital, Kandy.

Objective
Ascites is caused by endometriosis is an unusual phenomenon. It causes challenges in diagnosis and management as its presentation mimics gynecological malignancy.

Case Report
A 40-year-old mother of one child presented with abdominal pain and distension for a two-week duration. She had a history of dysmenorrhoea and heavy menstrual bleeding for a three-year duration. She didn't have any significant medical diseases. On examination, she was hemodynamically stable. No clinical features of heart, liver, or renal failure. However, the abdomen was non-tender with gross ascites without any abdominopelvic mass. On investigation, she is mild anemic with normal liver and renal function tests. Ultrasound scan shows evidence of gross ascites with features of left ovarian cyst and CECT revealed high-density ascites due to diluted blood products and with left adnexal lesion. Her CA125 was 81 U/ml with normal other tumor markers. USS guided paracentesis revealed grossly blood-stained ascites and cytology or cell block were negative for malignant cells. Laparotomy revealed grade 4 endometriosis with evidence of omental and peritoneal endometriotic patches and she underwent Total Abdominal Hysterectomy and bilateral salpingo-oophorectomy and infracolic omentectomy. The histology confirmed the diagnosis of pelvic endometriosis with multiple foci of endometriosis in the omentum without any evidence of malignancy. She showed excellent improvement post-operatively and followed up ultrasound scan findings were negative for ascites.

Discussion
Endometriosis is a common condition affecting up to 10% of women of reproductive age. Despite the numerous presentations of endometriosis, its association with ascites is rare. Though ascites may be associated with other gynecological conditions such as ovarian cancer, Meig's syndrome, ruptured ovarian cysts, and ectopic pregnancy, its relationship with endometriosis is important as it resembles malignancy.No pathognomonic biomarkers for endometriosis. However, imaging and paracentesis are helpful for the diagnosis. The confirmation of diagnosis is made on surgical assessment and histopathology. Medical treatment is important to reduce recurrence. Medical treatment options include combined oral contraceptives (COC), progestins, GnRH analogs, and danazol. Definitive surgical intervention in the form of bilateral salpingo-oophorectomy and hysterectomy in women who have completed their family is an effective treatment option with low rates of recurrence.

Conclusion
Massive ascites is a rare complication of endometriosis. Clinicians should be mindful of this unusual presentation as it mimics a gynecological malignancy.

OP/G – 25

A CASE OF PERITONEAL TUBERCULOSIS MIMICKING OVARIAN CANCER IN A YOUNG FEMALE

Visagan, S[1], Rathnayake, RMSK[1], Kishokumar, T[1] , Hapuarachchi, C[1]
[1] National cancer institute, Sri Lanka

Introduction

Tuberculosis is the second leading infectious disease in Sri Lanka with 14,000 new cases & mortality of 500 – 600 annually. Tuberculosis typically presents as a lung infection, although it can affect any organ system. Here, we describe peritoneal tuberculosis in a young female who presented with elevated CA-125 and radiological findings concerning ovarian malignancy.

Case Presentation

A 24 year old single woman was referred to the gynaecological oncology clinic for evaluation of suspected ovarian cancer. She reported six months of abdominal discomfort and distension, and weight loss. Her previous medical history was unremarkable except for a contact history of TB. On physical examination, she was generally well-appearing. The abdomen was distended but soft and non-tender to palpation. There was no thrush, peripheral lymphadenopathy, or lower extremity edema; heart and lung exams were normal. CT with contrast of the abdomen and pelvis showed a mild amound of free fluid throughout the abdomen with diffuse nodularity throughout the peritoneum, thickened omentum, and bilateral small ovarian cysts measuring 4, 6 cm at maximum diameter. Complete blood count and liver, and renal functions were normal. Blood CA-125 level was 800 U/mL (normal ≤ 35 U/mL). A midline laparotomy was performed. Upon inspection, there was diffuse studding of intraperitoneal surfaces with 1-2 mm tan nodules, and the omentum was thickened, with flimsy adhesions noted between bowel serosa and abdominal wall. Bilateral hydrosalpinxs were noted & ovaries were normal. Omental and peritoneal biopsies showed caseating granulomas. She was referred to chest physician with a diagnosis of tuberculosis peritonitis and standard tuberculosis treatment was started.

Discussion

Tuberculosis is caused by Mycobacterium tuberculosis and typically manifests as a pulmonary infection. However, tuberculosis can affect any organ system. Peritoneal tuberculosis is uncommon. A high index of suspicion is required since tuberculous peritonitis can present with a variety of systemic and organ specific signs and symptoms that can mimic other conditions. The characteristic surgical visual finding is diffuse studding of the peritoneum with tan nodules, septate ascites, and adhesions can also be present. The visual view can be deceiving even to experienced clinicians since these features can mimic disseminated abdominal malignancies. Granulomas on histopathologic examination were strongly supportive of the diagnosis of tuberculosis peritonitis. Mycobacterial culture and nucleic acid amplification testing of affected lesions should be performed to obtain a definitive microbiological diagnosis and antimicrobial susceptibility information.

Conclusion

Sri Lanka has a high incidence of TB, and there should be an awareness for the gynecologist, and gynecological oncologist to suspect peritoneal TB as a diagnosis for abdominal masses or differential diagnosis for ovarian cancer suspect cases.

OP/G – 26

LAPAROSCOPIC RESECTION OF ISTHMOCELE COMPLICATED BY A COMMUNICATING DEEP PELVIC ABSCESS OF THE VESICO-UTERINE POUCH: A CASE REPORT

Randombage P[1], Meegoda VJ[2], Shah RP[1], Keane F[1], Visvanathan SDK[1], Kajeepan, V[3]
[1]Whipps Cross University Hospital, Barts health NHS trust, London, United Kingdom
[2] Teaching Hospital – Kalutara, Sri Lanka
[3]Teaching Hospital, Ragama

Objective

Caesarean scar defects (CSD), also known as isthmocele, are wedge-shaped depressions in the anterior uterine wall that can occur following a caesarean section. Although rare, these defects can sometimes lead to the formation of an abscess or a fistula. We present a unique and intriguing case of a woman with an isthmocele complicated by a deep pelvic abscess communicating with the vesico-uterine pouch.

Case report

A 36-year-old para 3, with previous 3 caesarean sections (CS) presented to the gynaecology clinic with vaginal spotting and infra umbilical colicky pelvic pain for 3 months. She was on Mirena IUS for 15 months for postpartum contraception. Trans vaginal ultrasound scan (TVUS) was inconclusive. However, MRI scan revealed a bulging isthmocele at CS scar site. A combined operative hysteroscopy and laparoscopy was performed. Hysteroscopy revealed a small bulge at CS scar suggestive of an isthmocele. laparoscopy revealed an anteverted, anteflexed fixed uterus with a left fallopian tube adherent to anterior abdominal wall. Adhesiolysis and further exploration found a 4x2cm boggy mass in the vesico uterine pouch suggestive of a communicating abscess. Left para-vesical and vesico-uterine spaces were opened to drain altered blood from isthmocele and inspissated pus from pelvic abscess. Bladder integrity was established and improperly placed Mirena coil was replaced. Patient had an uneventful recovery and discharged the next day, pain symptoms improved completely. Pus cultures were sterile.

Discussion

In a cross-sectional study of women with CSDs - 39.6% had chronic pelvic pain and 53.1% had dysmenorrhea. Other possible causes for pain are adenomyosis, endometriosis and very rarely communicating pelvic abscesses. Currently there are no established diagnostic criteria for the diagnosis of a CSD with the majority being asymptomatic. Radiologic identification and clinical correlation, which is only done for symptomatic patients, are vital to make the diagnosis so that women may be counselled appropriately. As depicted by this case careful dissection of utero-vesical pouch to delineate the isthmocele and the communicating abscess from each other and the uterus is key to preventing organ injury.

Conclusions

CSDs are uncommon but can occasionally lead to the formation of pelvic abscesses. Therefore, CSDs should be considered in patients presenting with pelvic pain following a CS. With the increasing rate of CS, the incidence of isthmocele is likely to rise, highlighting the need for established guidelines for diagnosis and treatment. This case demonstrates that minimal access surgery is a feasible and effective approach for managing isthmocele.

OP/G - 27

EMBRACING THE TIDE - INTEGRATION OF ARTIFICIAL INTELLIGENCE(AI) IN OBSTETRICS & GYNAECOLOGY

Hewawitharana KG[1], Meegoda VJ[2]
[1]Whipps Cross University Hospital, East London,United Kingdome
[2] Teaching Hospital – Kalutara, Sri Lanka

Introduction

Artificial intelligence (AI) is revolutionizing Obstetrics and Gynecology (O&G) by improving diagnostic accuracy and streamlining clinical processes. Applications include fetal evaluation, cardio-tocography monitoring, early detection of preterm labor, and enhanced identification of ovarian cancer using neural networks among many others. While AI offers significant advancements, it is crucial to recognize that it complements rather than replaces clinical judgment, necessitating ongoing professional oversight and ethical considerations.

Objectives

This study aims to assess the preparedness of Sri Lankan O&G trainees to incorporate AI tools into their daily clinical practice.

Methods

A Google Forms-based questionnaire, created based on similar studies, was distributed among O&G trainees via social media channels.

Results

The survey revealed that the majority of respondents were aged 30-40 years (43.9%). Most respondents were male (77.2%), with consultants comprising 52.6% of the participants, medical officers 19.3%, senior registrars 12.3%, and registrars 12.3%. Regarding experience, 28.1% had less than 5 years, and 22.8% had 10-15 years in O&G. Notably, 57.9% of doctors had never used AI tools in their clinical practice, and only 38.6% were familiar with AI concepts in O&G. Among those familiar, 63.2% acknowledged AI's applications in diagnostics, including image analysis, predictive modeling, treatment optimization, patient monitoring, and research data analysis. However, only 8.8% had integrated AI into their practice, utilizing for tasks as gestation period calculation, cancer diagnosis prediction, clinical reference, and presentation preparation using ChatGPT. Concerns about AI use included potential for reduced accuracy (13.2%), loss of human touch with patients (18.6%), and challenges in critical decision-making in situations like complicated labor (12.2%). Conversely, 12.2% stated that AI has the means to reduce workload and improve accuracy in repetitive tasks. A significant 43.9% of respondents lacked confidence in handling AI tools, while 35.1% expressed willingness to adopt AI with prior training. Notably, 84.2% were open to receiving tailored training. None of the surveyed doctors had received any AI-related training to date. Regarding the future impact of AI, 82.4% believed it would positively influence patient management in O&G. However, concerns were raised about litigation, accuracy, decision-making, cost, availability, patient acceptance, loss of human touch, erosion of clinical intuition, and inadequate regulatory frameworks.

Conclusions

AI offers promising advancements for O&G but is currently underutilized among Sri Lankan trainees, who lack exposure and training in these technologies. Structured methodological training is urgently needed to bridge this knowledge gap and fully leverage AI's potential in enhancing clinical practice.

OP/G – 28

AN AUDIT ON UPTAKE OF CERVICAL SCREENING AND CERVICAL SCREENING OUTCOME AT MOH AREA MIRIGAMA

Ramachandran R[1], Ariyathilaka MWHU[2]
[1]University Obstetrics & Gynecology Unit, Colombo North Teaching Hospital, Ragama
[2]Base Hospital, Mirigama

Introduction

Cervical Cancer is the second most common cancer among the women in Sri Lanka. The mortality due to cervical cancer has been reduced in the past due to universal screening with cervical smears at MOH clinics. However, despite availability, the client uptake of cervical screening is unsatisfactory, probably due to poor education and compliance.

Objectives

We aimed to assess the uptake of Cervical screening by the targeted population and the outcome of cervical screening in our MOH area.

Design

A retrospective Audit was conducted over 1 year period from January to December 2023 at the Mirigama MOH division

Method

Data was collected from the registry of 53 MOH divisions. PAP smear was taken at peripheral units /central dispensaries and MOH of Mirigama.

Results

There were 2038 women aged 35 and 45 who were eligible for pap smear in the MOH area of Mirigama for the selected year. Each PHM division had a different uptake of cervical screening. Our data showed that 70% had PAP smear at 35. However, the 45-age group had only 53% of pap smear adherence. Out of 53 divisions 10 divisions had less than 50% acceptance in the 35-age group, whereas it accounts for 23 divisions in the 45-age group. Some PHM divisions had very low compliance with PAP smear in both the age groups (Kammalpitiya 7% and 4.7% respectively) and Pohonnaruwa (11.85% and 5.6% respectively). Most (98.3% (n=1243)) of the samples were negative for Intraepithelial lesions or Malignancy. Abnormal smears account for 1.7% (9), which includes two cases (0.4%) of Atypical Squamous cells (ASC), one case of (0.08%) Low-grade squamous intraepithelial lesion (LSIL) and Two cases of High-grade squamous intraepithelial lesion (HSIL). Insufficient samples account for 0.94% (n=12). High-Grade lesions were scheduled for colposcopy biopsies out of which one became positive for Squamous cell carcinoma in situ and underwent necessary treatment.

Conclusion

Our data shows that the age of 35 groups has a satisfactory uptake rate of cervical screening recommended by WHO. However, the age of 45 group has lower adherence to PAP smear. In some PHM divisions, the acceptance of cervical screening was well below the recommended percentage for both age groups. The percentage of unsatisfactory smears was nearly 0.9% which is slightly above the benchmark data (0.5%) recommended by the College of American Pathologists (CAP) Cytopathology Resource Committee. In a low-risk population, it was suggested that the rate of ASC should be less than 5% and our rate is well below the cut-off rate. The ASC/SIL ratio in our Audit was (5/3) 1.6, which is at a satisfactory level according to

the American College of Pathologists benchmark data. This is an indicator of quality assurance of PAP test in countries where HPV testing is not available. Need to address the reasons for poor compliance as well as need more training to reduce unsatisfactory smears.

OP/G - 29
ENDOMETRIOSIS AND LAPAROSCOPIC SURGERY: SYMPTOMS, QOL AND FERTILITY IN SRI LANKA

Jayawardane, MAMM[1], Perera, KR[1], Kumarasinghe, KN[1], Gangodawila, TH[1], Rusta, MMF[1]
[1]Department of Obstetrics & Gynaecology, Faculty of Medical Sciences, University of Sri Jayewardenepura

Introduction
Endometriosis, characterized by the presence of ectopic endometrial tissue, affects 6-10% of women globally. Infertility and pain are the most common presentations that hinder quality of life.

Objectives
To evaluate the proportion of endometriosis-related symptoms, Quality of Life (QoL), and fertility rates among women who underwent laparoscopic surgery for Endometriosis in a tertiary care hospital in Sri Lanka.

Design
Retrospective cross-sectional study

Methods
Clinical records of females aged 18-50 years who underwent laparoscopic surgery for endometriosis from 2018 to 2019 at Professorial Gynaecology ward of Colombo South Teaching Hospital were studied. Data on pain symptoms, Quality of Life, and fertility rates were collected at presentation and post-operatively at 3 months, 6 months,1 year, and 5 years. Data were analyzed using SPSS version 27.0.

Results
Among 72 females, the mean age was 34.31 years (SD = 6.255), and the mean BMI was 22.989 kg/m² (SD = 3.6291). Follow-up data were unavailable in 10 participants at 3 months, 13 at 6 months, and 14 at 1 year. The mean pain score on admission {24.13 (SD = 12.733)} reduced to 6.64 (SD = 9.348) at 3 months, then increased to 9.14 (SD = 12.625) and 9.67 (SD = 13.624) at 6 months and 1 year respectively. The mean QoL scale increased from 61.11 (SD = 23.290) to 81.13 (SD = 15.796) at 3 months, while slightly decreased to 80.00 (SD = 15.757) at 6 months and 79.66 (SD = 15.433) at 1 year. The proportion of premenstrual pain decreased from 68.1% (n = 49) to 29.2% (n = 21) at 3 months and remained consistent until 1 year. Menstrual pain reduced from 95.8% (n = 69) to 47.2% (n = 34) at three months, 45.8% (n = 33) at six months, and 47.2% (n = 34) at 1 year. Dyspareunia proportion decreased from 52.8% (n = 38) to 13.9% (n = 10) and remained consistent. On presentation, 72.2% (n = 52) were subfertile for more than two years, while 27.8% (n = 20) did not have fertility wishes. The overall pregnancy rate was 13.9% (n = 10) after surgery. Pregnancy rates were 1.4% (n = 1) at 3 and 6 months, 8.3% (n = 6) at 1 year and 2.8% (n=2) pregnancies were reported after.

Conclusions
Symptoms, QoL, and fertility were improved after laparoscopic endometriosis surgery. Establishing a national registry for endometriosis is crucial to improve diagnosis and support targeted research.

OP/G – 30
SURGICAL MANAGEMENT OF CERVICAL CARCINOMA FOLLOWING NEO-ADJUVANT CHEMOTHERAPY

Kishokumar, T[1], Hapuachchige, C[1], Dissanayake, DMC[1], Visagan, [14], Rathnayake, RMSK[1]
[1] National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Introduction
Cervical carcinoma is the commonest gynaecological malignancy in Sri Lanka. Radical hysterectomy or radical radiotherapy is best known curative treatment for cervical carcinoma. However it's better to avoid dual modality of treatment to reduce complications. Upto stage 11 A radical hysterectomy and from stage 11 B and beyond, combined chemoradiotherapy are indicated. Patients with central isolated pelvic recurrence who had previous radiotherapy with prolonged disease-free intervals can be radically excised by pelvic exenteration or radical hysterectomy depending on exact site of recurrence.

Case report
45-year-old lady , who is mother of three, investigated for foul smelling vaginal discharge for 8 months with heavy menstrual bleeding for 1 month duration . On risk factor assessment she had a history of early age of coitarche, at the age of 15 and absence of safe sex practices. Her pap smear screening was uptodate. She had multiple comorbidities of DM, Hypertension , Dyslipidaemia and Ischaemic heart disease with high BMI. On vaginal examination there was a large, irregular cervical growth > 4cm with left side parametrial involvement. EUA and Cervical biopsy was performed. Histology reveals Papillary adeno carcinoma with possibilities of endocervical adeno carcinoma or endometrioid adeno carcinoma. With EUA assessment, Clinically stage 11 B and inoperable tumour. 3 cycles of Neo-adjuvant chemotherapy were given by oncologist. Then Radical hysterectomy, bilateral salpingo-oophorectomy and bilateral pelvic lymph node dissection were performed.

Discussion
In this patient rationale for neo-adjuvant chemotherapy in locally advanced cervical cancer, is that it is effective in reducing tumour size, expediting the elimination of micro metastasis, improving operability and inducing surgical down staging. Combination of chemotherapy followed by surgery is associated with fewer side effects than, gold standard treatment of concurrent chemotherapy and radiotherapy in locally advanced cervical cancer. Following 3 cycles of chemotherapy, patient was reassessed, and she had a small nodule confined to cervix with much reduction in tumour size and parametrial spread. If this is considered as an isolated pelvic recurrence following chemotherapy, ideal option is pelvic exenteration. Pelvic exenteration is an extensive surgery with high morbidity with complications such as intestinal obstruction, bleeding, entero-perineal fistula, peristomal and perineal hernia, urinary conduit anastamotic leak and strictures, urinary sepsis , pyelonephritis, pelvic abscess, fistula, venous thrombosis and physical, psychological and social impairment. Therefore these complications are avoided by performing radical hysterectomy instead of pelvic exenteration

Conclusion
NACT has a substantial beneficial effects on local disease control in patients with locally advanced cervical cancer. This improves the opportunity of surgery, reduces surgery risk and allow young patients to retain their physiological functions. And also due to usage of NACT, pelvic exenteration is not always essential for isolated recurrences. NACT also significantly reduces the rate of LVSI. It has comparable survival benefits to CCRT with fewer side effects. Further trials are needed to confirm whether NACT can improve the prognosis in patients with cervical cancer.

OP/G – 31
PRIMARY DIFFUSE LARGE HIGH GRADE B-CELL LYMPHOMA OF UTERUS

Kishokumar, T[1], Hapuachchige, C[1], Dissanayake, DMC[1], Visagan, [14], Rathnayake, RMSK[1]
[1] National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Introduction
Primary diffuse large high grade B-cell lymphoma (DLBCL) is a rare clinical condition, commonly misdiagnosed due to similar clinical presentation to Gynaecological tumours. Lymphoma is a malignant neoplasm arise from lymphocytes in lymphnodes or extra-nodal lymphoid tissue. It is classified into Hodjkin's Lymphoma and Non-hodgkin's Lymphoma. Most common extra nodal sites of Non-hodgkin's lymphoma (NHL) are GIT, skin, bone and brain. Only 0.2-1.1% of extra nodal lymphoma of NHL are in female genital tract. It is difficult to diagnose due to its low incidence and non specific clinical symptoms. Due to this reason it is misdiagnosed with uterine sarcoma or fibroids. There are no standard treatment options for this condition.

Case report
72-year old, post menopausal lady, who is mother of three was investigated for persistent abdominal pain. She had comorbidities of CVA, Hypertension and Dyslipidaemia. On abdominal examination there was a large pelvic mass compatible with 20 weeks gravid uterine size. Her CA 125 6.8U/ml and CEA 5.12 ng/ml within normal limits. CECT Chest, Abdomen and Pelvis showed lobulated pelvic mass more towards left side encasing left side lower ureter with upper hydroureter. Primary debulking laparotomy was performed due to suspecting Leiomyosarcoma. Intraoperatively there was large uterine tumour mass mainly over fundus and body, invaded left side broad ligament and left side lateral pelvic wall. Distal 1/3rd of left side ureter was involved by the tumour. Bilateral ovaries were not enlarged. Deposits were not seen in bowel/ bladder/ omentum / liver. Total abdominal hysterectomy with bilateral salpingo – oophorectomy, bilateral ureteric stenting with left side ureteric tumour excision and left side ureteric reimplantation were performed. Histology revealed high grade B cell lymphoma of uterus with possibilities of diffuse large B cell lymphoma/ Burkitt lymphoma involving left ovary, left distal ureter and left side pelvic lymph nodes. Patient was referred to Haemato-oncologist for chemotherapy. Whole body PET-CT report suggested high grade B cell lymphoma of stage 4.

Discussion
Primary uterine DLBCL is an extremely rare and poorly reported disease that commonly occurs in postmenopausal women. Patients commonly present with abdominal or pelvic discomfort and AUB with enlarged uterus. On ultrasound scan, there will be uniformly enlarged uterus with homogeneous echogenicity with normal endometrium. MRI scan is essential for supporting diagnosis. The pathological histology shows diffuse large cell infiltrates with

homogeneous morphology. Treatment options are primary chemotherapy or surgery or combined therapy. Common chemotherapy regimen are CHOP regimen (Cyclophosphamide, Doxorubicin, Vincristine and Prednisolone). Chemotherapy is the main focus of treatment and surgery involves total clearance of uterus and adnexae, only for the purpose of confirmation of diagnosis. There is a role of pre-operative neo-adjuvant chemotherapy or chemoradiotherapy in the treatment.

Conclusion

Uterine DLBCL is a rare disease with low incidence and non specific clinical presentation. Appropriate diagnostic tools are crucial for clear diagnosis, staging and treatment. Therefore comprehensive analysis of clinical presentation, imaging, histology and immunophenotypes should be performed for accurate diagnosis. CHOP chemotherapy regimen is the first line effective treatment option. Early diagnosis and treatment are important for this disease.

OP/G – 32

DEVELOPMENT OF MAL-FUNCTIONED OBSTETRICS AND GYNAECOLOGY UNIT AS A WELL-ESTABLISHED OBSTETRICS AND GYNAECOLOGY UNIT AT BASE HOSPITAL WALASMULLA

Jayalath JAVS[1]
[1]Acting Consultant Obstetrician and Gynaecologist

Introduction

Base Hospital Walasmulla is a type B base hospital in Hambanthota District, and it covers large cross section of southern population. I was posted as the fifth consultant (acting) in obstetrics and gynaecology. By that time, the services rendered were limited to less than five spontaneous vaginal deliveries per month and antenatal care only. I felt that it was my prime responsibility to uplift the unit as a properly functioning obstetrics and gynaecology unit. Challenges I faced during the initial phase of the revolution included lack of human resources, lack of physical spaces and number of beds, non-availability of proper labour room facilities, non-availability of functioning theater and an anaesthetist, non- availability of PBU and proper neonatal care facilities, non-availability of proper guidance and supervision, and lack of training opportunities.

Developments and Methods

The existing ward was divided into three sections as antenatal, post-natal and gynaecology and the total bed capacity was increased from 15 to 40 beds. The labour room was refurbished as a model labour room with automated electric beds and individual maternal monitoring to ensure optimum care for the patients. All the basic and essential equipments were brought into the unit including high dependency care beds, multi-monitors, saline stands, BHT stands, infusion pumps, syringe pumps, instrumental delivery sets, baby cots, etc. Modern obstetrics and gynaecological instruments were introduced in the first time of the history which included Kiwi cups and post-partum Bakri catheters. The funds were collected from both Ministry of Health and non-governmental organizations including private donors. The human resources were consolidated from 5 nurses, 5 mid-wives and 2 health care attendants to 4 medical officers, 12 nurses, 7 midwives and 4 health care attendants with the assistance of the medical

administration. Both in-service and distant trainings programmes were arranged to train all the staff members. New guidelines, protocols, portogram and MEOWS charts were introduced. Clinics were expanded to proper antenatal clinic with scan facilities. New gynaecology, family planning and subfertility clinics were established. An anaesthetist was brought to the hospital and basic and essential theater equipment's were brought from medical supply division of the Ministry of Health. Minor and major surgical procedures were started first time in the history of the hospital which included complicated gynaecological procedures like TAH and Vaginal Hysterectomies. The first ever caesarean section was performed. Laparoscopy was also introduced and special training programmes on laparoscopy for the theater staff were arranged. First ever laparoscopy was performed to expand the care provided by the unit. Subfertility care was extended, and HSG was introduced for the first time along with laparoscopic dye test. After liaison with the private sector intrauterine insemination (IUI) was introduced.

Outcome and Analysis

Number of ward admissions were increased from less than 50 admissions per month (39 admissions in July 2019) to 300-350 admissions per month (344 admissions in July 2020). There were total 3113 admissions during this period. Number of antenatal clinic visits were increased from 50 (53 clinic visits in July 2019) to 450 per month (454 clinic visits in August 2020). There were total number of 4452 antenatal and 153 gynaecology clinic visits during this period. Total number of 3085 antenatal scans and 612 gynaecology scans were performed. Number of total deliveries were increased from less than 5 (4 deliveries in July 2019) to 100 deliveries per month (104 deliveries in September 2020). There were total 887 deliveries during this period. Number of caesarean sections were increased from 0 to 40 per month (43 in September 2020). There were total 335 Caesarean sections were performed during this period and the Caesarian section rate was 37.77%. Number of gynaecological surgical procedures were increased from 0 to 90 per month (88 procedures in September 2020). There were total 689 gynaecological procedures were performed during this period including 67 major gynaecological and 612 minor gynecological procedures. 53 subfertile couples got pregnant after successful treatments and among them 32 were primary subfertile and 21 were secondary subfertile. Most importantly there were no maternal deaths occurred and only 4 perinatal deaths occurred during this period. Maternal mortality rate was 0 per 100,000 women and perinatal mortality rate was 4.5 per 1000 deliveries.

Conclusion

During this period of one year, we were able to establish a properly functioning obstetrics and gynaecology unit with high quality care at Base Hospital Walasmulla, with tertiary care facilities including subfertility care. This demonstrates unwavering commitment, perseverance, proper attitude and correct planning are the key factors in overcoming obstacles, no matter how difficult their circumstances are.

E-POSTERS – OBSTETRICS

EP/O – 01
DECISION TO DELIVERY TIME IN CATEGORY ONE CAESAREAN DELIVERIES IN A TERTIARY OBSTETRICS UNIT: AN AUDIT

Madugalle TMSSB[1], Maddumaarachchi M[2], De Silva D[3]
[1]Teaching Hospital Kandy, Sri Lanka,
[2]Registrar in Obstetrics and Gynaecology, Teaching Hospital Kandy, Sri Lanka
[3]Consultant Obstetrician and Gynaecologist, Teaching Hospital Kandy, Sri Lanka

Introduction
Category one (CAT1) caesarean deliveries are conducted for immediate life-threatening clinical situations as a life saving measure. NICE guidance on caesarean birth recommends birth of baby within 30 minutes from time of decision making. Rate of CAT1 caesarean deliveries continue to rise worldwide and it is vital to maintain excellent standards to ensure quality and safe obstetric care and improve maternal neonatal mortality and morbidity rates (NHS England, 2024)

Methods
A retrospective audit was conducted in a consultant lead tertiary obstetrics unit in Teaching Hospital Kandy, Sri Lanka from November 2022 to September 2023. Audit standards were established according to NG912 guidelines on caesarean birth published on 31st March 2021 (National Institute for Health and Care Excellence, 2021). Clinical records of all caesarean deliveries that occurred in the unit during selected period were accessed with permission from the hospital director, CAT1 deliveries were identified, and data was extracted using a data sheet. Rate of delivery of baby within 30 minutes from decision making, rates of mode of anaesthesia and rate of Apgar score <7 at 5 minutes were calculated. Statistical analysis was performed using SPSS 26.

Results
Seventy-two CAT1 caesarean deliveries were identified. Average time from decision to delivery of the baby was 20.82 minutes. With regional anaesthesia it was 24.78 minutes and with general anaesthesia it was 20.25 minutes. Decision to delivery time was significantly shorter with GA (95% CI 2.1373 - 6.9227, p = 0.0003). 100% of CAT1 caesarean deliveries were performed and the baby was delivered within 30 minutes (n=72). Rate of Apgar score <7 at 5 minutes was 11.1% (n=8). 87.5% of caesarean deliveries were performed under general anaesthesia (n=63). All neonates with Apgar <7 at 5 minutes were after general anaesthesia and none after regional anaesthesia (n=8).

Conclusions and recommendations
Our established ‘crash’ caesarean delivery protocol achieved 100% of deliveries within the recommended 30 minutes. General anaesthesia was associated with shorter decision to delivery times but our data show that general anaesthesia may be associated with poorer perinatal outcome. Regular refreshers and simulations have been planned for the unit to maintain time

standards and further research is recommended to determine association between mode of anaesthesia and Apgar at 5 minutes after CAT1 caesarean deliveries.

EP/O – 02
A CASE REPORT OF PRENATALLY DIAGNOSED DUODENAL ATRESIA DUE TO ANNULAR PANCREAS.

Wijayarathna,Y.A.C.N[1], Leelarathna,G.T.S[1],De Silva,P.H.P[1] ,Ranawaka,R[1]
[1]Colombo North Teaching Hospital

Introduction
Duodenal atresia is a congenital disorder where the duodenum is obstructed due to narrowing causing a blockage of liquids and food passage from stomach into the duodenum. It's a rare condition with an incidence of 1 in 5000 to 10000 live births. It is usually associated with poly-hydramnios during antenatal period due to impaired swallowing of liquor amnii. Rarely, duodenal atresia is associated with annular pancreas, where there is a problem with the duodenal development, causing pancreatic tissue surrounding the entire circumference of the duodenum obstructing the duodenum.

Case presentation
A 38 year old woman (gravida 3, para 2) who had two previous caesarean sections, presented to the antenatal clinic with fundal height more than for her dates with an impaired glucose tolerance at 28 weeks of gestation. Blood sugar series and serial growth scans were done every two weeks. At 32 weeks of period of gestation she was found to have severe poly-hydramnios with an amniotic fluid index of more than 35cm.

On further evaluation the fetus was found to have the characteristic double bubble sign, the baby was small for the gestational age with normal Doppler. The woman had a satisfactory glycemic control with Metformine. The baby was delivered late preterm at 35 weeks of gestation by elective repeat caesarean section, since the woman developed difficulty in breathing. The APGAR score at delivery was normal, with a birth weight of 1900 grams. Baby was admitted to HD incubator, oxygen given via nasal prongs, kept nil by mouth and started on IV fluid and antibiotics.

Corrective surgery was done on day three with duodeno-duodenostomy. During the surgery annular pancreas was noted causing duodenal atresia with adhesions in the small bowel. Duodenum kocherized and diamond shape duodeno-duodenostomy done using 4/0 interrupted vicryl, and patency of anastomosis obtained by passage of normal saline through anastomosis. After successful surgery, the baby was discharged, following 15 days of NICU care after establishing breast feeding.

Discussion
The demonstration of fluid filled dilated stomach and dilated proximal duodenum gives the typical double bubble sign on ultrasound.Diagnosis of duodenal atresia during antenatal period enable prenatal counselling and preparation of parents psychologically and plan the delivery in a unit where there is facility for early surgical correction. Once the baby is born, a simple

antero-posterior radiograph (plain X-ray) of the abdomen shows the double bubble sign, and the definitive diagnosis can be made soon after birth.

After successful surgical repair, overall survival is more than 90% and nowadays, early mortality after procedure is less than 3% in most case series, though most infants (about 50%) of them have other associated anomalies such as cardiac defects.

Conclusion

Duodenal atresia is a congenital intestinal obstruction which is associated with polyhydramnios in utero and is one of the common causes of fetal bowel obstruction. Care full assessment of ultrasonic features enables the diagnosis prenatally, and the subsequent management is with multidisciplinary approach involving the neonatologist and the paediatric surgeon. Overall success of surgical management have been excellent.

EP/O – 03
SUCCESSFUL VAGINAL DELIVERY IN A PATIENT WITH CHIARI 1 MALFORMATION

Dissanayake, CN[1], Rasika, JKMK[1], Ranaweera, AKP[1,2]
[1] De Soysa Hospital for Women, Colombo 08
[2]Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo

Introduction

Chiari 1 malformation (CM-1) is a rare brainstem anomaly characterized by cerebellar tonsillar herniation of ≥5 mm below the foramen magnum with a prevalence of 1 in 1000. The classic presentation of CM-1 is occipital cough headache. Other symptoms include dizziness, blurred vision, and unsteady gait.

The diagnosis is by tonsillar herniation in Magnetic Resonance Imaging (MRI). Treatment modalities include foramen magnum decompression and ventriculoperitoneal (VP) shunting.
CM-1 poses a challenge during pregnancy as increased intracranial pressure (ICP) can aggravate symptoms. Literature on pregnancy and CM-1 is minimal due to its rarity, highlighting the need for further studies. We present a case of a woman on VP shut for CM-1 who had a successful vaginal delivery.

Case report

A 35-year-old woman in her second pregnancy with a history of first-trimester miscarriage presented at 12 weeks of gestation for the booking visit. She had been treated for basilar migraine since 2009. In 2015, her headaches worsened with vomiting and unsteady gait. MRI revealed CM-1 with hydrocephalus and she underwent cranio-vertebral decompression followed by VP shunt insertion. Her pregnancy progressed well except for well-controlled gestational diabetes mellitus on medical nutrition therapy. She was on multidisciplinary management in liaison with the neurosurgical team. Poor filling of VP shunt was detected at 38 weeks of gestation. However, the decision was taken to proceed with normal vaginal delivery at term with Pethidine for pain relief. She went into spontaneous labor at 39+5 and delivered a healthy baby boy weighing 2.965 kg. The postpartum period was uneventful.

Discussion

Women with CM-1 are of concern due to the risk of herniation and decreased cerebral perfusion during pregnancy owing to hormonal changes, increased ICP, blood volume changes, and physiological stress in labor. Anesthesia for pain relief is critical as epidural and spinal anesthesia carry a theoretical risk of CSF leakage and herniation. Mode of delivery should be a multidisciplinary decision since Valsalva can increase ICP while Cesarean delivery lengthens recovery. However, the risk of increased ICP is minimal with VP shunts allowing for vaginal delivery.

Conclusion

Due to its rarity, the optimal management of CM-1 in pregnancy is still debatable. VP shunts significantly reduce the associated morbidity. Multidisciplinary management at the tertiary level of such patients is essential for a successful outcome.

EP/O – 04
MANAGEMENT OF A RARE CASE OF ANGULAR PREGNANCY

Kanchana, JLS[1], Wickramasinghe, NH[2], Ekanayake, EMIN[1], Bandara, WWMMK[1], Fernando, LGN[1], Silva, R[1]
[1]Colombo North Teaching Hospital [2]Anuradhapura Teaching Hospital

Introduction

Angular pregnancy, a rare type of pregnancy, resulting from the implantation of an embryo in the lateral angles of the uterine cavity medial to the utero-tubal junction, close to the proximal ostium of the fallopian tube. Literature shows a risk of uterine rupture with this type of pregnancy. In early pregnancy, differentiation of angular pregnancy from interstitial pregnancy (pregnancy located in the interstitial or intramural part of the fallopian tube and surrounded by less than 5mm of myometrium in all imaging planes; “interstitial line sign”, an echogenic line in the upper lateral region of the uterus bordering the gestational sac visible in USS) could be difficult. Criteria for presumed angular pregnancy are; non-anomalous uterus, Implantation of the embryo in the lateral angle of the uterine cavity, just medial to the utero-tubal junction, no more than 1cm of myometrial thickness from the gestational sac to the outer border of the uterus, presence of completely circumferential endometrium surrounding the gestational sac and, therefore, diagnostic of uterine gestation and lack of an interstitial line sign”.

Case report

A 28-year-old in her first pregnancy with early-onset fetal growth restriction with no known medical comorbidities was admitted for fetal wellbeing assessment at 34 weeks and 3 days of gestation. In USS, the estimated fetal weight was 1.4kg and Doppler studies were normal. She underwent an emergency cesarean section due to fetal distress. Intraoperatively, following the delivery of the baby uterus was found to be asymmetrical with the area of placental attachment bulging at the right angle of the uterus. The overlying myometrium of the protruding part was discolored probably due to placental vasculature. The placenta was delivered with difficulty and myometrium was thin in the area of placental attachment. Following the delivery of the placenta uterus looked symmetrical and no uterine anomaly was noted. Medical management

was carried out for anticipated primary postpartum hemorrhage. The assessed blood loss was 750ml. The baby cried at birth and, was handed over to the Neonatalogy team for the care for prematurity and low birth weight(1390g). The postpartum period was uneventful. In this scenario, angular pregnancy was not diagnosed in an early pregnancy scan.

Discussion

Diagnosing an angular pregnancy can be challenging with considerable overlapping of ultrasound scan findings with features of interstitial ectopic, cornual pregnancy and also, it will appear to be a typical intrauterine pregnancy. In such circumstances, three-dimensional ultrasound can be used to confirm findings of two-dimensional USS findings. Misdiagnosis as an ectopic pregnancy can lead to interventions to terminate a pregnancy that is viable otherwise. A missed angular pregnancy, managed without anticipating the risk of uterine rupture can lead to catastrophic events leading to maternal morbidity and mortality. In this scenario, the angular pregnancy might have been missed due to the close resemblance to uncomplicated intrauterine pregnancy. Therefore, it is important to be watchful during early pregnancy scanning.

Conclusion

It is important to differentiate angular pregnancies from interstitial and cornual ectopic pregnancies to avoid unnecessary surgical or medical intervention in early pregnancy. In addition, the correct diagnosis will aid in close monitoring for the anticipated risk of uterine rupture with the advancement of pregnancy and in formulating a delivery plan with the anticipated risk of postpartum haemorrhage.

EP/O – 05
HYDATIDIFORM MOLE AND CO-EXISTING LIVE FETUS - A CASE REPORT

Kamalathasan, P[1], Sabaratnam, J[1], Balakrishnarajah, JR[1], Baskaran, JRJR[1], Paramanayakam, A[1]
[1]Colombo South Teaching Hospital, Kalubowila, Sri Lanka

Objectives

An extremely rare obstetric complication of a twin pregnancy involving a hydatidiform mole (HM) coexisting with a developing fetus typically presents as either a complete hydatidiform mole with a coexisting fetus (CHMCF) or a partial hydatidiform mole with a coexisting fetus (PHMCF)[1].

Case Presentation

Following secondary subfertility for 7 years, a 46-year-old patient with a previous intrauterine insemination (IUI) pregnancy leading to 2nd trimester miscarriage and myomectomy**,** presented with twin pregnancy that included one live fetus with fetal growth restriction and intermittent absent diastolic flow, and a concurrent hydatidiform mole, following in vitro fertilization with donor egg. She was referred to our tertiary care center at period of gestation (POG) 34+5 weeks for further management and neonatal care.

A live baby weighing 1.6kg was delivered followed by a hydatidiform mole which was sent for histology confirming the findings of a molar pregnancy and a normal placenta. After a 2 week stay in the neonatal unit, the neonate was discharged in stable condition.

The patient had chronic hypertension and gestational diabetes mellitus which was managed in the antenatal period. Post operatively her uncontrolled blood pressure was managed with 10mg enalapril twice daily and amlodipine 50mg twice daily.

Due to persistently elevated serum beta hcg levels, the patient was referred to the National Cancer Institute for further management of molar pregnancy.

Conclusion
In this report, a case of CHMCF was managed by close monitoring of blood pressure, and fetal condition during pregnancy. A live newborn was delivered by cesarean section. CHMCF is a clinically rare disease with high risks; hence mandating careful diagnosis using ultrasound while dynamically monitoring the patient as she decided to continue the pregnancy.

Discussion
Ideally, a case of this nature needs to be managed by a multidisciplinary team comprising of an obstetrician, fetal medicine specialist, neonatologist, endocrinologist, nurse, midwife, counsellor and include post-partum follow up to ensure good maternal and fetal outcome[2].

Key words
partial mole, twin pregnancy, case report, pre-eclampsia, molar pregnancy, hydatidiform mole, molar pregnancy, twins, intrauterine growth restriction, co-existing live fetus

EP/O – 06
NON COMMUNICATING RUDIMENTARY HORN PREGNANCY :A CASE REPORT

Nimsara, RMGP[1], Makarim, AHM[2]
[1] Relief House officer,Base Hospital Kamburupitiya,Sri Lanka
[2] Consultant in Obstetrics and Gynaecology,Base Hospital Kamburupitiya,Sri Lanka

Background
Rudimentary Horn pregnancy (RHP); which is an ectopic pregnancy in a rudimentary uterine horn is a rare obstetric condition associated with high risk of uterine rupture and maternal morbidity or even mortality. Therefore, early diagnosis is essential for timely intervention which lessen complications and improve prognosis.The majority of Rudimentary Horn Pregnancies terminate in rupture during late-first or second trimesters and are only detected during laparotomy after the rupture.

Objectives
Rudimentary horn pregnancy is a rare obstetric condition associated with a high risk of uterine rupture and significant maternal morbidity and even mortality if undiagnosed .Therefore, early diagnosis is essential for timely intervention and management.

Case report

A 22-year-old primi mother came to the antenatal clinic for her first visit. She was at 11 weeks of gestation and her history was unremarkable with no past medical or surgical issues. She had no specific complaints; there was no abdominal pain or PV bleeding. On examination, she was well looking and hemodyanamically stable, but tenderness in right iliac fossa was observed. Per vaginal examination revealed a normal uterine size with right side cervical motion tenderness. Ultra-Sound Scan showed no gestational sac inside the uterus, but a cystic-like lesion measuring 3.2 cm in diameter was noticed on right-side adnexia. Differential diagnoses were ovarian ectopic pregnancy and cornual ectopic pregnancy. She underwent laparoscopic surgery which revealed a gestational sac within a right-side rudimentary horn measuring 4 x 5 cm in size with ipsilateral round ligament and fallopian tube attached to it. The rudimentary horn and gestational sac were completely removed along with a part of the attached fallopian tube. The postoperative period was uncomplicated and the diagnosis was confirmed according to histopathological reports as well.

Discussion

Rudimentary horn pregnancies are generally asymptomatic in early gestation or even if present,quite non-specific;which includes abdominal pain which may get worse as pregnancy advances.Therefore a pre-rupture diagnosis of Rudimentary horn pregnancy is challenging . Many women are only diagnosed during laparotomy following uterine rupture.Despite of low incidence of rudimentary horn pregnancy, potential complications and risk of maternal morbidity and mortality is high.This article highlights the significance of early detection of rudimentary horn pregnancies to avoid complications

Conclusion

Early diagnosis of a pregnant rudimentary horn is challenging while the diagnosis is often missed on prenatal ultrasound in first trimester.The treatment is surgical removal of pregnant horn to prevent rupture and recurrent rudimentary horn pregnancies.

Keywords

Rudimentary horn pregnancy ,Ectopic pregnancy , Maternal morbidity and mortality, Ultrasound, Laparoscopy

EP/O – 07

DIAGNOSTIC ROLE OF SERUM URIC ACID IN PREGNANCY INDUCED HYPERTENSIVE DISORDERS

Madhurahini, R[1], Balayasothini, V[2], Jeneni, J[2], Arasaratnam, V[1], Muhunthan, K[3]
[1]Department of Biochemistry, Faculty of Medicine, University of Jaffna, Sri Lanka
[2]Department of Medical Laboratory Sciences, Faculty of Allied Health Sciences, University of Jaffna, Sri Lanka
[3]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Jaffna, Sri Lanka

Introduction and objectives

Pregnancy related hypertensive disorders pose a significant effect on both maternal and foetal health. Early diagnosis and timely intervention with a reliable marker aid in improved healthcare outcomes. This study conducted to assess the diagnostic efficacy of serum uric acid to be used as a predictor in Pregnancy related hypertensive disorders, aiming to early diagnosis and to prevent associated complications.

Method

This is a population-based analytical cross-sectional study conducted at the Antenatal Clinic, Teaching Hospital, Jaffna. Consecutive sampling method was used to recruit participants among the pregnant women who were visiting for the routine monthly check up at antenatal clinic. A total of 68 pregnant women who satisfied based on the inclusion and exclusion criteria were selected. Pregnant women those who were in 24th to 36th weeks of gestation with blood pressure on two or more occasions having normal of 120/80 mmHg (Group 1= 34nos) and Pregnancy induced hypertension (PIH) of 140/90 mmHg and without proteinuria (Group 2= 34nos) were selected, while those on diuretics, immune-suppressing drugs, with kidney diseases (glomerulonephritis, kidney failure), kidney infection and hyperthyroidism were excluded. Blood samples were collected to estimate serum uric acid levels by uricase method. Ethical approval was obtained from the Ethical Review Committee, Faculty of Medicine, University of Jaffna. Independent sample t-test and ROC curve (SPSS version 25.0) were used to evaluate the diagnostic performance of serum uric acid levels.

Results

Serum uric acid level was ranged from 1.73-3.84 and 3.38-6.77 mg/dL in Group 1 and Group 2 women respectively. Mean serum uric acid level of PIH women was 4.66 (±0.89) mg/dL and was significantly higher ($p<0.001$) than that of pregnant women with normal blood pressure (3.04 ±0.49 mg/dL). The area under curve (AUC) of ROC curve was 0.969 with the sensitivity and specificity of 91.2% and 94.1% respectively. The cutoff value for serum uric acid level was ≥ 3.66 mg/dL.

Conclusion

Findings showed that serum uric acid concentration had better diagnostic efficacy for hypertensive disorders with significantly elevated levels in those with PIH. High AUC, along with substantial sensitivity and specificity values validated the predictive ability of serum uric

acid in clinical setup for early diagnosis and timely intervention for Pregnancy related hypertensive disorders.

EP/O – 08
IMPACT OF USE OF NON PNEUMATIC ANTI-SHOCK GARMENT IN PPH

Agrahari, Amrita Madhab[1], Kumar, Preeti[2]
[1] Phoenix Hospital, Prayagraj, India
[2] Krishna Medical Center, Lucknow, India

Introduction
PPH is defined as cumulative blood loss accompanied by signs and symptoms of hypovolaemia within 24 hrs of birth process regardless of route of delivery. According to National Health Mission, PPH contributes 38% of all maternal deaths in India.

Objective
Rural areas are major areas where deliveries are conducted yet health care workers are not aware of the newer techniques**.** Pre and post training analysis of health care workers and doctors was done on use of Non Pneumatic anti shock garment in PPH management in rural areas of India.

Design
It is a cross sectional study.

Methods
4 Community health centers and 3 district hospitals in rural areas of Uttar Pradesh state in India were randomly chosen under the project Jeevandhara. Training was done and pre and post training assessment was done

Results
Online and onsite training showed improvement of 40% in health care workers and 3%in doctors**.**

Conclusion
Jeevandhara has significantly bought improvement in awareness and maintenance of Non Pneumatic Shock Garment and its uses in PPH among health care providers. Long term positive goals to reduce maternal mortality need regular training, obstetric drill and assessment of health care providers.

Keywords
Non Pneumatic Anti Shock Garment,PPH,Jeevandhara

EP/O – 09

PREGNANCY IN A PATIENT WITH CONGENITAL DYSERYTHROPOEITIC ANAEMIA - CASE REPORT

Jayasekara,GL[1] Withana,KH[1] Madushanka,AHLD[1] Kularathna,MDCS[1]
[1]German Sri Lanka Friendship Hospital for Women- Karapitiya, Galle

Introduction

Congenital dyserythropoietic anemias are rare form of inherited anemias. They are associated with specific maternal complications and also affects fetal outcomes related to maternal anemia. Correct and early diagnosis warrants proper management and better outcomes.

Case report

A 27 years old mother of one child with past cesarian section, had her booking visit at 15 weeks +4 days. She was a diagnosed patient with congenital dyserythoplastic anemia at 14 years of age and defaulted follow up. She had undergone multiple blood transfusions during her first pregnancy. She was pale but not symptomatic, booking hemoglobin was 7.7g/l. Ultrasound abdomen revealed hepatosplenomegaly, cholelithiasis and a normal kidney. Liver function tests were normal. Blood picture suggested normochromic normocytic anemia with macrocytes, polychromatic cells, anisocytosis. Serum ferritin was 468 ng/dl. She did not need iron chelation therapy.In conjunction with hematology team patient was managed with blood transfusion to keep hemoglobin 8g/dl. Total of 10 units of leukoreduced blood were given. Other routine antenatal care was continued except for iron supplements.Her pregnancy was complicated with fetal growth restriction and planned for delivery at 37 weeks. Hemoglobin was optimized before delivery, elective cesarean section was done with precautions to minimize blood loss. Baby weighed 2.2 kg and had normal hemoglobin. Postpartum period was uncomplicated. Postpartum hemoglobin was 8g/dl. Patient was discharged with follow up at hematology clinic on post operative day 3.

Discussion

Anemia in pregnancy is a relatively common complication. Dyserthropoietic anemias follow autosomal recessive pattern of inheritance. They are of 4 types type I, II, III. CDA type II is the most common type of congenital dyserythropoietic anemia. They present with various degrees of anemias some need transfusions. They are iron overloaded and may present with signs of hemochromatosis. Splenomegaly and gallstones are known complications. Anemia is aggravated by pregnancy as per our patient. Blood transfusion and close follow up improve the outcome of the neonate by reducing low birth weight incidence and premature delivery. Pregnancy outcome of type 2 alone has not been studied but close followup resulted in significantly better outcome in type I patients.

Conclusion

Anemia in very early pregnancy may be indicative of non nutritional anemias. Congenital dyserythropoietic anemia is associated with adverse maternal and fetal complications. Correct diagnosis multidisciplinary input , treatment of the anemia and close follow up will improve the maternal and fetal outcome

EP/O – 10

BERNARD-SOULIER SYNDROME: A CASE REPORT AND REVIEW OF DIAGNOSTIC AND MANAGEMENT STRATEGIES

Jatheeswaran, K[1], Ruthra, Y[1]
[1]The German-Srilanka Friendship Maternity Hospital Karapitiya

Introduction

Bernard-Soulier Syndrome (BSS) is a rare, inherited bleeding disorder(Autosomal recessive) characterized by a defect in platelet function due to a deficiency of glycoprotein Ib-IX-V complex.[1] This defect impairs platelet adhesion to the von Willebrand factor, leading to bleeding tendencies Bernard-Soulier Syndrome (BSS) is a rare genetic bleeding disorder characterized by a deficiency or dysfunction of the platelet glycoprotein complex, which impairs platelet adhesion and leads to bleeding tendencies[3]. Managing pregnancy in women with Bernard-Soulier Syndrome poses unique challenges due to the increased risk of bleeding and complications..

Case Discussion

34 Years old mother known patient with Bernard Soulier syndrome, presented in her third pregnancy at 14 weeks gestation. She had an uncomplicated vaginal delivery in her first pregnancy. She underwent elective LSCS in her second pregnancy for breech presentation with oligohydramnios .In her first trimester she under went midline laparotomy for ruptured corpus luteal cyst with haemoperitoneum. She was managed at ICU during post op period with 2 pints blood transfusion,5 units of Platelet and 4 units of ffp transfusion.She was managed with holistic approach involving multi disciplinary team involving Obstetrician, haematologist, Neonatologist and Anaesthetist. Her booking visit platelet count was 25000 Hb 7.9g/dl.She was treated with double dose haematinics.She didn't have bleeding manifestations during her antenatal period.She was followed with monthly FBC. Her antenatal period was uneventful. She went into spontaneous labour at 38 weeks with a low platelet count of 29000.She was given 5 units of adult platelets. Immediate post partum she developed atonic PPH and managed with Bakri catheter insertion and prophylactic IV tranexamic acid and oxytocin infusion.She recovered completely with no residual effects.She was offered jadelle as long acting reversible contraception.Baby didn't have any bleeding manifestations during immediate postpartum period. Baby's hamaetology profile was normal.

Conclusion

This case highlights the importance of considering Bernard-Soulier Syndrome in patients presenting with pregnancy related bleeding episodes. Early diagnosis through specialized platelet function assays and genetic testing is crucial for effective management. This report underscores the need for ongoing patient education and personalized treatment strategies to improve quality of life for individuals with this rare condition.

EP/O – 11
PREGNANCY COMPLICATED WITH SPORADIC CASE OF HAEMOPHILIA A-A CASE REPORT

Jatheeswaran, K[1], Ruthra, Y[1]
[1]The German-Srilanka Friendship Maternity Hospital Karapitiya

Introduction
Hemophilia A is a genetic bleeding disorder caused by a deficiency in clotting factor VIII. Managing pregnancy in women with Hemophilia A presents significant challenges due to increased risks of bleeding complications for both the mother and the fetus. This case report describes the management and outcome of a pregnancy complicated by Hemophilia A.

Case Discussion
37 years mother in her second pregnancy(first child affected with severe haemophilia A disease-with no previous family history) admitted at 37+^weeks of gestation. It was a non consanguineous marriage. There were no positive family history of bleeding disorder as well. She is a new haemophilia A mutation carrier. The first child was currently managed with recurrent episodes of factor 8 transfusion and activated prothrombin complex concentrates. Apart from this her antenatal period was uneventful. She underwent elective LSCS at 38 weeks of gestation. She was managed by a MDT team with holistic approach. Haematologist recommendations were to offer least traumatic mode of delivery (LSCS). Forcep or ventouse delivery was avoided. Prophylactic IV tranexamic acid was given. NSAIDs were avoided as pain killers. After birth aPTT values of baby were checked which was normal. Oral Vit K given to the baby instead of Intramuscular vit K injection. Patient was adviced on future surgical intervention, outdoor sports, transfusion related infections, avoidance of NSAIDS, non traumatic muscle building activities like swimming, Hepatitis B vaccination and future fertility.

Conclusion
Managing Hemophilia A during pregnancy requires a nuanced approach to prevent and manage bleeding complications. The complexity of balancing factor VIII replacement therapy with the demands of pregnancy and delivery highlights the importance of a multidisciplinary approach. This case underscores the recommendations in the literature for planned cesarean delivery in women with Hemophilia A to minimize bleeding risks, aligning with existing guidelines and best practices. Pregnancy in women with Hemophilia A necessitates careful planning and a collaborative, multidisciplinary approach to ensure maternal and fetal safety. This case demonstrates successful management strategies, including pre-conception counseling, individualized factor VIII replacement, and a planned cesarean section. Continued research and case documentation are essential for refining management protocols and improving outcomes for affected women.

EP/O – 12

NAVIGATING PREGNANCY ASSOCIATED BREAST CANCER-A MULTIMODAL APPROACH

Jatheeswaran, K[1], Ruthra, Y[1]
[1] The German-Srilanka Friendship Maternity Hospital Karapitiya

Introduction

Breast cancer is one of the most common malignancies diagnosed during pregnancy, posing unique challenges in terms of diagnosis, treatment, and management. The incidence of breast cancer during pregnancy has been increasing, highlighting the need for a thorough understanding of how to navigate this complex intersection of oncology and obstetrics.This review aims to summarize current knowledge on the epidemiology, diagnostic approaches, treatment strategies, and outcomes of breast cancer diagnosed during pregnancy. It seeks to provide healthcare professionals with a comprehensive overview to guide clinical decision-making and improve patient outcomes.

Case Discussion

32 years old mother in her second pregnancy presented at 36 weeks with a suspicious lesion on her left breast with a short history of two weeks. USS breast was offered to the patient which revealed 1.2x1.6x1.5cm well defined irregular hypoechoic lesion with few micro calcifications and minimal shadowing at the corner. (BIRADS 4a). FNAC of the lump came as atypical duct epithelial cells with hyper chromasia, pleomorphic nuclei with high N/C ratio. The cytological features are in keeping with carcinoma of the breast. Patient was managed by a MDT team involving Obstetrician, General surgeon. oncosurgeon, histopathologist and anesthetist. Following factors like mode of delivery, time of delivery, further investigations, need for surgical intervention, place for chemotherapy/radiotherapy, peri op precautions.(Surgery, Anaesthesia),post op care(Mother, Baby)/Lactation, contraception, future pregnancies., screening of family members, fertility preservation surgeries and future salpingo oophorectomy were discussed cut biopsy was done in the antenatal period. As she was close to term she was induced at 37 weeks. She had an uncomplicated vaginal delivery. She was referred back to oncologist and onco surgeon for further treatment after the delivery. She underwent mastectomy followed by adjunct chemo therapy.

Conclusion

Managing breast cancer during pregnancy requires a multidisciplinary approach involving oncologists, obstetricians, and other specialists. While the prognosis for many women has improved, individualized treatment plans are essential to optimize both maternal and fetal outcomes. Continued research and clinical trials are necessary to refine treatment protocols and support long-term health for both mothers and their children.

EP/O – 13

A RARE CASE REPORT OF PRUNE BELLY SYNDROME WITH INCOMPLETE VACTERL

Jatheeswaran, K[1], Ruthra, Y[1]
[1]The German-Srilanka Friendship Maternity Hospital Karapitiya

Introduction

Prune Belly Syndrome is an unusual disorder with an estimated prevalence of 1 in 30,000 live births. The etiology is not completely understood, but it is thought to involve a developmental defect in the mesodermal layer of the embryo. The syndrome is predominantly seen in males and can range in severity. Prune Belly Syndrome (PBS), also known as Eagle-Barrett Syndrome, is a rare congenital disorder characterized by a triad of symptoms: absent or underdeveloped abdominal muscles, urinary tract abnormalities, and cryptorchidism (undescended testicles) in males. This case report presents a detailed clinical evaluation of a patient diagnosed with PBS, highlighting the diagnostic approach, management strategies, and long-term outcomes

Case Discussion

28 years old primi gravida presented at POG with lower abdominal pain. She had taken folic acid pre conceptually. There were no other identified risk factors during the antenatal period. During the routine first trimester multiple anomalies were detected. The patient was referred for a radiology scan at that time.1st trimester scan revealed multiple anomalies like megacystis(enlarged bladder), polysystic kidneys, vertebral anomalies, and septal defects. Suspicion of VACTERL anomalies(V-vertebral anomalies, A-anal atresia, C-cardio vascular abnormalities, T-Tracheo-oesophageal fistula, E-Esophageal atresia, R-Renal tract/Radial abnormalities, L-Limb defects)were made.MDT team meeting was arranged involving Obstetrician, Neonatologist, and Radiologist. A bad prognosis was informed to both partner and patient. Routine antenatal care was given to the patient thereafter. She went into spontaneous labour at 31 weeks and delivered a baby weighing 2 Kg. Early neonatal death within minutes of birth was seen. Recurrence risk is thought to be low, though this may change as genetic etiologies are identified and genetic testing improves.

Conclusion

Prune Belly Syndrome is a complex condition requiring a comprehensive approach to diagnosis and management. Early and accurate intervention can significantly impact the patient's quality of life and overall prognosis. Continued research and clinical experience will aid in refining treatment strategies and improving outcomes for affected individuals. Management of Prune Belly Syndrome is multidisciplinary and tailored to the individual's needs: Management of renal function is crucial. This may include hydration, medication to control electrolytes, and regular monitoring of kidney function. Surgery may be required to address urinary tract obstructions or correct cryptorchidism. Procedures might include ureteral reimplantation or renal surgery. Physical therapy may help with motor development and abdominal muscle strengthening. Developmental assessments are necessary to address any delays or issues. Regular follow-up with pediatric nephrologists, urologists, and developmental specialists is important to monitor kidney function, manage potential complications, and support the child's overall development.

EP/O – 14

CAPACITY BUILDING & STRENGTHENING LINKAGES IN CLINICAL & NON CLINICAL STANDARDS FOR POSTPARTUM HEAMORRAGE (PPH) USING STANDARDIZE, COMPREHENSIVE & STEPWISE EMERGENCY CARE APPROACH AS PER FIGO GUIDELINE

Jaiswal, U[1], Kumar, P[1]
[1]Team SMC

Introduction

Capacity building & strengthening linkages in clinical & non clinical standards for (PPH)

Design

Pre training assessment done by questionnaire tool
3 detailed virtual trainings for 3 hours each for 2 days HCW s & clinicians
Gap analysis and identification of gap
Comprehensive and stepwise emergency care approach with specific protocols and proper referral linkages are a must to reduce MMR due to PPH

Objective

To sensitize obstetric healthcare providers for using standardized, comprehensive and stepwise approach in management of PPH.

Method

Target study areas were private and public HCF of Uttar Pradesh, Jharkhand & Bihar state of India. Overall 40 private HCF & 4 tertiary public HCF (400HCWs& 40 Clinicians) were enrolled. Study was supported by Jhpiego, MGH, MGIMS, UNICEF and Path finder International. Pre-training assessment was done by Questionnaire tool. The questions were based on Identification, Prevention and Management related to emergency care in PPH. Human resources and facility functioning were also assessed. Members of Safe Motherhood committee FOGSI & Core Committee FOGSI conducted 3 detailed virtual trainings for 3 hours each for 2 days (total duration-9 hours) for both the groups of Healthcare workers (HCWs) and Clinicians. Best 3 private HCF and 6 HCWs from private sector showing maximum improvement were felicitated.

Result

Amongst clinicians, baseline survey showed a maximum 30% gap in knowledge of optimal Hb level, 58% in performing Active management of third stage of labour (AMTSL), 56% in usage of tranexamic acid, 44% in compression maneuvers and 31% in Uterine ballon Temponade (UBT) application and 20% in application of Non pneumatic anti-shock garment (NASG).Amongst HCWs, maximum gap of 92% was seen in performing AMTSL, 56% were aware of NASG and 68.2% of UBT usage. 34% of Private HCW had no proper referral protocol and linkages.

Conclusion
Identification of gaps in healthcare practices among obstetric health care providers and the HCW, they are working in is a must to improve their capacity building for management of PPH. A standardized, comprehensive and stepwise emergency care approach with specific protocols and proper referral linkages are a must to reduce MMR due to PPH.

EP/O – 15
A CASE OF SUCCESSFUL PREGNANCY IN A MOTHER WITH UNILATERAL LUNG HYPOPLASIA

Mohamed, ALS [1], Jayasekera, RMMSB [1], Wijesiriwardana, Y.S [1], Eshwarage, K.S. [1], Karunasingha ,J [1]
[1] Castle Street Hospital for women.

Introduction
Unilateral lung hypoplasia is a rare congenital anomaly (occurring in about 1 in 50,000 births) characterized by incomplete development of the lung parenchyma. It can occur in isolation or in association with other abnormalities (diaphragmatic hernia, renal agenesis, or cardiac defect). Pregnancy poses unique challenges in these patients due to the increased physiological demands. This case report describes the successful management of woman with lung hypoplasia.

Case Description
A 25-year-old woman in her second pregnancy with one living child with a history of left lung hypoplasia and sub aortic ventricular septal defect VSD diagnosed in the neonatal period presented for antenatal careShe delivered her 1st baby via Elective LSCS due to lung hypoplasia. She also a known patient with bronchial asthma managed with Budesonide inhaler.

Management & follow-up
The patient was managed by a multidisciplinary team (MDT) consisting of obstetrician, pulmonologist, cardiologist, anesthesiologists and neonatologist. Regular monthly antenatal visits were scheduled to monitor her respiratory and cardiac status, as well as fetal growth. At 20 weeks of gestation, the patient experienced a respiratory tract infection, requiring ICU admission She recovered without major complications. Serial ultrasound scans showed normal fetal growth and no anomalies detected in the fetus. 2D echocardiography performed at 36 weeks of gestation revealed mild pulmonary hypertension. However the booking Echo was normal except for a heart shift to the right. Given the complexity of her condition, an elective LSCS was performed at 38 weeks of gestation under combined spinal and epidural anesthesia to minimize respiratory compromise. The delivery was uneventful, and no uterine anomalies noted and a healthy baby was born. Cu-IUD inserted at the time of LSCS. Postpartum recovery was uneventful without respiratory or cardiac complications. The patient continued to be monitored by the MDT, ensuring optimal management of her respiratory condition and overall health.

Discussion
Physiological changes of pregnancy, increased blood volume increase respiratory minute volume and decreased total lung capacity and diaphragmatic elevation further strain the already limited respiratory capacity of women with lung hypoplasia. This increases the risk for respiratory infections, pulmonary hypertension, and respiratory failure. Associated cardiac anomalies can further complicate maternal health. Multidisciplinary care is crucial for optimizing maternal outcomes. Close monitoring of maternal respiratory status, early intervention for complications, and planning for delivery are important aspects of management.

EP/O – 16
ACUTE SEVERE PANCREATITIS IN PREGNANCY

Fernando, MUM [1] ,De Silva, DYK[1] ,Mahdoom ,BWMA[1],Sumithraarachichi, LD[1]
Wijethunga,WMK M[1]
[1] National Hospital, Kandy

Background
Acute pancreatitis occurs in approximately 3 out of every 10,000 pregnancies. The causes of pancreatitis during pregnancy differ from those in non-pregnant women. The most common causes include gallstones (accounting for over 65% of cases), alcohol consumption, and hypertriglyceridemia. Less frequently, it can be linked to conditions such as hyperemesis gravidarum, AFLD, and HELLP syndrome. It has a high mortality and morbidity rate. Diagnosing acute pancreatitis in pregnancy is challenging due to non-specific symptoms. For a diagnosis, at least two out of three criteria must be met, similar to the criteria for non-pregnant women. These criteria include abdominal pain (typically epigastric pain that radiates to the back), elevated serum amylase or lipase levels (more than three times the upper limit of normal), and imaging findings characteristic of pancreatitis.

Case Report
A 25-year-old woman in her third pregnancy, at 36 weeks' gestation, presented with severe epigastric pain radiating to her back, accompanied by nausea and vomiting for one day. On examination, she was afebrile, tachycardic, and had epigastric tenderness. Further investigation revealed a high serum amylase level (961 U/L). These findings led to the suspicion of acute pancreatitis, which was further supported by ultrasound scan results. A multidisciplinary team was involved in her management, which included conservative measures such as intravenous fluids, pain relief, antibiotics, antiemetics, and close observation. Despite these efforts, her condition deteriorated, necessitating an emergency delivery. Tragically, the patient passed away on the second postoperative day due to very severe acute pancreatitis.

Discussion
The diagnosis of acute pancreatitis in pregnancy is based on a combination of clinical manifestations, laboratory findings, and radiological investigations. Treatment should involve a multidisciplinary team and can include either conservative management or surgical intervention, depending on the severity of the presentation and the overall condition of both

the mother and the fetus. Despite optimal management, very severe pancreatitis has a high mortality rate.

Conclusion
Early detection and appropriate therapy of acute pancreatitis will reduce the maternal mortality rate and prevent catastrophic outcomes. Early involvement of a multidisciplinary team will improve outcomes.

EP/O – 17
THE OUTCOME OF TRIPLET PREGNANCY AFTER ONE FETAL DEMISE AT 19 WEEKS OF GESTATTION
Mazahima, MM[1], Thirukumar, M[2], Karunkaran, KE[2], Jey Krishna, K[1], Rathnasekara, WADAK[1]
[1]Teaching Hospital Batticaloa
[2]Faculty of Health Care Sciences, EUSL

Introduction
The incidence of mortality and morbidity is greater among multiple pregnancies than among singleton pregnancies. Intrauterine fetal death of one fetus is an uncommon association in multiple pregnancies: 2.6% in twins and 4.3% in triplet pregnancies, respectively. Because of the rarity of the situation there are no established guidelines in the literature.

Case presentation
A 37 years old mother in her 2nd pregnancy with one miscarriage and history of secondary subfertility for 3 years, and her current pregnancy resulted in trichorionic triamniotic triplet after in vitro fertilisation, presented with one fetus demise at 19weeks of gestation. She had undergone cervical cerclage 12 weeks of gestation.In the assessment the demised fetus was near to cervix with ruptured amniotic cavity with two live fetuses.

The cervical cerclage was removed and the demised fetus was removed in the theatre under ultrasound guidance and the placenta kept inside. The cervical cerclage was reapplied and mother was kept on regular follow up. the pregnancy was continued upto 34 weeks and the two babies were delivered via lower segment caesarean section. The atrophied placenta was noted at the surgery.

Discussion
Mortality & morbidity have been reported to be more in multiple pregnancies comparison to singleton pregnancies. Single intrauterine fetal death in second and third trimesters places the other fetus at substantial risk, including preterm delivery and associated comorbidities of prematurity such as pulmonary hypoplasia, necrotizing enterocolitis, long term neurological complications and neonatal death. Another possible outcome is the death of the surviving fetus. In addition, there are increased risks to mother of pre eclampsia, coagulopathy and sepsis. But this mother's pregnancy was continued up to 34 weeks without any complications.

Conclusion
The removal of death fetus and re application of cervical cerclage with regular follow up of the mother by looking for any complication helped to continue the pregnancy and successful delivery.

EP/O – 18
AUDIT ON WRITING PROPER OPERATIVE NOTES AFTER PERFORMING AN INSTRUMENTAL DELIVERY

Fernando, MUM [1] ,De Silva, DYK[1] ,Mahdoom ,BWMA[1],Sumithraarachichi, LD[1]
Wijethunga,WMK M[1]
[1] National Hospital, Kandy

Introduction
10-15% of women undergo assisted vaginal delivery in developed countries. Instrumental delivery may be indicated in patients with suspected fetal compromise, delay in the active second stage, maternal exhaustion, and medical indications to avoid the Valsalva maneuver. Several complications can arise from instrumental delivery, including maternal complications such as third and fourth-degree perineal tears, postpartum hemorrhage, and fetal complications like cephalohematoma, lacerations, and intracranial hemorrhage (ICH). To improve the quality of instrumental deliveries and avoid unnecessary legal issues, proper documentation of operative notes is mandatory.

Objectives
To identify the percentage of proper operative note writing in instrumental deliveries.
To identify common mistakes during the writing of operative notes.
To identify solutions for preventing common mistakes during operative note writing.

Methods
A retrospective audit was carried out using details obtained from 25 Bed Head Tickets (BHT) from Ward 6, National Hospital Kandy, of patients who have already been discharged. SLCOG guidelines for assisted vaginal delivery operative notes (Annexure 1) were used as a guide for this audit.

Results
Out of 25 instrumental vaginal deliveries, all had some form of operative notes. 80% of the operative notes contained basic introductions such as patient information, time, date, and the operator's name. All cases included maternal and fetal assessments before performing the procedure. Out of 25 cases, 23 mentioned the indication for instrumental delivery. 66.6% documented the anesthesia used. Only 40% of the notes mentioned application methods and traction. 80% documented the number of pulls and placental examinations after delivery. Perineal assessment was mentioned in all cases. However, only 75% of cases mentioned the neonatal condition after delivery. Only 2 out of 25 cases included a signature at the end of the documentation.

Conclusion

Proper documentation is necessary for all instrumental vaginal deliveries. While 100% of cases contained some form of operative notes, 50% of the notes did not meet the criteria outlined in the SLCOG guideline's checklist. We have planned an educational program for ward staff and the preparation of a ward-level operative note structure to improve the quality and reliability of operative notes in assisted vaginal deliveries

EP/O – 19

POSTPARTUM VENOUS SINUS THROMBOSIS, REFRACTORY THROMBOCYTOPENIA WITH SYMMETRICAL IUGR; CYTOMEGALO VIRAL INFECTION.

Senarathna, TGDPR[1] , Ranathunga[2], RMDB , Abeykoon, W[3]
[1] Registrar in Gynecology and Obstetrics- National Hospital Kandy
[2] Senior Registrar in Gynecology and Obstetrics- National Hospital Kandy
[3] Consultant in Gynecology and Obstetrics- National Hospital Kandy

Introduction

Cytomegalovirus (CMV) is an enveloped DNA virus in the *herpes viridae* group. Maternal CMV infection is an obstetric concern mainly due to fetal and neonatal morbidity and mortality caused by vertical transmission of the infection. Infection in adults is commonly asymptomatic and self-limiting while rarely causing flu-like symptoms, hepatitis, venous thrombosis, and thrombocytopenia. Maternal primary infection is diagnosed with CMV IgM, IgG. CMV IgM is a sensitive test to diagnose primary infection, but it is not specific as the antibodies may remain positive for a long duration (up to one year) and can appear in reinfection. Hence CMV IgG avidity test is used to diagnose acute infection. One of the known complications of CMV infection in adults is venous thrombosis, commonly reported cases of deep vein thrombosis while few cases of cerebral venous sinus thrombosis also have been reported. Mother-to-child transmission can occur with maternal primary infection as well as from mothers who had previous infection and were immune at the time of conception (due to reactivation or re-infection with a different strain). Congenital infection can lead to Rash, Jaundice, Microcephaly, Low birth weight, intrauterine growth restriction, Hepato-splenomegaly, Retinitis, Hearing loss, and Intellectual disability.

Case report

An 18-year-old primy woman, who was admitted following a threatened miscarriage at 11 weeks of period of amenorrhea (POA) was investigated for thrombocytopenia during early pregnancy with a platelet count (PLT) of 41×10^{9}/L without other bleeding manifestations. In her history, there were no features of autoimmune diseases such as photo-sensitive rashes, oral ulcers, small joint poly arthritis, and hair loss. Basic investigations, Coagulation screening, liver functions, and Ultrasound scan of the abdomen were normal. The blood picture showed moderate thrombocytopenia without atypical cells. The patient was started on prednisolone therapy with a preliminary diagnosis of immune thrombocytopenic purpura (ITP). During the evaluation of the ITP, the Anti-nuclear antibody (ANA) was positive at POA 16 weeks (≥1:100 titer), VDRL was non-reactive and HIV 1 and 2 were negative. Due to persistent low PLT count $<50\times10^{9}$/l, the patient was started on Hydroxychloroquine and then started on azathioprine. During antenatal follow-up, diagnosed as intra-uterine growth restriction. At 35 weeks of POA patient was transferred to tertiary care for further management of thrombocytopenia with a PLT count of 12×10^{9}/l. At 35+3 POA patient went into spontaneous onset of labour and the 1530g baby was delivered. At delivery PLT was 19×10^{9}/l and 6 units

of PLT were transfused during delivery and prophylactic tranexamic acid and oxytocin infusion was given and the immediate postpartum period was uncomplicated without any bleeding manifestations. The baby was admitted to a special baby care unit due to prematurity and low birth weight and at there, confirmed symmetrical IUGR (OFC <-3SD microcephaly, Length <-3SD and weight <-3SD). The baby was diagnosed with early neonatal jaundice and thrombocytopenia (PLT-59×10^9/l)and the neonate's serum and urine PCR for CMV was positive. During postpartum, prednisolone and azathioprine were continued and the patient was asymptomatic.PLT count was improved up to 134×10^9/l. On post-partum day 32, the patient developed a generalized tonic-clonic seizure without a history of headache or focal neurological signs. NCCT-Brain was done and it was normal and blood pressure and urine albumin were negative. After neurology opinion patient underwent a CECT Brain + CT Venogram and EEG which showed anterior superior sagittal sinus thrombosis while the EEG was normal. The patient was started on anti-epileptics and low molecular weight heparin bridging with warfarin. After achieving PT/INR target patient was discharged from the ward on day 45 with a review plan with PT/INR.

Discussion

In this patient, acute infection of CMV in pregnancy was most possibly leading to the above clinical consequences. However, due to the unavailability of the IgG avidity test, we cannot confirm the recent infection or reactivation of CMV infection in this patient. ITP in pregnancy usually responds to corticosteroid treatment in 60- 80% of patients (7) while in this patient it poorly responded to steroid, azathioprine, and hydroxychloroquine treatment. Even though ANA was positive in this patient, there were no other clinical features suggestive of autoimmune disease while ANA can be positive in low titers in normal healthy populations as well. There was no other exact pathological cause for fetal microcephaly and symmetrical IUGR in this neonate other than possible congenital CMV infection. Late postpartum venous sinus thrombosis also a rare condition (8) and in this patient, there is no other possible etiology for this presentation as well. When considering all of the above clinical consequences, these are probably originating from a single clinical etiology which is most likely the CMV infection in this patient during early pregnancy.

EP/O – 20

HEMORRHAGIC SHOCK FROM RUPTURED ECTOPIC PREGNANCY WITH NEGATIVE URINE TEST: CASE REPORT

Atapattu, H [2], Manatunga, DS [1], Adikaram, WDCN,[1] Sarupa, SM [1]
Ojithmali, AGM [2],
[1] Ministry of Health, Sri Lanka
[2] De Soysa Hospital for Women, Colombo, Sri Lanka

Objectives

The aim of this case report is to highlight the diagnostic complexities and management challenges associated with a ruptured tubal ectopic pregnancy presenting with a negative urine beta-HCG test. This case underscores the importance of considering ectopic pregnancy in differential diagnoses, even with negative urine pregnancy tests.

Case Report

A 40-year-old woman, previously healthy with three children, presented to the Emergency Treatment Unit (ETU) unconscious and gasping, following multiple episodes of vomiting post-dinner. On admission, she displayed signs of shock with a low pulse rate (50 bpm), hypotension (86/50 mmHg), and low oxygen saturation (54%). Arterial blood gas analysis revealed mixed acidosis. Despite these critical findings, the urine human chorionic gonadotropin (HCG) test

returned negative, and the date of the patient's last menstrual period was unknown. After initial resuscitation, the patient underwent intubation and received intravenous (IV) administration of Noradrenaline and Vasopressin for hemodynamic support. An ultrasound scan showed a moderate accumulation of free fluids in the abdomen and pelvis. A contrast-enhanced computed tomography (CECT) scan confirmed ascites without active bleeding vessels but identified an ovarian mass, likely an ovarian cyst. Surgical intervention with emergency laparotomy revealed a ruptured left-sided tubal ectopic pregnancy, accompanied by approximately 1.5 liters of hemoperitoneum. A left salpingectomy was performed due to the severity of the rupture. During the postoperative period, the patient was managed in the ICU and received multiple blood transfusions due to significant blood loss.

Discussion
This case illustrates the need for heightened clinical suspicion and comprehensive diagnostic strategies in cases of suspected ectopic pregnancy, even when urine beta-HCG tests are negative. The patient's presentation with shock and critical findings despite a negative urine pregnancy test highlights the potential for atypical presentations of ectopic pregnancy. This case underscores the importance of using multiple diagnostic modalities and a multidisciplinary approach to manage such complex cases effectively.

Conclusion
This case emphasizes the critical need for clinicians to maintain a high index of suspicion for ectopic pregnancy in women of childbearing age presenting with atypical symptoms, even with negative urine beta-HCG tests. Comprehensive diagnostic approaches, multidisciplinary management and prompt surgical intervention are essential to mitigate the risks of adverse outcomes. Future research should focus on improving diagnostic protocols and increasing awareness among healthcare providers to enhance patient outcomes in similar cases.

Keywords Ectopic pregnancy, Negative urine HCG tests, Ruptured ectopic pregnancy, Salpingectomy

EP/O – 21
CHRONIC ECTOPIC PREGNANCY WITH A PALPABLE ABDOMINAL MASS: A CASE REPORT

Atapattu, H [2], Adikaram, WDCN [1], Manatunga, DS [1], Sarupa, SM [1]
, Ojithmali, AGM [2]
[1] Ministry of Health, Sri Lanka
[2] De Soysa Hospital for Women, Colombo, Sri Lanka

Objectives
This case report aims to highlight the diagnostic perplexities and management difficulties associated with a chronic ectopic pregnancy presenting with an abdominal mass.

Case Report
A 34-year-old previously healthy primigravida presented with left-sided lower abdominal pain for two weeks and per vaginal bleeding for one month. Her last-regular-menstrual-period was unknown, and urine Human Chorionic Gonadotropin(HCG) was positive on admission. She did not exhibit signs of shock; her pulse-rate was 88bpm, and her blood pressure was 100/70mmHg. She was neither pale nor febrile. Abdominal examination revealed an undetectable uterine size, with a palpable, tender, immobile mass of 5x4cm in the left-lumbar region extending to the left-groin. Speculum examination showed no bleeding, and the cervix appeared healthy.

Ultrasound scan demonstrated a left-sided ectopic pregnancy with a gestational sac measuring 0.7cm and a mass of 1.7x1.5cm surrounded by a haemorrhagic area measuring 2.9x5.1cm. Her Haemoglobin was 11.9mg/dL, Platelet was $322\times10^3/\mu L$, White Blood Cells was $8.57\times10^3/\mu L$, Serum-beta-HCG was 785.29mIU/mL, C-Reactive Protein was 0.9mg/L and Cancer-Antigen-125 was 38.1U/mL. Laparoscopy under general anaesthesia revealed a left tubo-ovarian mass. The tube and ovary were adhered to lateral pelvic wall, with the omentum adhered to mass and pelvic wall. Adhesiolysis was performed, and ovary and omentum were freed from the wall. A left-side chronic organized ectopic mass of 5x4cm was visualized. Left-salpingectomy was performed while preserving the ovary. The right-ovary and tube were normal. The uterus was normal.

Discussion
Recurrent small bleedings into the pelvic cavity in chronic ectopic pregnancies result in hematocele formation, including an inflammatory response and adhesions with adjacent structures, clinically presenting as a pelvic lump. Inflammatory markers in blood are often elevated, leading to misdiagnosis. Radiological findings are nonspecific, often demonstrating a non-homogeneous mass with signs of recurrent bleeding, failing to provide a definitive diagnosis. However, rarely the conceptus can rarely be visualized within the mass, as in this case. Due to the vague clinical presentation, non-specific radiological findings, and unreliable beta HCG values, the diagnosis remains a conundrum.

Conclusion
This case accentuates the importance of a comprehensive diagnostic approach and maintaining clinical suspicion for ectopic pregnancy in any sexually active woman of reproductive age. Definitive management of chronic ectopic pregnancy is ipsilateral salpingectomy, which poses significant surgical morbidity due to adhesions that may injure the bladder, bowel, and ureters. Preserving the ipsilateral-ovary can also be challenging.

Keywords
Chronic ectopic pregnancy, Abdominal mass, Salpingectomy

EP/O – 22
PEMPHIGOID GESTATIONIS – A RARE PREGNANCY SPECIFIC DERMATOSIS

Shakoor, MZ[1] , Shahana, MMF[1]
[1]Teaching Hospital Anuradhapura, Sri Lanka.

Objective
Pemphigoid gestationis(PG) is a rare pregnancy-associated autoimmune disease which is associated with pruritic papular and vesicobullous eruption of the skin. This is characterized by itchy ,red skin lesions around, and including, the Umbilicus. They have increased risk of Small-for-gestational age(SGA) neonates, preterm deliveries and neonatal pemphigoid gestationis .The risk of other autoimmune conditions also increased.

Case report
A 29 years old mother with a previous cesarean delivery presented with a itchy rash around the umbilicus for 5 days duration without fever at 35 weeks of gestation. On examination there was well defined vesicular clusters on and around umbilicus forming plaques and rest of the examination was normal. Fetal Scan and investigations including FBC,CRP performed and all were normal. Clinical diagnosis of Pemphigoid gestationis was made and treated with high

dose oral prednisolone. She responded to treatment and at 38 weeks the patient underwent elective cesarean delivery.

Discussion

Pemphigoid gestationis occurs in 1/50,000 to 60,000 pregnancies. IgG autoantibodies are directed to the hemidesmosome target antigens in the basement membrane and this triggers Compliment 3 deposition along the dermal-epidermal junction. The Inflammation will result in separation of the epidermis from the dermis and create a blister. Usual presentation is with an itchy rash either plaques or papules commonly involving the umbilicus and skin around the umbilicus which later spread to the extremities, back, chest, buttocks and palms and soles. Face and mucosal membranes are not usually involved. These are often intensely pruritic and can convert to blisters within the plaques after few weeks. High Incidents of PG has been reported with women with egg-donated pregnancies. PG increase the incidents of SGA fetuses and preterm deliveries. The risk of grave disease also shown to increase. About 10% of infants can have transient blisters which is usually resolve with clearance of maternal antibodies. These infants are at risk of skin infections and electrolyte abnormalities. It has a tendency to recure in subsequent pregnancies and flare-ups are common in 1st or 2nd day of postpartum. As this is a self-limiting disease, the goal of treatment is to manage the symptoms. Depending on the severity tropical and systemic corticosteroids can be used with an antihistamine to reduce symptoms.

Conclusion

Both an obstetrician and a dermatologist should be involved in caring for patients with pemphigoid gestationis. The pediatrician should be aware about the diagnosis and the medications the mother is receiving.

EP/O – 23
SURGICAL MANAGEMENT OF AN ABDOMINAL EPIDERMOID CYST: A CASE REPORT

Leelarathna, GTS[1], Senevirathna, JTN[2], Wickramasinghe NH[2], Dissanayaka AK[2]
[1] Colombo North Teaching Hospital, Ragama
[2]Teaching Hospital, Anuradhapura

Objective

Epidermoid cysts, or epidermal inclusion cysts, are benign growths typically found in about 1% of individuals. Though they are found most commonly found on skin, very rarely they can occur within abdominal cavity. Pregnancy does not increase their occurrence, but hormonal changes can lead to cyst enlargement. These cysts are characterized by a keratin-filled core and are lined with squamous epithelium. While they often do not cause symptoms, they can become infected, inflamed, or rupture, requiring medical attention. We report a case of abdominal epidermoid cyst which caused an acute abdomen in a pregnant woman.

Case report

A 36-year-old pregnant woman with diabetes presented at 13 weeks and 4 days gestation, with abdominal pain lasting five days. Stable vital signs and localized tenderness to the right abdomen were noted. Ultrasound confirmed intrauterine pregnancy alongside an 8 cm x 7 cm x 5 cm encapsulated mass in the right epigastric region, prompting concern for malignancy such as a gastrointestinal stromal tumor (GIST). MRI findings too very inconclusive and supported findings from the USS. Despite surgical risks, including preterm labor, surgery proceeded due to symptom severity and suspected malignancy at 15 weeks via midline

laparotomy. During surgery, large solid mass attached close to ilea-caecal junction was noted and resected without damage to bowel. The procedure was successful without complications, supported by meticulous care. Postoperative monitoring confirmed the well-being of both mother and baby. Histopathological examination identified an benign Epidermoid cyst, guiding subsequent management and follow-up.

Discussion

This case underscores the importance of a multidisciplinary approach in managing complex cases during pregnancy. The differential diagnosis of an abdominal mass in pregnancy is broad, including benign and malignant etiologies. Treatment during pregnancy is generally conservative, focusing on symptom management. Early surgical intervention, when indicated, can be lifesaving and prevent potential complications for both the mother and the fetus. Collaboration among obstetricians, surgeons, anesthesiologists, endocrinologists, and pathologists is crucial to ensure comprehensive care and optimize outcomes. Epidermoid cysts typically do not pose significant risks during pregnancy, vigilant monitoring and timely intervention are essential to address any potential complications promptly.

Conclusion

Timely diagnosis and management of abdominal masses in pregnant women are crucial. This case demonstrates the successful management of a large abdominal mass in a pregnant woman with diabetes, highlighting the importance of timely surgical intervention and the necessity for multidisciplinary collaboration.

EP/O – 24
INCIDENTALLY IDENTIFIED SERTOLI LAYDOG CELL TUMOR IN PREGNANCY

MMH Dissanayake[1], SA Ruwanpathirana[1], DSN Withana[1], SSN Chandrasiri[1], WFN Fereen[1]
[1]De Soyza Hospital for Women, Colombo, Sri Lanka

Introduction

Sertoli-Laydig cell tumor is a rare form of ovarian cancer accounts for less 0.5% of all ovarian malignancies. It is characterized by synthesis of male sex hormones leading to hyperandrogenic features and commonly occurs in females at reproductive age between 20-30 years. It is extremely rare to occur during pregnancy and exact prevalence is unknown. Overall prognosis is favourable as more than 80% of cases are diagnosed at early stage, having good chemosensitivity and relatively low recurrence rate.

Case report

A 27 years old mother in her second pregnancy with a history of past section due to oblique lie presented at 37 weeks of gestation with dribbling and moderate meconium. Her antenatal period was uneventful and in ward ultrasound scan on admission showed singleton live fetus in breech presentation. Thus she underwent an emergency cesarean section. During the surgery, found to a have a left sided suspicious bulky ovary. After discussing with consultant obstetrician left sided salpyngoophorectomy was performed and the specimen sent for urgent histology. She delivered a healthy baby girl weighing 3.2Kg and during newborn assessment she was found to have features of virilization. Her histology report revealed moderately differentiated Sertoli-Laydig cell tumor without vascular invasion. The patient was referred to gynecological oncology services and there she underwent complete debulking surgery at 6

weeks of postpartum with multidisciplinary team decision. After that she was treated with adjuvant chemotherapy and routinely follow up at clinic.

Discussion
Androgen secreting tumors during pregnancy can give rise to virilizing features in female neonates resulting ambiguous genitalia. Complete surgical debulking and chemotherapy are the cornerstones of managing sex cord stromal cancers. Fertility preservation, early menopause, adverse effects of chemotherapy and psychological concerns need to be addressed. Prognosis of the cancer depend on the tumour staging, pathological grading, patient comorbidties, availability of the oncological services and response to adjuvant therapy.

Conclusion
Inspection of ovaries is an extremely important step in all abdominal surgeries. Early diagnosis, early intervention, multidisciplinary team approach will help to improve the patients' outcome.

EP/O - 25
SUCCESSFUL PREGNANCY OUTCOME IN A BACKGROUND OF PLACENTA PRAEVIA AND UTERUS DIDELPHYS

MMH Dissanayake[1], CG Maggonage[2], RMAN Rathnayaka[1], WADP Wanniarachchi[1], DNS Sarathchandra[1]
[1]Professorial Unit of Obstetrics & Gynaecology, Teaching Hospital Peradeniya.
[2]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya.

Objective
Uterus didelphys (double uterus) is a rare congenital anomaly of the female genital tract resulting from failure to fuse the two Müllerian ducts during early embryological development, leading to duplication of uterus and cervix. It may associate with other Müllerian anomalies such as renal agenesis, longitudinal vaginal septum, vaginal agenesis and duplication of bladder and urethra.

Case Report
A 28-year-old mother in her first pregnancy presented to a local hospital at 7 weeks of gestation with biochemically positive pregnancy where she was undergone an ultrasound examination and managed as a pregnancy of an unknown location. Two weeks later a repeated ultrasound scan was done and she was diagnosed with didelphys uterus with gestational sac in left hemiuterus. She was regularly followed up at a tertiary care hospital until delivery. Her anomaly scan excluded any gross foetal malformations. As she declined two weekly cervical length assessment, she was given vaginal progesterone from 12 weeks to 36 weeks to prevent preterm birth. Her 34 weeks ultrasound scan revealed posterior placenta previa, breech presentation and small for gestation. Thus, she was undergone elective caesarean section at 37 weeks of gestation and delivered a healthy baby weighting 2.4kg. During caesarean section, it was found to have her gestation was confined to left hemiuterus and the right hemiuterus was empty. Fallopian tubes and ovaries appeared normal and separately fused with each side of the hemiuteri. On further evaluation she had a single cervix. Renal and urinary tract anomalies were excluded by an ultrasound scan.

Discussion
Most of women with uterus didelphys are asymptomatic but they can have dysmenorrhoea, hematocolpus, hematometrocolpus, chronic pelvic pain, dyspareunia and sexual dysfunction due to vaginal septum. It may associate with pregnancy complications such as spontaneous abortion, preterm birth, malpresentation, foetal positional defects, abnormal placentation, small for gestation and higher incidence of abdominal delivery. It carries a high risk of genital tears, retained placenta and postpartum haemorrhage if goes into a vaginal delivery. Difficulty in identifying lower segment, risk of bladder injury, extension of uterine incision, difficulty in anatomical repair and intra-operative haemorrhage are the anticipated problems during caesarean delivery.

Conclusion
Uterus didelphys is associated with wide spectrum of pregnancy complications. Regular close monitoring, early identification of complications and early interventions helped to improve the pregnancy outcome.

EP/O – 26
SURGICAL MANAGEMENT OF A CLASSIC CASE OF CAESAREAN SCAR PREGNANCY

MMH Dissanayake[1], CG Maggonage[2], RMAN Rathnayaka[1], WADP Wanniarachchi[1], DNS Sarathchandra[1]
[1]Professorial Unit of Obstetrics & Gynaecology, Teaching Hospital Peradeniya.
[2]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya.

Introduction
Caesarean scar pregnancy is a rare form of an ectopic pregnancy, in which gestational sac implants over the myometrial defect at the site of the previous uterine incision. The prevalence is around 1 in 2000 pregnancies. There are two types of Caesarean scar pregnancies. The first type grows into uterine cavity, which is potential to reach until viability and ended up as placenta accreta spectrum disorder. The second type grows towards the serial surface of the uterus and have a risk of rupture and bleeding at early gestation.

Case report
A 32 years old mother in her 2nd pregnancy, presented to the booking scan at 8 weeks of period of gestation. Her first pregnancy was ended up as an emergency caesarean section due to fetal distress during labour and otherwise it was uneventful. Her booking scan revealed gestational sac with single live foetus, which was implanted at the lower part of the uterine cavity, possibly over the previous caesarean scar. In further evaluation, she had an empty uterine cavity, an empty cervix and absence of sliding sign and the thin layer of myometrium between the gestational sac and urinary bladder. A department scan was performed and it confirmed the above diagnosis. As patient was willing for surgical management, it was planned to do a suction evacuation under laparoscopic guidance. But during laparoscopic procedure, there was a gestational sac with thin layer of myometrium and prominent blood vessels were noted over the gestation sac with contact bleeding. Thus, the procedure was converted to an open laparotomy. Due to persistent continuous bleeding, the surgery ended up in a hysterectomy. Patient was debriefed and counselled regarding the incident.

Discussion
Combined transabdominal and transvaginal ultrasound scan is the primary diagnostic modality of caesarean scar pregnancies. The magnetic resonance imaging is a second line investigation and serum beta hCG has no role in diagnosis. Available treatment options are conservative, medical and surgical approaches, which depend on the symptoms, fertility wishes, size of the sac, period of gestation, myometrial thickness and available facilities. Expectant management is suitable for small, nonviable scar pregnancies which partially implanted into the scar and grows into uterine cavity. It carries a high risk of failure and haemorrhage. Methotrexate can be administered locally into the gestational sac under ultrasound guidance, but it may associate with high risk of bleeding, infection and failure. Hysteroscopic guided evacuation carries high risk of bleeding, thus it may need additional homeostatic measures such as uterine artery embolization and tamponade. Surgical excision is technically difficult and invasive which carries a risk of recurrence and scar rupture in future pregnancies. Hysterectomies need to be considered in second trimester scar pregnancies, severe haemorrhages and scar rupture.

Conclusion
Caesarean scar pregnancy is a life-threatening condition which needs early diagnosis and intervention to prevent morbidity and mortality.

EP/O - 27
ACUTE FATTY LIVER IN PREGNANCY: A CASE REPORT

Perera,NNN[1], Abeygunawardana D[2]
[1]Colombo South Teaching Hospital, Colombo, Sri Lanka
[2]Base Hospital Homagama, Colombo, Sri Lanka

Objectives
Acute fatty liver of pregnancy (AFLP) is a rare but life threatening obstetric complication with a peak incidence in the third trimester. A patient typically presents with non-specific symptoms such as nausea, vomiting and abdominal pain and can be overlooked. We present a case report of a young woman with acute fatty liver at term with a fatal perinatal prognosis highlighting the need for high index of suspicion at all times.

Case report
A 33 year old woman, in her 2nd pregnancy with a previous normal delivery, at 37 weeks POA was referred from the MOH clinic due to jaundice. She experienced epigastric pain, nausea, vomiting and 3 days back and had been managed for Gastroesophageal reflux disease (GORD) which responded well to anatacids and antiemetics.

On admission, she was asymptomatic. Physical examination revealed deep jaundice and fetal heart sounds were inaudible. Ultrasound scan confirmed intrauterine death and labour was induced with Prostaglandin. Investigations revealed Total bilirubin 8.68 (0.1-1.2mg/dl), Direct bilirubin 8.42mg/dl (0.3-1.1mg/dl), AST 65 U/L(<30U/L), ALT 98 U/L(<30U/L), INR 1.69(<1.1), S.Creatinine 1.59mg/dl (0.6-1.1mg/dl), WBC 26.4 (4-10 x 10^9). Additional screening to exclude viral hepatitis and liver autoimmune screen was done and negative. Gastrointestinal specialist opinion obtained and she was managed with IV N- acetylcysteine infusion 72 hour regime, Ursodeoxycholic acid 300mg bd for 2 weeks until normalization of bilirubin,.IV Ceftriaxone 1g bd for 1 week and coagulation corrected with IV Vitamin K. Her liver and renal functions improved over the next week.

Discussion
The diagnosis was initially missed as her symptoms were overlooked as GORD and not further investigated. However, at her second presentation she was promptly investigated and managed resulting in good maternal outcome. AFLP poses a diagnostic dilemma as investigations show similar hepatic and renal manifestations as with conditions such as HELLP syndrome or intrahepatic cholestasis in pregnancy. In this case, AFLP was diagnosed using the Swansea criteria with the presence of 6 key features – clinical features of nausea and vomiting, elevated bilirubin, elevated liver enzymes, elevated Creatinine, elevated INR and leukocytosis. Definitive management is urgent delivery and supportive care in liaison with gastrointestinal team in this case.

Conclusion
Despite AFLP being a rare condition, this case highlights the importance of high index of suspicion of AFLP for a woman presenting with new onset GORD symptoms in the third trimester. Prompt management with urgent delivery and supportive measures could improve maternal and fetal outcomes.

EP/O - 28
GAUCHER DISEASE COMPLICATING PREGNANCY

Goonatilleke, D C[1],Abeysiriwardena, N J ,Fernando, A T N[1]
[1]Professorial Unit of Obstetrics and Gynecology Colombo South Teaching Hospital, Kalubowila

Objective
Gaucher disease is the commonest lysosomal storage disease seen worldwide. Gaucher results from an autosomal recessive disorder resulting in the deficiency of the lysosomal enzyme glucocerebrosidase. Pregnancy exacerbate manifestations in women with Gaucher Disease. Maternal complications such as gestational diabetes, splenomegaly, hepatomegaly, thrombocytopenia, osteoporosis and postpartum hemorrhage may occur as a result.The following is a case of a 33 year old pregnant woman with symptomatic type 1 Gaucher disease presenting with bicytopenia, hepatosplenomegaly and bleeding manifestations.

Case Presentation
33 year old woman in her 2nd pregnancy, presented to the antenatal clinic at 13 weeks of period of gestation (POG) and was found to have bicytopenia. In her previous pregnancy 7 years back anemia was detected but not further evaluated. She had a term emergency lower segment cesarean section (LSCS) with primary post partum hemorrhage where 1 pack blood transfusion was given and observed in the intensive care unit for one day. Current pregnancy was also complicated with gestational hypertension on antihypertensives. On and off petichial patches were seen through out pregnancy but no other bleeding manifestations. No symptoms of connective tissue dissorder(CTD) or family history of CTD. Blood picture showed features of iron deficiencyanemia and pregnancy related changes ,thrombocytopenia due to viral infection +/- immune mediated .No evidence of Microangiopathic hemolytic anemia noted in blood film. USS abdomen showed hepatosplenomegaly .Bone marrow features were suggestive of a storage dissorder most likely Gaucher Disease . Multidiciplinary meeting on delivery plan was held. Bicytopenia corrected prior to LSCS and underwent an uncomplicated elective LSCS with tubal sterilization at 37 weeks POG after discussion with the patient and family to prevent future pregnancy related complications. Further follow up conducted by hematology unit to undergo enzyme assay and arrangements are being made to procure enzyme replacement for her.

Discussion
Anticipatory guidance on contraception is necessary to prevent unintended pregnancies in this population.The principal manifestations of type 1 Gaucher disease are likely to affect females during reproductive events such as pregnancy, delivery and lactation. Enzyme replacement is efficient and effective in treating type 1 symptomatic Gaucher disease, which also reduces pregnancy complications , with no evidence to date of any untoward effect of enzyme replacement on the fetus, or on infants breast fed by mothers receiving it.

Conclusion
With early diagnosis and enzyme replacement women can experience pregnancy without overtly disease exacerbated complications in symptomatic type 1 disease.

EP/O - 29
RESCUE CERCLAGE: IS IT EFFECTIVE.

Gnanarathne S [1], Kariyawasam A [2]
[1]Senior lecturer in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya.
[2]Research Assistant, Faculty of Medicine, Peradeniya.

Objective
Rescue cerclage is not widely practiced, considering the risk of infection, preterm labor, rupture of membranes, anesthetic complications, and psychological impact. Here we discuss, two cases of rescue cerclage, with favorable neonatal outcomes.

Case report
A 26-year-old, with 3 previous first trimester miscarriages, presented in her 4th pregnancy following Invitro Fertilization. She was diagnosed with diabetes, and on Metformin. She underwent cervical cerclage at 18 weeks, as an ultrasound scan (USS) revealed funneling of the internal OS, with a short cervix of 2.5cm. At 19th week, she was presented with abnormal sensation in the vagina and the speculum examination revealed bulging membranes up to introitus. A rescue cerclage was performed with McDonald's technique using No.2 black silk. Three days later, a repeat cerclage with two stitches, was applied using McDonald's technique, with Mersilene tape and No. 1 nylon, at 1cm and 2cm above the external OS, following the reduction of membranes with hydrostatic pressure. A clindamycin vaginal pessary was inserted and deep intramuscular Progesterone was given. This pregnancy was extended up to 26 weeks and delivered vaginally with a favorable neonatal outcome.

A 32-year-old, presented in her 2nd pregnancy, with a history of preterm labor at 32 weeks in her first pregnancy. At 14 weeks of gestation, the cervical length was 3cm with an uncomplicated antenatal period. At the 17th week, she had vaginal discharge and discomfort, and bulging membranes at the cervix. A rescue cerclage was performed using McDonald's technique with No.1 nylon at 1cm and 2cm above the external OS, after the reduction of membranes with hydrostatic pressure. At the 37th week of gestation, a healthy baby was delivered vaginally.

Discussion
Cervical incompetence is a well-recognized cause of recurrent pregnancy loss. A transvaginal ultrasound scan can detect cervical changes in advance, ensuring timely interventions. Prophylactic cerclage can be performed between the 14th and 18th weeks as indicated by history with 2 or more mid-trimester pregnancy losses or with cervical length less than 2.5 cm. Rescue cerclage is an emergency procedure, in the second trimester, for painless cervical dilatation and protrusion of membranes, after excluding infections, active bleeding, and labor. The

membranes are reduced before the suture, to minimize the risk of rupture and infections, and to ensure the prolongation of pregnancy without complications.

Conclusion
Rescue cerclage is a direct, safe surgical procedure, allowing prolongation of gestation, and improving viability.

Keywords
cervical incompetence, rescue cerclage, recurrent pregnancy loss

EP/O – 30
AN ATYPICAL PRESENTATION OF ACUTE PANCREATITIS IN PREGNANCY.

Wijesiriwardhana,YS[1] Jayasekara, RMMSB[1] Mohamed, ALS[1] Eshwarage, KS[1] Karunasingha,JI[1]
[1]Castle Street Hospital for Women

Objectives
The incidence of acute pancreatitis in pregnancy is rare and reported to be 3 per 10,000 deliveries. Maternal mortality rate may go up to 3% if timely interventions are not done. Diagnosis of acute pancreatitis in pregnancy is more challenging and when managing pregnant patients, consideration of implications on the foetus poses an additional challenge. This case report reveals management of an atypical presentation of acute pancreatitis during pregnancy.

Case Report
A 30 year old second para at 34 weeks of gestation with a history of second trimester miscarriage, who's on a cervical cerclage presented with symptoms suggestive of preterm labour which did not respond to tocolytics. On day five of admission although cervical cerclage was removed as she developed regular contractions with cervical dilatation, labour did not progress. Instead she started bilious vomiting with absent bowel opening for 2 days along with an epigastric pain. A suspicion of intestinal obstruction was raised but further biochemical tests revealed a serum amylase level of 992 U/L. Ultrasound scan did not reveal any focus of pathology and there was an obvious difficulty in imaging with x-ray due to gravid uterus. A working diagnosis of acute pancreatitis with a functional intestinal obstruction was made. Conservative therapy with gastric decompression, anti-spasmodic drugs and intravenous antibiotics were commenced. Consideration on possible maternal and foetal complications if pregnancy was continued was raised. Agreed management in a multidisciplinary team involving general surgeon, obstetrician, physician and radiologist was to induce labour by artificial rupture of membranes as her clinical condition was worsening over time. Fortunately she delivered a live non-asphyxiated baby vaginally within 3 hours of induction of labour. Same management continued postnatally and mothers' condition improved substantially after delivery of the foetus. On day four of delivery her serum amylase level dropped to 160 u/l and she started tolerating normal diet.

Discussion
Etiology of 70% cases of acute pancreatitis is gallstone disease, secondary to physiological changes with elevated progesterone levels in pregnancy. Serum amylase aids in the diagnosis with a diagnostic sensitivity of 81% in pregnancy. Usefulness of Computed Tomography is substantially restricted in pregnancy due to potential radiation risk. Clinical diagnosis along with biochemical investigations is of utmost importance where clinical expertise is available.

Conclusion

Idiopathic acute pancreatitis in pregnancy is a rare but a fatal condition if not timely diagnosed and intervened. This case-report reveals the importance of multidisciplinary approach and timely decision making to give better maternal and foetal outcomes.

EP/O - 31

POST-PARTUM CEREBRAL VENOUS SINUS THROMBOSIS: A CASE REPORT

Ayeshmantha, DD[1] ,Shakoor, MZ[1]
[1] Teaching Hospital Anuradhapura

Introduction

Cerebral venous sinus thrombosis (CVST) is a rare life-threatening condition reported specially in pregnant and puerperal period due to hypercoagulable state causing partial or complete obstruction of cerebral veins. Here we present a rare case of CVST in which patient initially presented with headache which mimicked sinusitis.

Case presentation

A 28-year-old lady, 26 days after emergency lower segment cesarean section (LSCS) came with headache, rhinorrhea for 5 days and vomiting for 1 day. On admission she had frontal headache and vomiting. She was afebrile, conscious, rational and GCS 15/15. Neurological examination was normal without focal neurological signs and papilledema. She was normotensive and urine albumin was not detected. She was initially managed as sinusitis.Non Contrast Computed tomography (NCCT) was performed due to intractable headache and vomiting. Venous sinus thrombosis in superior sagittal sinus extending in both transverse sinuses with partial recanalization was diagnosed with the help of CT venogram. She was successfully treated with low molecular weight heparin (LMWH) and mannitol without complications. Follow up was arranged with warfarin for 6 months targeting INR between 2-3.

Discussion

Prevalence of CVST in pregnancy is 1.2 per 100 000 deliveries. Headache, neurological deficits and seizures are the main presentations of CVST in which headache is the commonest presentation. Diagnosing is challenging due to varied presentation and symptom overlapping between common conditions like eclampsia, cerebrovascular accidents, meningitis, post dural puncture headache. CT venogram can be used as a substitute for magnetic resonance venogram. Pregnancy is a risk factor for CVST due to prothrombotic state which lasts 6-8 weeks after the delivery. Sepsis, preeclampsia, cesarean section are other risk factors associated with pregnancy. Unfractionated heparin or low molecular weight heparin followed by vitamin k antagonist for 6 to 12 months is recommended. Surgical decompression might be necessary if the cerebral edema not resolved to mannitol.

Conclusion

This case highlights the importance of adding CVST as a differential diagnosis if a lady coming with persistent headache during antenatal period or postpartum. Early diagnosis with CT

EP/O - 32

SUCCESSFUL PREGNANCY IN A MOTHER WITH CHIARY MALFORMATION WITH A VENTRICULOPERITONEAL SHUNT - CASE REPORT

De Silva, WVD[1], Rasika, JKMK[1], Rishard, MRM[1], Piyadigama, I[1]
[1] De Soysa Hospital for women, Colombo, Sri Lanka

Introduction

Chiary malformation is a congenital anomaly of hindbrain, where part of cerebellum & brain stem lie below foramn magnum, causing abnormal circulation of cerebro-spinal fluid. Its prevalence is around 1 in 1000 in general population. It's a spectrum of disorders; types I,II,III,IV. Type 1 is the commonest, least severe & oftern diagnosed in adulhood. Type II is less common, more severe & almost always associated with myelomeningocele. Types III & IV are generally uncompatible with life.

Case report

35 years old mother in her second pregnancy, with a previous uncomplicated vaginal delivery 5 years back, was diagnosed with Chiary malformation by a MRI 2 years ago, while being investigated for headache. Ventriculoperitoneal shunt (VP shunt) has been inserted afterwards.
She has been conceived by an unplanned pregnancy. Multidisciplinary management was carried out since the early pregnancy, involving the Obstetrician, Neurosurgeon & Anaesthetist, with regular assessment of shunt functioning. Pregnancy was otherwise uncomplicated and she went into spontaneous labour at POA of 38+2. A baby boy of 3.2kg was delivered by an uncomplicated vaginal delivery, within 2 hours after the admission to hospital. Pain management was done only with Entonox. Ephysiotomy was sutured under sterile condition & Intravenous Cefuroxime & Metranidazole was given in paostpartum.
With maternal request, bilateral ligation & resection of Fallopian tubes was done in postpartum day 3 under spinal anaesthesia. Post-surgically, intravenous antibiotics were continued for 2 more days. She had an unevenful postpartum period, and was discharged on postpartum day 4, with oral antibiotics for 5 days.

Discussion

Women with a VP shunt need a multidisciplinary management during pregnancy. They should be evaluated prior to pregnancy by a CT/MRI to assess shunt functioning and to get a baseline measurements for further comparison, in case if ventricular dilataion worsens during pregnancy. VP shunt catheter can be obstructed during pregnancy due to increased intra-abdominal pressure & infections. So regular monitoring of VP shunt by the neurosurgeon is essential. Obstructed VP shunt can be presented with headache, vomiting, seizures & gait imbalance.Vaginal delivery is the choice of delivery mode in an uncomplicated pregnancy. In case of anaesthesia, spinal anaesthesia has the risk of possible VP shunt infection. And raised intracranial pressure should also be excluded. General anaesthesia has the advantage of reduced intracranial pressure & minimal shunt infection.There is no evidence of increased postpartum infection rate in mothers with a VP shunt. But to prevent shunt infection, we have managed with antibiotics.

Conclusion

Managing a woman with a VP shunt during pregnancy is challanging. Optimal preconceptional and antenatal multidisciplinary management will improve the outcome with minimal neurological and shunt related complications.

EP/O – 33
PRENATAL DIAGNOSIS OF UNILATERAL MULTICYSTIC DYSPLASTIC KIDNEY: A CASE REPORT

Dissanayake AD[1], Madanayake YR[2]
[1]Consultant Obstetrician and Gynaecologist, Senior Lecturer, Sir John Kothelawala Defence University, Sri Lanka
[2]Senior house officer, Obstetrics and Gynaecology Department, Kothelawala Defence University Hospital, Sri Lanka

Objective
Multicystic dysplastic kidney (MCDK) is a developmental renal abnormality, detectable by antenatal ultrasonography. Although the prevalence of MCDK is 1 in 4000 live births, antenatal detection rates are low. Unilateral MCDK with no other associated abnormalities has good prognosis. Bilateral MCDK occur frequently in male fetuses and is generally lethal in utero.

Case Report
A 31-year-old primigravida, diagnosed with type 2 diabetes mellitus on metformin 1g twice daily, presented at 18 weeks gestation to the antenatal clinic. Her HbA1c was 6.8% and nuchal translucency was 1.4mm. A 22 week anomaly scan detected a female fetus with no structural abnormalities. Ultrasonography at 32 weeks revealed a right sided MCDK with a normal left kidney. No hydroureter, bladder outflow obstruction was noted. Fetal growth and liquor volume were normal. Mother was followed up two weekly till delivery. She underwent induction of labour at 38 weeks, followed by emergency caesarean section due to failed induction. Neonatal ultrasonography confirmed right sided MCDK. Baby had multiple neonatal admissions due to urosepsis and is currently under follow up by peadiatric urologist.

Discussion
MCDK is the most common cystic renal disease in the newborn occurring due to failure of metanephros to unite with the ureteric bud. 75% are unilateral and isolated with good prognosis. Ultrasound reveals echogenic renal parenchyma with multiple non communicating cysts of variable sizes with no features of obstructive uropathy indicated by normal bladder and normal amniotic fluid index (AFI). Bilateral MCDK 25%, has poor prognosis and is associated with anhydramnios. Extra renal defects found in 25% of cases include cardiac, gastrointestinal, nervous system, skeletal defects[1]. In such cases Brachio-otorenal syndrome, VACTERL association, Short- rib polydactyl, Meckel gruber syndrome, Trisomy 18 should be suspected. Pre-existing diabetes mellitus increases risk of MCDK[2]. Mode of delivery will be according to obstetric indications. Following delivery baby requires pediatric urology follow up. Recurrence risk in isolated disease is 1-2%.

Conclusion
MCKD is a genitourinary abnormality detectable by antenatal sonography easily. Disease prognosis is poor if bilateral, presence of associated other anomalies, genetic conditions. Diabetes mellitus increases risk of fetal renal anomalies.

EP/O - 34

SECONDARY SPONTANEOUS PNEUMOTHORAX IN PREGNANCY IN A PATIENT WITH PAST HISTORY OF SMEAR POSITIVE PULMONARY TUBERCULOSIS (TB)

Chandrarathna, M[1] , Withana, KH[1] , Liyanagama, PMJ[1]
[1]New District General Hospital, Kamburugamuwa, Matara, Sri Lanka.

Objectives

Spontaneous Pneumothorax is a rare but potential life threatening condition in pregnancy. It's challenging to come to a prompt diagnosis of pneumothorax as nonspecific respiratory symptoms are common during pregnancy. Delaying of diagnosis can lead to sudden respiratory compromise due to progression to tension pneumothorax.

Case report

26 year old primi gravida presented at 28 weeks of gestation with sudden onset shortness of breath & pleuritic type chest pain with no history of fever or trauma. Her past medical history is significant for smear positive pulmonary TB & treatment completed in 2019. On physical examination her blood pressure was 110/70mmHg with pulse rate of 115 bpm & no murmurs, respiratory rate was 22 breaths per minute with reduced air entry on right side. Chest X-ray PA taken with abdominal shield and found to have right side pneumothorax due to ruptured bullae (Figure 1).Following insertion of right side IC tube pneumothorax resolved (Figure 2). After 1 week patient was discharged after removal of intercostal (IC) tube following clinical improvement. After two weeks patient readmitted with same symptoms and found to have recurrent pneumothorax and IC tube was reinserted. Multidisciplinary team involving Respiratory physician, Anesthetist & Obstetrician decided to keep IC tube until termination of pregnancy. Live fetus was delivered via CAT 4 LSCS & patient was transferred to National Hospital for respiratory diseases, Welisara for further surgical management

Discussion

Pneumothorax should be considered in any pregnant women who presented with acute onset of dyspnea with chest pain. Radiological diagnosis should not be delayed as delayed treatment leads to progression to tension pneumothorax which is life threatening.

Conclusion

This case report highlights the successful management of recurrent pneumothorax due to ruptured bullae due to smear positive pulmonary tuberculosis during pregnancy. It underscores the importance of early detection using radiological images, prompt intervention and multidisciplinary collaboration in managing severely ill patients.

EP/O - 35
HUNTINGTON DISEASE IN PREGNANCY

Sumithraarachchi, LD[1], Karunasinghe, J[2], Kasturiarachchi, SS[3], Perera YARS[4], Emalka, WJ[5].
[1]Obstetric and Gynaecology unit, National Hospital Kandy.
[2]Obstetric and Gynaecology unit, Castle Street Hospital for Women, Colombo.
[3]Premature baby unit, District General Hospital, Nawalapitiya.
[4]Obstertric and Gynaecology unit, Base Hospital, Galgamuwa.
[5]Medical unit, National Hospital of Sri Lanka, Colombo.

Introduction and Objectives
Huntington disease (HD) is a neurodegenerative, autosomal dominant disorder with progressive movement, cognitive and psychiatric deterioration, leading to death. Symptomatic HD seen in pregnancy is a rare occurrence given its late onset. Multidisciplinary management of a patient with advanced HD in pregnancy is discussed in this case.

Case report
A 37-year-old mother of two with a poor socioeconomic background, who was previously undiagnosed of any illness, self-admitted to the gynaecology ward with abdominal pain and was found to have a 26-week singleton pregnancy. Considering her having involuntary choreiform movements, drooling of saliva and slurred speech together with maternal side relatives with similar symptoms, a diagnosis of HD was made. It was decided by a multidisciplinary team (MDT) involving a neurologist, anaesthesiologist, neonatologist, obstetrician, nutritionist, physiotherapist and social services officer, to deliver the baby via caesarean section and provide sterilization under spinal anaesthesia and to hand the baby over to probationary care, with the consent of the mother. A category 3 caesarean delivery was performed at 36 weeks due to preterm premature rupture of membranes and gestational hypertension. The baby was handed over to the neonatology team immediately and was given for probationary care at 1 month of age. The mother is continuing follow up with neurological treatment, social services support and physiotherapy. Genetic counselling for the previous two children was arranged.

Discussion
Motor symptoms of HD makes bearing down in the 2nd stage and management of labour challenging. Hence the decision of caesarean delivery was made. Spinal anaesthesia was considered better, to avoid the risk of aspiration but a possible increase in choreiform movements in the upper body due to ensuing anxiety was anticipated and was treated with an anxiolytic. The baby was immediately handed over to the neonatology team as the mother was deemed unfit to handle the baby with her choreiform movements. However, expressed breast milk was given during the hospital stay. The baby was taken into probationary care as the mother was unable to care for the baby considering the lack of family support. Psychiatric input was taken, given a 50% chance of depression in HD. Sterilization was performed as she is not fit to undergo another pregnancy considering the incurable nature of the disease.

Conclusion
Clinicians must be aware of the challenges to be expected in the management of a patient with motor, autonomic and psychiatric symptoms related to HD in pregnancy. MDT approach is best adopted preconception.

EP/O - 36

A RARE PRESENTATION OF POST RICKETSSIAL RETINAL VASCULITIS COMPLICATING REACTIVATION OF TOXOPLASMOSIS IN PREGNANCY

Eshwarage KS[1], Samarawickrama S[1]
[1] District General Hospital Hambanthota

Background

Typhus fever , endemic in Asia and Sri Lanka ,caused by bacteria transmitted by the fleas and tics. Although rare In Pregnancy,complications include miscarriage , fetal growth restriction and preterm labour.Untreated severe cases can lead to maternal mortality. Some rare complications like systemic vasculitis and inflammation also there. *Toxoplasma gondii* ,following initial infection, can remain dormant in tissues and may reactivate due to immunosuppression. . Reactivation can cause miscarriage, stillbirth, or congenital abnormalities including neurological deficits, hydrocephalus, retinochoroiditis (eye lesions), and developmental delay. In this particular case of typhus fever got very rare complication of retinal vasculitis and pregnancy was complicated by reactivation of toxoplasmosis due to iatrogenic immunosuppression.

Case report

A 27-year-old woman in her second pregnancy at 23 weeks gestation presented with 4 days of high fever, arthralgia, myalgia, and a rash. Typhus fever was diagnosed clinically and confirmed through serological test. She treated with oral Azithromycin and intravenous ceftriaxone , improving over a 5-day hospital stay and discharged with oral antibiotics. Three weeks later, she returned with recent onset blurred vision. Evaluated for pre-eclampsia, which was ruled out, she was referred to ophthalmology where she showed signs of autoimmune vasculitis like multiple cotton wool spots and macular star sign and affecting her vision with visual accuity 6/60, diagnosed as post-rickettsial retinal vasculitis according to clinical ground. Despite initial improvement with IV methyl prednisolone therapy as started according to multidisciplinary team decision , her vision worsened over time. Intravitreal triamcinolone acetonide injections at national eye hospital improved her condition.Offered Screening for auto immune diseases and toxoplasmosis revealed negative anti-nuclear antibodies and positive Toxoplasmosis IgM and IgG, indicating toxoplasmosis reactivation due to iatrogenic immune suppression.Throughout pregnancy, fetal growth was monitored and deemed appropriate. Elective caesarean section was performed at 37 weeks according to multidisciplinary team decision. The baby was admitted to NICU and developed spontaneous pneumothorax on day 2 of life , also testing positive for toxoplasmosis. With careful management, both mother and baby were discharged on post-operative day 14.

Discussion

Post-rickettsial vasculitis with retinal involvement, a rare complication of typhus fever, underscores the need for vigilant monitoring during pregnancy. Prompt specialist referral is crucial due to the potential for systemic vasculitis to present uniquely. Treatment complexities, including systemic steroids and intravitreal corticosteroid injections, highlight the delicate balance required for maternal and fetal health. Visual recovery in post-rickettsial vasculitis varies; initial improvement may be followed by deterioration, necessitating specialized intervention. Reactivation of toxoplasmosis in pregnant women manifests with nonspecific symptoms like fever and malaise, raising concerns for fetal health. Diagnosis involves clinical

suspicion and serological tests for Toxoplasma antibodies (IgG and IgM), crucial for detecting recent infection or reactivation.

Conclusion
Diagnosis of typhus fever and identification of rare complications like vasculitis and the management demands meticulous oversight and specialized care. Before starting immune suppressive treatments it is always better to screen for possible congenital infections.

EP/O - 37
MIDGUT VOLVULUS IS SECONDARY TO CONGENITAL MALROTATION CAUSING PROXIMAL BOWEL OBSTRUCTION DURING PREGNANCY. A RARE CASE REPORT

Jey Krishna K[1], Linganathan K[2], Dinamithra N P[2] Premarathna HRSDB3 Akalanka WADAK1
[1]Teaching Hospital Batticaloa
[2]Teaching Hospital Polonnaruwa
[3]German Sri Lanka Friendship Hospital for Women, Galle, Sri Lanka

Background
Bowel obstruction during pregnancy is a rare but potentially life-threatening condition, with a reported incidence of approximately 1 in 10,000 pregnancies. Among the various causes of bowel obstruction, sigmoid volvulus and intestinal malrotation stand out as unusual and challenging diagnoses in the pregnant population. This case report presents a 28-year-old primigravida who experienced a complex diagnostic journey, highlighting the unique challenges in identifying and managing such conditions during pregnancy.

Case Description
The patient initially presented with episodes of bilious vomiting, epigastric pain, and appetite loss at 19 weeks of gestation. Despite initial unremarkable findings, her symptoms worsened, leading to her readmission at 22+6 weeks of gestation. Laboratory results revealed elevated liver enzymes, and concern for hepatitis arose. However, the patient's condition continued to deteriorate, marked by significant weight loss and an inability to tolerate solid foods. Several Upper gastrointestinal endoscopy attempts were inconclusive, further complicating the diagnostic process. Ultimately, an MRI revealed midgut malrotation with volvulus causing partial small bowel obstruction, a diagnosis that had been challenging to reach due to overlapping symptoms with normal pregnancy discomforts. The multidisciplinary team opted for conservative management with total parenteral nutrition until 32 weeks of gestation. A lower segment caesarean delivery was planned, combined with surgical correction of the malrotation. Fortunately, the postoperative period was uneventful.

Conclusion
This case underscores the diagnostic complexity of midgut volvulus and malrotation during pregnancy. The overlapping symptoms of these conditions with those of normal pregnancy, combined with the reluctance to employ radiological investigations due to radiation concerns, make timely diagnosis a formidable challenge. Nevertheless, early detection, appropriate use of radiological studies, and timely surgical interventions are imperative to reduce maternal mortality and prevent catastrophic outcomes associated with bowel obstruction in pregnancy. Increased awareness among healthcare providers regarding these conditions and their unique presentation during pregnancy is essential for ensuring optimal maternal and fetal outcomes.

Key words
Midgut volvulus, congenital Midgut malrotation, pregnancy, small bowel obstruction

EP/O - 38
ENHANCING MATERNAL AWARENESS AND PERCEPTION OF LABOUR ANALGESIA: IMPACT OF AN EDUCATIONAL INTERVENTION: DID IT IMPROVE KNOWLEDGE?

S S Pinnaduwa,[1] K Jatheeswaran,[1] K O V R Karunanayake,[1] S Marleen[1]
[1] Sri Jayewardenepura General Hospital

Background
The persistent concern about pain management during labour necessitates a focus on addressing individual perceptions of labour pain for effective pregnancy management and high-quality care provision. Adequate pain management enhances intrapartum care and reduces postnatal complications, both physical and psychological. In many developing countries, there is an underutilisation of labour analgesia practices, resulting in heightened maternal anxiety during labour, often due to a lack of understanding of labour analgesia. Our goal was to assess the level of knowledge among expectant mothers regarding the various pain relief methods available at our hospital and to measure the impact of an educational intervention on maternal awareness and perception of labour analgesia.

Method
A structured, self-administered questionnaire was completed by 150 consenting antenatal mothers at SJGH antenatal clinic before and after the intervention. After completing the pre-intervention questionnaire, mothers received a written leaflet and watched a video on pain relief methods, effectiveness, and side effects. Analytical statistics were then performed on the data; $p < 0.05$ was taken as significant.

Results
Following the educational intervention, there was a significant increase in overall awareness of the availability of labour analgesia, rising from 53% pre-intervention to 84% post-intervention ($p < 0.001$). Maternal awareness of the availability of Entonox increased by 13.2%, Pethidine by 11.3%, and Epidural analgesia by 4.70%. The educational intervention also increased awareness regarding analgesia's effect on labour duration, rising from 18% to 27% ($p < 0.001$), with 75% correctly identifying epidural analgesia as the method causing labour prolongation. Furthermore, there was a significant increase in maternal awareness of the association between labour analgesia and the increased risk of instrumental deliveries post-intervention, with 80% correctly citing epidural analgesia as the risk factor ($p < 0.001$). The majority (74.0%) of women did not consider labour analgesia as a cause for an increase in caesarean sections post-intervention ($p < 0.001$), and 84.0% did not consider labour analgesia as a cause for neonatal complications ($p < 0.001$). However, 15% expressed concerns related to pethidine. Willingness to accept any form of pharmacological analgesia increased from 53.33% to 85.33% ($p < 0.001$) following the educational intervention. There was also a 25% increase in willingness to accept self-help methods for pain relief ($p < 0.001$). Cost concerns, particularly for epidural analgesia, remained a barrier among 9% of participants.

Conclusion
Understanding the available options for labour analgesia, along with their benefits and side effects, helps pregnant women make informed choices about their pain management during labour. Healthcare workers are instrumental in educating women, advocating for labour analgesia, and providing timely information to empower women to make informed decisions. This approach can result in a more positive and empowered labour experience, benefiting both mother and baby.

EP/O - 39
THE LEFT SIDE COMMON PERONEAL NERVE INJURY AFTER INSTRUMENTAL DELIVERY- A CASE REPORT

Fonseka, NA[1], Herath, R[2], Thilakaratne, KMH[1], Edirisinghe, EKMP[1], Weerawardhana, CD[1], Kajeepan, V[1]
[1]Colombo North Teaching Hospital, Sri Lanka
[2]Faculty of Medicine, University of Kelaniya, Sri Lanka

Objective
Common peroneal nerve injury is an uncommon complication of childbirth, with the nerve being at risk of injury due to its superficial location over the fibular head. This case report discusses a common peroneal nerve injury following mid-cavity forceps delivery.

Case Presentation
A woman in her 20s, pregnant for the first time, with an uncomplicated antenatal period, presented at 40 weeks of gestation with spontaneous labour. Due to lack of progress during the second stage of labour, she underwent an instrumental delivery. The patient was positioned in lithotomy, and forceps delivery was performed without complications. The following day, the patient reported numbness in her left calf, and a neurological examination revealed sensory impairment in the anterolateral aspect of the left calf with foot drop. A clinical diagnosis of left common peroneal nerve injury was made, and the patient was referred to a neurologist and physiotherapist. She was prescribed oral methylprednisolone and received supervised limb physiotherapy with electrical nerve stimulation, leading to significant improvement within four weeks.

Discussion
Neuropraxia, characterised by a disruption of conduction across a small portion of the axon, is the most common type of nerve injury during obstetric procedures. The common peroneal nerve, also known as the common fibular nerve, is the terminal branch of the sciatic nerve. Common peroneal nerve injury during labour can result from prolonged or forceful external compression on the fibular head. Regional anesthesia, prolonged labor in lithotomy position, nerve compression by the lithotomy stirrups, and undue external pressure by assisting staff are possible mechanisms of injury. Nerve conduction studies reveal conduction velocity abnormalities over the nerve segment, and electromyography aids in localising the lesion. Treatment involves physiotherapy, rest, and eliminating triggering factors such as leg crossing. A short course of corticosteroids may be considered in resistant or severe cases.

Conclusion
Simple measures during intrapartum care can be adopted to minimise the common peroneal nerve injury. Recommendations include repositioning every 10-15 minutes during the second stage of labour, using the lithotomy position in selected cases, employing non-motor-blocking

neuraxial analgesia to allow mobility, protecting the patient's legs from the hard surface of the stirrups, and ensuring frequent training of labour care assistants.

EP/O - 40
RUPTURED CESAREAN SCAR ECTOPIC PREGNANCY: A CASE REPORT

Hamsudeen, SUMA[1] Vithanage, RR[2]
[1]Ashraff Memorial Hospital – Kalmunai. [2]Ashraff Memorial Hospital – Kalmunai

Objective
Implantation of blastocyst to other sites, then the endometrium is called an ectopic pregnancy where fallopian tube is the commonest location. It does also implant in the cervix, myometrium, ovary, abdominal wall and previous caesarean scar. Previous uterine scar ectopic is rare and occurs one in 2000 pregnancies. When the embryo implants in the previous uterine scar it is termed as a scar ectopic.

Case Report
In this case a 32-year-old lady Gravida 3 para 2, with a past history of 2 cesarean sections and last one done a year ago admitted following a fall due to dizziness at 11 weeks POA and complained on lower abdominal pain and she didn't have bleeding per vagina at that time. On examination she was afebrile, not pale, Blood pressure 80/50mmHg, Pulse rate 100/min thready. Abdomen was tender and the rest of the examination was normal. Initial transabdominal ultrasound revealed a gestational sac with a live 11-week fetus and developed free fluid in the peritoneum later during the admission. Suspecting a bowel injury due to the fall, the surgical and obstetric team together planned a diagnostic laparoscopy, which went onto a laparotomy due to a hemoperitoneum. Intraoperatively a hemoperitoneum with bleeding at the anterior wall of the uterus and a ruptured uterine scar through which an amniotic sac with a live fetus was protruding was noted (Figure 01). Finally, a subtotal hysterectomy was performed and intraoperative blood transfusion, ICU care was given. Her post operative period was uneventful, and she was discharged on the 3rd post operative day.

Discussion
Scar ectopic was first recorded in 1978 and since then the prevalence has increased due to higher rates of caesarean sections. Ectopic pregnancy is one of the leading causes of maternal mortality in the 1st trimester causing fatal complications like uterine rupture, hemorrhagic shock and death. Scar ectopic pregnancy will have an ominous outcome and it should have a low threshold of suspicion. Ultrasound imaging aids in early diagnosis and prompt management.

Conclusion
This case signifies the importance of precise ultrasound imaging in a pregnant woman with a history of a previous uterine scar, to establish the location of implantation, as it leads to serious complications.

EP/O - 41

A PREGNANCY COMPLECATED WITH MYASTHENIA GRAVIS AND UNEXPLAINED PROTEINURIA –CASE REPORT

Jayasekara RMMSB[1], Karunasinghe J[1],Wijesiriwardhane YS[1] , Eshwarage KS [1],Mohamed ALS[1]
[1] Castle Street Hospital for Women

Introduction

Myasthenia gravis is a neuromuscular autoimmune disease that affects muscle strength and causes fatigability. Pregnancy complicated with this medical condition presents unique challenges for both the mother and the fetus. Myasthenia gravis has a prevalence of 1-4 in 10,000 with a slight female predominance. It causes muscle weakness and fatigue due to neuromuscular transmission blockage. Pregnancy may exacerbate the disease in 40% of women, with no change or remissions in 30%. Postpartum exacerbations occur in 30%. Infants born to mothers with myasthenia may develop transient neonatal myasthenia gravis (TNMG) due to trans placental transfer of IgG antibodies.

Case report

A 35 year old primi gravid diagnosed with Myasthenia gravis admitted to the antenatal ward at 32 weeks of gestation for further evaluation of protein uria. She was a diagnosed with gestational diabetes mellitus since 12 weak of gestation and serial blood sugar evaluation was normal with medical nutritional therapy .She underwent Thymectomy 2years back and currently on Pyridostigmine and prednisolone. Prednisolone was stopped before pregnancy. There is no symptoms and signs of muscle weakness with treatment and on regular neurology follow up at clinic. System examination found to be normal, including blood pressure. Fetal growth scan with normal CTG . Screening for unexplained proteinuria reveals positive ANA, increased 24 hour urinary protein levels which is nephrotic range and increased C4 levels .Other investigations found to be normal. After Haematology opinion she was started low molecular weight heparin (LMWH) prophylactic dose to prevent DVT. A multi-disciplinary team (MDT) meeting involving a Neurologist, Nephrologist, Hematologist, Anesthesiologist, and Neonatologist was arranged. The MDT recommended an elective cesarean section at 37 weeks of gestation and monitoring the neonate for TNMG. The surgery was uncomplicated, and medication was continued post-surgery. A renal biopsy was scheduled for three months later.

Discussion

Myasthenia gravis is a rare autoimmune neuromuscular disease in pregnancy and exacerbation in pregnancy is less likely if the woman has undergone previous thymectomy .Transplacental passage of antibodies to the fetus may results developing contractures due to lack of movement. Impaired swallowing in the fetus can lead polyhydroamnios.

Conclusion

Overall, pregnant women with myasthenia gravis require careful intervention and management by a multidisciplinary team of specialists. This case highlights the importance of monitoring patients throughout their pregnancies, including close attention to proteinuria and the potential effects of myasthenia gravis on maternal health and fetal development. With the appropriate interventions, however, it is possible to successfully manage this condition and ensure the safety of both mother and child during pregnancy and delivery.

EP/O - 42

A SUCCESSFUL PREGNANCY OUTCOME IN A PATIENT WITH A SPINAL CORD INJURY

Adikari, AMLM[1], Gunaratne ,P[2], Wijesinghe, D[3]
[1,3] Speciality Registrar , Obstetrics and Gynaecology, Buckinghamshire NHS trust, Uk
[2] Consultant Obstetrician and Gynaecologist , Buckinghamshire NHS trust, Uk

Introduction

Pregnancy in a patient with a spinal cord injury is a challenging scenario for the patient as well as for the obstetricians. Patients are at a high risk as it may exacerbate many of their existing problems.

Case report

This case is about a successful pregnancy two years following a spinal cord injury due to a road traffic accident. This 32-year-old woman suffered a complete paraplegia below Thoracic 7 (T7) level following the injury. This was her first pregnancy. It was managed by a multidisciplinary team involving a dedicated obstetrician, Obstetric anesthetist, specialists in spinal cord injury, specialist midwife, physiotherapist, occupational therapist and the community midwife. She was provided with routine antenatal care. She could not feel the fetal movements properly but she was advised to palpate for it. She had neurogenic bladder with abnormal sensation and neurogenic detrusor over activity. She had intermittent self-catheterization and was treated with solifenacin prior to pregnancy which was converted to oxybutynin in pregnancy. Since the third trimester she required an indwelling catheter. She suffered recurrent urinary infections. For neuropathic pain, medications were changed from gabapentin to amitriptyline .

For the muscle spasms she continued baclofen and the vibrators till the third trimester and thereafter had hydrotherapy only as baclofen could cause neonatal withdrawal and vibration massage had the risk of placental disruption. Although the injury was in the T7 level, she developed episodes of autonomic dysreflexia related to spasms and urine retention. She was admitted since 37 weeks in order to prevent unplanned delivery. A vaginal delivery was planned at 39 weeks and labor was induced with prostaglandin gel. At the onset of labor early epidural was cited before rupture of membranes to prevent autonomic dysreflexia (AD). Labor was augmented with oxytocin. Continuous fetal monitoring provided during labor. During labor she developed increased blood pressure which was suggestive of AD and was treated with nifedipine. The second stage was managed by instrumental delivery. For the third stage intramuscular oxytocin was given avoiding ergometrine. She was supported for breastfeeding and advised on contraception avoiding oestrogen.

Discussion

The number women getting pregnant following spinal cord injuries getting increased. They suffer many disabilities as well as life threatening conditions like autonomic dysreflexia

Conclusion

A successful pregnancy outcome can be achieved by multidisciplinary care and by optimizing the exacerbated symptoms and complications.

EP/O - 43
FAMILIAL HYPERCHOLESTEROLAEMIA COMPLICATING PREGNANCY

Mahdoom, Bwma[1] , De Silva, Dyka[1] , Arachchi M.A.M.M [1], Wijethunge W.M.K.M [1].
[1] National Hospital, Kandy.

Objective
Familial hypercholesterolaemia is a rare disease. Management during pregnancy is challenging due to limited recommendations.

Case Report
A 30 year old mother of 1 child presented in her second pregnancy at the PoA of 34 weeks with high level of total cholesterol 847mg/dl and LDL-C 734mg/dl. She is diagnosed patient with familial hypercholesterolaemia since 10 years old when she presented with Tuberous Xanthoma with very high level total and LDL cholesterol. Since 10 years old, she was on lipid lowering statin medication. Her first pregnancy 4 years back was uncomplicated, delivered vaginally at term with normal weight baby, where she stopped statin during antenatal period and restarted again in postpartum. Current pregnancy was planned and prepregnancy statin was stopped. Antenatal was not complicated with gestational Diabetes Mellitus, pre eclampsia or large for gestational age. Her high level of LDL-C was managed conservatively without any medication and postpartum 3 months. She delivered uncomplicated baby vaginally at term with normal weight. Multi disciplinary team decided to restart statin in postpartum 3 months.

Discussion
Familial hypercholesterolaemia is associated with adverse pregnancy outcomes such as gestational diabetes mellitus, preeclampsia, large for gestational age, small for gestational age and pancreatitis. Fortunately this pregnancy didn't have any complication despite high cholesterol level. Currently, there are no recommendation concerning the management of hypercholesterolaemia in pregnancy. But options for managements are similar to those of hypertriglyceridaemia including dietary modification, statin ,omega-3 and plasmapheresis.

Conclusion
Familial hypercholesterolaemia in pregnancy need to have close surveillance for adverse outcome in pregnancy and multi disciplinary team involvement is needed for individualized management.

EP/O - 44
COMPLETE MOLAR PREGNANCY IN A POSTMENOPAUSAL WOMAN: A RARE DIAGNOSTIC CHALLENGE

Perera NNN[1], Lasanthinie DDM[1], Akmeemana SP[1], Meegoda VJ[2]
[1]Colombo South Teaching Hospital
[2]Base Hospital – Tangalle

Introduction
A complete hydatidiform mole(CHM) results from the abnormal fertilization of an anucleate egg, leading to a diploid mass of hydropic villi without fetal tissue. Although CHM risk increases with maternal age, cases in postmenopausal women are extremely rare, with only 14 reported instances.

Case presentation
A 51-year-old woman with 14 months of amenorrhea and a history of five children presented with a single episode of postmenopausal bleeding. She had no personal or family history of gynecological cancer and had never used hormonal contraception. Examination revealed an enlarged uterus (18 weeks size), and transvaginal ultrasound showed an 18 cm x 10 cm uterus with an endometrial thickness of 8 cm. A pipelle biopsy was performed for urgent histology. Three days later, the patient experienced heavy vaginal bleeding, severe abdominal pain, and high fever. She was pale, with a blood pressure of 120/60 mmHg and a temperature of 102°F. Speculum examination revealed products at the external cervical os, with a large amount of expelled tissue. Macroscopic examination showed grape-like hydropic villi with cystic areas, and tests revealed a positive urine hCG and a high serum beta-hCG level of 191,559. Laboratory results indicated severe anaemia (Hb-6.6g/dl), elevated WBC (12,000), and high CRP (112). The patient was resuscitated with fluids and 2 units of blood transfusion and treated with IV meropenem. After evacuation, her serum beta-hCG dropped to 195 by day 7. Histology confirmed a complete hydatidiform mole, leading to the decision for hysterectomy.

Discussion
During perimenopause, erratic ovulation due to declining estrogen levels results in a mix of ovulatory and anovulatory cycles. Pregnancies during this period often lead to unfavourable outcomes, with a 20-fold increase in the incidence of gestational trophoblastic disease(GTD). Diagnosing GTD in postmenopausal women is challenging because pregnancy-related issues are often overlooked when evaluating postmenopausal bleeding(PMB). In this case, PMB was initially investigated with a focus on endometrial hyperplasia and cancer, while a urine hCG test was only conducted after grape-like vesicles were observed, raising suspicion of GTD.
Management of molar pregnancy depends on age and future fertility plans. For women over 40, hysterectomy is typically recommended due to the higher risk of malignant complications in this age group.

Conclusion
Though rare, molar pregnancy can occur in postmenopausal women, so GTD should be included in the differential diagnosis of PMB to avoid diagnostic delays, with hysterectomy being the preferred treatment for CHM in this age group.

EP/O - 45
REFRACTORY IMMUNE THROMBOCYTOPENIA IN PREGNANCY MANAGED WITH THROMBOPOIETIN RECEPTOR AGONISTS

Mathananayanan G[1], Ekanayake S B[1], Meegoda V J[2]
[1]General Hospital – Kandy
[2]Base Hospital – Tangalle

Objectives
Immune thrombocytopenia(ITP) in pregnancy results in low platelet counts and can be associated with complications. Elthrombopag, a thrombopoietin receptor agonist that stimulates platelet production, is used for refractory ITP in non-pregnant patients. However, its use in pregnancy is limited due to insufficient safety and efficacy (WHO pregnancy category C).

Case report
A 22-year-old primigravida with a history of ITP diagnosed at 16 years presented at 24 weeks of gestation with a platelet count of 17,00/µl. Her ITP had been asymptomatic in first trimester.

Initial treatment with intravenous immunoglobulin(IVIg), prednisolone, and azathioprine raised her platelet count to 61,000 per microliter. At 26 weeks, she experienced nasal bleeding and her platelet count fell to 7,000/µl. Further treatment with IVIg, IV methylprednisolone, oral prednisolone, and azathioprine led to a temporary increase to 32,000/µl, but her platelet count soon dropped back to 7,000/µl within two weeks. Despite ongoing treatment, her platelet count remained below 10,000/µl without significant bleeding symptoms. After excluding other causes and consulting a multidisciplinary team, she was prescribed Elthrombopag 50 mg twice daily. However, this treatment did not improve her platelet count. By 34 weeks, she developed an upper respiratory tract infection and her platelet count dropped to zero, accompanied by bruising of upper limbs. After correcting her platelet count with apheresis, the multidisciplinary team decided on an elective cesarean section. Postoperatively, the mother experienced no major complications and her platelet count gradually increased to 61,000/µl before discharge. The premature infant, managed by the neonatology team, had low platelet counts, which were treated appropriately.

Discussion

Immune thrombocytopenia (ITP) is the most common cause of thrombocytopenia during the first trimester of pregnancy. While ITP generally does not lead to significant complications, some reports highlight notable maternal morbidity and mortality associated with the condition. Current guidelines recommend corticosteroids and intravenous immunoglobulin (IVIG) as first-line treatments during pregnancy, with increasing support for the use of biologics under specific conditions. Refractory ITP is diagnosed when a patient fails to respond to two or more conventional treatments. The use of eltrombopag in pregnancy remains contentious and is currently advised only if the potential benefits outweigh the risks. There is conflicting evidence regarding the efficacy of eltrombopag, and, as illustrated in this case, it may not always produce the desired effect.

Conclusion

The evidence regarding the use of Elthrombopag for thrombocytopenia during pregnancy is both limited and inconsistent, highlighting the need for further research and evaluation.

EP/O - 46
RISING PREVALENCE OF ANAEMIA DURING PREGNANCY IN RURAL SRI LANKA: AN OVERLOOKED ISSUE

Hewawitharana KG[1] Meegoda VJ[2]
[1]Base Hospital – Mahaoya
[2]Base Hospital – Tangalle

Objectives

This study aimed to assess the prevalence, risk factors, and consequences of anaemia in pregnancy in a rural setting in Sri Lanka. Anaemia in this region is predominantly caused by nutritional deficiencies and hemoglobinopathies and can lead to maternal and fetal complications

Design & Methodology

A retrospective cohort study was conducted using data from Bed Head Tickets at Mahaoya Base Hospital, covering deliveries over the past two years (2024 May– 2022 May).

Results

The study reviewed records of 196 mothers who delivered live babies during the specified period. The age of participants ranged from 17 to 42 years, with the majority (46.2%) in the

20-25 year age group. Primigravidae constituted 39.8% of the cohort, followed by 32.7% who were pregnant for the second time, and one case of grand multiparity. Most deliveries were normal vaginal (58.2%), with 21.9% undergoing elective cesarean sections and 19.9% emergency cesarean sections. Among multiparous women, the age of the youngest child ranged from 1-10 years, with 69.2% conceiving within 5 years of their previous child. Initial hemoglobin (Hb) levels varied from 6.7 to 14.4 g/dl, with a mean pre-delivery Hb of 11.3 g/dl. Anemia was identified in 56.2% of the mothers (Hb <11 g/dl), with 72% classified as mildly anemic (Hb 10.9-9 g/dl), 26% as moderately anemic, and 2% as severely anemic. Among anemic mothers, 68.2% were non-compliant with iron and vitamin supplements. Post-delivery, the mean Hb was 11.2 g/dl. Blood transfusion was required in seven cases during pregnancy, while 4.6% of mothers experienced postpartum hemorrhage, with 1.5% having major hemorrhages. Thalassemia was diagnosed in 1.5% of the mothers, and 1% had the thalassemic trait. Neonatal birth weights ranged from 1.8-3.6kg, with a mean weight of 2.7 kg. Fetal Hb levels, measured in 15 cases, ranged from 9.8-19.5g/dl, with a mean of 14.2 g/dl. There was no statistically significant association between the degree of maternal anemia and the need for blood transfusion or fetal birth weight.

Discussion & Conclusions

The prevalence of anaemia among this rural cohort (56.2%) significantly exceeds the national average of 14.1% reported in 2022. This discrepancy highlights a pressing need for targeted interventions to address nutritional deficiencies and manage hemoglobinopathies in this population. Addressing these issues is crucial to reducing the long-term adverse effects of anaemia on pregnancy outcomes and improving maternal and fetal health in rural Sri Lanka.

EP/O - 47
ACUTE FATTY LIVER OF PREGNANCY: A CASE REPORT

Bandara YMDA[1], Silva SACK[1], Priyasantha GK[1], Chamikara DGM[1] weerasinghe DGK[2]
[1]Obstetrics and Gynaecology unit German Sri Lanka Friendship Hospital for women, Galle
[2] Cardiology Unit National Hospital Kandy

Background

AFLP is a disease of the third trimester that is unique to human pregnancy and was described by Sheehan in 1940. The condition was associated with high mortality rates but this has improved because of early diagnosis and prompt delivery of the foetus. The approximate incidence of AFLP is 1: 7,000 to 1:20,000. Conditions unique to pregnancy that causes liver dysfunction include intrahepatic cholestasis of pregnancy, pre-eclampsia, Haemolysis Elevated Liver Enzymes Low Platelet count (HELLP) syndrome and AFLP. While intrahepatic cholestasis of pregnancy (ICP) and preeclampsia are frequently seen, AFLP is rare and potentially life-threatening. The pathogenesis of AFLP remains unclear but there is emerging evidence of the genetic basis of AFLP where defective mitochondrial fatty acid beta-oxidation in the foetus is implicated in some cases of AFLP. We present a case where the diagnosis was delayed with subsequent poor outcome.

Case presentation

A 22-year-old primi mother at POG of 35 weeks presented to the hospital as a referral from Base hospital Udugama due to twin pregnancy with CTG abnormalities in one twin. She had been generally unwell for 4 days prior to this presentation and reported that she had nausea followed by vomiting six times. There was no history of diarrhoea or flu like symptoms. She was booked and the Antenatal Clinic (ANC) visits were unremarkable. Human

Immunodeficiency Virus (HIV) and VDRL status were negative. She had no chronic illnesses and gave no history of paracetamol, aspirin, sodium valproate or herbal medicine ingestion.

Clinical examination revealed a deeply jaundiced patient who was fully conscious at initial examination. The blood pressure, pulse and temperature were 118/69 mmHg, 101 bpm and 37.1 degrees Celsius respectively. Respiratory and cardiovascular examinations were normal. The abdomen was soft and there was no hepatomegaly or splenomegaly. The height of fundus was 40 weeks and the foetal heart was present and normal base line. She had undergone EM-LSCS birth weight were 2020g and 2140g respectively in two T_1 and T_2. She did not have postpartum haemorrhage. The patient was admitted to ICU for further care and observation. The vital signs remained normal. Investigations show hypoglycemia (RBS-56mg/dl), hyperkalemia (k+ 5.5mmol/l), hyperbilirubinemia (T-SIL 8.43mg/dl, D-Bil 5.53mg/dl), elevated liver enzymes (ALT-130U/L, AST-156U/L, ALP-745U/Lr-GT-102U/L) hyperuricemia (8.16mg/dl), elevated LDH (638 U/L) elevated WBC (19000/UL), low platelets (120000/ul to 82000/ul), normal Hb,blood picture shows no evidence of MAHA, urine albumin 2+ ,clotting studies were normal, Hepatitis A and B were negative. Rapid Diagnostic Test (RDT) for malaria was negative. The urine was dark but urinalysis was negative. She had several episodes of hypoglycemia (1.1–2.3 mmol/l) which were corrected with 50% dextrose followed by infusion of 10% dextrose 8 hourly. She was managed in ICU set up with the MDT involvement. She was given IV antibiotics, IV NAC and IV Vit K with oral UDCA for 10 days. she was discharged on day 12 with two healthy babies.

Conclusion
AFLP is a rare, life-threatening complication of third trimester which requires a high index of suspicion for early diagnosis. Urgent delivery and maximum supportive care should be instituted to prevent poor outcomes.

EP/O - 48
THYROID STORM IN THE EARLY POST-PARTUM PERIOD: A CASE REPORT

Bandara YMDA[1], Silva SACK[1], Priyasantha GK[1], Chamikara DGM[1], Dissanayake CN[1] weerasinghe DGK[2]
[1]Obstetrics and Gynaecology unit German Sri Lanka Friendship Hospital for women, Galle
[2] Cardiology Unit National Hospital Kandy

Background
Hyperthyroidism in pregnancy is rare, occurring in only 1–4 in 1000 pregnancies. The incidence of hyperthyroidism in pregnancy is about 0.2% and most cases are subclinical. Thyroid storm is a rare complication of improper treatment of hyperthyroidism in pregnancy. A thyroid storm is precipitated when hyperthyroidism effects surpass the patient's ability to compensate cardiovascular, thermoregulatory and metabolic systems. The risk of developing thyroid storm in pregnant hyperthyroid patients can be 10 times higher than in the general population. Precipitant of thyroid storm includes thyroid surgery, withdrawal of antithyroid drugs, infection, emotional stress and trauma. Several obstetric conditions that can precipitate thyroid storm include pre-eclampsia, induction of labour, surgery and pregnancy itself.

Case presentation
A 37-year-old mother in her second pregnancy with one living child delivered via vaginally 12 years ago, admitted to antenatal ward at 39 weeks and 5 days for delivery. Patient was diagnosed as hyperthyroidism since 2 years before admission (Autoimmune thyroiditis) and

she was on propylthiourecil150mg three times per day. but she was defaulted treatment for last 3 months duration. On admission she was completely asymptomatic and her vitals were normal. She was sent to labour room following 48 hours of Foley induction. She delivered baby girl and birth weight was 2820g.she was given IM pethidine as analgesics and there were no intrapartum complications throughout the labour.

The patient was in agitation state of consciousness, she had Glasgow Coma Score of 12 consisted of 3 for eye opening response score, 4 for verbal response score and 5 for motoric response score. Her blood pressure in the labour room was 140/90 mmHg, and her heart rate 146 times/min. She had fever with temperature of 38.4°C and an increased respiratory rate of 36 times/min with oxygen saturation 95% in room air. Patient was underwent laboratory investigations, such as blood gas analysis, urinalysis, serum creatinine level, aspartate aminotransferase (AST)/alanine aminotransferase (ALT) level, Hb, PLT and In addition, her electrocardiogram showed sinus tachycardia. Her thyroid stimulating hormone (TSH) and FT4 level come afterwards, and showed low TSH (<0.02 μIU/mL) and high free T4 (3.75 ng/dL), her lactate dehydrogenase (LDH) was 547 U/L as well. The patient was given a non-rebreathing mask with oxygen 15 L/min, after that her oxygen saturation level was going up. For her thyroid condition gaven propranolol 40 mg, propylthiouracil (PTU) 600 mL, and 5 drops of Lugols iodine 2% in ICU setup. She was managed with the MDT involvement and arrange for fallow up plan. She was inserted jadelle as a contraception. She was discharged on day 3 with heathy baby.

Conclusion

Thyroid storm is a rare complication of hyperthyroidism. Delivery is an important precipitating factor, especially in pregnancies with uncontrolled hyperthyroidism. Thyroid storm can cause life-threatening complications, including acute decompensated heart failure, acute lung oedema and respiratory failure. Immediate and aggressive treatment needs to be done in patients with thyroid storms, especially in the peri partum period.

EP/O - 49
AUDIT ON MAINTENANCE OF PARTOGRAM IN AN OBSTETRIC UNIT OF NATIONAL HOSPITAL, KANDY, SRILANKA

Muthumali YGRMA[1], Dahal P[1], Mahdoom BWMA[2], De Silva DYK[2]
[1] Medical Student, Faculty of Medicine, University of Peradeniya.
[2] National Hospital, Kandy.

Background

The partogram is a graphical representation of labor progression and an essential tool for assessing maternal and fetal well-being during labor. For optimal outcomes for the mother, foetus, and newborn, the partogram must be well maintained. With monitoring during the latent phase, the redesigned partogram is intended to be easier to use. Still, both domestic and foreign hospitals have found that its use is not at all optimal.

Objective

The objective of this audit was to assess the maintenance of partogram in a tertiary care hospital in SriLanka.

Method
Retrospective data collection was conducted by looking at the partographs of 32 women who gave birth vaginally during a two-week period in a maternity unit at the National Hospital Kandy. Every foetus displayed a cephalic presentation. A frequency analysis of the data was produced after it was examined using Google Sheets.

Results
The introductory section was filled out in every one of the 32 partographs for labour stage one that were reviewed, and 30 of them (93.75%) had the foetal heart rate recorded.Conversely, just two partograph (6.25%) recorded the contraction-free interval, 10 (31.25%) recorded the oxytocin dose, sisteen (50%), documented cervical dilatation, and eight (25%) recorded abdomen descent. Prenatal heart rate and the introduction were the sections that were most consistently recorded, whereas the contraction-free interval was the least filled. There were no partographs in the second stage of labour that showed the foetal heart rate. The time of complete dilatation and the start of pushing were only recorded by two partograph (6.25%). No partograph was completed for the remaining sections of this stage.Regarding intrapartum specifics, every partograph had 100% of the baby's birth and delivery information filled in. Information about the placenta and tears was recorded in 30 (93.75%) partographs, but information regarding analgesia and episiotomy was completed in 14 (43.75%) and 26 (87.5%) partographs, respectively.The findings show that the majority of the partogram was not completed to the required extent, especially during the second stage of labour when the foetal heart rate was hardly ever recorded and other crucial monitoring was not well documented.

Conclusion
To identify maternal and foetal issues during labour and to ensure a good outcome for the neonate, it is imperative that labor-related events are documented. But according to this study, the partogram was not used as effectively as it may have been. Determining the causes of this partogram's subpar utilisation and implementing the necessary changes to make it better would be advantageous. Providing directions on how to complete the partogram correctly and holding a presentation on the significance of preserving it are two examples of how to do this. Once these interventions are implemented, re-evaluating the partogram maintenance could aid in evaluating the progress made and guaranteeing future compliance.

EP/O - 50
A POSTPARTUM PATIENT WITH ACUTE KIDNEY INJURY AND POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME

Mohamed, FR[1], Madugalle, MEMYDB[2], Jayasinghe, KL[2], Akmeemana, SP[1], Marleen, FS[1]

[1]Sri Jayawardenapura General Hospital, Thalapthpitiya, Sri Lanka
[2]Teaching Hospital Mahamodara

Objectives
Posterior Reversible Encephalopathy Syndrome (PRES) is a rare complication in patients with acute hypertensive disorders. PRES's pathogenesis remains unclear but seems to be associated with vasogenic oedema in the occipital lobe. Preeclampsia/HELLP syndrome, immunosuppressive/cytotoxic drugs, thrombotic thrombocytopenic purpura/hemolytic uremic syndrome, acute or chronic renal diseases, steroid therapy, and liver failure seem to be the causes of the onset of oedema. The objective of this case report is to alert physicians that PRES could occur in a postnatal patient without any antenatal history of pre-eclampsia/ eclampsia/ HELLP or other co-morbidities. Hence, early detection of warning symptoms and signs is paramount to institute early treatment and prevention of morbidity and mortality.

Case Report
A 26-year-old primi mother underwent an emergency Caesarian Section due to Fetal growth restriction and intermittently reversed diastolic flow in the umbilical artery at 30 weeks. She had no significant past medical history and no gestational hypertension. Her baby was in Neonatal Intensive care. On her 3rd post-op day, she developed mild hypertension, was investigated and monitored and started on antihypertensive treatment. She had no proteinuria but Serum creatinine was rising and was managed as NSAID-induced Acute Kidney Injury (AKI). On her 5th postop day, she developed a generalised tonic-clonic seizure and was treated with Magnesium Sulphate. Her MRI showed features of PRES with normal MRA and MRV and her EEG was also in favour of an encephalopathy. The next day, her blood pressure (BP) was on the rise and needed additional antihypertensives. Her Creatinine levels declined and became normal. By the 14th postop day her BP was within the normal range without antihypertensive medication and she was discharged on her 16th postop day.

Discussion
The pathogenesis of PRES seems to be associated with rapid development of hypertension that leads to a malfunction of cerebral autoregulation; in particular in occipital lobe where the sympathetic innervation is less widespread, resulting in vasogenic edema of the subcortical white matter in the posterior occipital and parietal lobes. This syndrome is manifested by neurologic symptoms: headache, nausea or vomiting, generalized seizures, visual disturbance, and altered sensorium.

Conclusion
PRES is reversible in a few days, but if appropriate management is delayed there is high risk of permanent neurologic damage secondary to cerebral infarction or hemorrhage and transtentorial herniation resulting in death. Early recognition of symptoms is fundamental for a timely diagnosis. Cerebral MRI is the gold standard diagnostic tool.

EP/O - 51
MACROPROLACTINOMA WITH APOPLEXY AND PREGNANCY, FROM SUBFERTILITY TO SUCCESSFUL VAGINAL DELIVERY: A RARE CASE REPORT

Jey Krishna K[1] Thirukumar M[2] Karunakaran KE[2] Mazahima MM[1] Rathnasekara WADAK[1] Abhiramy V[2] Premarathna HRSDB[3]
[1]Teaching Hospital Batticaloa
[2]Faculty of Health Care Sciences, EUSL
[3]German Sri Lanka Friendship Hospital for Women, Galle

Background
Prolactinomas, the most prevalent pituitary adenomas, often lead to anovulation and infertility. Pregnancy in women with prolactinomas necessitates careful management. Treatment is usually discontinued upon pregnancy confirmation due to the elevated risk of tumor enlargement and potential for apoplexy. This case study details a successful pregnancy outcome in a patient with macroprolactinoma despite apoplexy.

Case Description
A 30-year-old woman, investigated three years ago for oligomenorrhea and primary subfertility, presented with a serum prolactin level of 5897 mIU/L, TSH of 19 mU/L, and cortisol of 21 mcg/dL. MRI imaging confirmed a diagnosis of macroprolactinoma, complicated with hypothyroidism and adrenal insufficiency. A multi-disciplinary team (MDT) initiated treatment with Cabergoline, Thyroxine, and Hydrocortisone. Over 15 months, the patient

showed remarkable improvement, with regular menstrual cycles resuming. Before attempting pregnancy, she received pre-pregnancy care from the MDT. Subsequent MRI revealed the macroprolactinoma was stable, and her serum prolactin level had dropped to 6.01 mIU/L. Cabergoline treatment was discontinued upon confirmation of pregnancy, which progressed well initially. However, the patient developed severe headaches and visual disturbances, and MRI revealed apoplexy at 30 weeks of gestation. This was managed conservatively without complications. The MDT decided to allow vaginal delivery (VD). At 39 weeks gestation, the patient spontaneously went into labor with double dose of hydrocortisone under intrapartum surveillance for increased intracranial pressure (ICP) and delivered a healthy baby girl weighing 3.42 kg. The postpartum and lactation period were uneventful, and she resumed routine follow-up with her endocrinologist.

Discussion

Macroprolactinomas pose management challenges due to pregnancy's impact on pituitary adenomas and associated risks to mother and fetus. Addressing infertility in these patients is complex. Once pregnancy is achieved, MDT for high-risk pregnancy monitoring is required. Proper pre-pregnancy care is essential to mitigate drug-related effects and manage tumor syndromes. During pregnancy, careful handling of apoplexy and increased ICP is crucial, as these conditions can resemble pre-eclampsia.

Conclusion

Upon discontinuation of treatment following pregnancy confirmation, regular monitoring for tumor enlargement and apoplexy is essential. If increased ICP is suspected, an MRI and pre-eclampsia screening should be promptly arranged. The mode of delivery should be decided on an individual basis; in the absence of increased ICP, VD with appropriate analgesia is recommended.

EP/O - 52

A RARE CASE ACUTE KIDNEY INJURY (AKI) IN TWIN PREGNANCY DUE TO URETERIC OBSTRUCTION IN A PATIENT WITH SINGLE KIDNEY- CASE REPORT

Chamikara DGM1 Bandara YMDA1, Silva SACK1, Priyasantha GK1, Chamara PBKR1, Dissanayake CN[1]

[1]Obstetrics and Gynaecology unit German Sri Lanka Friendship Hospital for women, Galle

Introduction

Acute kidney injury (AKI) in pregnancy is a rare but serious complication. It is even rare in multiple pregnancies. It can be devastating to mother as well as the fetus even more life threating in a patient with a single kidney. AKI can be categorized as pre renal, renal & post renal causes. AKI due to ureteric obstruction is a classic example of post renal AKI. AKI in pregnancy is associated with septic shock, dehydration related to hyperemesis gravidarum, amniotic fluid embolism, severe preeclampsia, obstructive uropathy, or severe hemorrhage. The incidence of AKI in twin pregnancies is not well-documented, and the presence of a single kidney adds a layer of complexity to the management and prognosis. This case report aims to highlight the diagnostic challenges and management strategies in such a unique clinical scenario.

Case presentation

A 22 year old primigravida with DCDA twin pregnancy was referred from a peripheral hospital in 28 weeks of gestation for further management of obstructed infected system complicated with AKI. She presented with reduced urine output, Right side flank pain, dysuria and fever.

For 48 hours. Laboratory investigations revealed WBC 37.7* 10x3 CRP 195, SCr 3.9 mg/dL. Urine full report and urine culture was positive. Ultrasound scan revealed she is having a right side solitary kidney with moderate hydronephrosis and Right side hydroureter. JJ stenting had been tried twice but failed. Then proceeded with Percutaneous Nephrostomy (PCN). Started IV antibiotics after cultures. Growth scans of the two babies were done and non-stress test done to assess the fetal wellbeing. Corticosteroids were given for the lung maturation and Neonatology team was alerted. During ward stay she developed Pre term pre labor rupture of membranes (PPROM) and went in to Labor. Since first twin was in cephalic presentation allowed for vaginal delivery and two baby girls were born with birth weight of 945gand 1070g respectively. Following delivery patient developed post-partum hemorrhage and managed medically and one pint of blood transfused. Post-delivery ICU care given in collaboration with Anesthetist, Physician, Urologist, Microbiologist and Obstetrician. Over the next 24 hours patients urine output, Renal functions and Inflammatory markers began to improve. Nephrostomy tube left insitu for another two weeks and decided to clamp it and patient had adequate urine output and planned to remove nephrostomy following Nephrostogram. One baby died in post-partum day 13 due to complications of prematurity and sepsis and other baby was stable.

Conclusion

AKI in twin pregnancy especially with a solitary kidney is very rare but early diagnosis and multidisciplinary approach is essential for better maternal fetal outcomes.

EP/O - 53

AUDIT ON VAGINAL EXAMINATION FREQUENCY IN PROFESSORIAL OBSTETRIC UNIT TEACHING HOSPITAL PERADENIYA

Wanniarachchi, WADP[1] Ghanarathne, S[2] Liyanagae, LNM[1] Dissanayake, DMVC[1] Manamperi, MMJP[1]

[1]Professorial Obstetrics & Gynaecology unit, Teaching Hospital Peradeniya

[2] Department of Obstetrics & Gynaecology, Faculty of Medicine University of Peradeniya

Introduction

Vaginal examinations (VE) are a routine part antenatal assessment of cervical favorability with modified Bishop score. Aids to assess the progression of labour during intrapartum period.(1)(2). Unindicated frequent vaginal examinations may increase the risk of Chorioamnionitis and maternal discomfort and anxiety(3). The unit policy for VEs in latent phase of labour is less than six times at Antenatal ward. Despite the World Health Organization's recommendation for a VE every 4 hours during labour a substantial number of women undergo VEs frequently than recommended(2). It is important to maintain standards to minimize complications & inconvenience.

Objectives

To identify VE frequency in the Labour suite.

To identify VE frequency Antenatal ward at latent phase of 1st stage.

To assess unit status of VE frequency with gold standard references.

To find out deficient areas & strengthen them with intervention.

To upgrade the antenatal and intrapartum care to the both pregnant women & their fetus.

Design
A retrospective audit will be carried out using details acquired through bed head tickets (BHT) of pregnant women who delivered in Professorial Obstetric unit of teaching hospital Peradeniya from 24th of January 2024 to 24th of February 2024.

Method
All women admitted to the labour suite included for study. Including both vaginal & Emergency Caesarean deliveries. All VE documentations were checked with time, indication & category of performed medical officers. WHO labour care guide & Antenatal VE unit policy considered as gold standard. Frequent vaginal examination with reasonable clinical background were excluded from deviation from standard care.

Results
Total number of patients included to the study was 110.
Frequent unindicated VE,

- At Antenatal ward & Labour suite both were three patients (2.72%)
- At Antenatal ward only was six (5.45%)
- At Labour suite only was seven (6.36%)
- Total was sixteen patients (14.54%)

One newborn out of 16 cases (6.25%) received antibiotics for 7 days with suspected infection
Out of 16, Intern medical officers involved in 11 cases, Registrars in 8 cases, senior registrars in 4 cases & consultants in 1 case. For eight cases (50%) more than one category of doctors involved

Conclusions
Frequent unindicted VE represents 14.54% of study sample. Most of them were performed by junior doctors who are the first contacts in Labour suits & Antenatal wards. There is a significant deviation from accepted standards. Re-audit will be carried out after implementation of education programs for doctors & reemphasizing the accepted standards.

EP/O - 54
POSTPARTUM CEREBRAL VENOUS SINUS THROMBOSIS (CVST) FOLLOWING OBSTETRIC NEURAXIAL BLOCKADE: A CASE REPORT

Jey Krishna K[1] Thirukumar M[2] Karunakaran KE[2] Rathnasekara WADAK[1] Abhiramy V[2] Premarathna HRSDB[3]
[1]Teaching Hospital Batticaloa
[2]Faculty of Health Care Sciences, EUSL
[3]German Sri Lanka Friendship Hospital for Women, Galle

Background
CVST is a rare complication of pregnancy and the puerperium, with an incidence of 1:10,000 to 1:45,000. CVST risk is elevated in the first 6 weeks postpartum, often presenting as a nonspecific headache. Distinguishing CVST from post-dural-puncture headache (PDPH) can be challenging, particularly in patients who received neuraxial anesthesia. This case study reports a woman diagnosed with CVST on the 16th postpartum day following an emergency caesarean section (EM/CS), who was successfully treated with anticoagulants.

Case Description
A 26-year-old woman, 16 days postpartum, presented to the emergency department with severe headache and confusion. Upon admission she experienced a generalized seizure and had blood pressure measuring 180/100 mmHg. Initially diagnosed with eclampsia, she was treated with

magnesium sulfate and hydralazine. No focal neurological deficits were noted, reflexes were normal, and fundoscopy revealed no papilledema. Blood investigations showed a normal complete blood count (hemoglobin 11.5 g/dL) and normal renal, hepatic, and coagulation profiles. Seventeen days prior, she(G1P1) had undergone an EM/CS indicated by fetal distress. Her pregnancy and immediate postpartum period were uneventful, leading to discharge on postoperative day 2. Her venous thromboembolism (VTE) score was 3 postnatally. Given the persistent severe headache and a second seizure episode, urgent CT brain & venography were performed revealing superior sagittal and transverse sinus thrombosis but no venous infarction. Upon multi-disciplinary team (MDT) decision therapeutic dose of low-molecular-weight-heparin (LMWH) was commenced. The symptoms improved over the next few days, and follow-up CT venography showed no evidence of filling defects in cortical or dural venous sinuses.

Discussion

CVST can be overlooked in women who present with headache following neuraxial block. Key distinguishing features CVST from PDPH are a change in headache character with loss of postural element, and focal neurological signs. This case highlights the diagnostic challenge, where elevated blood pressure initially led to an eclampsia diagnosis. As her postnatal VTE score was > 2 on discharge she should have been given thromboprophylaxis for at least 10 days.

Conclusion

Postpartum seizures require thorough evaluation to avoid delays in diagnosis. CVST, if undiagnosed, can be life-threatening, but timely recognition and early anticoagulant therapy result in favorable outcomes. An MDT approach ensures effective treatment and recovery without mortality or residual weakness. Every woman should be assessed for VTE risk at discharge and treated accordingly.

EP/O - 55

AUDIT ON OBTAINING CONSENT FOR PLANNED CAESAREAN BIRTH

Wijethunga WMKM[1], De Silva DYK[1], Mahdoom BWMA[1],Sumithraarachchi LD[1] ,Fernando MUM[1]
[1]National hospital Kandy

Introduction

Informed written consent is an important aspect of preoperative management of the women planned caesarean birth. information in the attached consent form, healthcare professionals should explain to women about the procedure the potential risks for planned caesarean birth or planned vaginal birth. Form of complete consent is a legal document which is used by means of a court of law in case of a lawsuit. Procurement of an informed consent is a duty which should be paid by senior medical officer and it is cross-checked during the sign in to the operating theatre to ensure patient'ssecurity.

Objectives

To identify the percentage of proper Consent form for planned caesarean birth To identify what are the common mistake during writing proper Consent form for planned caesarean birth Identify solution for preventing common mistake during consent form writing.

Methods
Retrospective audit had been carried out using details gained from 40 Bed Head Tickets (BHT)from ward 06 National hospital Kandy patients who discharged already from February 2024. RCOG guidelines for Planned Caesarean Birth using as guide for this audit.

Results
A total of 40 consent forms were assessed separately and all had written consents before surgery. Almost all the (100%) consent forms were contained patients name ,age, BHT number and name of the surgeon. Name of the proposed procedure, type of anesthesia , risk of planned caesarean birth compared to planned vaginal birth and risk for mothers were documented in all consent forms. But none of the consent form contained the risk to the baby due to planned caesarean birth. Only 20% of consent form contained name of the anesthetist and consent for emergency hysterectomy. None of the consent form contained the consent for extra procedures like blood transfusion and repair of any damaged to bowel, bladder and blood vessels. Patient signature were obtained in all cases (100%) and only 10% were mentioned the designation. Date and time were documented on 86% of consents forms.

Conclusion
Few key issues were identified by looking through the results, most of the consent forms have been completed by the junior medical officers rather than senior medical officers. We have planned education programs for ward staff and preparing ward level for writing proper Consent form for planned caesarean birth. We are planned to re-audit after proper education and practical sessions.

EP/O - 56

TRAUMATIC UTERINE RUPTURE IN EARLY PREGNANCY: A RARE CASE REPORT

Rathnasekara WADAK[1], Thirukumar M[2], Karunakaran KE[2], Mazahima MM[1], Jey Krishna K[1]
[1]Teaching Hospital Batticaloa
[2]Faculty of Health Care Sciences, EUSL

Background
Uterine rupture is a rare and catastrophic obstetric emergency often seen in late pregnancy and prior uterine scarring. Its occurrence in early pregnancy with an intact uterus is exceptionally rare and the actual incidence in literature is unclear. This case report emphasize the importance of prompt diagnosis and management of such a rare event.

Case Description
A 23 year old mother of one child in her second pregnancy with one NVD presented to the emergency department with a two-day history of abdominal pain and dizziness at 14 weeks' gestation. She reported a history of physical assault by her husband three days prior. On examination, the patient exhibited pallor, tachycardia, tachypnea, hypotension, and cold extremities. Abdominal examination was notable for flank dullness but otherwise unremarkable.An urgent bedside ultrasound revealed a significant amount of free intraperitoneal fluid, an empty uterine cavity with evidence of uterine rupture at the fundus, and an intra-abdominal fetus. Fluid resuscitation was done with crystalloids and packed red cells. Intraoperatively, a massive hemoperitoneum of approximately 2 liters was encountered. A 5 cm transverse uterine rupture was identified in the left uterine fundus with the fetus and placenta located in the pouch of Douglas. The uterine rupture was repaired, and hemostasis

was achieved. The abdomen was thoroughly explored to exclude any associated injuries to the bowel, bladder, or other organs by the surgical team. The peritoneal cavity was irrigated with normal saline. The abdominal wall was closed in layers. The patient was admitted to the intensive care unit for postoperative monitoring and transferred to the ward on the following day. She was discharged on the third postoperative day in a stable condition.

Discussion

Uterine rupture, a serious obstetric complication, was unexpectedly found in an early pregnancy with an intact uterus. The patient's history of physical assault with evidence of shock highlighted the need for considering trauma in seemingly uncomplicated pregnancies.

Conclusion

The clinical presentation of a uterine rupture in early pregnancy might be nonspecific leading to delay in diagnosis. This may lead to catastrophic bleeding and mortality. A high index of suspicion is therefore important especially in the presence of unstable vitals with history of abdominal trauma. Early sonographic evaluation and MDT approach is crucial for a favorable outcome. This case serves as a reminder of the potential severity of traumatic uterine rupture, even in the first trimester. Further research is warranted to better understand the incidence, risk factors, and optimal management strategies.

EP/O - 57

A CASE OF CONSERVATIVELY MANAGED PUMP TWIN IN A TWIN REVERSED ARTERIAL PERFUSION (TRAP) SEQUENCE FROM MONOCHORIONIC TWIN PREGNANCY

Priyashantha, KAG[1], Silva SACK[1,] Bandara YMDA, Nimesha DMC, Chamikara DGM
[1]German Sri Lanka Friendship Maternity Hospital, Galle.

Introduction

TRAP Sequence occurs in 1% of monochorionic twining with an incidence of 1 in 35,000 births. Donor twin the “pump” perfuses recipient the “acardiac”, through arterio-arterial anastomoses. oxygen-poor blood flow of the acardiac twin prevents its upper body formation. Acardiac twin can have four anatomical forms: *Acardius acephalus*, being the most common subtype. Pump twin may complicate polyhydramnios, cardiac failure, hydrops and death. Differential diagnosis for acardiac is vanishing or severely malformed co-twin. Diagnosis is best done with confirming pathognomonic reversed blood flow into the acardiac twin through its umbilical artery, other findings are multiple deep malformations, lack of a heart and massive edema. Pump twin can show growth restriction, doppler changes in umbilical artery ductus venosus, heart failure signs (tricuspid regurgitation, cardiomegaly, pericardial and pleural effusion), polyhydramnios, ascites, subcutaneous edema and hydrops. Diagnosis is almost made in second or third trimester. Pump twin has 50-55% mortality. Prognosis is aided by presence of pump twin malformation, Twins′ weight ratio and Pump twin’s biophysical profile, Color and power Doppler velocimetry. Management options are conservative with hope of eventual vascular disjunction, interventional or mixed approach. Shifting to interventional approach based on cardiovascular impairment of pump twin, polyhydramnios and larger or rapid growth of the acardiac mass.

Case presentation

A 28 year old multigravida was referred from a base hospital at 23 weeks of gestation with live foetus and associated mass containing skeletal structures. No head or cardiac doppler flow identified within the mass, acardiac twin pregnancy was diagnosed and fetal medicine referral was done. Pump twin had not any gross structural anomaly. TRAP was confirmed by foetal

medicine team at 26 weeks and pump twin showed anaemia without heart failure. Further plan of intra uterine transfusion and laser ablation was made with 2 weekly follow up. Ultrasonography at 28 weeks showed reduced trap mass so conservative management chose while monitoring and delivery at 32 weeks. Growth, umbilical artery, middle cerebral artery – peak systolic velocity, Ductus Venosus doppler and liquor were monitored. Breech presentation, normal dopplers and no polyhydramnios were identified in subsequent studies. Elective caesarean section was carried out at 32 weeks following Antenatal corticosteroids for foetal lung maturity and collaborative neonatology team. Specimen of acardiac twin was handed over to Ruhuna Medical faculty following maternal consent.

Conclusion

Early diagnosis and good counselling are crucial in this rare, severe condition to reduce fetal demise of pump twin. Negligible and poor-quality evidence limit emergence of guidelines.

E-POSTERS - GYNAECOLOGY

EP/G – 01
CHALLENGES OF COMPLETE ANDROGEN INSENSITIVITY SYNDROME: A CASE REPORT

Wickramasinghe, SGCN[1], Jayasiri, KBK[2]
[1]Gynecology and Obstetrics Unit, Colombo South Teaching Hospital Kalubowila, Sri Lanka
[2]Queen Elizabeth Queen Mother Hospital, East Kent University Hospitals, United Kingdom

Objectives
Androgen Insensitivity Syndrome (AIS) is a rare genetic disorder; which is characterized by impaired androgen receptor function, leading to feminization of external genitalia despite a male chromosomal pattern. This concise case report aims to provide an overview of AIS, including its clinical presentation, diagnosis, management, and psychosocial considerations.

Case Report
We present a case of a 18 year old individual assigned female at birth who presented with primary amenorrhea and female external genitalia with inguinal palpable lumps. Hormonal evaluation revealed elevated testosterone levels, while imaging studies confirmed the presence of testes. Genetic testing confirmed a mutation in the androgen receptor gene. The diagnosis of AIS was established, and the patient underwent gonadectomy and initiated hormone replacement therapy to induce feminizing secondary sexual characteristics. The patient was offered reconstructive vaginal surgery, but the patient and the partner refused that. Counseling was given and long-term oral Premarin was continued after a multidisciplinary approach with the endocrinology team.

Discussion
The discussion emphasizes the complexities associated with Androgen Insensitivity Syndrome (AIS). It highlights the importance of a multidisciplinary approach for diagnosis and management, involving endocrinologists, geneticists, psychologists, and reproductive specialists. Psychosocial considerations, such as gender identity and body image concerns, are crucial aspects of care. The need for further research to enhance understanding, develop tailored treatments, and assess long-term outcomes is emphasized. Overall, the discussion underscores the challenges of AIS and the significance of comprehensive care and ongoing research in improving patient outcomes.

Conclusion
Androgen Insensitivity Syndrome presents challenges in diagnosis, management, and psychosocial well-being. Early recognition, multidisciplinary collaboration, and tailored interventions are essential for optimal patient care. Further research is needed to enhance our understanding of AIS and to develop personalized therapeutic approaches.

EP/G – 02
A RARE CASE OF A BARTHOLIN'S GLAND CYST IN A NEONATE

Wickramasinghe, SGCN[1], Jayasiri, KBK[2]
[1]Gynecology and Obstetrics Unit, Colombo South Teaching Hospital Kalubowila, Sri Lanka
[2]Queen Elizabeth Queen Mother Hospital, East Kent University Hospitals, United Kingdom

Objectives
This case report aims to highlight the exceptional occurrence of a Bartholin's gland cyst in a neonate, an age group where such cases are exceedingly rare. The report underscores the importance of accurate diagnosis and appropriate management to prevent complications and ensure optimal outcomes.

Case Report
A four-day-old neonate, delivered at term with no complications during the antenatal or intrapartum periods, was noted to have a lump in the vulva on the first day after birth. The lump, located in the left labia minora below the hymen, remained unchanged in size and was not associated with any signs of infection or inflammation. The neonate was otherwise healthy, exhibiting normal urination and no irritability. Differential diagnoses considered included a Bartholin's gland cyst, a hymenal cyst, or a Gartner's duct cyst. An ultrasound scan revealed features consistent with a Bartholin's gland cyst. Surgical intervention involved marsupialization of the cyst under anesthesia, and histological examination confirmed the diagnosis of a Bartholin's gland cyst.

Discussion
Bartholin's gland cysts are extremely uncommon in neonates, primarily because these glands are not fully developed or functional until puberty. The rarity of such cases in neonates poses a diagnostic challenge, often leading to misdiagnoses such as Gartner's duct cysts or hymenal cysts. Accurate diagnosis is crucial due to the potential risk of infection and abscess formation, which can cause significant discomfort and complications. Clinical assessment, supported by radiological imaging and histological confirmation, is essential for accurate diagnosis. Early and appropriate surgical intervention, such as marsupialization, is recommended to alleviate symptoms, prevent infection, and minimize recurrence. This case emphasizes the need for heightened awareness and consideration of Bartholin's gland cysts in neonatal differential diagnoses to ensure timely and effective management.

Conclusion
This rare case of a Bartholin's gland cyst in a neonate underscores the importance of considering this diagnosis even in atypical age groups. Accurate diagnosis through a combination of clinical, radiological, and histological evaluations is essential to guide appropriate management and prevent complications. Future research should focus on the underlying etiologies and optimal management strategies for Bartholin's gland cysts in neonates. Clinical practice should incorporate a broader differential diagnosis for vulval lumps in neonates to avoid misdiagnosis and ensure timely intervention.

EP/G – 03

PSEUDOMYXOMA PERITONEI ASSOCIATED WITH INTRADUCTAL PAPILLARY NEOPLASM OF THE PANCREAS

Dissanayake, CN[1], Tissera, G[1], Rathnapriya, DY[1,] Karunaratne, NLKG[1,2]
[1] De Soysa Hospital for Women, Colombo 08
[2]Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo

Introduction

Pseudomyxoma peritonei (PMP) is a rare manifestation of primary mucinous neoplasms with an incidence of 1-2 per million laparotomies. It is characterized by gelatinous ascites and mucinous deposits over peritoneum and abdominal organs. The majority are associated with mucinous tumors of the appendix and occasionally ovary. On the contrary, intraductal papillary mucinous neoplasm (IPMN) of pancreas is characterized by mucin production and papillary growth of pancreatic duct system. PMP of ovarian origin in a patient with a history of IPMN of the pancreas is rarely documented in the literature. We report such an unusual case of a patient who underwent a total pancreatectomy and was later diagnosed with PMP.

Case report

A 55-year-old menopausal female presented with a 2-month history of abdominal pain and distention with dyspeptic symptoms. Her medical history revealed that she underwent total pancreatectomy, splenectomy, and distal gastrectomy for IPMN of pancreas 6 years ago for which she is on lifelong penicillin prophylaxis and pancreatic supplementation. She had been asymptomatic after surgery until the current presentation. Examination revealed gross ascites. She was investigated with Contrast Enhancing Computerized Tomography (CECT) in suspicion of tumor recurrence which showed a large right adnexal cystic lesion measuring 24.4cm×18.4cm×24.1cm with thin septa, mild ascites with multiple peritoneal and anterior abdominal wall deposits. Her tumor markers were normal except for CA 125 being 68.6 U/ml. She underwent staging laparotomy which revealed bilateral large mucinous ovarian tumors with extensive mucinous material in the peritoneal cavity. Extra-fascial hysterectomy, bilateral salpingo-oophorectomy, and infra-colic omentectomy were performed. Histology confirmed the clinical diagnosis of PMP.

Discussion

PMP is a rare condition characterized by mucinous deposits in the peritoneal cavity. It arises from mucinous tumors of the appendix or ovary. Its association with IPMN of the pancreas is less known. Patients usually present with progressive abdominal distention and pain with dyspeptic symptoms as in our patient. CT scan is widely used to establish the diagnosis. Tumor markers CA 125, CEA, AFP, LDH, and beta HCG are used to assess the severity of the disease. Preferable treatment modalities are cytoreductive surgery and perioperative chemotherapy.

Conclusion

PMP is a form of primary mucinous neoplasms whose diagnosis and management are a subject of debate due to its rarity. However, on clinical suspicion, it should be included in the differential diagnosis.

EP/G – 04

RARE CASE OF 46XY OVOTESTICULAR DIFFERENCES OF SEXUAL DEVELOPMENT

Dissanayake, CN[1], Tissera, G[1], Rathnapriya, DY[1], Karunaratne, NLKG[1,2]
[1] De Soysa Hospital for Women, Colombo 08
[2]Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo

Objective

Differences of sexual development (DSD) is an umbrella term where the development of chromosomal, gonadal, or anatomical sex is atypical. Among DSDs, nearly 5% are true hermaphrodites or ovotesticular DSDs, in which both seminiferous tubules and ovarian follicles are present in the same individual. In true hermaphrodites, 90% have 46XX karyotype, followed by 46XX/46XY mosaicism and, very rarely, 46XY. We describe the case of a 46XY ovotesticular DSD.

Case presentation

A‘girl’ presented at the age of 16 years with primary amenorrhea without breast development and features of virilization. Her height was comparable to that of her colleagues, and she had axillary and pubic hair development. She also noticed a deepening of her voice. 3cm clitoromegaly was presented and the bilateral inguinal mass was palpated. MRI revealed an absent uterus and probable undescended gonads in the inguinal canal. The patient’s karyotype was 46XY. The patient and her family members were counselled. The patient was started on oral oestrogen following bilateral gonadectomy. Interestingly, her gonadal biopsy revealed that both gonads contained both ovarian and testicular tissues, which was confirmed by immunohistochemistry staining. Thus, this is a very rare case of 46XY ovotesticular DSD. Following oestrogen therapy, breast development occurred up to Tanner's stage 3, and her voice became softer. She has sufficient knowledge about her condition, and she is aware that she will be amenorrhic and will not be able to conceive.

Discussion

The diagnosis of DSD is based on hormonal, imaging and genetic studies. The management of individuals with DSD should involve a multidisciplinary team to provide holistic care throughout their life. The decision regarding the sex at which to rear is challenging for individuals with 46XY ovotesticular DSD, and such a decision is based on gender identity and sexual orientation. In our case, the individual decided on the female sex for rearing. This is important for gradual feminisation with pubertal development and psychosexual development. There are several regimens available for estrogen replacement, including combination with progestrogens; however, 17β-estradiol (oral or transdermal) is preferred. Individuals with ambiguous genitalia require feminising genitoplasty. Individuals with 46XY DSD who have undescended testes are prone to developing gonadal tumours, especially germ cell tumours.

Conclusion

The 46XY ovotesticular DSD is one of the rarest forms of DSD. The main arms of such patient management include counselling, psychological support, gender determination, genitoplasty, and hormonal maintenance of designed gender, reproductive and sexual health.

EP/G – 05
A CASE OF OVARIAN HYPERTHECOSIS IN A POSTMENOPAUSAL WOMAN

Wijayarathna, Y.A.C.N[1], Leelarathna, G.T.S[2], Srisubakaran[2], De Silva, P.H.P[3]
[1]Registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital
[2]Senior Registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital
[3]Consultant Obstetrician and Gynaecologist, Colombo North Teaching Hospital

Introduction
A condition known as ovarian hyperthecosis (OHT), which is mainly observed in postmenopausal women, is marked by extreme hyperandrogenism and insulin resistance. As a result of the ovarian interstitial cells differentiating into steroidogenically active luteinized stromal cells, the ovarian stroma contains nests of luteinized theca cells, a condition known as hyperthecosis. They can present with Symptoms and signs of hyperandrogenism, such as deepening voice, acne hirsutism, frontal alopecia, clitoromegaly. Other features include obesity, hyperinsulinemia, acanthosis nigricans and metabolic syndrome. There is an increased risk of vaginal bleeding, endometrial hyperplasia and carcinoma, cardiovascular pathology and diabetes mellitus. It is important to exclude androgen producing adrenal tumors (late onset congenital adrenhyperplasia) where DHEAS level is usually increased as a differential diagnosis.

Case report
A 64 year old woman with type 2 diabetes mellitus referred for the Gynaecology opinion by the dermatology team with extensive hirsutism with Ferryman Gall way score of more than 20, deepening of voice, male type alopecia and clitoromegally, all of which were suggestive of progressive hyperandrogenism. Her serum testosterone level was 7.23 ng/dl, FSH 44.6mIU/ml and LH 25.1mIU/ml, which were in the range of menopause. Normal TSH of 2.3 mIU /ml and normal s.prolactin of 240.0 ng/ml. The DHA was 1.37mmol/l, which was also in the normal range. On ultrasound left ovary was slightly enlarged with no endometrial hyperplasia. MRI appearances are more in favour of fibro-thecoma of the left ovary. A laparoscopic bilateral salpingo-ophorectomy was done. Histology revealed ovarian stromal hyperplasia and hyperthecosis (scattered clusters of luteinized stromal cells with uniform round nuclei). Follow ups, testosterone level came down to 1.09 ng/dl within 2 weeks of surgery, and the hirsutism disappeared.

Discussion
When stromal hyperplasia and luteinization coexist, the condition known as hyperthecosis develops. The luteinized cells release androgens, which may cause virilization (or masculinization) and hirsutism in impacted women. Hyperthecosis etiology may potentially involve insulin resistance. Insulin resistance is common in women with hyperthecosis, and insulin may increase the synthesis of androgen in the ovarian stroma. The relationship between hyperestrinism, or the body's excess of estrogens, and hyperthecosis suggests that in postmenopausal women, hyperthecosis may also play a role in the pathophysiology of endometrial polyps, endometrial hyperplasia, and endometrioid cancer. Therefore, early detection is important.

EP/G – 06
A CASE OF CLITORAL INCLUSION CYST IN AN ADOLESCENT GIRL

Mohamed, ALS [1], Jayasekera, RMMSB [1], Wijesiriwardana, Y.S [1], Eshwarage, K.S. [1], Karunasingha ,J [1]
[1] Castle Street Hospital for women.

Introduction
Clitoral inclusion cysts are rare benign lesions. The formation of clitoral inclusion cysts is primarily associated with genital trauma, including surgical interventions and injuries like FGM. These cysts can also arise congenitally or spontaneously, although these instances are less common. Histologically, they are lined by squamous epithelium and contain keratinous material. Understanding this condition helps in the accurate diagnosis and appropriate management, reducing patient discomfort and anxiety.

Case Description
A 16 year old girl presented with a painless swelling in the clitoral area for 1 month duration. She denied a history of trauma, surgery, and genital mutilation. She didn't have a history of amenorrhea and features of virilisation. On examination, she has appropriately grown for her age with secondary sexual characteristics. She didn't have features of hyperandrogenism (Alopecia, hirsutism, balding, acne etc.) On vaginal examination. A well-defined, non-tender, cystic lesion was noted at the clitoris. The urethra was identified separately from the cyst. Diagnosis Differential diagnoses were Clitoral inclusion cyst Hyperandrogenism (e.g., adrenal hyperplasia) and Abscess. Hyperandrogenism was excluded based on clinical findings. Routine blood tests were normal. Ultrasound showed a hypo-echoic, well-circumscribed cyst without internal vascularity. Management & follow-up The patient was agreed for surgical management. However, the cysts drained spontaneously (had serous fluid) and resolved during the hospital stay. The patient had an uneventful recovery with no recurrence at the 6-month follow-up

Discussion
Clitoral cysts are rare. It should be differentiated from clitoromegaly . A good clinical examination should be sufficient in differentiating the clitoral cyst from clitoromegaly (uniform and symmetrical enlargement of the clitoris). Surgical excision remains the gold standard due to its definitive nature, allowing for complete removal and histopathological analysis. The spontaneous drainage of a clitoral cyst is rare can lead to immediate relief of symptoms, such as discomfort or swelling. However, this resolution is not without potential complications such as incomplete drainage, recurrence, and infection. Regular follow-up, topical antibiotics and hygiene practices would prevent complications. Further research is needed to better understand the prevalence, natural history, and optimal management strategies for spontaneously draining clitoral inclusion cysts

EP/G – 07

INCARCERATED HERNIA CONTAINING LEFT OVARY MISDIAGNOSED: DISCOVERY OF CANAL OF NUCK CYST

Wijesinghe, D[1], Gunaratne, PG[2]
[1] Registrar in Obstetrics and Gynaecology, Buckinghamshire NHS Trust, UK
[2] Consultant in Obstetrics and Gynaecology, Buckinghamshire NHS Trust, UK

Objective

Underscores the importance of adhering to fundamental principles in patient assessment, emphasizing the pivotal role of thorough history taking and comprehensive clinical examination in arriving at an accurate clinical diagnosis.

Case Report

A 42-year-old woman presented to surgical unit with a painful swelling in her left inguinal region. Clinical suspicion pointed to a strangulated inguinal hernia, prompting a CT scan of the abdomen and pelvis, which suggested an incarcerated hernia with the hernial sac possibly containing the left ovary. Further inquiry by the gynaecology team, the patient reported a long-standing, painless swelling in the left vulval area that had increased in size near her last childbirth three years ago but had only become painful and migrated to the inguinal region in the past five days. On examination, a small, soft, mildly tender mass was noted in the left inguinal region, with no other remarkable abdominal findings. Surgical exploration via a left lower groin incision revealed a 3-4 cm lump following the path of the inguinal canal to the internal ring. There were no signs of a strangulated hernia or connection to the peritoneal cavity. Further examination suggested a possibility of a canal of Nuck cyst. Diagnostic laparoscopy confirmed normal bilateral ovaries, tubes, and uterus, and the absence of peritoneal cavity connection. Histological analysis of the excised mass confirmed it as a cyst of the canal of Nuck.

Discussion

The emergence of painful, non-reducible swelling in the inguinal canal of a female necessitates considering differential diagnoses such as a cyst of the canal of Nuck, an embryological remnant unique to females. This condition can mimic more common diagnoses like hernias. Accurate diagnosis relies on thorough clinical assessment, including a detailed history and physical examination.

Conclusion

This case underscores that while modern diagnostic tools are essential, they should complement rather than substitute comprehensive clinical assessments. Detailed patient history and meticulous physical examination are crucial for formulating a differential diagnosis and guiding appropriate investigations and treatment. This approach ensures accurate diagnosis and effective management, particularly in identifying unusual presentations of common conditions like inguinal swellings in women. It reaffirms the enduring value of fundamental clinical skills and broad medical knowledge in contemporary medical practice.

EP/G – 08

CARDIOVASCULAR RISK ASSESSMENT IN OBESE PCOS WOMEN BASED ON LDL/HDL RATIO

Vijayakumar, G[1], Balendrarajah, K[1], Murugathas, V[1], Arasaratnam, V[1], Muhunthan, K[2]
[1]Department of Biochemistry, Faculty of Medicine, University of Jaffna, Sri Lanka
[2]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Jaffna, Sri Lanka

Introduction & Objective
To assess cardiovascular disease (CVD) risk, the LDL/HDL ratio is one of the markers. Obesity aggravates polycystic ovarian syndrome (PCOS) and is linked to an increased risk of CVD complications. The objective of the study was to evaluate LDL/HDL ratio in obese PCOS women attending Obstetrics and Gynaecology Clinic, Teaching Hospital, Jaffna.

Methods
An analytical cross-sectional study with a convenient sampling method was used. Among the 125 PCOS women recruited from the Obstetrics and Gynaecology Clinic, Teaching Hospital, Jaffna. 60 women were identified as obese. The weight & height of the obese women were measured, and BMI was calculated. Based on New Asian Guidelines, Obese women were categorised into Obesity Class I (BMI 27.5- 29.9 kgm^{-2}), Class II (BMI 30.0- 34.9 kgm^{-2}) and Class III (BMI ≥35 kgm^{-2}). Fasting blood samples were analysed for serum Total Cholesterol, Triglycerides (enzymatic methods) and HDL-Cholesterol (HDL-C; precipitation method). The LDL-Cholesterol (LDL-C; Friedwald equation) and LDL/HDL ratio were calculated. The LDL/HDL ratio was classified into normal (≤2.5) and elevated (>2.5) categories. Ethical Review Committee, Faculty of Medicine, University of Jaffna gave ethical approval. The data were analysed by SPSS version 25.

Results
The mean BMI and LDL/HDL ratio of the women were 32.34 (±4.27) kgm^{-2} and 3.63(±1.43) respectively. The PCOS women belonged to obese Class I, II and III were 31.67 (19nos.), 51.67 (31nos.), and 16.67% (10nos.) respectively. Among them, 25% and 75% had normal and elevated LDL/HDL ratios. The number of women with normal and elevated LDL/HDL ratios observed in Class I were 3 & 16 nos.; Class II were 11 & 20 nos. and Class III were 1 & 9 nos. respectively. When the LDL/HDL ratios of PCOS women who had normal values were compared between Class I & II women ($p = 0.265$), Class I & III women ($p = 0.907$) and Class II & III women ($p = 0.241$) showed no significant difference. Similarly, LDL/HDL ratios of the PCOS women who had elevated values were compared between Class I & II ($p= 0.306$), Class I & Class III ($p= 0.963$) and Class II & Class III ($p= 0.597$) revealed no significant difference.

Conclusion
Majority of obese PCOS women belonged to different classes had both normal and elevated LDL/HDL Ratios with higher numbers having elevated ratios. However, there was no statistically significant difference between the different classes of Obese PCOS women.

EP/G – 09

EXPERIENCE IN MANAGEMENT OF PREGNANCY IN RUDIMENTARY HORN OF UTERUS

Kanchana, JLS[1], Wickramasinghe, NH[2], Ekanayake, IN[1], Silva, R[1]
[1]Colombo North Teaching Hospital
[2]Anuradhapura Teaching Hospital

Introduction

A pregnancy located in the rudimentary uterine horn of a unicornuate uterus is termed "Rudimentary uterine horn pregnancy". The term "cornual pregnancy" was originally used for this nature of pregnancies and for pregnancies located in one horn of the bicornuate uterus. These are the rarest form of ectopic pregnancies with a reported incidence of about 1 in 76000 pregnancies. An ultrasound scan will show the gestational sac, mobile and separate from the uterus and completely surrounded by myometrium with a vascular pedicle adjoining the gestational sac to the unicornuate uterus. A single interstitial portion of fallopian tube in main uterine body may be visible too.

Case report

A 20 year old, married for four months duration, presented with mild per-vaginal bleeding and lower abdominal pain for one day duration with an uncertain last menstrual period. She was haemodynamically stable on admission. She was in pain and on abdominal examination, there was suprapubic tenderness but, no guarding or rigidity in the abdomen. On vaginal examination, OS was closed, Cervix looked healthy, and mild altered bleeding through os was noted. No cervical excitation. A urine pregnancy test was positive. Ultrasound scan showed an empty uterus with a gestational sac with a live fetus (Crown-rump length 11+ 4 weeks) adjacent to the left side of the uterus. The sac was mobile and surrounded by a myometrial layer of about 4-5mm thickness. No free fluid in the pelvis and interstitial line sign was not seen. Differential diagnoses were cornual ectopic pregnancy and abdominal pregnancy. She was planned to proceed with a diagnostic laparoscopy as she was symptomatic. Intraoperative findings were, Left sided rudimentary horn of the uterus with an Ectopic pregnancy within the cavity. Bilateral ovaries appeared to be normal and right fallopian tube was normal and attached to unicornuate uterus. Surgery was converted to a laparotomy due to surgical difficulty. Excision of the left-sided rudimentary horn of the uterus was done along with ectopic pregnancy and the specimen sent for Histology. The uterus was reconstructed with No.1 vicryl.

Discussion

In this scenario, the possibility of uterine anomaly had been anticipated and considered in differential diagnoses. As the diagnosis was uncertain, and the patient was symptomatic, the decision was taken to perform a diagnostic laparoscopy. However, if the patient is hemodynamically stable, MRI scan has a place for confirmation of diagnosis. Timely identification and management of pregnancy in a rudimentary horn is important as rupture of the ectopic pregnancy can cause catastrophic bleeding endangering woman's life. Moreover, if surgical expertise is available, laparoscopic resection of rudimentary horn is preferred due to less post operative pain, shorter hospital stay and cosmetic advantages.

Conclusion

A pregnancy in a rudimentary horn is extremely rare. Still, it is important to be vigilant during early pregnancy scanning identify rare types of ectopic pregnancy. Early diagnosis will aid in optimum management in order to prevent maternal morbidity and mortality with unexpected events with rupture of rudimentary horn of uterus.

EP/G – 10

OVARIAN VEIN THROMBOSIS: A CASE REPORT

Jayasundara, DMCS[1,2], Palihawadana, SH[3], Tissera, WGM[2], Rathnapriya, DY[2], Fernando, LAD[3]

[1]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo

[2]De Soysa Hospital for Women, Colombo, Sri Lanka

[3]Navaloka Hospital, Negombo

Introduction

Ovarian vein thrombosis is a rare but potentially serious condition occurring in 1/600 to 1/2000 pregnancies. This usually present with acute abdominal pain, mimicking a surgical abdomen. Untreated complications can be significant. This case report discusses the evaluation of a patient presenting with severe abdominal pain.

Case Report

A 30-year-old woman, postpartum day 7 following caesarean section, presented with sudden onset severe abdominal pain with vomiting and shortness of breath. She had a high BMI and primary subfertility with her pregnancy achieved via intrauterine insemination. On examination she was tachycardic and the abdomen was tense with generalized tenderness. Her investigations revealed an elevated WBC of 14 and CRP of 133. Ultrasound scan revealed a post-partum bulky uterus with an empty cavity, thin rim of free fluid in the hepato-renal pouch with no other abnormalities.Urgent Contrast Enhancing Computerized Tomography (CECT) abdomen and pelvis was performed due to ongoing clinical suspicion and a diagnosis of right ovarian vein thrombosis with patent IVC and pelvic veins was established. She was managed with the liaison of multi-disciplinary teams and started on anticoagulation with S/C Enoxaparin and antibiotic coverage. And once she was stable, she was discharged on Asprin and Riveroxiban.

Discussion

Ovarian vein thrombosis is a rare but potentially life-threatening condition. While it is classically a puerperal process with the incidence rising with caesarean section, it may also arise in non-puerperal settings such as endometritis, pelvic inflammatory disease, malignancy, thrombophilia and gynaecological surgeries. Ovarian vein is the commonest vein involved in puerperal pelvic thrombophlebitis and the right ovarian vein is involved in 80-90% of the cases due to its length, lack of retrograde flow and compression of the inferior venacava and right ovarian vein by the gravid uterus. The clinical course is variable however prompt anticoagulation is necessary to minimize sequalae of complications including pulmonary embolism. A high degree of clinical suspicion is needed for its diagnosis. Ultrasound scan findings while helpful, is highly operator dependent therefore Computerized Tomography is the investigation of choice. It is treated with anti-coagulation and broad-spectrum antibiotics.

Risk of recurrent ovarian vein thrombosis is low however anticoagulant prophylaxis during subsequent pregnancies is recommended.

Conclusion
Ovarian vein thrombosis is a rare condition commonly associated with post-partum period. High degree of clinical suspicion is needed, and imaging modalities can be helpful in confirmation of diagnosis. Anticoagulation is the treatment of choice.

EP/G – 11
A RARE CASE REPORT OF COMPLETE MOLAR PREGNANCY IN A PERI MENOPAUSAL WOMEN

Jatheeswaran, K[1], Ruthra, Y[1]
[1] The German-Srilanka Friendship Maternity Hospital Karapitiya

Introduction
Complete molar pregnancy, a form of gestational trophoblastic disease, is rarely encountered in peri-menopausal women. This case report presents a detailed account of a peri-menopausal patient diagnosed with a complete molar pregnancy, including diagnostic evaluation, management, and follow-up care. The aim is to highlight the clinical challenges and management strategies for this rare presentation. Complete molar pregnancy (CMP) is characterized by abnormal placental development where there is a proliferation of trophoblastic tissue, leading to a nonviable pregnancy. It is most commonly seen in younger women but can occur in peri-menopausal women, where it may present diagnostic and management challenges. Early identification and treatment are crucial to prevent complications such as persistent gestational trophoblastic disease or choriocarcinoma.

Case Discussion
49 years old mother of four children presented to the gynaecology ward with lower abdominal pain and irregular per vaginal bleeding for 2 days duration. She had an amenorrhea for for 9 weeks duration. She was not on any contraception. She had four uncomplicated vaginal deliveries previously. On Abdominal palpation uterus was 14 weeks in size. Speculum examination revealed vesicle like material coming out through the cervical opening. Scan revealed intra uterine snow storm appearance with a size of .6x6 cm with no fetal poles. Her beta hCG value was 140,000. Chest X-ray was normal. FIGO 2000 score was 7.Options were discussed with the patient. The patient underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Histology came as complete hydatidiform molar pregnancy with no invasion/neoplastic changes. The patient was followed until beta hCG dropped below 15U/L. A negative value was obtained before discharging the patient from the clinic.

Conclusion
With appropriate management, including timely evacuation and thorough follow-up, the prognosis for patients with complete molar pregnancy is generally favorable. Persistent trophoblastic disease is rare but requires prompt treatment. Long-term outcomes are typically good, provided that the patient adheres to follow-up protocols. This case highlights the importance of considering complete molar pregnancy in the differential diagnosis of peri-

menopausal women presenting with abnormal vaginal bleeding and elevated beta-hCG levels. Early diagnosis and comprehensive management are essential to mitigate risks and ensure favorable outcomes. Continued awareness and education on this rare presentation are important for improving patient care in similar cases.

EP/G – 12
PAPULAR RASH FOLLOWING PROGESTERONE INJECTION:? SWEET'S SYNDROME.

Senarathna, TGDPR [1], Thanthirige, LD[1], Padeniya, AGTU [2], Panadare, A[2], Ekanayake, S [3].
[1] Registrar in Obstetrics and Gynecology Unit, Teaching Hospital –Gampola.
[2] Consultant in Obstetrics and Gynecology Unit, Teaching Hospital –Gampola.
[3] Consultant Dermatologist, Teaching Hospital –Gampola

Introduction
Sweet's syndrome is Acute Febrile Neutrophilic Dermatosis which comprises of four cardinal features which are fever, neutrophil polymorphonuclear leukocytosis of the blood, raised painful plaques on the limb, face, and neck, and histologically a dense dermal infiltration with mature neutrophil polymorphs [1]. Common associations of Sweet's syndrome are malignancies, pregnancy, infections, inflammatory bowel disease, and drug-induced [2] [3]. Antineoplastics, antipsychotics, colony-stimulating factors, and progesterones such as levonorgestrel also have been associated [2] [4] [5]. Diagnosed by presence of both major criteria [Abrupt onset of painful erythematous plaques and dense neutrophilic infiltrate without evidence of leukocytoclastic vasculitis] and two out of four minor criteria [Pyrexia >38°C, Association with an underlying hematologic or visceral malignancy, inflammatory disease, or pregnancy, Excellent response to treatment with systemic corticosteroids, Abnormal laboratory values at presentation (three of four): erythrocyte sedimentation rate >20 mm/hr; positive C-reactive protein; >8,000 leukocytes; >70% neutrophils]

Case report
A 45-year-old lady who had a history of primary subfertility for 18 years underwent an in vitro fertilization (IVF) and she was started on progesterone supplementation including intramuscular progesterone 100mg injections. After 1st injection on 2nd day patient developed a high fever and mild feverishness that lasted for another two days. After 2nd dose of progesterone on the same day night patient developed a fever again which lasted for one day. Initial facial and neck papular rash developed two days after 2nd fever spike and the following day it was speeded to bilateral upper limbs and ultimately to lower limbs. The rash was reddish plaques and papules and associated with a painful burning sensation and itching without mucosal involvement. The patient had constitutional symptoms such as arthralgia and myalgia without any sinister symptoms. Investigations showed WBC 21.1 with Neutrophil 18.3 (86.5%), HB 13.2, and C - reactive protein 109.3 mg/l with normal liver and renal functions. Skin biopsy showed superficial and mid-dermal perivascular interstitial inflammatory infiltrate comprising neutrophils, lymphocytes, and prominent eosinophils are noted. leucocytoclasia and extravasated red cells are noted without fibrinoid necrosis. which is suggestive of leucocytoclastic vasculitis.

The patient was started on oral prednisolone 20 mg daily dose. On day 3 of prednisolone, the papular rash started to regress and completely settled in two weeks. Prednisolone was gradually tailed off weekly over two month's duration

Discussion

Sweet's syndrome is known to be associated with both pregnancy and progesterone treatments. This patient had fulfilled all major and minor criteria for Sweet's syndrome. Histology did not show typical dense neutrophilic infiltrate. However, evidence says in some Sweet's syndrome lesions, the neutrophils have been observed to be perivascular and exhibiting pathologic changes consistent with leukocytoclastic vasculitis [6,7,8,9,10,11]. In these lesions of Sweet's syndrome, the vascular changes are considered to be those of a "secondary" leukocytoclastic vasculitis occurring as an epiphenomenon and not representative of a "primary" vasculitis [12]. The typical features of drug-induced Sweet's syndrome were also observed in this patient and those are the Temporal relationship between drug treatment and clinical presentation and the temporally related resolution of lesions after drug withdrawal or treatment with systemic corticosteroids[13].

Conclusion

In obstetrics and gynecology practice progesterones are used commonly in several routes including oral vaginal intra muscular and intrauterine. Though it is rare, awareness regarding Sweet's syndrome is important since it is commonly associated with pregnancy and progesterone use to avoid confusion with other dermatological conditions and prompt starting of treatments.

EP/G – 13
GIANT OVARIAN CYST MANAGEMENT VIA SUB-UMBILICAL INCISION: A NOVEL APPROACH

Chandraratne, SMP[1], Chandraratne, AR[2], Godakumbura, LT[1], Punsara, NL[1]
[1] Teaching Hospital, Rathnapura
[2] Faculty of Medical Sciences, University of Sri Jayewardenepura

Objectives

This report aims to highlight the surgical elements of managing large ovarian cysts and bring to attention the rare massive ovarian mass encountered.

Case report

A 55-year-old post-menopausal woman presented with a 3-year history of abdominal distension and constitutional symptoms. Examination revealed a cystic mass with unclear margins extending up to xiphisternum. Ultrasound and contrast-enhanced computed tomography (CECT) imaging confirmed a large, multiloculated ovarian cyst (45cm x 34cm x 35cm) compressing abdominal viscera and bowel, with associated uterine fibroids. CA-125 level was elevated at 72 ng/ml. After pre-operative evaluation and optimization, a sub-umbilical midline laparotomy was performed under general anesthesia. Meticulous packing of the cyst prevented leakage during aspiration of 25 liters of fluid through a small incision on the cyst wall. A second suction unit was employed to manage any potential spillage. Each compartment of the

multiloculated cyst was systematically dissected and drained. A total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed and sent for histology. There was no evidence of local spread or lymph node involvement.

Discussion

The surgical management of large ovarian cysts poses significant challenges. Here, we describe a case utilizing a midline sub-umbilical incision instead of the conventional xiphisternum-to-pubic symphysis incision. This approach offers reduced pain, bleeding, analgesic requirements and improved wound healing and cosmesis, with decreased infection and incisional hernia rates. Although the suprapubic transverse incision is more user-friendly, it poses significant difficulties when dissecting if the posterior wall of the mass is adhered, increasing the risk of bowel and ureteric injury. Meticulous handling of cystic contents was paramount in this case to prevent spillage with risk of peritoneal dissemination and associated complications, particularly given the large fluid volume. While laparoscopy is increasingly being recognized as a viable option for cysts extending beyond the umbilicus, this case illustrates the limitations of laparoscopy in the context of giant cysts. CECT findings does not support a laparoscopic approach due to the position of the fluid free component of the cyst, the higher risk of spillage and due to the bulky uterus.

Conclusion

This case demonstrates the successful management of a giant ovarian cyst via a sub-umbilical incision, highlighting its potential advantages over traditional approaches. Such cases requires an individualized approach, tailored to the individual cyst and patient characteristics. This report contributes to the ongoing exploration of alternative surgical options in gynecologic oncosurgery.

EP/G – 14

A CASE OF RECURRENT COMPLICATED URINARY TRACT INFECTION IN A WOMAN WITH NEUROGENIC BLADDER-A DIAGNOSTIC DILEMMA

Wijayarathna,Y.A.C.N, Srisubakaran,S, De Silva,P.H.P[3]
[1.] Registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital
[2.] Senior Registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital
[3.] Consultant Obstetrician and Gynaecologist, Colombo North Teaching Hospital

Introduction

Recurrent urinary tract infections are defined as two or more episodes of acute bacterial cystitis, along with associated symptoms within the last six months or three episodes within the previous year. Urinary tract infections are more common among women, with a life time prevalence of at least one symptomatic UTI in more than 50% of women. Among them, 20 to 30% of women who have a UTI will have a recurrent UTI. Most UTI recurrences are typically acute simple cystitis with reinfections rather than relapses or complicated UTI.

Case report

A 45 year old woman, who had three previous vaginal deliveries, was referred for vaginal hysterectomy due to hypertrophic elongation of cervix, first degree utero-vaginal prolapse.

However, she had associated urgency, urge incontinence, nocturia, multiple episodes of acute urinary retention and recurrent urinary tract infections during last six months and acute pyelonephritis on admission. On further evaluation, it was noted that she had three hospital admissions for, reduce urine output with acute urinary retention complicated with overflow incontinence recently. She was also diagnosed with diabetes mellitus on recent assessment, but had good control. However, it was apparent that, her pelvic flow dysfunction was unlikely to have been the cause for such severe symptoms. On careful assessment, she was found to have numbness in her left lower limb. She has had frequent episodes of constipation and autonomic dysreflexia on top of urinary symptoms, during the last six months making the diagnostic a dilemma. This woman was referred to the neurologist and for a MRI, which revealed a dural venous malformation and anterior displacement of the conus medullaris with partial obstruction of the cauda equine. The maximum involvement is from L1 to L3. There was bladder wall thickening suggestive of neurogenic bladder. The woman was referred for a cystoscopy and for further management with the neurology follow up and put on clean intermittent self catheterization. She has been planned to refer for urodynamics and uroflowmetry for urogynaecological assessment.

Discussion

The main function of the lower urinary tract is to store urine and to empty the bladder at the appropriate moment. This coordinated activity of the bladder and urethra is maintained at optimal levels by the nervous system with multi-level neurological inputs. Neurogenic lower urinary tract dysfunction depend upon the level of neurological impairment and usually present with urinary retention, storage symptoms, overflow incontinence and recurrent infections. Comprehensive history taking with bladder diary, urological assessment with ultrasonography and urodynamic studies provide useful information about the underlying pathology. Spinal dural venous fistulas or vascular malformations are commonly encountered treatable vascular malformations of the spinal card. They are classically found in the thoracolumbar region. If left untreated, these vascular malformations can lead to severe morbidities like progressive myelopathy and bladder and bowel dysfunction. Among untreated patients, 50% become severely disabled in 3 years according to the estimates. Surgical occlusion is considered the mainstay, most definitive, and curative treatment modality for spinal dural venous malformations and that effectively improves the neurologic symptoms in most patients.

Conclusion

Comprehensive clinical assessment including the history and uro-gynaecological symptom analysis will provide valuable information for the diagnosis in complex cases with overlapping symptoms. Furthermore, urodynamic studies, including uroflowmetry and video urodynamics may help to distinguish the underline pathology. The treatment goal of spinal venous malformation is to halt the progression of the disease and the prognosis largely depends on the duration of symptoms and the clinical condition at the time of start of treatment.

EP/G – 15
POLYEMBOLOKOILAMANIA; A CASE SERIES

Vidyatilake, LP [1], Fonseka, NC [1], Manage, N [1], Perera, MANAP [1], Weerawardhana, CD [1], Fonseka, NA 1, Hettipathirana, PS [1,2], Chandradasa, M [1,2]
[1] Colombo North Teaching Hospital, Ragama, Sri Lanka
[2] Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka

Objectives
Polyembolokoilamania, the insertion of objects inside bodily orifices, though not uncommon, is reported scarcely. These four cases highlight the commonalities and management challenges in teenage polyembolokoilamania experienced by gynaecology and psychiatry services.

Case Report
Miss W, a 16-year-old girl from a child development center (CDC), presented repeatedly with impulsive insertion of objects, i.e. batteries inside her introitus, leading to recurrent vaginal infections. were tried with minimal improvement.

Miss D, 16, borderline IQ, from a CDC, polysubstance dependent, presented with recurrent vaginal infections after repeated insertions of objects inside her vagina.

Miss T, 16, from a CDC, with dependence and dealing with methamphetamine, and had recurrent insertion of nails inside the introitus. She was managed on lithium, sertraline, and olanzapine and principles of NET. She Miss S, 17, on levetiracetam for epilepsy, and repeatedly absconding from CDCs, now living with her father, was referred twice following the swallowing of toothbrushes and inserting batteries inside the introitus.

All four girls had histories of sexual and physical abuse, average IQ and borderline personality (BPD) traits. They underwent examination under anaesthesia and foreign body removal under antibiotic cover. From the psychiatry aspect, multiple drug regimens including combinations of lithium, clonidine, olanzapine, principles of dialectical behaviour therapy (DBT) narrative exposure therapy (NET), and harm reduction approaches were used. Miss T achieved remission in six months. Others showed minimal improvement.

Discussion
Over time there out of four of the affected teenagers failed to adhere to management plans due to motives such as sexual gratification, “seeking to quieten the traumatic memories”, and relieving boredom and attention. Ultimately both specialities get burdened.

Conclusion
Inspite of empathetic approaches the prognosis is often poor. Risk minimisation, regular follow up and modifying the expectations of healthcare professionals would be the key to management of these individuals.

EP/G – 16

HERLYN-WERNER-WUNDERLICH SYNDROME WITH RUDIMENTARY HEMIUTERUS AND CERVIACAL AGENESIS

Jaysekara,GL[1] Abeysinghe,AGAW[1]
Teaching Hospital, Kurunegala

Objectives.

To present possible presentations, the diagnostic and therapeutic approaches in HWW syndrome, and to hightligt the challenges in diagnosis in low resource acute setting, that may coexist with various complications.

Case Report

A 12 years old girl presented with symptoms of acute abdomen, found to have tender mass palpable in lower abdomen. She had attained menarche 9 months back. Transabdominal Ultrasound revealed large multilocular cyst with echogenic fluid in the pelvis without free fluid. Bilateral ovaries were normal. Right kidney was not identified. Exploratory laparotomy revealed uterine didelphus with right rudimentary and left larger horn with large hematometra, left distorted tube with hematolalphynx with large endometrioma at fimbrial end of the tube and multiple omental adhesions, but normal right tube and ovary. Examination Under Anesthesia revealed cervical agenesis and hematocoplus. Endometrioma cystectomy was done, hematometra was drained about 1.5 liters for symptom relief. CECT revealed bicornuate uterus, larger left horn and a smaller right horn. Left uterine cavity hematometra, ipsilateral blind hemivagina with hematocolpus, and background vaginal septum. Solitary right kidney with compensatory hypertrophy. Parents were counselled regarding the condition and the fertility outcome and options and decided for hysterectomy. Abdominal hysterectomy was done. Vaginal septum was resected and vaginal reconstruction was done. Patient was discharged postoprative day 3 without complications.

Discussion

HWW syndrome or OHVIRA syndrome is a rare, developmental anomaly of the genitourinary tract including uterus didelphys with blind hemialgia and ipsilateral renal agenesis, resulting from maldevelopment of Mullerian and Wolfian ducts. Mullerian anomalies and endometriosis are associated. The syndrome can present in various symptoms. Endometriosis is a late complication even though our patient had developed early. MRI and ultrasound are the gold standard in the diagnosis. Laparoscopy can be an additional diagnostic method. CECT provided much information on this patient as MRI was not available. Excision or marsupialization of the vaginal septum ensures outflow of the menstrual blood and relieves pain. Fertility is preserved although pregnancy outcome is variable. In cases of stenosis and recurrent hematometra and cases with cervical atresia hemi hysterectomy is recommended. But for this patient, the rudimentary right horn and cervical agenesis lead towards the decision of total hysterctomy.

Concusion
HWW syndrome is a rare and has variable presentations. Presence of menstruation and nonspecific abdominal pains may deviate the diagnosis but possibility should be considered. Presence of urinary tract abnormality should rise the suspicion of genital tract abnormality. Early diagnosis can prevent complications and and improve fertility outcome. Transrectal USS may provide adequate information for diagnosis in low resource setting. Resection of vaginal septum is the accepted management, in cases of recurrence and stenosis cervical atresia, hemihysterectomy is considered.

EP/G – 17
BILATERAL PARAFIMBRIAL CYSTS LEADING TO ACUTE ABDOMEN IN A PREPUBERTAL GIRL

MMH Dissanayake[1], SA Ruwanpathirana[1], AMLM Adikari[1], DSN Withana[1], SSN Chandrasiri[1]
[1]De Soyza Hospital for Women, Colombo, Sri Lanka

Objective
A parafimbrial cyst is a fluid filled cyst which attached to the fimbrial end of the fallopian tubes. These also are known as paratubal cysts, paraovarian cysts or hydatid cyst of Morgagni. They are remnants of Wolffian duct in the mesosalpinx and not arise from the ovary. It is usually benign in nature and may grow up to 20cm. Most of the time they are asymptomatic and might cause pressure symptoms, abdominal pain and fullness due to its size and cyst accidents. It accounts for 10-20% of adnexal masses and commonly seen in 20 to 40 years of age group and rarely seen in teenage females. It tends to get larger in teenage females.

Case report
A 10 years old prepubertal girl presented to casualty ward complaining severe abdominal pain for 6 hours duration with vomiting and other autonomic symptoms. She has had on and off mild lower abdominal pain over 4 months duration involving either right or left iliac fossa without any bowel or urinary symptoms or fever. Trans abdominal ultrasound scan revealed thin walled bilocular adnexal cyst in 12cm x 9cm size with clear fluid, absence of vascularity and free fluid. Thus she underwent an emergency mini laparotomy under general anaesthesia and found to have bilateral twisted parafimbrial cysts in 10cm x 7cm size in left side and 7cm x 5cm size in right side. Both cysts were detwisted and parafimbrial cystectomy performed.

Discussion
Torsion, rupture, hemorrhage and becoming very large are the common complications of parafimbrial cysts. They may present with acute abdomen and may require surgical interventions. Even though Laparoscopic cystectomy is the ideal surgical management option, laparotomy may require in large and complicated parafimbrial cysts. Treatments are not indicated in asymptomatic cases. It rarely recurs after surgical excision or spontaneous resolution. As it develops from remnants of Wolffian ducts, it can occur during any age group of females.

Conclusion
Parafimbrial cyst is a rare cause of acute abdomen in prepubertal females. It warrants surgical treatment in symptomatic cases.

EP/G – 18
INGUINAL SOFT TISSUE METASTASIS AFTER 25YEARS FOLLOWING CURATIVE TREATMENT FOR ENDOMETRIAL CARCINOMA

MMH Dissanayake[1], SA Ruwanpathirana[1], SN Senaratne[1], AMLM Adikari[1], SSN Chandrasiri[1], WFN Fereen[1]
[1]De Soyza Hospital for Women, Colombo, Sri Lanka

Objective
Endometrial carcinoma is the most common gynecological cancer in developed world. It commonly metastasised to loco-regional structures such as cervix, vagina, bladder, bowel and lymph nodes. Skin and soft tissue nodules are extremely uncommon and it is a sign of expansive spreading disease with poor prognosis. Reported frequency of skin metastasis of endometrial carcinoma is 0.8% with mean survival of 4 to 12 months.

Case Report
A 60 year old lady presented to gynecology ward with a history of lump at inguinal region for 5 years duration. The size of the lump has slowly increased over the time. She has developed localized pain, over last 3 months which directed her to the medical care. On further evaluation, she has undergone a total abdominal hysterectomy and bilateral salpingoophorectomy 25 years ago due to endometrial carcinoma. She has not received adjuvant therapy as it was an early stage endometrial carcinoma. Department ultrasound scan and CT scan suspected a possible soft tissue deposit of previous endometrial carcinoma. Thus a wide local excisional biopsy of the lump was done and the histology report confirmed it as deposits from previous endometrial adenocarcinoma. She was referred to gynecological oncology centre for further management and there she was treated with radiotherapy and chemotherapy.

Discussion
This is a very rare form of late recurrence of endometrial carcinoma after 25 years from primary treatment. As the patient was having slow growing lump at inguinal region for more than 5 years, it is an unusual presentation of a cutaneous metastasis of endometrial cancer. Pathophysiology of inguinal skin metastasis is still not fully understandable and suggested mechanisms are hematogenous spread, lymphatic spread and the spread along the round ligament. Therefore these patients need to be evaluated for distant and local recurrence. Hence contrast enhance CT chest, abdomen and pelvis is indicated. Management of metastatic disease involves complete secondary debulking with adjuvant or neoadjuvant chemo-radiotherapy.

Conclusion
Even-though most of the cases of endometrial carcinomas are associated with early recurrence, delayed recurrence is still a possibility after curative treatment. This is an unusual presentation of cutaneous metastasis of an endometrial carcinoma.

EP/G – 19

EARLY PULMONARY EMBOLISM FOLLOWING ADJUVANT RADICAL HYSTERECTOMY IN CERVICAL ADENOCARCINOMA- A CASE REPORT

Dissanayake, DMC[1], Hapuachchige, C[2]
[1]Medical officer, National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.
[2]Consultant Gynae-oncological Surgeon, National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Objectives

Optimal management of patients with primary cervical tumors greater than 4 cm in diameter is debated and neoadjuvant chemotherapy followed by radical hysterectomy is one option. The prognostic significance of the adenocarcinoma histologic type is more controversial compared to the squamous cell type. Cervical adenocarcinoma however relatively less responsive to radiotherapy. Large tumor growth can be challenged by chemotherapy and response is assessed. Once the possible surgical resection is achieved, surgery is planned. Although thromboembolic complications are uncommon following hysterectomy, developing pulmonary embolism within the first 24 hours without previous risk factors is uncommon. This case emphasizes the challenges of management and recognition of complications.

Case history

A 41-year-old mother of 3 children presented with post-coital bleeding and was diagnosed with moderately differentiated cervical adenocarcinoma. She was diabetic, hypertensive, and asthmatic with a BMI of 23. There was no family history of DVT, and she was on OCP till the diagnosis of cancer was made. CECT has shown a large tumor extending to the uterine body where the bladder and rectal involvement could not be excluded. She received 3 cycles of chemotherapy IV carboplatin/paclitaxel. However, there was no significant clinical response hence she underwent radical hysterectomy, bilateral salpingo-oophorectomy, omentectomy, and bilateral pelvic lymph node dissection via midline incision. Post-op day 1 she developed shortness of breath and tachycardia and CTPA confirmed right upper and lower lobe pulmonary emboli (PE). Hemoglobin was 10.5g/dl. She was started on a therapeutic dose of enoxaparin which was later complicated with wound hematoma and subsequently wound infection requiring IV antibiotics and drainage. Histology confirmed residual invasive adenocarcinoma of endocervix with minimal response to chemotherapy. The tumor involved a parametrium and 7 out of 22 lymph nodes and the omentum showed tumor deposits. She was referred for adjuvant treatment.

Discussion

In large tumors that are relatively less sensitive to chemoradiotherapy where primary surgery is not an option, a patient was challenged with chemotherapy. This patient however had minimal response hence the radical surgery was performed. A background history of asthma and post-operative tachycardia with shortness of breath in post-op day 1 could raise the other common possibilities including primary hemorrhage, masking the diagnosis of PE.

Conclusion
Having high clinical suspicion for PE in the early postoperative period is important to recognize and reduce surgical morbidity and mortality. Prompt recognition and timely management of complications are essential to prevent delays in the adjuvant treatment.

EP/G – 20
AN EXTRA-PELVIC ENDOMETRIOSIS MIMICKING AN INGUINAL LUMP; DECISION MAKING AT A NON-GYNAECOLOGICAL SETTING.

Subasinghe, D[1,2], Wimalasena, TBGH[2], Jayawickrama, A[1]
[1]University Surgical Unit, National Hospital of Sri Lanka, Colombo
[2]Department of Surgery, Faculty of Medicine, University of Colombo

Objectives
Endometriosis is defined as "Presence of functioning endometrium (glands and stroma) other than uterine mucosa", and may be either pelvix or extrapelvic. This case is reported due to the rarity of inguinal endometriosis and its diagnostic challenges, which emphasize the importance of considering it in differential diagnosis of inguinal lumps in women of reproductive age.

Case Report
A 44-year-old woman with a history of pelvic endometriosis diagnosed in 2006 presented with a lump in her right groin for a duration of two years. The lump caused cyclical pain, worsening before and after menstruation, and its size fluctuated with the menstrual cycle. There were no abdominal symptoms, vomiting, abdominal distension, or any systemic illness. The patient had a history of subfertility and was treated for heavy menstrual bleeding and secondary dysmenorrhea in 2019 with the insertion of a levonorgestrel-releasing intrauterine system (LNG-IUS). Clinical examination revealed a cystic, ill-defined lump of 5cm by 3cm in the right groin without a palpable cough impulse. Ultrasound examination showed a 5cm by 2.3cm cystic lesion, atypical for an inguinal hernia or lymph node. Differential diagnoses included a cyst of the canal of Nuck, inguinal lymphadenopathy or inguinal endometriosis. The patient underwent right inguinal canal exploration, en bloc resection of round ligament with lump, and mesh repair under spinal anesthesia. Intraoperatively, the lump was attached to the round ligament at the deep ring. The specimen was sent for histological assessment, confirming endometriosis with suppurative inflammation. The patient remained asymptomatic one month post-surgery and was referred to a gynecologist for continued care.

Discussion
Inguinal endometriosis is rare, occurring in less than 0.3% - 0.6% of endometriosis cases, with a majority on the right side. The diagnosis is often confirmed histologically, with ultrasonography aiding in identification. The absence of perilesional and intralesional vascular flow is characteristic. Surgical management typically involves excision of the mass along with the extraperitoneal part of the round ligament. Mesh reinforcement was performed due to posterior wall weakness observed intraoperatively. Given the association of inguinal endometriosis with intraperitoneal endometriosis, long-term gynecological follow-up is essential.

Conclusion
This case highlights the need for awareness of inguinal endometriosis as a differential diagnosis for inguinal lumps in women of reprodictive age group. Proper diagnosis and surgical management are crucial, and gynecological follow-up is recommended to monitor for potential intraperitoneal endometriosis.

Keywords
Inguinal endometriosis, extrapelvic endometriosis, round ligament

EP/G – 21
A RARE CASE REPORT ON ECTOPIC PARTIAL MOLAR PREGNANCY

Premarathna HRSDB[1], Amaradivakara PW[1], Perera WME[1] Witharane BK[1], JeyKrishna K[1]
[1] German Sri Lanka Friendship Hospital for Women, Galle, Sri Lanka

Introduction
An ectopic pregnancy, where implantation occurs outside the endometrial cavity, affects approximately 11 per 1,000 pregnancies.[1] The incidence of partial or complete molar pregnancy is 1 in 1000. [2,3] The combination of these pathologies is extremely rare, with about 200 reported cases in the literature and an estimated incidence of 1.5 per 1,000,000 pregnancies.[4] Here, we report a case of an ectopic pregnancy with a partial mole which presented with signs of rupture.

Objectives
To highlight the rarity and importance of timely, accurate diagnosis to prevent maternal morbidity.

Case report
A 36-year-old mother of two presented with right sided lower abdominal pain and irregular vaginal bleeding for three weeks. She was diagnosed with hypertension which was managed with Angiotensin-converting enzyme (ACE) inhibitors. She was pale and hemodynamically unstable with BP 90/50 mmHg and PR 110 bpm. Examination showed tenderness in the right iliac fossa. Elevated serum beta-hCG (13,654 U/L) indicated a possible ectopic pregnancy. Ultrasound confirmed a right ruptured tubal ectopic pregnancy. Emergency mini-laparotomy was performed due to the lack of laparoscopy and right-side salpingectomy was done as the contralateral tube appeared normal. Postoperative recovery was unremarkable and she was discharged the next day with a plan to repeat urine hCG in three weeks. Histopathological evaluation revealed a right tubal ectopic pregnancy with features of a partial hydatidiform mole. There was no tissue invasion. Follow-up of the patient revealed no significant symptoms and her serum beta-hCG was negative after six weeks.

Discussion
Hydatidiform mole is an abnormal gestation resulting from abnormal fertilization and are classified as either partial or complete molar pregnancies.[5,6] Most tubal molar pregnancies are managed surgically and diagnosed incidentally via histopathology. Ectopic pregnancies managed with methotrexate might include a few unrecognized tubal molar pregnancies. The

clinical presentation of patients with ectopic molar pregnancies is generally indistinguishable from non-molar tubal pregnancies. The level of β-hCG is not helpful in differentiating the two conditions, even though some may show unusually high hCG levels to an ectopic pregnancy.[7] Timely diagnosis of molar pregnancy, whether complete or partial, is essential due to the risk of persistent gestational trophoblastic disease, which can lead to malignancy if untreated.[8,9]

Conclusion
Partial ectopic molar pregnancy is a rare but important diagnosis to consider in cases of ectopic pregnancy with unusually high β-hCG levels. Early surgical intervention and comprehensive follow-up can prevent life threatening complications.

EP/G – 22
A CASE OF RECTAL PAIN; MIGRATION OF AN OLD IUCD MANAGED ENDOSCOPICALLY

Senanayake, D[1], Wimalasena, TBGH[1], Fernandopulle, N[1,2]
[1]Department of Surgery, Faculty of Medicine, University of Colombo
[2]University Surgical Unit, National Hospital Sri Lanka, Colombo

Objectives
Intrauterine contraceptive device (IUCD) is an effective and safe contraceptive method that's commonly used. Despite being a safe contraceptive method, complications are known to occur. IUCD migration, which is one such complication can present with menstrual bleeding abnormalities and abdominal pain. However, it's also known to be asymptomatic or giving incidental findings of the IUCD migrating into adjacent organs. Here we report a rare case of a patient who conceived despite having an IUCD in place and later presented with the IUCD partially in the rectum.

Case report
A 38-year-old female presented with pain in the rectum for 4 months duration and digital rectal examination revealed a protruding rod-like object anteriorly. The sigmoidoscopy showed a tubular plastic stump protruding through the anterior rectal wall. X-ray and CT of the pelvis revealed an arrow-shaped object extending from the vagina to the rectum. On further questioning patient revealed that she had undergone insertion of an Intrauterine contraceptive device (IUCD) 10 years ago but had not been removed yet. She had also noticed gas passing out from the vagina but ignored it. Surprisingly she had also conceived once after inserting this IUCD. Later a repeat sigmoidoscopy was performed, and the loop was removed using a snare. A 3mm defect was seen at the anterior rectal wall which appeared epithelialized causing a recto-vaginal fistula. The defect opening was coagulated with argon plasma (APC) and three endo-clips (Resolution 360™ Clip) were applied to close the defect by the third author (NF). Following the intervention the passage of gas from the vagina and rectal pain subsided and she remains asymptomatic 6 months post intervention.

Discussion
IUCD migration is rare, but a recognized complication and the most common target sites include bladder, omentum and intestines, while rectum is reported to be the target location in

12% of migrated cases. They may cause peritonitis, bowel perforation, fistula and abscess formation. Retrieval can be done via various management approaches including endoscopy, hysteroscopy, laparoscopy and laparotomy, depending on the location and the degree of embedment. In our case since the limbs of IUCD were visualized during sigmoidoscopy it was possible to retrieve and repair the fistula endoscopically.

Conclusion
IUCD migration to the rectum is rare but can lead to significant complications. Regular self-examination and follow-up are recommended for early detection. Endoscopic retrieval and closure of defects is a successful non-invasive method for management when limbs are visible through the rectum.

EP/G – 23
LEIOMYOMA OF THE ROUND LIGAMENT – A CASE REPORT.

Witharane, BK[1] Amaradivakara, PW[1] Premaratne, HRSDB[1] Ranatunga, RJKLD[1]
[1]German Sri Lanka Friendship Hospital for Women.

Objectives
Uterine fibroids are very common but their localization in the round ligament is rare. It may present as a mass in the vulva, an intra-abdominal mass, a hernia or an enlarged lymph node. This case report highlights a rare form of a very common pathology.

Case Report
A 41-year-old nulliparous woman presented with worsening right-side groin pain of 7 years duration. This was not associated with any bowel, bladder or sexual dysfunction. There was no abnormal uterine bleeding. She developed secondary dysmenorrhea to which she allocated a pain score of 10/10. The right-side groin pain too worsened over time and caused pain during walking. She had no family history of malignancies. Routine examination revealed a large mass comparable to a 20-week gravid uterus and a painless, firm immobile lump in the right-side inguinal region, 3x4cm in size. An ultrasound scan confirmed the presence of multifocal uterine leiomyomas. However, the right inguinal mass continued to baffle us. Since MRI/CT scan is not available at our hospital, after discussion with the consultant, the patient was offered surgery. The histopathology report which confirmed the inguinal mass to be a leiomyoma.

Discussion
A third of round ligament leiomyomas are located inside the abdomen while the others are extra-peritoneal. The risk factors this patient possessed are early menarche, nulliparity, and obesity. Other, less common round ligament tumours include endometriomas and mesothelial cysts. These may present with groin pain and examination will reveal a painless, irreducible mass. They are mostly found on the right side and tend to be solitary and unilateral. The predilection for appearance on the right round ligament remains unexplained. More than half of these patients will have synchronous uterine fibroids too.

Conclusion
Preoperative diagnosis of this rare benign condition is difficult due to the lack of specific findings in imaging. CT/MRI is still not available at many hospitals in Sri Lanka. We must rely on routine gynaecological examination to exclude a sinister pathology like inguinal/femoral hernia, lymphadenopathy, abscess or femoral artery aneurysm. We must bear in mind that common pathologies can occur in uncommon locations among certain patient groups.

EP/G – 24
SUCCESSFUL MANAGEMENT OF A RUPTURED HETEROTOPIC TRIPLET PREGNANCY

Jayasingha, T I[1], Bandara, W W M M K[1], Ratnasiri, U D P[1]
[1]Castle street hospital for women

Objectives
Heterotopic pregnancy is a rare condition in which there is coexistence of intrauterine and extrauterine pregnancies which could lead to diagnostic difficulties as well as life threatening implications to the woman. The incidence of heterotopic pregnancies in the general population is 1:30000 whereas in the women who have had assisted contraception is it higher 1-3:100.

Case report
This is a report of a 46-year-old with a history of primary subfertility and had undergone an IVF resulting in a triplet pregnancy which was found to be a combined ruptured left cornual singleton ectopic and an intrauterine dichorionic diamniotic twin pregnancy. She was admitted with severe generalized abdominal pain, dizziness and faintness without vaginal bleeding and was found to have tachycardia(116/min), blood pressure of 90/60mmHg, severe tenderness over left iliac fossa associated with guarding. Ultrasound revealed an intrauterine DCDA twin and a left cornual ectopic having fetal heartbeat along with free fluid in the pouch of Douglas and the hepatorenal pouch and the diagnosis of a heterotopic pregnancy with a ruptured ectopic was made. She was immediately stabilized and was proceeded with a laparotomy. There was a cornual rupture due to weakening of the cornua due to a degenerated fibroid in the cornual region. Myomectomy and repair of the ruptured site was performed after evacuation of the pregnancy products under general anaesthesia. Post operative Ultrasound showed a live intrauterine DCDA twins. Patient was discharged on day 2 post op for the antenatal clinic followup.

Discussion
Diagnosis as well as management of heterotopic pregnancy is challenging. Clinical features may be mistaken for early pregnancy symptoms and physical signs may be helpful but not always diagnostic. Beta hCG has no place in the diagnosis due to the coexistent intrauterine pregnancy. Transvaginal ultrasound is the important investigation, but it should be done having the possibility of a heterotopic in mind.

Conclusion
Suspicion of Heterotrophic pregnancy is crucial in In vitro fertilization especially after more than one embryo transfer .This case represents the value of correct and timely identification

and diagnosis of a heterotopic pregnancy and signifies the importance of the medical personal who perform early pregnancy ultrasonography that the visualization of an intrauterine pregnancy does not emancipate the necessity of accurate evaluation of the adnxae which would prevent life threatening maternal complications.

EP/G – 25

A RARE CUTANEOUS MANIFESTATION OF CERVICAL ADENOCARCINOMA: SISTER MARY JOSEPH NODULE

Jayasingha, T I[1], Chinthaka R G[2], Rathnayake, R M S K[1,3], Wijesuriya, M W A B[1], Dissanayake,
D M C[1], Hapuachchige, C[1]
[1]National cancer institute Maharagama
[2] Teaching hospital Anuradhapura
[3] Teaching hospital Peradeniya

Objectives

Cervical adenocarcinoma is a malignancy occurring in the mucus-producing glandular cells of the endocervix. It is less common than squamous cell carcinoma of the cervix and accounts for about 12.5 % of all cervical carcinomas. Sister Mary Joseph nodule is an umbilical metastatic deposit of an internal malignancy, the incidence being 1-3% of intra-abdominal or pelvic malignancies.

Case report

This is a report of a 52-year-old woman presenting with postmenopausal bleeding and occasional purulent vaginal discharge, on examination was found to have a bulky cervix and a normal uterus and endometrium for which a cervical biopsy has been performed which has shown an endocervical adenocarcinoma. She was also found to have a 3*3*2 cm^3 irregular fixed hard mass in the umbilicus. The rest of the system examination was normal. She was proceeded with a type c Radical hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic node dissection, infracolic omentectomy and umbilectomy. Histology revealed an endocervical adenocarcinoma of the cervix with normal endometrium ovaries and tubes. The omentum and all pelvic nodes were free of tumor but with histological evidence of tumor deposits being present within the umbilicus confirming it to be a Sister Mary Joseph nodule. She was then referred for further Oncological care.

Discussion

Sister Mary Joseph node signifies a metastasizing advanced intraabdominal malignancy and generally indicates poor prognosis with a survival time of 10 months. It was named after sister Mary Joseph who was the first to observe a malignant umbilical deposit association with intra-abdominal malignancy, by the English surgeon Sir Hamilton Baily in 1949. It usually presents as a firm nontender usually vascular swelling in the periumbilical region which rarely exceed the diameter of 5 cm and hypothesized to be spread by peritoneal, haematogenous or lymphatic system. Furthermore, it is a rare cutaneous manifestation of adenocarcinoma of cervix.

Conclusion
This case signifies the importance of thorough examination which would be imperative of precise diagnosis and clinical staging for a pragmatic approach of management.

EP/G – 26
VAGINAL CHORIOCARCINOMA: A RARE PRESENTATION OF A RARE ENTITY.

Jayasingha, T I[1], Chinthaka R G[2], Rathnayake, R M S K[1,3], Wijesuriya, M W A B[1], Dissanayake,
D M C[1], Hapuachchige, C[1]
[1]National cancer institute Maharagama
[2] Teaching hospital Anuradhapura
[3] Teaching hospital Peradeniya

Objectives
Choriocarcinoma is one of the malignant forms of gestational trophoblastic disease which arise from abnormal placentation. The evident risk factors for gestational trophoblastic diseases are extremes of maternal age and previous molar pregnancy which indicates abnormal gametogenesis and thus fertilization of ova produced at the extremes of age. Choriocarcinoma usually arises in utero in women of the reproductive age and primary extrauterine choriocarcinoma is a rare occurrence and causes diagnostic difficulties. The commonest site of metastasis of choriocarcinoma is the lung**.**

Case report
A 37 year old mother of 2 children with past 2 miscarriages presents (last pregnancy 7 years back delivering via a vaginal delivery) presents at 14 weeks and 5 days of period of amenorrhoea due to mild on and off spotting per vaginum for 2 weeks which was associated with progressive lower abdominal pain and backache and loss of appetite but without nausea or vomiting. She also has developed a new onset dry cough, mild shortness of breath with haemoptysis. On investigation her urine pregnancy test has been positive and serum beta hCG has been 98000 mIU/mL. Ultrasound revealed no intrauterine pregnancy but a suspicious mass in the vagina. Chest CT showed evidence of malignant shadows in both lung fields. A diagnostic laparoscopy was found to be normal and on examination under anaesthesia a right anterolateral paracervical nodule was found and was excised. The histology revealed a choriocarcinoma. The patient was referred to Oncology for chemotherapy with EMA-CO regime.

Discussion
Vaginal choriocarcinoma being a rare type has its own diagnostic dilemmas. MRI has a place in the diagnosis, evaluating tumor extension, vascularity and in overall staging. The mainstay of treatment is chemotherapy as choriocarcinoma is found to be highly chemosensitive. The treatment regime is selected based on the prognostic factors in FIGO score. Radiotherapy has a limited role. Following treatment, surveillance for relapse is done by hCG monitoring monthly for up to 12 months along with a reliable contraception during this period.

Conclusion
The importance of bearing in mind the possibility of extrauterine forms of gestational trophoblastic tumors in the presence of positive hCG with an empty uterine cavity and an antecedent pregnancy, would permit early diagnosis and treatment and thus ultimately save lives.

EP/G – 27
OVARIAN VEIN THROMBOSIS: A CASE REPORT

Jayasundara, DMCS[1,2], Palihawadana, SH[3], Tissera, WGM[2], Rathnapriya, DY[2], Fernando, LAD[3]
[1]Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo
[2]De Soysa Hospital for Women, Colombo, Sri Lanka
[3]Navaloka Hospital, Negombo

Introduction
Ovarian vein thrombosis is a rare but potentially serious condition occurring in 1/600 to 1/2000 pregnancies. This usually present with acute abdominal pain, mimicking a surgical abdomen. Untreated complications can be significant. This case report discusses the evaluation of a patient presenting with severe abdominal pain.

Case Report
A 30-year-old woman, postpartum day 7 following caesarean section, presented with sudden onset severe abdominal pain with vomiting and shortness of breath. She had a high BMI and primary subfertility with her pregnancy achieved via intrauterine insemination. On examination she was tachycardic and the abdomen was tense with generalized tenderness. Her investigations revealed an elevated WBC of 14 and CRP of 133. Ultrasound scan revealed a post-partum bulky uterus with an empty cavity, thin rim of free fluid in the hepato-renal pouch with no other abnormalities.Urgent Contrast Enhancing Computerized Tomography (CECT) abdomen and pelvis was performed due to ongoing clinical suspicion and a diagnosis of right ovarian vein thrombosis with patent IVC and pelvic veins was established.She was managed with the liaison of multi-disciplinary teams and started on anticoagulation with S/C Enoxaparin and antibiotic coverage. And once she was stable, she was discharged on Asprin and Riveroxiban.

Discussion
Ovarian vein thrombosis is a rare but potentially life-threatening condition. While it is classically a puerperal process with the incidence rising with caesarean section, it may also arise in non-puerperal settings such as endometritis, pelvic inflammatory disease, malignancy, thrombophilia and gynaecological surgeries. Ovarian vein is the commonest vein involved in puerperal pelvic thrombophlebitis and the right ovarian vein is involved in 80-90% of the cases due to its length, lack of retrograde flow and compression of the inferior venacava and right ovarian vein by the gravid uterus. The clinical course is variable however prompt anticoagulation is necessary to minimize sequalae of complications including pulmonary embolism. A high degree of clinical suspicion is needed for its diagnosis. Ultrasound scan findings while helpful, is highly operator dependent therefore Computerized Tomography is

the investigation of choice. It is treated with anti-coagulation and broad-spectrum antibiotics. Risk of recurrent ovarian vein thrombosis is low however anticoagulant prophylaxis during subsequent pregnancies is recommended.

Conclusion

Ovarian vein thrombosis is a rare condition commonly associated with post-partum period. High degree of clinical suspicion is needed, and imaging modalities can be helpful in confirmation of diagnosis. Anticoagulation is the treatment of choice.

EP/G – 28

NAVIGATING DUAL CHALLENGES: VAGINAL HYSTERECTOMY IN A PELVIC KIDNEY PATIENT WITH PELVIC ORGAN PROLAPSE: CASE REPORT

Kajeepan,V[1] , Fonseka, N[1], Edirisinghe, EKMP[1], Thilakarathna,KMHC[1] , R P, Herath[1]

[1]Professorial obstetrics and gynecology unit, Colombo North Teaching Hospital

Introduction

Pelvic organ prolapse is a common condition in postmenopausal women and mostly requires surgical treatment. The presence of an ectopic pelvic kidney presents a unique anatomy incident in 1 in 2500 and thus requires very cautious planning of surgery and its execution to avoid complications.

Case Presentation

A 64-year-old postmenopausal lady without urodynamic dysfunction and with a history of three lower segment caesarean section deliveries presented with grade 2 pelvic organ prolapse. She had one episode of postmenopausal bleeding which was investigated by hysteroscopy guided endometrial biopsy and the results were unremarkable. Her recent TSH was 3.2 and her hypothyroidism was treated with 50 mcg of thyroxine per day. Diagnostic imaging which included a CT urogram, CT abdomen and pelvis and ultrasound revealed a left extra renal baggy pelvis and a left pelvic kidney. There was no evidence of ovarian or uterine pathology, while the right kidney was normal. An eGFR of 90ml/min/1.73m^2 revealed normal kidney function. Since there was no evidence of bladder dysfunction, urodynamic studies were not recommended.

Preoperative planning included detailed counseling about the pros and cons of the procedure and the multidisciplinary team to be involved, including a urologist. Adequate hydration and preventive antibiotics were ensured. The patient was positioned in lithotomy while under spinal anesthesia. A cystoscopy was done, followed by the insertion of a left-sided ureteric stent. Careful vaginal dissection was done to free the uterus without damaging the pelvic kidney. The cardinal, uterosacral round, ligaments were divided, clamped, and ligated. Special care was taken to tie the uterine vessles, especially on the left side where the ureter had been encountered, and because of the preplaced stent, it was successfully avoided. The uterus was excised through the vaginal route, and the vaginal vault was suspended to avoid prolapse in postoperative cases. Full care was taken not to damage the ectopic kidney and its vessels during the process. The patient recovered uneventfully with little discomfort in the postoperative

period. The left-sided ureteric stent was removed six weeks after surgery without any complications.The patient described her symptoms to be significantly improved.

Discussion
POP management needs individualized surgical techniques and intra-operative vigilance in an ectopic pelvic kidney patient. Pre-operative ureteric stenting played a vital role in the identification and protection of the ureter during the procedure. A multidisciplinary team involvement minimized chances of renal injury and ensured thorough care.

Conclusion
In patients with a pelvic kidney and pelvic organ prolapse, vaginal hysterectomy is still a viable option that could yield positive results by carefully ensuring good surgical technique, interdisciplinary teamwork, and appropriate preoperative planning. This case illustrates the merit of specialized methods in the management of complex anatomical variations that achieve successful outcomes with remarkable symptomatic improvement in the patient. The case presented herein thus demonstrates individualized care of a patient and adds to the extremely scant literature on this aspect.

Keywords
POP, vaginal hysterectomy, pelvic kidney, ureteric stent

EP/G – 29
A SUCCESSFUL PREGNANCY FOLLOWING VAGINAL RECONSTRUCTION FOR CONGENITAL VAGINAL ATRESIA

Perera, YARS[1], Karunasinghe, J[2], Abeywickrama, WY[3], Sumithraarachchi, LD[4], Kasturiarachchi, SS[5].
[1]Base Hospital Galgamuwa, Sri Lanka.
[2]Castle Street Hospital for Women, Colombo, Sri Lanka.
[3]Colombo South Teaching Hospital, Kalubowila, Sri Lanka.
[4]National Hospital Kandy, Sri Lanka
[5]District General Hospital Nawalapitiya, Sri Lanka.

Objectives
We aim to discuss the course of management of this patient with an isolated vaginal atresia, which resulted in a normal sex life with a successful pregnancy following vaginal reconstructive surgery.

Case report
She presented at 14 years with primary amenorrhoea, cyclical abdominal pain and normal secondary sexual characteristics with normal external genitalia. Ultrasound showed bilateral hydrosalphinx, haematometron extending up to the cervix with absent vagina and normal ovaries. CT Intravenous Urography was normal. A multidisciplinary team (MDT) meeting including two gynaecologists, a plastic surgeon and a radiologist was held where a vaginal reconstructive surgery was planned when the patient turns 18. Till then her menstruation was suppressed. During the surgery, Y shaped incision was made and the space between rectum and

bladder was dissected with digital palpation by the plastic surgeon. Cervix was dissected and the endometrial cavity was opened blindly. Thick split thickness skin graft, harvested from the left thigh was applied over a sponge cylinder and anchored with a polygalactin suture. 1.5 cm diameter remodelled candle stick was used to keep the patency of the vagina for 3 months. Afterwards, menstruation was suppressed till the graft was taken up.

3 years later she got married and had no difficulty with menstruation and intercourse. She had fertility wishes from the beginning but subsequently she developed bilateral endometriomas which were drained laparoscopically, following which ovulation induction and timed intercourse was planned, which lead to a successful pregnancy. At 33 weeks she underwent a category 2 emergency caesarean section due to probable chorioamnionitis. Post operatively, endometritis with collected blood was seen since cervical patency was not achieved properly. Since dilatation and location of the cervix was difficult, hysterotomy was performed to evacuate the blood and a foley catheter was inserted from the uterus to the cervix and guided out of the vagina to maintain the cervical patency. After 2 weeks the mother went home with a healthy baby.

Discussion

Problems which were encountered were, during the surgery the difficulty locating the cervix and the rectal injury, endometriosis which needed laparoscopic drainage and not obtaining cervical patency adequately during the caesarean section which lead to endometritis.

Conclusion

MDT approach is important in managing such cases. Surgery is done to reinstate the continuity of the reproductive tract from the uterus to the vagina leading to a normal sex life and a successful pregnancy.

Keywords

Congenital vaginal atresia, hematometrocolpos, vaginoplasty

EP/G – 30

OVARIAN DYSGERMINOMA: CASE REPORT

Introduction

Ovarian dysgerminomas are the most common type of ovarian germ cell tumors, commonly occurring in the second to third decade of the life. While all dysgerminomas are malignant, only one-third metastasize and all are radiosensitive.As these tumors commonly occur in young females, fertility preservation is a challenge.Here,we present a case of a large ovarian dysgerminoma successfully managed with fertility-preserving surgery.

Case report

A 24year old nulliparous woman, married for 2 months, presented with abdominal pain and dstension.Upon examination, a36 week sized, well mobile, abdomino-pelvic mass was found.An USS of the abdomen showed a large,heterogenous,solid adnexal mass measuring 20x17x10cm.A contrast-enhanced CT scan showed a large, solid, well demarcated enhancing mass lesion arising from the pelvis without evidence of metastasis, increasing the suspicion of

a germ cell tumor. The tumor marker LDH was elevated to 7960 U/L.CA125 was 15 ng/ml ,AFP was 1.43 ng/ml ,CEA was 0.7 ng/ml and serum beta HCG was 33.3 ng/ml. She underwent midline laparotomy with right sided salphingo-ophorectomy,peritoneal washing and infracolic omentectomy.Post operative period was uneventful.Histology confirmed pure ovarian dysgerminoma ,without definitive lymphovascular emboli, staged as FIGO stageIA.

Discussion

Malignant ovarian germ cell tumors accounts for less than 5% of ovarian malignancies.Dysgerminoas are the most common among them. 90% of cases occurring in young individuals age less than 30 years.Most common side is right side and 10-15% presenting bilaterally.The common presentation includes lower abdominal pain and abdominal distension.Also can be present with menstrual irregularities.Tumor markers are crucial for diagnosis,as well as baseline for follow-up studies.Elevated LDH is present in case,while serum beta HCG rise in only 5% of case and serum alpha-fetoprotein values are usually normal in pure dysgerminomas. Ultrasound imaging typically shows a large, well capsulated, multilobulated cystic mass , hypoehogenic with prominent fibrovasclar septa and predominant solid areas.The mean diameter is 15cm.CECT and MRI scans are helpful in preoperative staging.Surgical staging and histology are required for a definitive diagnosis.That will guide the need for adjuvant treatment.For young women, fertility preserving surgery is the treatment of choice.However,this is not recommended for those who have completed their family.For fertility preserving surgery in young women includes peritoneal washings for cytology,unilateral salphingo-oophorectomy, ipsilateral pelvic and bilateral paraaortic lymphnode dissection ,infracolic omentectomy and multiple peritoneal biopsies.Biopsy of the contralateral ovary should be avoided if it appears normal.Depending on histology and surgical grading adjuwent chemo-radiotherapy may be required.

Conclusion

Ovarian dysgerminoma should be suspected in young females presenting with a large adnexal mass together with raised LDH and serum beta hcg levels.Stage 1A disease can be successfully managed with fertility preserving surgery with or without adjuvant treatment.Proper patient education about the condition and good compliance with the speciality followup plan will improve the patient outcome and will able early detection of recurrences.

EP/G – 31

A RARE CASE REPORT OF OVARIAN MUCINOUS CYSTADENOCARCINOMA SUCCESSFULLY MANAGED DURING PREGNANCY

Fernando, LGN[1], Roshan, BE[2], Kanchana, JLS[1], Bandara, WWMMK[1]
[1]Colombo North Teaching Hospital
[2]Teaching hospital Kandy

Objectives

Ovarian neoplasms during pregnancy are exceedingly rare, occurring in approximately 1 in 1500-32000 pregnancies, with most being benign. Surgical intervention may be necessary due to risks such as rupture, torsion, or suspicion of malignancy. Optimal management strategies for ovarian cancers in pregnancy lack specific guidelines, with limited literature consisting

primarily of retrospective studies and case reports. Factors influencing management include disease stage, gestational age, fertility wishes and patient preferences, often necessitating a multidisciplinary approach to balance maternal and fetal outcomes.

Case Report

A 27-year-old primigravida presented at 16 weeks gestation with an uncomplicated pregnancy but a concerning finding on routine ultrasound: a 17 cm × 15 cm multilocular right adnexal mass with increased vascularity. There were no solid components, ascites, or contralateral involvement. The CA 125 level was normal. Due to high suspiciousness of malignancy, surgical intervention was scheduled. At 18 weeks gestation, midline laparotomy revealed a large right ovarian cyst (17×14.5×9.5 cm) with mucoid material, without involvement of contralateral ovary, tubes, uterus or omentum. Ascites was not present. Right salphingo-oophorectomy and surgical staging was done. Pathology confirmed mucinous cystadenocarcinoma (stage IA).
Following a multidisciplinary discussion involving obstetrics and gynecology, oncology, radiology and pathology teams, the decision was made for conservative management with elective lower segment caesarian section at 38 weeks gestation with appendicectomy. The procedure was uneventful, yielding a healthy newborn. Biopsies of the contralateral ovary and omentum, along with peritoneal fluid cytology, were negative for malignancy. Maternal postpartum recovery was uncomplicated, with oncological follow-up showing normal CA-125 and CEA levels.

Discussion

This case underscores the challenge of managing ovarian tumors in pregnancy, especially when malignant. Despite the rarity of such cases, timely intervention is crucial given potential risks to both maternal and fetal health. Conservative surgical approaches, as in this case, aim to balance oncological efficacy with fertility preservation. Close multidisciplinary collaboration is essential for individualized management plans tailored to disease stage, patient preferences, and gestational age.

Conclusion

In conclusion, while guidelines are lacking, this case highlights successful management of early-stage ovarian carcinoma during pregnancy through conservative surgery and timely delivery. Long-term surveillance remains critical for both maternal and neonatal outcomes, emphasizing the importance of vigilance and multidisciplinary care in similar clinical scenarios**.**

EP/G – 32

RIGHT COMMON ILIAC ARTERY INJURY DURING LAPAROSCOPY: OUR EXPERIENCE AND REVIEW OF LITERATURE

Fonseka, NA[1], Karunarathne, M[2]
[1]Senior Registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital, Sri Lanka
[2]Consultant Obstetrician and Gynaecologist, Sri Jayewardenepura General Hospital, Sri Lanka

Objectives

Laparoscopic gynaecological surgeries have become a standard approach for many conditions due to their numerous benefits. Despite this, blind insertion of needles and trocars can result in vascular injuries, which, although rare, can be life-threatening. This is our experience of diagnosing and managing a right common iliac artery injury that occurred during laparoscopic cystectomy.

Case presentation

A mid-20s unmarried woman was admitted for laparoscopic cystectomy for a right-sided endometrioma. She is a thin-built woman with a BMI of 18.4 kg/m^2 and an unremarkable surgical history. The patient was placed in a modified Lloyd-Davies position, and a Veress needle was inserted 2 cm supra-umbilically. Following that, Palmer's test was performed, and fresh blood spurting into the syringe was noted. The procedure was abandoned, and laparoscopic entry was done through Palmer's point. A retroperitoneal haematoma was noted, and immediately a consultant general surgeon, vascular surgeon, anaesthetist, radiologist, and transfusion medicine specialist were called. The patient was haemodynamically stable after resuscitation, and an urgent contrast-enhanced CT (CECT) scan and a CT angiogram were arranged. The CECT scan showed a retroperitoneal haematoma, and a 3D reconstructed angiogram demonstrated the site of injury, which was the anterior surface of the right common iliac artery nearly 1 cm from the aortic bifurcation. A midline laparotomy was performed, and the injury site was quickly identified according to preoperative imaging findings. The puncture site was sutured with 3.0 prolene, and complete haemostasis was achieved. There were no other visceral injuries, and the intended procedure was abandoned.

Discussion

Vascular injury complicates approximately 0.1–1.1% of all gynaecological laparoscopic procedures, making it the second most common cause of death from laparoscopy. Most commonly, vascular injuries happen during Veress needle insertion or primary trocar entry. Case reports, case series, and systematic reviews on Google Scholar and PubMed were referred to. The reviewed literature indicates that the choice of entry technique should be tailored to the patient's anatomy and the surgeon's experience, while no single method is definitively superior. Proper patient selection, imaging techniques, alternative entry points, alternative entry techniques, and complimentary imaging techniques show promise in reducing complications.

Conclusion

The incidence of major vascular injuries during gynaecological laparoscopic procedures can be further reduced by thorough preoperative planning, careful selection of entry techniques, and intraoperative vigilance.

EP/G – 33

FERTILITY SPARING TREATMENT FOR ENDOMETRIAL CANCER IN YOUNG FEMALES; A CASE REPORT

Rathnayaka RMAN[1], ,Wijerathne YMTY[2], Hapuachchige HDKC[2]
[1]Teaching Hospital Peradeniya
[2] National Cancer Hospital Maharagama
3National Cancer Hospital Maharagama

Introduction

Endometrial cancer is the most common gynecological cancer in high- and middle-income countries. It is estimated to increase more than 50% worldwide by 2040. Although it is common among post-menopausal group, about 5% incidence can be seen among females less than 40 years of age. The fertility requirement plays a major role in younger population and required to address in management.

Case Report

We report a patient who had a successful outcome with fertility sparing treatment. A 33-year-old female presented to gynaecology clinic with secondary subfertility for 2 years. She had regular periods since menarche and has never been on any form of contraception. Her hormonal profile and the partner's seminal fluid analysis were normal and had taken ovulation induction several times. Hysterosalpingogram showed multiple irregular intraluminal filling defects with patent left tube. Hysteroscopy and biopsy showed irregular polypoidal endometrium and invasive adenocarcinoma of the endometrium. MRI confirmed the diagnosis of stage IA disease. She was commenced on medroxyprogesterone acetate and followed up with endometrial assessment. Follow up hysteroscopy revealed progesterone induced changes in the endometrium. She underwent two more endometrial assessments which confirmed the disease remission. She was referred to fertility specialist for the subfertility treatment.

Discussion

Fertility sparing management with high dose progesterone therapy of early endometrial cancer among young females is challenging. Grade 1 endometrioid type tumors without myometrial invasion can be offered fertility sparing treatment and following disease remission can be offered assisted reproduction. Patients who do not respond to medical management by 6 months, poor compliance for drugs and inability to follow up should offer standard surgical management.

EP/G – 34

POLYCYSTIC OVARY; AN ENTITY FOR OVARIAN TORSION AND INFARCTION; A CASE REPORT

Rathnayaka,RMAN[1], Wanniarachchi,WADP[1], Sarathchandra,DNS[1], Dissanayaka,MMH[1], Abeysundara,A, Gihan,C[1]
[1]Teaching Hospital Peradeniya, Sri Lanka

Objective

Polycystic ovarian syndrome is one of the commonest endocrine disorders among reproductive age females. The syndrome gives rise to adverse short- and long-term outcomes which negatively affects the quality of life of a female. We report an unusual case of a torsion of giant polycystic ovary which lead to hemorrhagic infarction.

Case Report

A 31-year-old female, a diagnosed patient with polycystic ovarian syndrome was on life style modifications, presented to the emergency department with two days history of right side lower abdominal pain and back pain with nausea and vomiting. The pain was intermittent and constricting in nature and she denied urinary or bowel symptoms. On examination she was afebrile and hemodynamically stable and revealed tenderness over right lower quadrant without guarding or rigidity. Her full blood count and urine full report was normal and pregnancy test was negative. An ultrasound scan of the pelvis showed bi-lateral polycystic ovaries and massively enlarged right ovary 9.81x6.26x4.51cm, 145 ml volume without internal vascularity and free fluid. She underwent diagnostic laparoscopy and found ovarian torsion which led to ovarian necrosis and right side salphingo oophorectomy done. Histology revealed hemorrhagic infarction of the ovary in the back ground of polycystic ovarian disease.

Discussion

Polycystic ovarian syndrome manifests with anovulation, clinical or bio chemical evidence of hyperandrogenism and polycystic ovaries on ultrasound. The ultra sound will show more than 20 follicles per one ovary at least and ovarian volume of more than 10ml. Although there are numerous complications associated with polycystic ovarian syndrome, a huge discrepancy between the sizes of two ovaries and one becoming significantly enlarged to give rise to torsion and hemorrhagic infarction is extremely rare but a possible entity.

Conclusion

Diagnosis of polycystic ovarian syndrome is made according to the Rotterdam consensus criteria, where the two out of three criteria is sufficient to make the diagnosis (ultrasound evidence of poly cystic ovaries, evidence of oligo or anovulation, clinical or bio chemical signs of hyperandrogenism). However, the ultrasound characteristics of each ovary might reveal the risk of getting rare, but possible complications like ovarian torsion which leads to hemorrhagic infarction of the ovary.

EP/G – 35

ASSESSMENT OF PHYSICAL FITNESS AMONG SRI LANKAN POSTGRADUATE TRAINEES IN OBSTETRICS AND GENECOLOGY

Ethayarooban E[1], Samarakkody S[1], Meegoda VJ[2]
[1] Hervey Hospital, Queensland, Australia
[2]Base Hospital – Tangalle

Introduction

Obstetrics and Gynaecology (O&G) is a demanding field that places significant stress on its trainees. The heavy workload, limitation of free time, reduces opportunities for physical activities. Combined with unhealthy eating habits, this lifestyle increases the risk of non-communicable diseases (NCDs).

Objectives

To identify the risk factors for NCDs among O&G trainees and explore strategies to mitigate these issues.

Design & Methods

A Google Forms-based questionnaire was developed using insights from previous studies and distributed to trainees via social media platforms.

Results

A total of 54 trainees responded to the survey. Of these, 55.6% were under 30 years old, followed by 33.3% in the 30–35-year age group. The majority were male (77.8%). In terms of training levels, 55.6% were senior registrars, 38.9% were in their third year, and 5.6% were second-year registrars. Regarding BMI, 44.4% were <25 kg/m², 33.3% had a BMI between 30-35 kg/m. During the training period, 38.9% reported weight loss, 22.2% experienced weight gain (ranging from 1-8 kg), and 38.9% had stable weight. At the time of the study, 55.6% of participants had no diagnosed NCDs, while 16.7% had not been screened. Among those with NCDs, 22.2% had dyslipidaemia, 11.1% had diabetes mellitus, and 5.6% had hypertension. Additionally, 77.8% had a first-degree relative with an NCD, with the majority (71.4%) having a family history of diabetes. Most trainees (72.2%) engaged in routine physical activities outside of work, such as jogging, brisk walking, yoga, gym workouts, or martial arts. However, only 22.2% reported participating in the recommended 30 minutes of vigorous physical activity five days a week, as advised by the WHO. Reasons for not fulfilling this guideline included lack of time (50%), fatigue after work (33.3%), and difficulty finding suitable exercise facilities near hospitals (8.3%).Regarding physical activity at work, 38.9% of trainees reported standing for more than 6 hours on theatre days, and 22.2% stood for 4-6 hours. On average, trainees engaged in operative work for 17.3 hours per week, with 11.1% working over 20 hours per week. Additionally, 61.1% of trainees experienced musculoskeletal difficulties due to improper posture and prolonged standing during procedures and surgeries.

Conclusions

The stressful working environment and lack of time for physical activities are contributing to the development of NCDs among O&G trainees. To address these issues, administration should

implement measures to provide easier access to physical activity facilities, reduce workloads, and allow trainees more free time.

EP/G – 36
LAPAROSCOPIC MANAGEMENT OF CHRONIC RICHTER'S HERNIA

Gnanarathne. S [(1)], Rathnayake. A [(2)], Kariyawasam. A[(3)]
[1]Senior lecturer in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya.
[2]Senior lecturer in Anesthesiology, Department of Anesthesiology and Critical Care, Faculty of Medicine, University of Peradeniya.
[3]Research Assistant, Faculty of Medicine, Peradeniya

Objectives
Richter's hernia is a rare condition, in which only a portion of the bowel wall protrudes, typically through an abdominal wall defect, while the involvement of the uterus is exceedingly rare. This case report details the first documented instance of a chronic Richter's hernia, possibly through the cervical wall, secondary to dilatation and curettage (D&C), elaborating the importance of thorough intraoperative assessment in gynaecological surgeries.

Case report
A 44-year-old woman presented for a total laparoscopic hysterectomy due to heavy menstrual bleeding for three years, unresponsive to medical therapy. She had undergone D&C, three years ago, for the same presentation. She had no bowel symptoms or abnormal vaginal discharge. During the laparoscopic hysterectomy, the uterus was anteverted and the bowel adhesions to the posterior wall of the uterus were noted. Further dissection revealed a part of the rectum herniated through the posterior cervical wall without any obstruction of the lumen. The part of the rectum herniated was released en bloc with the part of the cervical wall involved without rupturing the bowel wall. The post-operative recovery was uneventful.

Discussion
Richter’s hernia usually involves less than two-thirds of the circumference of the bowel wall. It can cause strangulation without an obstruction. It can involve any segment of the bowel, from the stomach to the colon, including the appendix. The diagnosis can be challenging with the subclinical presentation, which is confirmed at the surgery. Unlike more common, acute, symptomatic presentations, this details a chronic and incidental finding during a laparoscopic hysterectomy. D&C is a common diagnostic and therapeutic procedure in which intrauterine tissue is removed using suction or sharp curettage. It can cause complications such as uterine perforation (0.3 -5.1 %), cervical injury, incomplete evacuation, and intrauterine adhesions. In this case, a perforation in the cervical wall, likely caused by D&C, might have facilitated the herniation of the rectum into the cervical wall. The laparoscopic approach facilitates detailed visualization and precise dissection. In this case, it allowed the surgeons to identify the rectal herniation into the cervical wall and manage it without damaging the bowel. Thus, Laparoscopy enabled meticulous handling of a complex presentation and a patient-safe approach.

Conclusion
This is the first case of late presentation of Richter's herniation. It is important to consider complications from past procedures and the crucial role of laparoscopy in the diagnosis and management of unusual presentations.

Keywords
Richter's hernia, rectal herniation, cervical perforation, laparoscopy

EP/G – 37
LAPAROSCOPIC PORT SITE SCAR ENDOMETRIOSIS: A RARE ENCOUNTER - A CASE REPORT

Sanjeewani DMD[1], Sanjeewan K[1], Naleethan S[1], Kalhara WWLD[1], Kadotgajan T[1]
[1]Castle Street Hospital for Women, Colombo, Sri Lanka

Introduction
Abdominal wall endometriosis is a rare condition, often reported following caesarean section.Laparoscopic port site emdometriomas are extremely rare, typically presenting as painful lumps at the surgical site, with pain exhibiting a characteristic cyclical nature.Surgical excision of endometriomas is the preferred management approach.Here, we report a case of laparoscopic port site endometrioma following diagnostic laparoscopy.

Case report
Mrs LS, a 44 year old mother of one child, presented to the gynecology clinic with a 6 month history of localized right sided abdominal pain and a palpable swelling.The patient complained of periodic pain related to menstruation, which had intensified over the past few months.she had undergone diagnostic laparoscopy and dye test 10 years prior.Examination revealed a tender, nodular lump at the previous laparoscopy port entry site. Ultrasound examination revealed a 4x5cm hypoechoic lesion just below the subcutaneous tissue, leading to a diagnosis of scar site endometrioma.The patient underwent surgical excision of the endometrioma.Surgical exploration revieled a 4x5cm dense mass attached to the underlying external oblique and internal oblique muscles. Complete excision of the mass,along with the surrounding fat tissue was performed. Both external oblique and internal oblique muscles properly propery approximated.The postoperative period was uneventful.

Discussion
Endometriosis is defined as the presence of endometrial like glands and stroma outside the endometrial lining. The abdominal wall is an uncommon site for extrapelvic endometrisis and is usually associated with old surgical scars.With the increasing trend of laparoscopic surgeries, the incidence of laparoscopic port entry scar endometriosis has risen, particulary following endometriosis related surgeries. Diagnosis is generally made clinically, with patients presenting with classic symptoms of periodic abdominal pain related to menstruation, a palpable painful mass and a history of incision at the site. Imaging may help assess the lesion's extension and the degree of infiltration into surrounding structures.The treatment of choice is wide local excision of the mass along with surrounding healthy tissue, as negative margins minimize

recurrences.Pathological diagnosis is crusial, as soft tissue sarcoma, desmoids tumors and suture granulomas can present similarly.Post surgery medical management for ovulation suppression is used to prevent recurrences in young women without fertility wishes,using methods such as oral contraceptive pills,GnRH analogues and aromatase inhibitors.Radiofrequency ablation therapy is another option.

Conclusion

Although rare, scar endometrioma should be considered as a differential diagnosis in women presenting with periodic surgical site pain and a tender lump.It is usually a clinical diagnosis, and complete surgical excision is the treatment of choice.Recurrences are common in women of childbearing age and ovulation suppression can reduce these recurrences.

EP/G – 38
CHRONIC ADENEXAL TORSION IN PREGNANCY: A CASE REPORT

Sanjeewani DMD[1], Sanjeewan K[1], Naleethan S[1], Kalhara WWLD[1], Kadotgajan T[1]
[1]Castle Street Hospital for Women, Colombo, Sri Lanka

Introduction

Ovarian torsion in pregnancy is a rare emergency in obstetric practice.It involves the partial or complete rotation of the adnexa around its vascular pedicle, leading to ischaemia.Unilateral abdominal pain, tenderness,and associated gastrointestinal symptoms can be misdiagnosed as acute appendicitis..We present a case of adnexal torsion during pregnancy presented with abdominal pain for one week.

Case report

A 30 years old primi ,was admitted with right sided lower abdominal pain and vomiting for one week ,which had been treated with analgesics at a local hospital.USS at that time showed a right sided simple ovarian cyst 2.8x 2.4 x 2.2 cm and normal blood flow.On examination haemodynamically stable and temperature 100.6F. Significant right iliac fossa tenderness was noted without palpable adnexal masses.CRP and WBC count were normal.Urgent ultrasound revealed a single live fetus with a CRL of 11+0 weeks.The Right ovary showed heterogenous hyperechogenicity, absent Doppler flow, and increased size(5x 4.5 x 3 cm). With informed written consent, exploratory laparotomy using a pfanneinsteil incision under general anesthesia was performed. The right ovary was enlarged in size with necrosis of both the ovary and fallopian tube.The adnexa were twisted three times at the infundibulopelvic ligament and slightly adhered to the lateral pelvic wall.Careful detorsion was performed, but no colour improvement noted after 20 minutes. Right salpingo-oophorectomy was performed . The postoperative period was uneventful. Post surgery,a single dose of IM progesterone was given, and oral Progesterone was continued untill the end of 16 weeks.

Discussion

Ovarian torsion is the fifth common case of gynaecology emergency. Torsion more commonly occurs on the right with an incidence ratio of 3:2.1.Incidence rises fivefold during pregnancy, typically occuring between the sixth and fourteenth weeks due to laxity of the ligaments and increased ovarian volume from an enlarged corpus luteal cyst.Symptoms are non specific and

often present as acute unilateral abdominal pain with nausea and vomiting.A highly tender unilateral mass is often palpable.Gastrointestinal symptoms can lead to misdiagnosis as acute appendicitis in right adnexal torsion. Diagnosis is made via ultrasonography and colour doppler analysis of the ovary.Stromal oedema,internal haemorrhage and presence of ovarian cyst can be seen.Management involves emergency detorsion, either through laparotomy or laparoscopy.If the corpus luteum cyst is removed,progesterone supplementation is indicated.

Conclusion

Ovarian torsion is a gynaecological emergency that should be suspected in all cases of unilateral abdominal pain.Normal Doppler flow may not exclude the diagnosis due to possible spontaneous detorsion and retorsion.Eary diagnosis and timely management are crucial for adnexal survival.

EP/G – 39

PELVIC ACTINOMYCOSIS: A CASE REPORT

Visagan S, Rathnayake RMSK, Kishokumar T, Hapuarachchi C
National cancer institute, Sri Lanka

Introduction

Actinomycosis is a rare chronic and suppurative infection caused by anaerobic Gram-positive bacteria: actinomyces. actinomyces can infect the pelvis and typically present in a nonspecific manner mimicking other more common conditions such as tubo-ovarian abscess or pelvic malignancy.

Case Report

We present a case of a 40-year-old, female G1P1, with copper intrauterine device (IUD) in place, presented with abdominal pain, loss of appetite & weight for 2 months duration. she was afebrile. Physical exam revealed mild tenderness in the suprapubic region with right adnexial tenderness. USS showed solid & cystic ovarian mass in right adenexia. CT scan of the abdomen and pelvis showed IUD in place and a large right side pelvic mass with para aortic lymphadenopathy, concerning ovarian malignancy. Her Ca125 levels were 15 U/ml. In blood investigations: FBC showed WBC count of 13x 10^3 (N-81%)/ml. CRP -283 mg/L, rest of liver, renal functions were normal. Due to concern for malignancy or pelvic abcess, the patient underwent laparotomy and Intraoperative findings showed the right side tubo-ovarian mass with dense adhesions from the omentum and bowel without any evidence of ascites or carcinomatosis. She underwent a hysterectomy with bilateral salpingo-oophorectomy with infracolic omentectomy as well as pyogenic cultures. She was treated with IV cefuroxime & metronidazole during the inward period for 7 days. Her histology showed chronic pelvic inflammatory changes with actinomycosis. She was treated with oral penicillin for 2 months duration with the plan for penicillin prophylaxis for another 6 months.

Discussion

It is somewhat established that IUDs can be associated with actinomyces infection. Additionally, it is known that pelvic actinomyces can mimic malignancy and this case provides an example of how the disease can present in a more nonspecific manner. In investigations, a

high level of WBC is noticed with anemia. USS, CT scans are non specific, mostly a solid or cystic mass mimicking ovarian malignancy. The diagnosis is based on bacteriologic or pathologic examination. Bacteriologic culture must be in anaerobic environment with examination in Gram staining to identify gram positive bacillus. Bacteriologic identification is made only in 50% of cases due to its sensibility to oxygen, slow growth, and association with other anaerobic germs. Management consists of penicillin antibiotics and surgery for abscess drainage Intravenous administration of 10–20 millions of penicillin G for 2 weeks followed by oral route of penicillin V (2–4 g/day) is recommended for several months. Without surgical approach, recurrence and complications may occur as an extension to pelvic organs, digestive or cutaneous fistula and systemic dissemination

Conclusion

Pelvic actinomycosis is an extremely rare chronic infection which can present with vaginal discharge, tubo-ovarian abscess and pelvic tumors mimicking gynecologic malignancies. It is difficult to diagnose. Association with IUD history was recognized. Management is based on surgery and long-term antibiotic administration.

EP/G – 40

A RARE UTERINE MALFORMATION- ACCESSORY CAVITATED UTERINE MALFORMATIONS –(ACUM)- A CASE REPORT

Rathnayake, RMSK[1], Visagan S[1], Hapuachchige, C[1]
[1]National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Objectives

Accessory cavitated uterine malformations (ACUMs) are increasingly recognized myometrial lesions. They are considered as rare but significant cause of severe dysmenorrhea, often in young women. ACUMs are isolated cavitated lesions located within the lateral aspect of the myometrium, inferior to the attachment of the round ligament of the uterus. They are considered to be of embryological origin[1]. Other than that, these cases considered as juvenile and isolated cystic adenomyomas and are different from true adenomyomas with an internal cystic area or degeneration associated with adenomyosis, leiomyomas, or both observed in older women.[1] Currently the literature on ACUMs are limited to case reports and case series and the definitive managements are also challenging. The prevalence of this condition is unknown and possible reasons is poor recognition of the condition among clinicians. Some authors have proposed that ACUMs can only be diagnosed in women under the age of 30 years.[2] However, while 84% (78 out of 93 cases) of the reported cases are in women under the age of 30 years, although there are published cases of ACUMs in older women.

Case History

A 22 year old married nulliparous women came with right side abdominal pain for 6 months duration specially associated with severe secondary dysmenorrhea for one year duration. Dysmenorrhea was progressively increased with time. She is a married woman for 2 years duration and she is having fertility wishes. She didn't use any contraceptive methods. For her condition she sought medical advices several times. She was treated with analgesics including non-steroidal anti-inflammatory drugs but not responded. Ultrasound scan was done and it

reveals a 33 x 25 mm thick walled cystic lesion at right adnexa between the lower uterine body and right ovary. CECT abdomen and pelvis shows a well demarcated centrally hypodense lesion at the right adnexal region, attached to right uterine wall, at the cervico-uterine junction. Differential diagnosis was given as degenerative fibroids, adenomyomas or ACUM. As she was symptomatic and she was not responded to medical treatment planed to go ahead with diagnostic laparoscopy. On laparoscopic exploration there was a globular mass (3 X 3cm) at right side of the uterus under the round ligament. Both the ovaries and the uterus were normal and there were two normally developed fallopian tubes with no abnormality, communicating with the normal uterus. Laparoscopic excision done after injecting vasopressin. The mass was resected completely without entering into the endometrial cavity.

The blunt and sharp dissection methods were used bidirectionally, and finally, the lesion was enucleated. The mass was incised, and chocolate-like brownish fluid spilled out from the cavity of the mass. The myometrial defect was approximated and closed with a polyglactin absorbable suture. Histopathological examination revealed the endometrial lining cavitated mass surrounded by myometrium, and thus, it was consistent with the diagnosis of ACUM. The post-operative period was uneventful and the patient was discharged from the ward on day 2 without any complaint.

Discussion

Diagnosis of ACUMs is very challenging for a clinician as rarity of condition and also various differential diagnosis. When we considering clinical presentation of patient with ACUM, severe dysmenorrhea is the commonest presentation.[3] the pain can be central or ipsilateral and may be accompanied by chronic pelvic pain. Other symptoms can be dyspareunia and hypogastric pain.[4] Pain can be persisted or even increase after the onset of menstruation. There are no published data to say that ACUMs are associated with menorrhagia or subfertility. Sometime ACUMs can be clinically palpable tender mass on vaginal examination could be mistaken for an ovarian cyst or adenomyomas. Ultrasound scan especially transvaginal scan can be used to diagnose ACUMs. On ultrasound ACUMs appear as well-circumscribed, spherical, cavitated lesion with a myometrial mantel and echogenic fluid content.

Conclusion

When teenage girl came with severe dysmenorrhea, even though an ACUMs is rare it should be one of differential diagnosis. Having suspicious of disease, it is better to go for advance imaging modalities.

EP/G – 41

CASE REPORT - MÜLLERIAN DUCT ANOMALIES - UTERINE DIDELPHYS AND RENAL AGENESIS

Thilakaratna, KMH[1], , Herath, RP[1,2], Fonseka, NA[1], Edirisinghe, EKMP[1], Weerawardhana, CD[1], Kajeepan, V[1].
[1]Colombo North Teaching Hospital, Sri Lanka
[2]Faculty of Medicine, University of Kelaniya, SriLanka

Objective

Müllerian duct anomalies (MDAs) are congenital disorders resulting from improper development of the Müllerian ducts. Uterine didelphys, characterized by two separate uterine cavities, frequently coexist with renal anomalies. This case report details a patient with uterine didelphys and unilateral renal agenesis who presented with severe dysmenorrhea.

Case Report

A 21 year old girl presented with severe dysmenorrhea and persistent vaginal discharge. A transabdominal ultrasound showed two distinct uterine cavities, suggesting uterine didelphys and a left-sided hematometra. Additionally, left renal agenesis was identified. MRI of the abdomen and pelvis confirmed the diagnoses of uterine didelphys, left side hematometra and left renal agenesis, with the right kidney showing compensatory hypertrophy. Patient underwent an examination under anesthesia and diagnostic laparoscopy. The examination revealed normal external genitalia, a patent right cervical canal leading to a well-developed right hemi-uterus, a narrow left cervical opening with a rudimentary left hemi-uterus filled with hematometra, and no vaginal septum. Uterine didelphys was confirmed laparoscopically. A left cervical dilation was performed to drain the hematometra. Nephrology follow up arranged for the unilateral renal agenesis. She was advised on the potential reproductive implications of her condition, as well as the importance of regular follow-up. During follow up, patient reported notable improvement of her symptoms.

Discussion

Uterine didelphys is a rare MDA characterized by two separate uterine cavities, each with its own cervix and sometimes a double vagina. This anomaly arises from incomplete fusion of the Müllerian ducts during fetal development, with an estimated incidence of 0.1-0.5% in the general population. MDAs are often associated with renal anomalies due to the close developmental relationship between the urinary and reproductive systems. In this case, the patient had unilateral renal agenesis, leading to hypertrophy of the remaining kidney. Severe dysmenorrhea and continuous vaginal discharge were attributed to obstruction caused by the rudimentary left hemi-uterus due to narrow or non-communicating cervical canal leading to hematometra. These anomalies can lead to significant gynaecological and reproductive issues such as severe dysmenorrhea, infertility, and complications during pregnancy. The patient's dysmenorrhea improved with the drainage of hematometra, highlighting the need for personalized treatment strategies.

Conclusion
This case underscores the importance of considering MDAs in patients with severe dysmenorrhea. A multidisciplinary approach, including imaging studies and conservative management, can provide significant symptomatic relief and enhance quality of life. Ongoing follow-up is essential to monitor reproductive health and address potential complications.

EP/G – 42
PITUITARY TUMOR MASQUERADING AS SECONDARY AMENORRHEA: A CRITICAL DIAGNOSTIC CHALLENGE

Hewawitharana KG[1] Meegoda VJ[2], Raiyees RA[3], Mallawarachchi J[4]
[1]Whipps Cross University Hospital, Leytonstone, East London, United Kingdom
[2]Teaching Hospital – Kalutara, Western Province, Sri Lanka
[3]District General Hospital-Ampara, Eastern Province, Sri Lanka
[4] Base Hospital-Mahaoya, Eastern Province, Sri Lanka

Objectives
Secondary amenorrhea, defined as the absence of menstruation for three or more consecutive cycles with previously normal menstrual cycles, is a common clinical presentation with a broad differential diagnosis. Pituitary tumors are rare but a significant cause, which may often be overlooked as a diagnosis.

Case report
A 35-year-old woman, who had undergone a cesarean section and received Depo-Provera injections for two years, presented with secondary amenorrhea upon attempting to conceive her second child. She presented to our team five years after the onset of amenorrhea, which had previously been investigated without a definitive diagnosis. Her clinical history lacked common risk factors for secondary amenorrhea, including major postpartum hemorrhage, curettage, or family history of premature ovarian failure. Notably, she did not report symptoms like headaches, diplopia, breast discharge, or significant climacteric symptoms.On physical examination, notable findings included hyperpigmentation of the skin, particularly in the skin creases, prognathism, enlargement of hands, feet, supra-orbital ridges, nose, chin & enlarged tongue. Patient claims that she had noted a change in her facial appearance and had to change her shoes annually over the last 3 years due to the enlarging size. These features raised suspicion of acromegaly, caused by a pituitary tumor.

CECT of the brain identified a pituitary macroadenoma (2.2 x 1.1 x 1.3cm) with compression of the pituitary stalk. An MRI was not performed due to metallic elements in scalp from a bomb blast. Hormonal assays indicated elevated growth hormone, markedly increased prolactin levels (7093 mIU/L), and reduced levels of FSH, LH, and thyroxine. These findings confirmed the diagnosis of a mammosomatotroph cell adenoma, a rare pituitary tumor that secretes both growth hormone and prolactin. A multidisciplinary team was assembled, and the patient was initially treated with Cabergoline. Subsequently, she underwent successful transsphenoidal resection of the tumor with an uneventful recovery. Despite this, the delay in diagnosis and treatment adversely affected her plans for a second pregnancy.

Discussion
Pituitary tumors can disrupt the hypothalamic-pituitary-ovarian axis and lead to menstrual irregularities. Due to their ability to present with symptoms that overlap with more common gynecological conditions, these tumors can be easily overlooked. Misdiagnosis or delayed diagnosis of pituitary tumors can result in prolonged patient suffering and unnecessary treatments

Conclusions
This case underscores the importance of considering pituitary pathology in the differential diagnosis of secondary amenorrhea and highlights the need for timely diagnosis to prevent long-term impacts on patient quality of life.

EP/G – 43
UTERINE RUPTURE IN SCARRED UTERUS - A CASE REPORT

Introduction
Uterine rupture is a relatively rare ,life-threatening obstetric emergency which associated with significant maternal and fetal morbidity and mortality. This case report describes a incident of uterine rupture in a woman with a history of previous cesarean section and current pregnancy complicated with Twin pregnancy emphasizing the importance of vigilant monitoring and timely intervention. Uterine rupture most commonly occurs in women with a history of uterine surgery, such as cesarean section, Myomectomy and etc. This is usually presented with acute abdominal pain, vaginal bleeding, and fetal distress. However, in rarely uterine rupture can occur silently, without the typical clinical manifestations, complicating the diagnosis and potentially delaying treatment

Case presentation
A 35-year-old mother of one child delivered by caesarean section 2 years ago. This is monochorionic diamniotic twin pregnancy which was complicated with gestational diabetes mellitus and managed with medical nutritional therapy. This time she presented with sudden onset severe generalized abdominal pain followed by faintishness at 33weeks and 5days of gestation. However, she was not having per vaginal bleeding but unable to felt fetal movements since onset of lower abdominal pain. Examination revealed clinically pallor, Blood pressure 90/50mmHg, pulse rate110bpm & Respiratory rate 22/min. generalized abdominal tenderness and guarding. Ultrasound scan found to have absence of fetal heart beat in leading twin & severe bradycardia in upper twin and moderate free fluid in hepatorenal pouch. Her laboratory investigations showed low hemoglobin and normal platelet and other Liver and renal functions were normal. Emergency laparotomy performed and both babies delivered and handed over to the neonatology team. 1500 ml of haemoperitoneum noted and there was 5cm size lower segment uterine rupture extending to the posterolateral wall from the previous uterine scar. Uterine scar and tear sutured with two layers and drain inserted. Two pints of blood given intraoperatively. Both babies were resuscitated and ended up with stillbirth. Mother was counselled and debriefing done and advised for the next pregnancy. Jadelle was inserted as a contraception in post-partum day 1.

Conclusion
Uterine rupture is a rare complication off scarred and non-scarred uterus. Rupture of the non-laboring uterus is rare event in which the life of both the mother and the child are in danger. Spontaneous ruptures are almost always intrapartum and risk factors that can predispose to uterine rupture are a cesarean section scar, advanced maternal age, uterine abnormalities, grand multiparity, macrosomic fetus, cephalopelvic disproportion, and uterine trauma from prior instrumentation from abortion, version and oxytocin stimulation.

EP/G – 44
A CASE REPORT OF COLORECTAL CANCER IN PREGNANCY

Chamikara DGM[1] Bandara YMDA[1], Silva SACK[1], Priyasantha GK[1], Chamara PBKR[1], Dissanayake CN[1]
[1]Obstetrics and Gynaecology unit German Sri Lanka Friendship Hospital for women, Galle

Introduction
Adenocarcinoma of the colon during pregnancy is an extremely rare condition, making significant diagnostic and therapeutic challenges. This case report describes a case of adenocarcinoma of the descending colon complicating a pregnancy, emphasizing the importance of early suspicion and diagnosis as well as multidisciplinary approach to management Colorectal carcinoma in child bearing age is extremely rare and also symptoms can be misleading due to physiological symptoms in pregnancy overlapping with the colorectal carcinoma symptoms

Case presentation
A 42year old in her 4th pregnancy with 3 living children presented to the antenatal ward with the history of left side flank pain at 26 weeks of gestation. The pain was mildly severe and not associated with nausea and vomiting. No urinary symptoms but her bowel habits were altered during last 4 months. No any episodes of PR bleeding. She had loss of appetite but no significant weight loss. Examination revealed left flank mass which was firm in consistency and tender. Ultrasound scan revealed suspicious mass origin in large bowel. MRI performed and confirmed mass arising from descending colon without distal metastasis. Colonoscopy guided biopsy done and histology confirmed adenocarcinoma in the descending colon. Other basic investigations were normal. She was discussed in MDT and decided to do surgical resection of the tumor and adjuvant therapy following the delivery. Surgery done at 30 weeks of gestation and pregnancy continued up to 36 weeks and delivered via vaginally. There was no intrapartum or post-partum complications. She was discharged post-partum dayday3 with the healthy baby and arranged adjuvant therapy.

Conclusion
Diagnosis and treatment of colorectal cancer during pregnancy is a challenge for the obstetrician and oncological team. Diagnosis of colorectal cancer during pregnancy is usually made at an advanced stage due to unspecific symptoms. Prognosis for pregnant women with advanced colorectal cancer is serious.

EP/G – 45

AN AUDIT TO ASSESS THE QUALITY OF OPERATIVE NOTES IN A NATIONAL HOSPITAL IN SRI LANKA

Sumithraarachichi, LD[1], De Silva DYK[1], Mahdoom, BWMA[1], Fernando, MUM[1], Wijethunga, WMKM[1],
[1] National Hospital, Kandy, Sri Lanka.

Introduction

Operative notes indicate what happened during the surgery and provides guidance on what to do and expect in the post operative period. The quality of an operative note directly affects patient safety and the standard of care provided whilst aiding in the defense of medicolegal inquiries.

Objectives

To assess the quality of current operative note writing practice by identifying the presence of mandatory components against the standards set by the Royal college of surgeons (RCS) of England. To identify the missing components in operative notes and to plan a reaudit to assess improvement following intervention.

Design and methods

A retrospective audit was carried out using bed head tickets of all patients who underwent major surgeries in June 2024, in a gynaecology unit in a National hospital in Sri Lanka, which included a sample size of 39. An assessment was carried out against 21 standards stipulated by RCS.

Results

Out of the 39 surgeries, 21 were laparoscopic, 12 were open and 6 were combined surgeries. All operative notes were hand written. Patient identification details, date of surgery, name of operating surgeon and assistant, operative procedure carried out, operative findings, operative diagnosis, details of tissues removed, added or altered, details of closure technique, antibiotic prophylaxis, postoperative care instructions, signature and legibility were met to a 100% standard. Unfortunately, whether the procedure was an elective or emergency, name of the anaesthetist, anticipated blood loss and DVT prophylaxis was not documented in any of the notes. The incision was mentioned in 84.6% (n=33) while any extra procedures performed were mentioned in 46% (n=18). Problems or complications were mentioned in only 15.4% (n=6) and the time of the surgery was only documented in 7.7% (n=3) of the notes. Prostheses were not used in any of the surgeries that were performed.

Conclusion

57.1% of the RCS standards were met completely. However, 19% of the components were not documented in any of the notes. As proper documentation is essential in post operative care of patients as well as in the defense of a surgeon in a medicolegal inquiry, educating all doctors of the unit on the standards of operative note writing was deemed mandatory. As such a reaudit will be done once an education program is held.

EP/G – 46

POSTPARTUM CEREBRAL VENOUS SINUS THROMBOSIS (CVST) FOLLOWING OBSTETRIC NEURAXIAL BLOCKADE: A CASE REPORT

Jey Krishna K[1] Thirukumar M[2] Karunakaran KE[2] Rathnasekara WADAK[1] Abhiramy V[2] Premarathna HRSDB
[1]Teaching Hospital Batticaloa
[2]Faculty of Health Care Sciences, EUSL
[3]German Sri Lanka Friendship Hospital for Women, Galle

Background

CVST is a rare complication of pregnancy and the puerperium, with an incidence of 1:10,000 to 1:45,000. CVST risk is elevated in the first 6 weeks postpartum, often presenting as a nonspecific headache. Distinguishing CVST from post-dural-puncture headache (PDPH) can be challenging, particularly in patients who received neuraxial anesthesia. This case study reports a woman diagnosed with CVST on the 16th postpartum day following an emergency caesarean section (EM/CS), who was successfully treated with anticoagulants.

Case Description

A 26-year-old woman, 16 days postpartum, presented to the emergency department with severe headache and confusion. Upon admission she experienced a generalized seizure and had blood pressure measuring 180/100 mmHg. Initially diagnosed with eclampsia, she was treated with magnesium sulfate and hydralazine. No focal neurological deficits were noted, reflexes were normal, and fundoscopy revealed no papilledema. Blood investigations showed a normal complete blood count (hemoglobin 11.5 g/dL) and normal renal, hepatic, and coagulation profiles. Seventeen days prior, she(G1P1) had undergone an EM/CS indicated by fetal distress. Her pregnancy and immediate postpartum period were uneventful, leading to discharge on postoperative day 2. Her venous thromboembolism (VTE) score was 3 postnatally. Given the persistent severe headache and a second seizure episode, urgent CT brain & venography were performed revealing superior sagittal and transverse sinus thrombosis but no venous infarction. Upon multi-disciplinary team (MDT) decision therapeutic dose of low-molecular-weight-heparin (LMWH) was commenced. The symptoms improved over the next few days, and follow-up CT venography showed no evidence of filling defects in cortical or dural venous sinuses.

Discussion

CVST can be overlooked in women who present with headache following neuraxial block. Key distinguishing features CVST from PDPH are a change in headache character with loss of postural element, and focal neurological signs. This case highlights the diagnostic challenge, where elevated blood pressure initially led to an eclampsia diagnosis. As her postnatal VTE score was > 2 on discharge she should have been given thromboprophylaxis for at least 10 days.

Conclusion

Postpartum seizures require thorough evaluation to avoid delays in diagnosis. CVST, if undiagnosed, can be life-threatening, but timely recognition and early anticoagulant therapy

result in favorable outcomes. An MDT approach ensures effective treatment and recovery without mortality or residual weakness. Every woman should be assessed for VTE risk at discharge and treated accordingly.

EP/G – 47
BILATERAL OVARIAN DERMOID CYSTS IN PREGNANCY: A CASE REPORT

Dayaratna.O ,1 Somirathne.D2, Gunasekara T3
[1].Medical officer B.H.Walasmulla
[2].Consultant Obstetrician &Gynaecologist
[3.] Medical officer B.H.Walasmulla

Objectives
To evaluate the clinical presentation, diagnosis and management of ovarian dermoid cysts in pregnancy. To evaluate the complications of dermoid cysts in pregnancy and its effects on pregnancy outcome

Case Report
A 26 year old primigravida at 37 weeks and 3 days period of gestation presented with a history of fever associated with vomiting and diarrhoea for 2 days, complaining of lower abdominal pain for a few hours. Expedited delivery with lower segment caesarean section was planned due to pathological CTG.A live non-asphyxiated baby was delivered following routine steps of lower segment caesarean section. On examination of ovaries; bilateral dermoid cysts were noted (left- 5X4cm, right- 4X4cm). Bilateral ovarian cystectomy was done and remaining ovarian tissue was preserved. Routine closure was done after achieving complete haemostasis. Grossly the diagnosis of dermoid cysts was confirmed due to a presence of hair and sebum within the thick walled cyst and samples were sent for histopathological evaluation. Post-operative recovery of patient was uneventful.

Discussion
Adnexal masses are diagnosed at a rate of 2-20 per 1000 pregnancies out of which dermoid cysts account for 32% (18%-50%) [1]. There are a number of guidelines regarding management of ovarian cysts in non-pregnant patients, however the management of ovarian cysts including dermoid cysts in pregnancy remains largely unexplored. Dermoid cysts account for 70% of benign ovarian tumours in premenopausal women[2-4] and are largely asymptomatic unless complicated with torsion, perforation or infection[5-7]. Incidental diagnosis of adnexal masses are common due to the widespread use of ultrasonography during pregnancy[8]. Dermoid cysts have a characteristic appearance of a hyper-echoic mass (dermoid plug)[8,9].Conservative management is offered for cysts measuring < 5cm in size[5], while surgical intervention is considered for ovarian cysts measuring >5cm due to risk of complications[8]. In non-urgent cases laparoscopic cystectomy is planned during the second trimester. Laparoscopic approach has not been associated with adverse pregnancy outcome when compared to open surgery[10,11]. The presence of an ovarian cyst alone does not warrant a caesarean delivery in the absence of an obstetric indication, however in the event of an emergency caesarean delivery a cystectomy or oophorectomy should be performed.

Conclusion
The management of dermoid cysts in pregnancy must be decided after careful risk-benefit analysis based on size of cyst and period of gestation. Antepartum surgery is not known to have significant adverse pregnancy outcome, but surgery may be postponed till after delivery in low risk cases.

EP/G – 48
PERI-PUBERTAL MENORRHAGIA AND MULTIPLE SOMATIC COMPLAINTS: IS IT ATTENTION DEFICIT HYPERACTIVITY DISORDER?

Vidyathilaka, LP[1], Manage, N[1], Perera, MANAP[1], Hettipathirana, PS[1,2], Chandradasa, M[1]
[1]Colombo North Teaching Hospital, Sri Lanka
[2]Faculty of Medicine, University of Kelaniya, SriLanka

Objectives
Attention Deficit Hyperactivity Disorder (ADHD) is a common neurodevelopmental disorder with interesting presentations. Concurrent menorrhagia poses a management challenge due to limitations in treatment options. We discuss a teenager who presented with menorrhagia and was incidentally diagnosed with ADHD.

Case report
A 15 year old girl having menorrhagia for six months was referred to psychiatry services due to multiple body aches, lack of interest in school work and easy irritability when pressed to study. She had poor appetite, erratic sleep and excessive indulgence on tiktok around the same period. She had frequent arguments with her siblings. The haematological parameters and ultrasound scan findings were normal (Hb 12g/dl and serum TSH 1.7 mmol/L, uterus and ovaries of normal size, thin endometrium and no adnexal masses. Parents reported difficulty in focusing on studies, exam preparation only at the spur of the moment and active sports as opposed to seated work. She had an athletic build, was less expressive and had good eye contact during the interview. She spoke few details and had a mildly depressed mood. From gynaecology she was managed on tranexemic acid 500mg tds and mefenemic acid 500mg tds during menstruation for three months. From psychiatry she was diagnosed to have ADHD with a comorbid depressive adjustment reaction and was managed on risperidone 0.5mg nocte. Psychoeducation and information on behaviour therapy and emphasized the need to follow up for the family.

Discussion
Despite good intelligence, unmanaged inattentive symptoms of ADHD pose long term risks of poor school performance and sibling rivalry. Menorrhagia can be a very individualised perspective and needs objective evaluation in a teenager who is already inattentive. ADHD with concurrent menorrhagia poor menstrual hygiene due to inattention, mood swings and pain syndromes due to emotional dysregulation add to the disease burden. Risks of menorrhagia with methylphenidate and worsening of abdominal cramps with atomoxetine pose treatment limitations.

Conclusion
Good intelligence, denial by the parents, and frequent novelty seeking to curb boredom pose difficulties in ADHD management in the adolescent age group. Vigilance, dismantling cognitive biases, timely referral, and regular follow up will lead to improved quality of life in teenagers and youth, a message to all adults.

EP/G – 49
HETEROTROPHIC INTERSTITIAL PREGNANCY: A RARE CASE REPORT WITH SUCCESSFUL OUTCOME

Rathigashini, R[1], De Silva, A[2], Herath, RP[2]
[1]Base Hospital, Mirigama, Sri Lanka
[2]Univeristy Obstetrics & Gynecology Unit, North Colombo Teaching Hospital, Ragama, Sri Lanka

Background
Heterotrophic pregnancy is a rare pregnancy complication after natural conception with an incidence of 1 in 30,000 pregnancies. Out of which interstitial heterotrophic pregnancy are extremely rare with less than 100 cases published in literature. We report a interstitial heterotrophic pregnancy, following a natural conception, which ended up in good fetal and maternal outcome.

Case Report
A 31-year-old woman in her second pregnancy presented at 7 weeks of gestation with lower abdominal pain with positive pregnancy test. Her first pregnancy was a tubal ectopic pregnancy and had undergone right salpingectomy. Ultrasound revealed heterotrophic pregnancy with free fluid in the pelvis. Patient had tachycardia of 100 b/min with blood pressure of 100/70mmHg. She underwent laparoscopy and found to have a right interstitial ectopic pregnancy with hemoperitoneum of 1000ml. Laparoscopy converted to laparotomy in view of resection of interstitial ectopic pregnancy without disturbing the live intrauterine pregnancy. Right interstitial ectopic pregnancy resected and the uterus was repaired in two layers with No 1 Polyglactin suture. Postoperatively she recovered well and viable intrauterine pregnancy noted. Her early pregnancy was supported with injectable and vaginal progestogen. Routine antenatal care given with ultrasound monitoring for possibility of uterine dehiscence due to weak scar. Ultrasound scan done at 20 weeks revealed uniform myometrium without any thinning of the myometrium, where the resection was done. Her antenatal period was uneventful. Elective caesarean section was carried out after administration of corticosteroids at 37 weeks of gestation. Postpartum was uneventful and the patient was discharged on day two.

Discussion
Heterotrophic interstitial pregnancy is extremely rare and carries diagnostic and therapeutic challenges. Ultrasound features such as Intrauterine pregnancy with co-existing ectopic pregnancy would support the diagnosis of heterotrophic pregnancy. However, interstitial heterotopic pregnancy is diagnosed during laparoscopy/laparotomy. There should be high suspicion in assisted reproductive tecghnology (ART). However, Heterotrophic interstitial pregnancy after natural conception like in our case may present after rupture with symptoms.

Management includes watchful waiting; medical and surgical management depends on clinical presentation and medical experience. In our case surgery was the only option due to ruptured pregnancy and laparotomy was carried to achieve a proper repair. The outcome of intrauterine pregnancy is generally good and caesarean section is recommended to prevent rupture.

Conclusion
Early correct diagnosis, Proper imaging, and planned surgery are important to provide better outcomes in heterotrophic interstitial pregnancy.

EP/G – 50
MANAGEMENT OF OVARIAN GERM CELL TUMOURS WITH CHEMOTHERAPY INDUCED LUNG TOXICITY

Kishokumar, T[1], Hapuachchige, C[1], Dissanayake, DMC[1], Visagan, S[1], Rathnayake, RMSK[1]
[1] National Cancer Institute (Apeksha Hospital), Maharagama, Sri Lanka.

Introduction
Yolk sac tumors, a type of ovarian germ cell tumor, present in early life with markedly elevated AFP levels. Treatment involves surgery and chemotherapy. The recommended chemotherapy regimen is a six-cycle combination of Bleomycin, Etoposide, and Cisplatin (BEP). However, the use of Bleomycin can cause serious lung injury, with mortality rates of 10–20% in affected patients. Symptoms of Bleomycin- induced lung injury include exertional dyspnea, cough, tachypnea, and cyanosis.

Case report
24–year-old lady who is a mother of one, had a history of constipation and backache for 2 weeks duration and was investigated. On abdominal examination, there was no palpable mass. On bimanual pelvic examination there was a large, hard and irregular fixed mass in POD. Ultrasound scan abdomen and pelvis showed an irregular heterogenous POD mass 6 × 8.8 cm in size. She had markedly elevated AFP (6910 ng/ml), slightly elevated LDH (534u/l), and CA 125 (63.4u/ml) with normal beta hCG and CEA. CECT Chest, Abdomen, and Pelvis showed large, irregular, heterogenous mass in POD with lung and liver metastasis. EUA and Excisional Biopsy were done. Histology stated Yolk sac tumour with a glandular variant and Immunohistochemistry showed strongly positive for CD 117. 4 cycles of chemotherapy with Bleomycin, Etoposide, and Cisplatin were arranged. Prior to chemotherapy normal baseline lung function test and DLCO were confirmed. At the end of 4 cycles, the patient had shortness of breath at rest, exertional dyspnoea, and dry cough for 2 weeks duration. Lung function tests showed a severe restricted pattern and HRCT scan suggested nonspecific interstitial pneumonia. It was conclude symptoms were due to Bleomycin induced lung toxicity. So further cycles of chemotherapy were withheld and planned for surgery. Repeat CECT Chest, Abdomen and Pelvis after chemotherapy suggested significant reduction in tumour with good response to chemotherapy. Therefore interval debulking laparotomy was planned. During pre-op anaesthetist assessment, it was planned give spinal anaesthesia instead of general anaesthesia. Since tumour was located in mid-vagina, modified radical hysterectomy with bilateral salpingo-oophorectomy, omentectomy and dissection of recto-vaginal septal deposits were performed and complete cytoreduction was achieved.

Discussion

Bleomycin is linked to potential pulmonary toxicity, including pneumonitis, pulmonary fibrosis, and fatal acute respiratory distress syndrome. Oxygen administration can exacerbate this toxicity, particularly during general anesthesia. Risk factors for Bleomycin-induced lung damage include high total Bleomycin dose, impaired renal function, smoking, advanced tumor stage, and older age. Mechanisms of damage may involve oxidative damage, genetic enzyme deficiency, and release of inflammatory cytokines. Lower preoperative FVC and pre-existing pulmonary damage due to Bleomycin increase the chances of postoperative pulmonary morbidity. Patients with established interstitial pneumonia face increased risk of pulmonary complications during major surgery. Lower FVC and pre-existing Bleomycin- induced lung damage are considered predictors of post-operative lung morbidity and are used to determine the mode of anesthesia.

Conclusion

The patient received spinal anesthesia before lengthy surgery to reduce the risk of excessive oxygen exposure during general anesthesia. Extensive pre-operative evaluation, including CECT Chest Abdomen and Pelvis and lung function tests, was conducted to assess anesthesia suitability. Post-operative care involved preferring colloids over crystalloids, restrictive fluid strategies, and use of spinal anesthesia to avoid lung ventilation and reduce pulmonary toxicity risk.

PROF SIR SABARATHNAM ARULKUMARAN YOUNG GYNAECOLOGIST AWARD – 2024

YGA - 01
EFFICACY, SAFETY AND MATERNAL ACCEPTABILITY OF MEMBRANE SWEEP VS CERVICAL MASSAGE AS ADJUNCTS TO PREVENT FORMAL INDUCTION: A RANDOMIZED CONTROLLED TRIAL

Madugalle T.M.S.S.B [1], Jayawardane I.A [2], Jayasundara D.M.C.S [3]
[1]Senior registrar in Obstetrics and Gynaecology, National Hospital Kandy,
[2]Senior Lecturer and Honorary Consultant Obstetrician and Gynaecologist,
Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo,
[3]Senior Lecturer and Honorary Consultant Obstetrician and Gynaecologist, Department of Obstetrics and Gynecology, Faculty of Medicine, University of Colombo

Introduction
Compared to spontaneous onset, labour induction carries a higher resource requirement,higher cost, lower maternal satisfaction rates, and higher labour complications. Prolonged pregnancy and post maturity is associated with higher emergency caesarean delivery rates, perinatal morbidity, mortality and maternal anxiety making labour induction necessary. Our hospital induction protocol recommends formal induction at 41 weeks of gestation in uncomplicated pregnancies to prevent post-term unless spontaneous labour sets in. Any intervention aimed at maximizing spontaneous onset of labour, thereby preventing formal induction, will be beneficial to the client and welcome by the provider.

Objectives
To determine efficacy, safety and maternal acceptability of membrane sweep and cervicalmassage when used as an adjunct to the induction of labour process to prevent formal induction (interventions) compared to a non-sweep/massage vaginal examination (control).

Methods
We recruited and randomized 312 singleton uncomplicated pregnancies at 38 weeks of gestation into membrane sweep (MS), cervical massage (CM) and sham sweep (control) groups. Each intervention was administered at 39 weeks and repeated at 40 weeks of gestation if spontaneous labour didn't follow. Spontaneous labour was defined as Modified Bishop's Score of 7 or more. (Sri Lanka clinical trials registry - SLCTR/2020/003)

Results
Membrane sweep significantly reduced the need for formal induction of labour while cervical massage did not (MS vs C- RR – 1.4195, 95% CI 1.0326 – 1.9513, p – 0.0310), (MS vs C - OR 1.8739, 95% CI – 1.0664 – 3.2927, p – 0.0290, Number Needed to Treat =7), (CM vs C – RR – 1.2043, 95% CI – 0.8598 – 1.6867, p – 0.2795). "Survival without spontaneous labour" was significantly lower after membrane sweep compared to controls overall (MS vs C – p - 0.007,

CM vs C – p – 0.261), among primiparous (MS vs C – p – 0.047, CM vs C – p – 0.269), and multiparous (MS vs C – p – 0.038, CM vs C - p – 0.456) women. Membrane sweep and cervical massage were safe in terms of feto-maternal complications and both significantly reduced duration of hospital stay among multiparous women (MS vs C - p - <0.0001, 95% CI – 0.5293 – 1.1791, CM vs C – p - <0.0001, 95% CI – 0.6816 – 1.3552). There was no increase in risks of emergency cesarean delivery, oxytocin augmentation, uterine hyperstimulation, postpartum bleeding, maternal pyrexia, Apgar score <7 at 5 minutes (p > 0.05). Membrane sweep was significantly less acceptable compared to cervical massage regardless of party (MS vs C Primi – p – 0001, Multi p – 0.0216).

YGA - 02
DESCRIPTIVE STUDY - ASSESSING THE FACTORS CONTRIBUTING TO CAESAREAN DELIVERY ON MATERNAL REQUEST IN A SRI LANKAN SETTING

Fonseka, NA[1], Karunarathne M[2], Illangakoon R[3]
[1]Senior registrar in Obstetrics and Gynaecology, Colombo North Teaching Hospital, Sri Lanka
[2]Consultant Obstetrician and Gynaecologist, Sri Jayewardenepura General Hospital, Sri Lanka
[3]Medical Officer, Sri Jayewardenepura General Hospital, Sri Lanka

Introduction
The rate of caesarean deliveries (CD) in Sri Lanka is steadily increasing, reaching 43.1% in 2021 according to the Family Health Bureau, Sri Lanka. CD adversely affects the immediate and long- term maternal and neonatal well-being and poses a significant burden on health economics. Cesarean delivery on maternal request (CDMR) is a modifiable contributor to the increase in CD rates. This study aims to identify the factors contributing to CDMR in the Sri Lankan setting.

Objective
To identify the factors contributing to CDMR.

Design
A descriptive research method was used.

Method
The study was conducted at Sri Jayewardenepura General Hospital, a semi-government hospital in Sri Lanka. Data were collected prospectively from 01.10.2021 to 30.07.2022 in both general and paying wards. Ethical approval was obtained from the relevant authorities. Expectant mothers admitted for elective delivery who requested CD in the absence of maternal and fetal indications were selected for the study. Expectant mothers with contraindications for vaginal delivery (VD), breech presentation, and multiple pregnancies were excluded. The sample size was calculated using the formula N=4pq/d^2 (p=95%). The final sample size was 115. Simple random sampling was used. Expectant mothers selected for the study were given

questionnaires in Sinhala and English, and data were collected by the chief author and co-author using Google Forms.

Results
A total of 115 cases were analyzed. The leading reasons for requesting CD included fear of pain (20, 17.4%), history of subfertility (16, 13.9%), fear of tears/episiotomy (14, 12.1%), underlying medical conditions not contraindicated for VD (13, 11.3%), vaginismus (10, 8.6%), simultaneous female sterilization (7, 6.1%), having health insurance (7, 6.1%), timing of delivery (6, 5.2%), and advanced maternal age (5, 4.3%). The reasons for CDMR varied based on parity, with nulliparous women citing fear of pain, history of subfertility, fear of tears/episiotomy, and vaginismus, while multiparous women mentioned simultaneous female sterilization, previous bad experiences, and fear of subsequent sexual dysfunction.

Conclusion
Lack of knowledge about normal labor, pain management options, perineal care, and long-acting reversible contraception are major contributors to CDMR. Socioeconomic factors such as timing of delivery and insurance policies also influence decision-making for CDMR.

Keywords
maternal request on caesarean delivery, MRCD, requested caesarean delivery.

YGA – 03
HYPOTHYROIDISM AND THYROID PEROXIDASE ANTIBODIES IN PREGNANCY AND ASSOCIATED PREGNANCY OUTCOMES: A COHORT STUDY

Lasanthinie, DDM[1], Dilrangi WHH[1], Vivekanantharajah, KS[1], Karunanayake, V[1], Athukorala, DPR[1], Goonewardene, M[2], Marleen, FS[1]
[1] Obstetrics and Gynaecology Unit, Ward 09, Sri Jayewardenepura General Hospital, Nugegoda, Sri Lanka.
[2] Department of Obstetrics and Gynaecology, Faculty of Medicine, Sabaragamuwa University of Sri Lanka.

Objectives
Thyroid dysfunction during pregnancy can have significant implications for maternal and fetal health. This study aimed to assess the rate of thyroid hypofunction disorders and thyroid peroxidase (TPO) antibody positivity in pregnant women at a tertiary care hospital in Sri Lanka and examine their association with adverse pregnancy outcomes.

Method
This prospective cohort study was conducted at Sri Jayewardenepura General Hospital from November 2021 to October 2023. The study included all consented, consecutively enrolled pregnant women without any history or current diagnosis of thyroid disorder and with a gestational age of less than 20 weeks. Thyroid function was assessed using TSH and free

thyroxine (FT4) levels, along with TPO antibody status, at the booking visit, and the participants were followed up until delivery. Adverse pregnancy outcomes, including miscarriage, hypertensive disorders, hyperglycemia, placenta praevia, preterm birth, preterm prelabour rupture of membranes, 5 minutes APGAR score <7 at birth, and birth weight <2.5kg, were recorded.

Results

A total of 440 pregnant women participated in the study, with a mean age of 29 years and a mean gestational age of 11 weeks at recruitment. The rate of euthyroidism was 89.3%, subclinical hypothyroidism 7.2%, overt hypothyroidism 0.3%, and hyperthyroidism 3.3%. There were no cases of isolated hypothyroxinaemia. TPO antibody positivity was observed in 23.6% of the participants. The prevalent adverse pregnancy outcomes included miscarriage (5.0%), hypertensive disorders (5.6%), hyperglycemia (23.7%), preterm birth (6.9%), and low birth weight (14.0%). Statistically, there were no significant differences in adverse pregnancy outcomes between TPO antibody-positive and negative euthyroid and subclinical hypothyroid pregnant women. TPO antibody positivity did not demonstrate significant predictive capability for any adverse pregnancy outcomes studied. Subclinical hypothyroidism was found to be significantly associated with hyperglycemia during pregnancy compared to euthyroidism (p=0.030).

Conclusion

This study provides valuable insights into the increasing occurrence of minor thyroid dysfunction in pregnant women in Sri Lanka. Given the well-established risks associated with hyperglycemia in pregnancy for both the mother and the fetus, further evaluation of the statistically significant heightened risk of hyperglycemia in pregnancy among those with subclinical hypothyroidism is warranted. The relatively limited sample size from a single geographic region raises questions about the generalisability of the study findings to the broader Sri Lankan population. Therefore, larger-scale, multicenter studies are needed to formulate universal guidance for routine thyroid screening in early pregnancy.

YGA - 04
THE USEFULNESS OF THE WHO C- MODEL TO OPTIMIZE THE CAESAREAN DELIVERY RATE IN A TERTIARY CARE HOSPITAL SETTING IN SRI LANKA

S S Pinnaduwa [1] S Jayasundara [1] W Abeykoon [1]
[1] Department of Obstetrics and Gynecology, National Hospital Kady

Introduction

Globally, there has been a noticeable rise in the number of caesarean deliveries. The optimal rate for caesarean delivery (CD) remains a subject of ongoing debate. The World Health Organization (WHO) has developed the C-Model, a mathematical tool designed to generate a personalized expected CD rate for health facilities, tailored to maternal characteristics. The C-Model provides a customized benchmark for CD rates within health facilities, aiming to enhance obstetric and perinatal outcomes rather than establishing a fixed CD rate.

Objective
To compare WHO C- Model derived CD rates with actual CD rate at a Tertiary care hospital setting in Sri Lanka.

Method
A prospective predictive validity study was conducted between July 2021 and October 2021 in antenatal ward at the National Hospital Kandy. Clinical and obstetric data were collected over a four-month period from 550 antenatal mothers using a questionnaire, and the probability of CD was calculated for each participant using the WHO e- calculator. Comparisons were made for the entire cohort and for each Robson Classification group to determine whether there was 'under' or 'over usage' of CD based on the C-Model estimates. Data analysis was performed using SPSS to evaluate the accuracy of the C-Model predictions and identify any discrepancies in CD usage.

Results
In the study sample,80.4% of total participants belonged to the low-risk Robson groups (Group1-5), with Group 3 having the highest representation of 18.2%, followed by Group 5A 13.6%, and Group 4A 12.4%. Conversely, only 19.6% were classified within the high-risk Robson groups (Group 6- 10). The majority of cesarean deliveries were elective (70.5%) compared to emergency procedures (29.5%). The actual cesarean delivery rate was 46.9%, compared to the C-Model predicted rate of 36.2%, resulting in a deviation of 10.7% and accounting for 64 additional Cesarean deliveries. Moreover, Who C-Model demonstrated a moderate sensitivity of 75.2% and high specificity of 98.3%, indicating a strong predictive capability. The Area Under the Curve (AUC) was 0.927, with a standard error of 0.012 and a p-value & lt; 0.0001(CI:0.903 to 0.950), indicating a good discriminatory capacity. Furthermore, the model demonstrates varying levels of performance across different Robson groups, with particularly a high accuracy in Groups 5B (AUC=0.913), 8B(AUC=0.931), 9A(AUC=0.901), and 10B (AUC=0.899).

Conclusion
The C-Model demonstrated high predictive accuracy for the mode of delivery, highlighting its significance as a reliable tool for clinicians to make informed decisions about delivery methods.

Key words
Caesarean delivery rates, WHO C-Model, Sri Lanka, predicting CD rates, Rates according to Robson groups

YGA - 05

COMPARING OUTCOMES IN WOMEN WITH GESTATIONAL DIABETES USING A SMART PHONE APPLICATION

Somirathne, D[1], Bolton, E [2]
[1]PHO Maternity unit Bundaberg Base Hospital
[2]Staff specialist Bundaberg Hospital

Introduction

There has been a recent trend of using mobile applications with the aim to improve care for women with gestational diabetes (GDM). Limited studies regarding this have not clearly shown any benefits.

Objectives

The aim of the study is to assess if there is a difference in maternal and neonatal outcomes before and after introducing the app.

Methods

A retrospective cohort study was conducted of women with GDM managed by a Queensland regional unit between January 2021 and June 2023. The unit transitioned from paper based (PB log)blood glucose (BGL) monitoring to smart phone application (SPA) based BGL monitoring in October 2021. 124 women managed with PB logs were compared to 161 women managed with SPA (N=285). Primary outcomes were maternal weight gain, number of appointments, birth weight, APGAR score and gestational age at delivery. Secondary outcomes were mode of delivery, shoulder dystocia and perineal tears events. All outcomes were analysed as subgroups depending on the treatment (diet, metformin, insulin, metformin +insulin).

Results

Maternal demographics were similar in both groups. In women treated with metformin and insulin, the number of appointments were significantly less in the SPA based monitoring groups compared to PB groups ($p=0.023$, $p=0.0013$ respectively). No significant differences were showed in other outcomes among all treatment groups, irrespective of BGL monitoring method.

Discussion

Benefit was shown from using a SPA for BGL monitoring, by reducing the number of antenatal appointments, without compromising health outcomes for mothers or neonates. This is a feasible option for units experiencing pressure on availability of antenatal appointments.